SCRUTINY

Epping Forest District Council

Overview and Scrutiny Committee
Tuesday, 9th June, 2015

Place:	Council Chamber, Civic Offices, High Street, Epping
Room:	Council Chamber
Time:	7.30 pm
Democratic Services Officer:	Stephen Tautz, Democratic Services Manager, Directorate of Governance email:democraticservices@eppingforestdc.gov.uk Tel: 01992 564249

Members:

As appointed at the Annual Council Meeting on 28 May 2015.

PLEASE NOTE THAT THERE WILL BE A SHORT PRE-MEETING FOR ALL MEMBERS OF THE COMMITTEE STARTING AT 7pm IN COMMITTEE ROOM 2, SO THAT THEY CAN DISCUSS THEIR LINE OF QUESTIONING FOR THE PRESENTATION.

PLEASE NOTE THAT THIS MEETING IS OPEN TO ALL MEMBERS TO ATTEND

1. WEBCASTING INTRODUCTION

1. This meeting is to be webcast. Members are reminded of the need to activate their microphones before speaking.

2. The Chairman will read the following announcement:

"This meeting will be webcast live to the Internet and will be archived for later viewing. Copies of recordings may be made available on request.

By entering the chamber's lower seating area you consenting to becoming part of the webcast.

If you wish to avoid being filmed you should move to the public gallery or speak to the webcasting officer"

2. APOLOGIES FOR ABSENCE

3. SUBSTITUTE MEMBERS

(Director of Governance). To report the appointment of any substitute members for the meeting.

4. MINUTES (Pages 9 - 32)

Decisions required:

To confirm the minutes of the meetings of the Committee held on 27 April 2015.

5. DECLARATIONS OF INTEREST

(Director of Governance). To declare interests in any items on the agenda.

In considering whether to declare a personal or a prejudicial interest under the Code of Conduct, Overview & Scrutiny members are asked pay particular attention to paragraph 11 of the Code in addition to the more familiar requirements.

This requires the declaration of a personal and prejudicial interest in any matter before an OS Committee which relates to a decision of or action by another Committee or Sub Committee of the Council, a Joint Committee or Joint Sub Committee in which the Council is involved and of which the Councillor is also a member.

Paragraph 11 does not refer to Cabinet decisions or attendance at an OS meeting purely for the purpose of answering questions or providing information on such a matter.

6. BARTS HEALTH NHS TRUST - WHIPPS CROSS UNIVERSITY HOSPITAL (Pages 33 - 180)

Whipps Cross University Hospital provides a range of general inpatient, outpatient and other medical and emergency services to a significant part of the population of the Epping Forest District. The Committee has been extremely worried to read the recent report of the Care Quality Commission (CQC) on its 'inadequate' judgement of the quality of care at Whipps Cross Hospital, particularly in terms of the implications of the findings of the Commission for the healthcare requirements of the Council's residents. A copy of the report of the CQC is attached as an appendix to this report.

Lyn Hill-Tout, the Interim Managing Director of Whipps Cross and Dr. Mike Roberts, the interim Medical Director at the hospital, will be attending the meeting to report to members in connection with Barts Health NHS Trust's detailed plans for improvement in the areas of concern identified by the CQC. Jo Carter, the Trust's Stakeholder Relations Manager, will also be in attendance.

Essex County Council has delegated its health scrutiny powers in the south of the county to the Outer North East London Joint Health Overview and Scrutiny Committee (HOSC). The County Council nominates one member to this body (Councillor Chris Pond) and this Council is able to also nominate one member representative to the HOSC, although this position hasn't been appointed to in recent years. At the request

of the Committee at its last meeting, a new member appointment was considered at the recent annual Council meeting.

Barts Health NHS Trust has indicated that it will provide its key local authority partners (including this Council and Waltham Forest and Redbridge London Borough Councils) with a regular report on the progress of its improvement plan for Whipps Cross Hospital. This will be published in the Council Bulletin.

7. SCRUTINY PANEL MINUTES (Pages 181 - 228)

RECOMMENDATION:

To agree the last minutes of the last five Scrutiny Panel meetings.

As the five Scrutiny Panels have now been disbanded and replaced by four Select Committees, the notes of their last meetings are in need of being agreed.

To this end the last minutes of the Housing Scrutiny Panel (24 March 2015); the Constitution and Member Services Scrutiny Panel (3 March and 17 March 2015 (reconvened meeting)); the Finance and Performance Management Scrutiny Panel (10 March 2015); the Safer Cleaner Greener Scrutiny Panel (28 April 2015); and the Planning Services Scrutiny Panel (14 April 2015) are attached to this agenda for agreement by their parent Committee.

8. REVIEW OF CABINET FORWARD PLAN (Pages 229 - 236)

(Leader) To review the Cabinet's Key Objectives and Forward Plan for the coming year.

9. CORPORATE PLAN KEY OBJECTIVES 2014/15 - OUTTURN (Pages 237 - 266)

(Director of Governance) To consider the attached report.

10. APPOINTMENT OF MEMBERSHIP TO SELECT COMMITTEES

Decision Required:

(1) To appoint members to the following Select Committees in accordance with pro-rata in the proportions shown below (**full name list to follow**):

Select Committee	Appointment to places required:
Governance Select Committee	Cons (7): Lib Dem (1): LRA (2): Other (1):
Housing Select Committee	Cons (7): Lib Dem (1): LRA (2): Other (1):

Neighbourhoods & Community Services Select Committee	Cons (7): Lib Dem (1): LRA (2): Other (1):
Resources Select Committee	Cons (7): Lib Dem (1): LRA (2): Other (1):

(2) To consider requests for appointments to Select Committees by non affiliated members; and

(3) To appoint a Chairman and a Vice Chairman to the following Select Committees:

Select Committee	Appointments Required:
Governance	Chairman: Vice Chairman:
Housing	Chairman: Vive Chairman:
Neighbourhoods & Community Services	Chairman: Vice Chairman:
Resources	Chairman: Vice Chairman:

1. (Director of Governance). The Council has agreed that pro rata apply to Overview and Scrutiny Select Committees only. The Overview and Scrutiny rules provide that the memberships must reflect pro rata requirements and the lowest number of members required to achieve cross-party representation whilst allowing the inclusion of members who are not members of a political group or are not members of the Overview and Scrutiny Committee. This year it has been agreed by Group Leaders that the Select Committees should have 11 members.

2. The Committee are asked to make appointments to Select Committees in accordance with the Overview and Scrutiny Procedure rules.

3. Nominations to Chairman and Vice Chairman of these Select Committees are excluded from the calculation required under the Council's protocol regarding allocation of Chairman and Vice-Chairman positions between the political groups.

4. Nominations to the Select Committees, which may be submitted up until the day of the meeting, were sought through officer liaison with the Group Leaders and via the Appointments Panel. A list of any further nominations will be tabled at the meeting.

11. APPOINTMENT OF OVERVIEW AND SCRUTINY TASK AND FINISH PANELS (Pages 267 - 268)

Recommendation:

(1) To appoint members to the two existing Task and Finish Panels; and

(2) To agree the Terms of Reference for the Youth Engagement Review Task and Finish Panel

1. (Director of Governance) Last year this Committee set up two Task and Finish Panels, the Grant Aid Review Task and Finish Panel and the Youth Engagement Review Task and Finish Panel.

2. The Terms of Reference for the Youth Engagement Review Task and Finish Panel is attached and will need to be agreed by the Committee.

3. This Committee had also requested that the membership of these Panels be kept into the new year.

Last Years Grant Aid Review Task and Finish Panels consisted of:

Caroline Pond (Chairman) (LRA);
J Knapman (Vice Chairman) (Con);
T Boyce (Con);
A Mitchell (Con);
S Murray (Ind);
G Shiell (Con); and
B Surtees (LibDem)

The Youth Engagement Review Task and Finish Panel consisted of:

S Murray (Chairman) (Ind);
G Mohindra (Vice-Chairman) (Con);
R Butler (UKIP);
C Roberts (LRA);
B Surtees (Lib Dem); and
Plus 1

K Adams - *was not re-elected in May and therefore a vacancy has now arisen on this Panel.*

4. The Overview and Scrutiny Rules state that 'Task and Finish' Scrutiny Panels shall be flexible as to the number of Councillors appointed to membership. There is no restriction on the numbers appointed.

5. Any Councillor may be a member of a 'Task and Finish' Scrutiny Panel, save that a member of the Cabinet may not be a member of any Panel which bears directly on his or her portfolio. Additionally no 'Task and Finish' Scrutiny Panel can be comprised of members of a single political group only.

6. It is a requirement of the procedure rules that a Chairman and Vice - Chairman should be appointed to each Panel.

12. OVERVIEW AND SCRUTINY ANNUAL REPORT 2014/15 (Pages 269 - 328)

(Director of Governance) to consider the attached report.

13. WORK PROGRAMME MONITORING (Pages 329 - 340)

(a) To consider the updated work programme

The current Overview and Scrutiny work programme is attached for information.

(b) Essex County Fire and Rescue Service

Essex County Fire and Rescue Service (ECFRS) has recently attended the Council's Leadership Team in connection with a review of service provision across the county. ECFRS will be developing its proposals over the coming months, with a view to undertaking a public consultation exercise from November 2015 to January 2016, and has expressed a wish to make a presentation to the committee as part of this exercise.

The only meeting of the Committee during the period of the public consultation is on 5 January 2016. As the Epping Forest Youth Council is also due to attend this meeting, the Committee is requested to consider how it wishes to approach these respective presentations.

(c) Reserve Programme

A reserve list of scrutiny topics is required to ensure that the work flow of OSC is continuous.

OSC will 'pull out' items from the list and allocate them accordingly once space becomes available in the work programme following the completion of existing reviews.

Members can put forward any further suggestions for inclusion in the reserve list either during the meeting or at a later date.

Existing review items will be dealt with first, then time will be allocated to the items contained in the reserve work plan.

A blank PICK form is attached for members use.

14. EXCLUSION OF PUBLIC AND PRESS

Exclusion: To consider whether, under Section 100(A)(4) of the Local Government Act 1972, the public and press should be excluded from the meeting for the items of business set out below on grounds that they will involve the likely disclosure of exempt information as defined in the following paragraph(s) of Part 1 of Schedule 12A of the Act (as amended) or are confidential under Section 100(A)(2):

Agenda Item No	Subject	Exempt Information Paragraph Number
Nil	Nil	Nil

The Local Government (Access to Information) (Variation) Order 2006, which came into effect on 1 March 2006, requires the Council to consider whether maintaining the exemption listed above outweighs the potential public interest in disclosing the information. Any member who considers that this test should be applied to any currently exempted matter on this agenda should contact the proper officer at least 24 hours prior to the meeting.

Confidential Items Commencement: Paragraph 9 of the Council Procedure Rules contained in the Constitution require:

(1) All business of the Council requiring to be transacted in the presence of the press and public to be completed by 10.00 p.m. at the latest.

(2) At the time appointed under (1) above, the Chairman shall permit the completion of debate on any item still under consideration, and at his or her discretion, any other remaining business whereupon the Council shall proceed to exclude the public and press.

(3) Any public business remaining to be dealt with shall be deferred until after the completion of the private part of the meeting, including items submitted for report rather than decision.

Background Papers: Paragraph 8 of the Access to Information Procedure Rules of the Constitution define background papers as being documents relating to the subject matter of the report which in the Proper Officer's opinion:

(a) disclose any facts or matters on which the report or an important part of the report is based; and

(b) have been relied on to a material extent in preparing the report and does not include published works or those which disclose exempt or confidential information (as defined in Rule 10) and in respect of executive reports, the advice of any political advisor.

Inspection of background papers may be arranged by contacting the officer responsible for the item.

EPPING FOREST DISTRICT COUNCIL
OVERVIEW AND SCRUTINY MINUTES

Committee:	Overview and Scrutiny Committee	**Date:**	Monday, 27 April 2015
Place:	Council Chamber, Civic Offices, High Street, Epping	**Time:**	7.30 - 9.27 pm
Members Present:	Councillors R Morgan (Chairman, Overview and Scrutiny Committee) (Chairman) K Angold-Stephens (Vice-Chairman) K Chana, T Church, D Dorrell, L Girling, J Knapman, J Lea, A Mitchell MBE, B Rolfe, Mrs M Sartin, Mrs G Shiell, B Surtees and D Wixley		
Other Councillors:	Councillors K Adams, R Bassett, Mrs A Grigg, Mrs H Kane, Ms Y Knight, A Lion, J Philip, C C Pond, Mrs C P Pond, D Stallan, Ms S Stavrou, G Waller, C Whitbread, Mrs J H Whitehouse and J M Whitehouse		
Apologies:	Councillors G Chambers, P Keska, S Murray and A Watts		
Officers Present:	D Macnab (Deputy Chief Executive and Director of Neighbourhoods), K Durrani (Assistant Director (Technical Services)), S G Hill (Assistant Director (Governance & Performance Management)), S Tautz (Democratic Services Manager), T Carne (Public Relations and Marketing Officer), M Jenkins (Democratic Services Assistant) and A Hendry (Democratic Services Officer)		

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71. WEBCASTING INTRODUCTION

The Chairman reminded everyone present that the meeting would be broadcast live to the Internet, and that the Council had adopted a protocol for the webcasting of its meetings.

72. APOLOGIES FOR ABSENCE

It was noted from the Cabinet that Councillor W Breare-Hall had tendered his apologies.

73. SUBSTITUTE MEMBERS

It was noted that Councillor J Knapman was substituting for Councillor P Keska.

74. MINUTES

RESOLVED:

That the minutes of the last Committee meeting held on 23 March 2015 be agreed.

75. DECLARATIONS OF INTEREST

There were no declarations of interest made pursuant to the Member's Code of Conduct.

76. PRESENTATION FROM THE NORTH ESSEX PARKING PARTNERSHIP

The Committee received a presentation from officers of the North Essex Parking Partnership (NEPP), namely Mr R Walker, Parking Partnership Group Manager, Mr M Adamson, Area Manager Western District and Mr M Young, Head of Operational Service.

NEPP officers outlined the background to their organisation:

(a) Essex County Council decriminalised parking functions between 2002-2004, which led to them being policy makers with 12 agencies in districts and boroughs running parking enforcement.

(b) A growing deficit reaching £900,000 across the county led, in 2009, to the County Council ordering district and boroughs to cancel all agencies.

(c) The agencies were replaced by North and South Essex Parking Partnership. The North was responsible for Epping Forest, Harlow, Uttlesford, Braintree, Colchester and Tendering, the South were responsible for Brentwood, Basildon, Chelmsford, Maldon, Rochford and Castle Point.

(d) The strategic priorities for the NEPP were:

(i) Improving safety;

(ii) Improving business opportunities through better parking policies;

(iii) Increasing enforcement to improve availability for Blue Badge holders; and

(iv) Greater environmental efficiency.

(e) The NEPP Business Plan was to improve on efficiency and be financially sustainable. The NEPP had inherited a deficit of £574,301, currently they had a small surplus of £80,000.

Questions from the Committee

Officers had requested questions from District Council members in advance of the meeting, as far as possible, so that NEPP representatives could prepare answers. Member questions were as follows:

(a) Could NEPP wardens take action in cases where vehicles were parked on verges and green areas?

Supplementary Question – If wardens could take action, was this jurisdiction restricted to land administered by Essex County Council, the District Council or even Epping Forest itself?

NEPP representatives replied not yet. The Committee was advised of the Essex Act, peculiar to this county, which allowed for enforcement. In cases where land was owned by an authority, it was advised that legislation should be checked first. Highways owned land required an S50 application for entering the highway to carry out mowing. Each licence needed to be applied for separately, by the authority carrying out the mowing work, and each area needed proof that it was kept in the condition to which the law related. Enforcement could then be carried out by notice. A trial had been carried out in Braintree with successful results.

It was felt that in the medium to longer term, better enforcement could be achieved with this legal mechanism.

(b) Were wardens aware of the different land ownerships involved?

NEPP representatives replied that wardens were aware of different land ownerships.

(c) Could the wardens also take action regarding obstructive parking on pavements or was this solely a matter for the police?

It was advised that unnecessary obstruction of the footway, where there was no other parking restriction, was a matter for the police. Driving on the footway was an offence as was “pavement” parking.

(d) Did the NEPP have comprehensive data on where all yellow lines were, and did the NEPP have a work programme to monitor those lines and re-paint them where necessary?

The NEPP officers confirmed that they did have a comprehensive database. It was advised that there was limited funding to cover maintenance of all lines across NEPP (£150,000 for the whole area) and so maintenance was done by priority. NEPP informed the Committee that lines were made of plastic which bonded with the road surface, it could only be laid during the summer months.

(e) Was NEPP responsible for dealing with requests for yellow lines and with the legal requirements to get them installed?

Supplementary Question - Did it have a record of historical requests for yellow lines and a way of communicating whether or not it intended approving such requests so that Councillors could be kept informed?

NEPP officers replied that either NEPP or ECC could deal with Traffic Regulation Orders depending on what the status of the road was. Safety and congestion schemes would first fall to ECC as were new developments, the rest fell to NEPP.

The NEPP representatives had a list of schemes which had been passed to it, with schemes being progressed by Essex County Council as Area Reviews. It was advised that there was no funding for NEPP, new schemes were scored and given a priority.

(f) Contacting NEPP in the past had not been a satisfactory experience for some residents, please could you comment?

NEPP officers had brought with them copies of a “Who’s Who” of their staff and contact details. Members asked for the staff guide to be circulated via the Council Bulletin.

(g) What were the working hours for wardens as it had been noticed that vehicles left overnight on double yellow lines without any action being taken. Although this may have been the case because lines were sometimes so worn as to be barely visible.

NEPP advised that enforcement times varied. However, if there was an area which required more enforcement then Members could notify the Area Enforcement Manager. If there was a clear system of lines and signs in place then action could be

taken, however if lines were very worn then enforcement action may not have a chance of success.

(h) Members asked NEPP to outline the stages that a request for a resident's parking scheme went through, once the scheme had been agreed.

How many officers were there to undertake the work at each stage and what was the timescale for each stage?

NEPP officers advised that a new Traffic Road Order (TRO) could take up to two years to implement. NEPP had two officers who could write and implement new TROs and a further five officers who carried out work on site and with contractors.

(i) Recently notices had been displayed and put on cars in Allnutts Road, Epping stating that no cars were to park at the Bower Hill end as work was taking place on 23/24 April. However no work took place and the notices removed. What work was expected and why wasn't it undertaken?

NEPP officers explained that some re-lining works were planned but did not take place. These works would be re-scheduled later in the lining season. Three new orders have been planned for this year including the St. John's/Ashlyn Road scheme which also included Chapel Road.

(j) In some areas, signage indicating parking restrictions was not as clear and obvious as it was in the district. What steps did NEPP take to ensure that a minimum standard of clarity was achieved to ensure road users did not inadvertently park in restricted areas?

NEPP advised that the minimum standard for signage and lines was covered in the national rules. All enforcement had to be of a sufficient standard to withstand an appeal. The rules for signage were presently being reviewed for implementation this year, the intention being to reduce signage wherever possible. Councils were being encouraged to use "zone" systems to reduce the amount of signage in place.

(k) On occasions Enforcement Officers intervened effectively to support road users by managing local congestion or difficulties caused by vehicle breakdown, at other times they refused to do so. Was there an agreed policy that should be adhered to by NEPP staff?

NEPP officers were, first and foremost, Parking Enforcement Officers and not Traffic Police. Although some staff had Police Accreditation and were able to assist with some traffic matters.

(l) Corresponding on general matters not connected with contesting enforcement notices could take a long time in receiving a response and reminders were sometimes necessary before a query was answered. Were there any existing or planned targets for the timely response to enquiries?

NEPP replied that the timescale for responses varied depending on the complexity of the question/response and level of work. In some cases, such as where comments related to new schemes being consulted upon, all responses would be left until the end of the statutory consultation period and included in the final report.

(m) The Committee asked about the monitoring of parking around schools and the availability of officers, at short notice, to attend to illegal parking outside schools.

NEPP representatives replied that CCTV cars toured school areas and officers were posted to schools on a rota, they could build on this, if requested. They added that their officers were verbally abused by parents on occasion.

(n) A Councillor complained of the parking situation at Abridge, whereby he claimed that some teachers were breaking parking regulations at schools.

NEPP replied that they could undertake a site visit to the place concerned, if the Member could send NEPP an email on this.

(o) Another Committee Member asked about parking in their area around a corner shop which needed enforcement.

NEPP responded that they could undertake separate action, could the Councillor email them regarding this.

(p) The Committee asked about the strategic direction of NEPP in terms of Government thinking on localism, when they were based in Colchester, beyond Chelmsford, the local authority base for the county. Was there an element of cross subsidisation going on whereby in Buckhurst Hill, 1,000 parking tickets were issued and in Chigwell, 100 were issued.

The NEPP officers replied that their service was delivered on behalf of Essex County Council. Deficit problems were for the county to solve. The NEPP had an office in Harlow, not far from Epping, they had staffing shortages with 6 vacancies in one area. There was a lack of people applying for NEPP positions. The NEPP felt that cross subsidisation made operation more efficient.

NEPP officers said they would like to organise a sit visit to Chigwell to discuss parking enforcement there.

(q) A Committee Member suggested that the 10 minute parking rule near schools was being sidelined. Did this apply to schools?

The NEPP said that this rule did not apply to yellow lines or the areas outside schools. The Member had made numerous complaints to the NEPP about parking near a school in his ward. NEPP officers advised that it was illegal to pull up near a school. The Member said that this was not enforced which over time may have made this behaviour acceptable. There was a problem with the number of enforcement officers involved as they travelled to various locations by bus. The NEPP officers said that they did not have the resources to cover the entire district, their officers also travelled by underground to district locations.

(r) The Committee asked about taxis parking in Waltham Abbey causing congestion.

The NEPP advised that their enforcement officers tried to move taxis on rather than issue tickets.

Following questions from Committee Members, the Chairman asked for questions from the non-Committee Members present.

(i) Members asked about the length of time taken before Road Traffic Orders were made.
NEPP advised that it took two years for a road traffic regulation order to be formulated.

(ii) The Vice-Chairman mentioned difficulties experienced by nurses caring for elderly residents who could not park locally to their patients. There was apparently a long waiting list.

NEPP advised that Blue Badges were issued by the County Council, there were perhaps 250 schemes on-going to assist with parking.

(iii) A Member from Chigwell asked about cars parking outside flats in Manor Road, Chigwell, representations had been made requesting double yellow lines, however nothing had occurred.

The NEPP representatives advised that a list was published by them on the Internet, indicating the order in which schemes were approved.

(iv) A Member from Loughton asked about enforcement in the Loughton area after 6.30p.m. and on Sundays.

The NEPP officers replied that the later shift end at 7.00p.m. but shifts could be changed to deal with certain problems, he confirmed that they work weekends. The NEPP suggested putting their work rotas on their website. However it was felt better for them not to advertise where their operatives would work.

(v) The Committee asked how many parking spaces have been created by the NEPP?

The NEPP representatives advised that it was the District Council which administered car parks.

(vi) The Leader of the Council asked about NEPP's ability to undertake their tasks.

NEPP replied that they hoped for public confidence, but everything done was with their partners.

The Deputy Leader said that the NEPP were doing the best they could with the resources at their disposal. Smaller, localised working was best. However, she felt the current model did not work.

The NEPP officers offered Councillors an opportunity to accompany their enforcement team on patrols.

The Chairman thanked the NEPP officers for attending the meeting.

77. OVERVIEW AND SCRUTINY DRAFT ANNUAL REPORT

The Democratic Services Manager presented to the Committee the Overview and Scrutiny Draft Annual Report for 2014-15. It was noted that it was currently incomplete as not all scrutiny panels had held their last meetings for this year at the time of going to print. It was still possible to submit comments by 15 May 2015. The final report would be submitted to the next Overview and Scrutiny Committee on 9 June 2015 for endorsement and onward recommendation for approval to the nearest Full Council meeting.

78. GRANT AID REVIEW TASK AND FINISH PANEL - INTERIM REPORT

The Committee received an interim report regarding the Grant Aid Review 2014/15.

Members noted that the Grant Aid Budget for 2015/16 had been reduced by £11,517, which had reduced the overall budget to £83,543 in the next financial year. It was advised that £43,457 was committed to three year agreements. In effect, this left £40,000 for the consideration of applications for one-off major grants.

The Committee was asked to consider any amendments or additions required. At this stage, there was no specific section dealing with "Acknowledgements" for those assisting in carrying out the review. This was awaiting the completion of Part 2 of the review in respect of Service level Agreements, which was intended to be carried out in 2015/16.

Councillor C Pond reported that the interim and final recommendations of the Panel would be made to the Cabinet later in the year.

The Committee thanked Councillor C Pond for her chairmanship of the Task and Finish Panel. It was advised that this interim report would be put before the Cabinet.

RECOMMENDED:

That the interim report regarding the Grant Aid Review 2014/15 be noted.

79. WHIPPS CROSS UNIVERSITY HOSPITAL

The Democratic Services Manager advised that the Overview and Scrutiny Committee Chairman's letter to the Chairman of Barts Health NHS Trust regarding the recent CQC report on the inadequate rating of Whipps Cross Hospital, had not yet received a reply. A further letter had been sent. There was a joint scrutiny committee the Outer North East London Joint Health Overview and Scrutiny Committee (also involving Redbridge and London Borough of Waltham Forest) looking at healthcare at Whipps Cross and it would be useful to have the District Council represented.

The Committee was advised by Councillor C C Pond that the joint scrutiny committee had met last week and there had been 6 representatives at the meeting. Waltham Forest Council would continue to monitor the situation and said they would keep the Councillor informed of developments.

80. WORK PROGRAMME MONITORING

(a) Overview and Scrutiny Committee

The Committee noted their work programme to date which was now complete. An outturn report in respect of Item 6 Key Objectives 2014/15 was due in July 2015.

(b) Scrutiny Panels

(i) Housing Scrutiny Panel

The Panel Chairman had tendered his apologies for this meeting. It was noted that the Panel had made good progress during the year, some unfinished items were being transferred to the new Housing Select Committee.

(ii) Constitution and Member Services Scrutiny Panel

The Panel Chairman advised that this Panel would cease to exist at the end of this municipal year, but its current work regarding the review of the Constitution would be continued by the new Constitution Working Party reporting directly to Council.

(iii) Safer Cleaner Greener Scrutiny Panel

The Panel Chairman advised that their last meeting would have representatives from Thames Water in attendance.

(iv) Planning Scrutiny Panel

The Panel Chairman advised that the Panel met for the last time on 14 April 2015. They discussed the progress made on the management of electronic information and systems. Work was on-going with scanning paper files and in converting to an electronic database historical microfiche planning records.

They received an update on the Local Plan, advising that the consultant's final report on updating the Strategic Housing Market Assessment had been delayed as new household projections had been published by the Government. The draft final report was expected very soon.

A Member workshop was being scheduled for May to report on policy choices for the Community Infrastructure Levy and S106 Agreements.

There would be an extra meeting of the Local Council's Liaison Committee on 15 June 2015 to discuss the Phase 1 report of the Green Belt Review.

The Panel was notified that there were three Neighbourhood Plans being consulted on or considered. New regulations stipulated that future designations would need to be made within 8 weeks. The District Council would be writing to all local councils outlining the level of support, guidance and funding available, to those progressing Neighbourhood Plans.

The District Council were objecting to the proposed scheme by Enfield Borough Council regarding the North Gateway Access Road and would be attending the examination at the end of this month with local council's representatives as well.

The Planning Policy Portfolio Holder advised that he had attended a liaison meeting held at City Hall in London regarding the strengthening of communication between agencies in planning and development matters. This would be a regular fixture in the future.

The Chairman said that the Planning Scrutiny Panel had completed its Work Programme for this municipal year.

Members asked about placing an item in the Bulletin about a Local Plan workshop scheduled for 19 May 2015. Officers advised they could do this although a letter had been sent to each Councillor notifying them of the workshop.

(v) Finance and Performance Management Scrutiny Panel

The Panel Chairman updated the Committee on its work. They had their last meeting in March, when, they had completed most of their Work Programme. There were

three items which should be carried over to the new Select Committee representing this area, these were:

- Item 11 Sickness Absence
- Item 14 Call response/handling performance indicator
- Item 15 Use/cost of consultants

(c) Task and Finish Panels

(i) Grant Aid Review Task and Finish Panel

The Panel's Terms of Reference had been agreed at the last Committee meeting, they would now carry over into the new municipal year when they would be looking at the Citizens Advice Bureau and Voluntary Action Epping Forest.

(ii) Youth Engagement Task and Finish Panel

It was reported that this Panel had met on 20 April and would be meeting again on 18 May. Their terms of reference would be going to the next Overview and Scrutiny Committee for agreement.

(d) Reserve Programme

The Members were reminded that they should use the established PICK form for submitting new items of scrutiny work.

81. REVIEW OF CABINET FORWARD PLAN

The Committee noted the Cabinet's Forward Plan for March 2015. They had no specific items they wished to consider.

82. LAST OVERVIEW AND SCRUTINY COMMITTEE MEETING OF THE MUNICIPAL YEAR

The Chairman reminded the Members that this was the last meeting of the Overview and Scrutiny Committee for this municipal year. He thanked Councillors and officers for their work over the past year.

CHAIRMAN

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North Essex Parking Partnership

Matthew Young, Head of CBC Operational Services
Richard Walker, NEPP Group Manager

PARKING PARTNERSHIP NORTH ESSEX

www.parkingpartnership.org

Bringing together the parking operations for North Essex

Introduction

History of decriminalised parking in Essex

Strategic Overview

Functions of the North Essex Parking Partnership (NEPP)

Policies and Processes

History

Essex decriminalised parking functions between 2002-4

Essex County Council (ECC) policy-makers with 12 Agencies in Districts and Boroughs to run parking enforcement

4 area offices and other agencies/contractors

- Engineering,
- Traffic Regulation Orders; and
- Maintenance

Growing deficit reached £900,000 countywide

In 2009 ECC issued notice to District & Boroughs to cancel agencies

Strategic Priorities

Safety: for drivers and pedestrians

Business: clear short term parking, increases potential for local trade; commuters encouraged to use long stay car parks freeing up spaces shoppers;

Residents: discouraging commuters from parking in permit only areas;

Blue Badges: increased enforcement improving availability for Badge holders.

Environmentally efficient: Reducing congestion; better traffic flow and accessibility by reducing inconsiderate and dangerous illegal parking

Improved safety, better Emergency service access; low floor buses will be able to reach the kerb at bus stops

Strategic Priorities

Responsive to the public's needs: the local Council through the Joint Parking Committee controls both provision and management of parking;

Clarity: Single responsibility for parking means greater clarity to the public;

Town Centres: Supporting town centre vitality/rennaisance;

Efficient: Supporting the increasing costs of running and refurbishing car parks;

Supporting the Local Travel Plan:

- Encouraging travel outside peak hours;
- Influence supply, demand and congestion;

Fit for purpose: Managing price elasticity and resistance; best mix.

PARKING PARTNERSHIP
NORTH ESSEX

PARKING PARTNERSHIP
SOUTH ESSEX

NEPP
Business Plan

All parking matters brought into one place – single business case

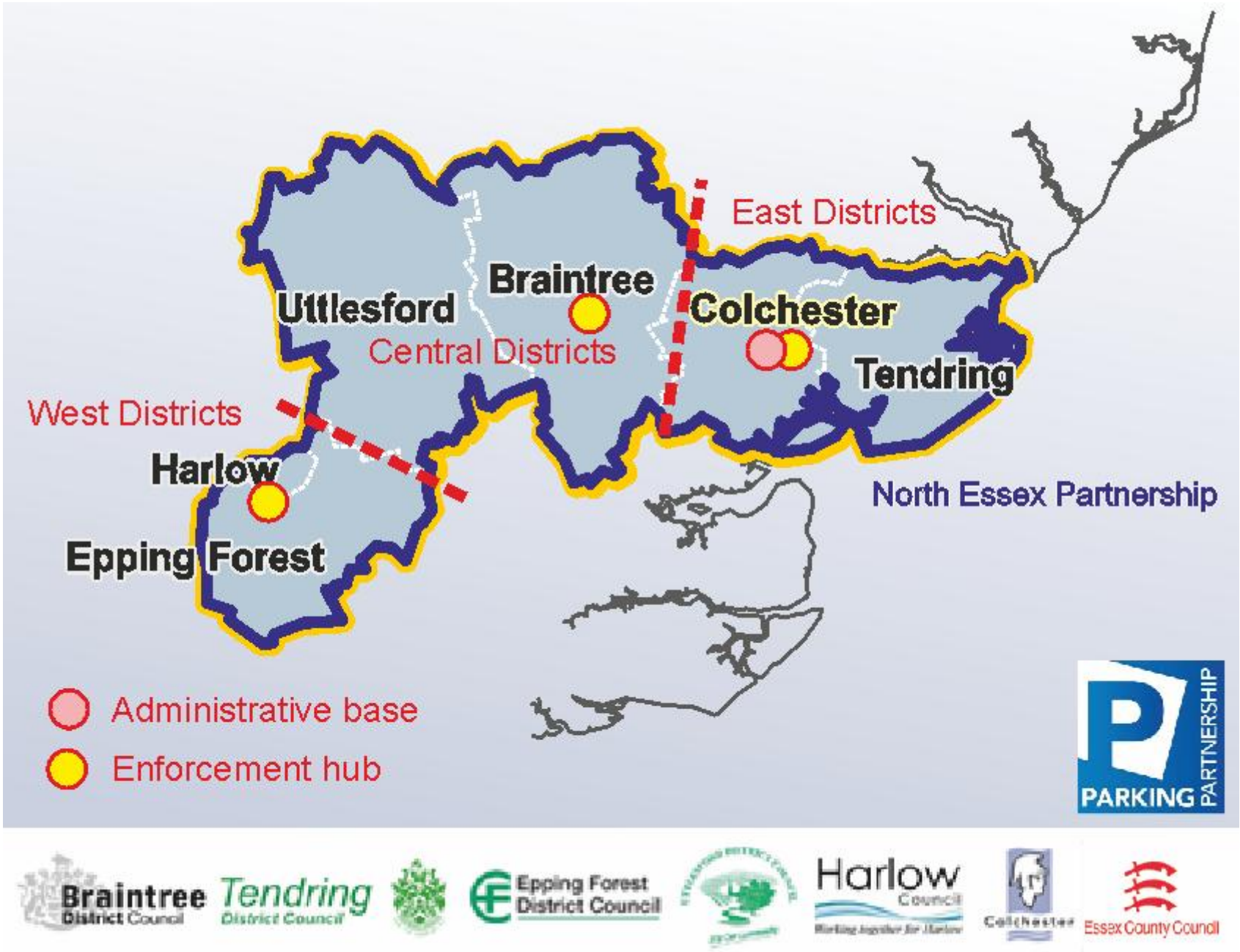
Signage and restriction backlog improvement – budget agreed

Maintenance of signs and lines passed to Partnerships

Sign up to *off-street* services is optional

The NEPP Arrangements:

- Maintain income from PCNs as far as possible, within policy
- Provide improved enforcement and follow-up of PCNs
- Council shared service, not client/contractor
- Make efficiencies in whole operation to eliminate deficit
- Make savings from reduced management, overheads and accommodation.


East Districts
Braintree
Uttlesford
Colchester
Central Districts
Tendring
West Districts
Harlow
Epping Forest
North Essex Partnership
Administrative base
Enforcement hub
PARKING PARTNERSHIP
Braintree District Council
Tendring District Council
Epping Forest District Council
Harlow Council
Colchester
Essex County Council

Summary of Legislative and Policy Background

Restrictions

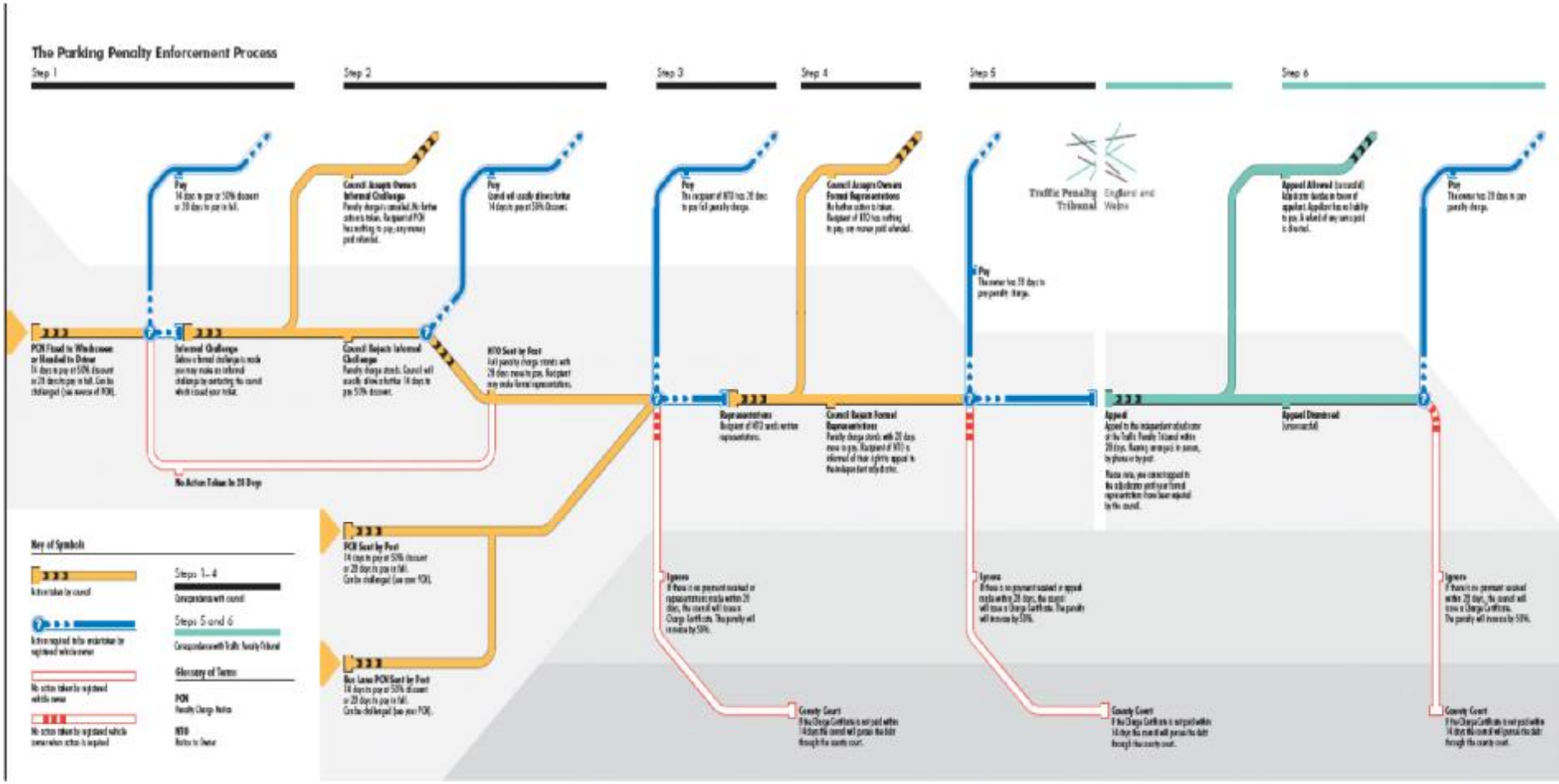
- Road Traffic Regulation Act 1984
- Traffic Regulation Orders made under RTRA1984 (yellow lines, bays)
- The Essex Act 1987 (verges etc.)
- Bus Stop Clearway Circular & SI
- Decriminalised Parking SI
- Circular 1/95 (superseded)
- Dropped Kerb Enforcement Circular/SI
- ECC-NEPP Agreement
- NEPP TRO Policy
- Traffic Signs Manual (Ch3, 5), TSRGD
- The Local Authorities' Traffic Orders (Procedure) (England and Wales) Regulations 1996

Enforcement

- Traffic Management Act 2004
- The Civil Enforcement of Parking Contraventions (England) General Regulations 2007;
- The Civil Enforcement of Parking Contraventions (England) Representations and Appeals Regulations 2007;
- The Civil Enforcement Officers (Wearing of Uniforms) (England) Regulations 2007 (made under TMA2004)
- The Civil Enforcement of Parking Contraventions (England) General (Amendment) Regulations 2015
- The Civil Enforcement of Parking Contraventions Regulations (England) General (Use of Approved Devices Amendment) Regulations 2015
- Secretary of State's statutory guidance to local authorities on the civil enforcement of parking contraventions
- Operational guidance to local authorities: parking policy and enforcement
- ECC-NEPP Agreement
- NEPP Parking Enforcement Policy
- NEPP Parking Operational Protocol
- NEPP Parking Policies (Discretion, Cancellation, etc.)
- *Right to challenge parking policies - Traffic Management Act 2004: network management duty guidance*

See website for details

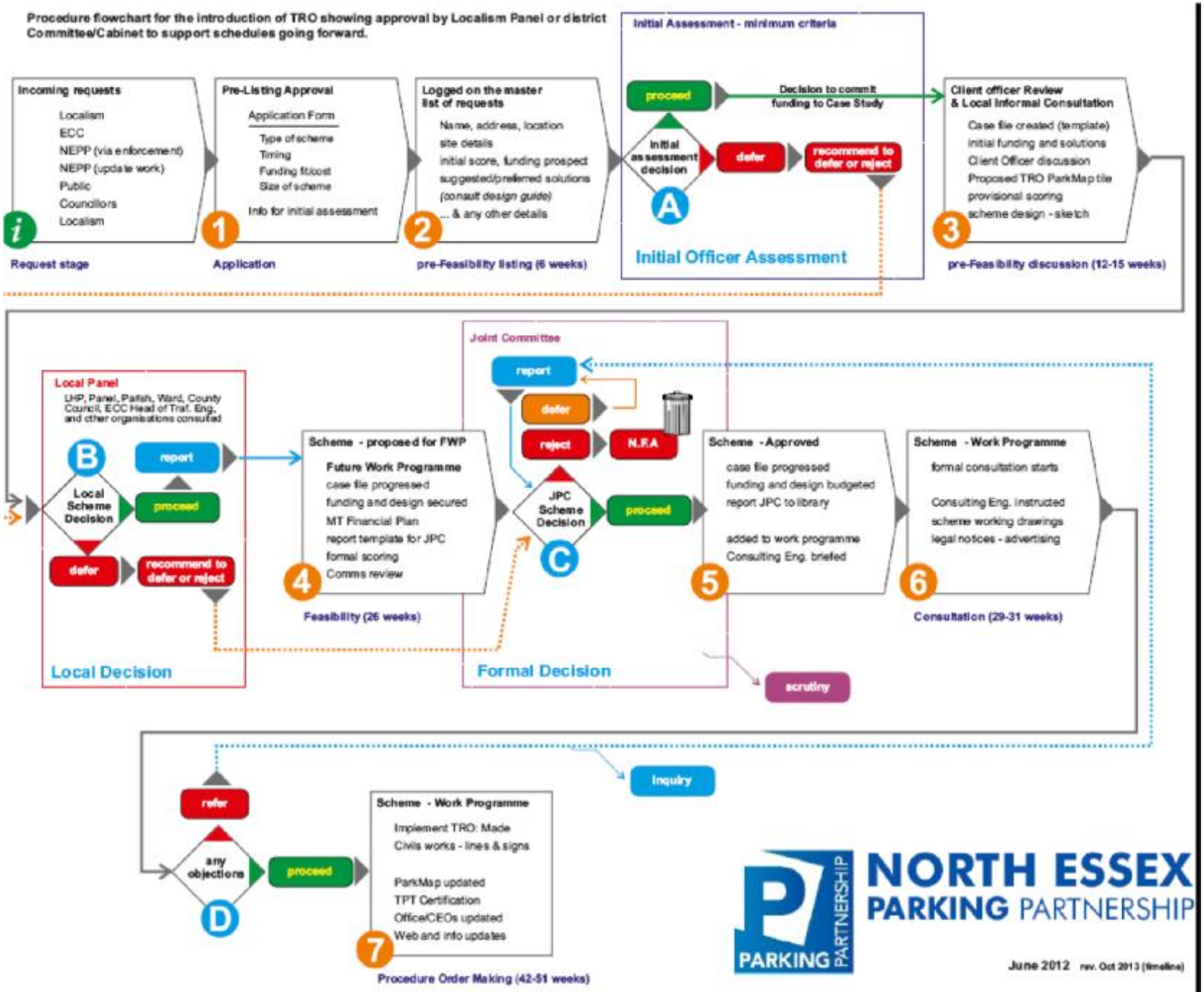
The Enforcement Process



Financial

£	Income	Expend	
2011-2012	1579	1638	- 59 dr
2012-2013	2163	2223	- 60 dr
2013-2014	2244	2092	152
2014-2015	2233	2145	88

In the previous financial year, under the old arrangements for the separate North districts, there was a combined total of £574,301 deficit.


Procedure flowchart for the introduction of TRO showing approval by Localism Panel or district Committee/Cabinet to support schedules going forward.
Incoming requests
Localism
ECC
NEPP (via enforcement)
NEPP (update work)
Public
Councillors
Localism
Request stage
Pre-Listing Approval
Application Form
Type of scheme
Timing
Funding fit/cost
Size of scheme
Info for initial assessment
Application
Logged on the master list of requests
Name, address, location
site details
initial score, funding prospect
suggested/preferred solutions
(consult design guide)
... & any other details
pre-Feasibility listing (6 weeks)
Initial Assessment - minimum criteria
proceed
Decision to commit funding to Case Study
Initial assessment decision
defer
recommend to defer or reject
A
Initial Officer Assessment
Client officer Review & Local Informal Consultation
Case file created (template)
initial funding and solutions
Client Officer discussion
Proposed TRO ParkMap tile
provisional scoring
scheme design - sketch
pre-Feasibility discussion (12-15 weeks)
Local Panel
LHP, Panel, Parish, Ward, County Council, ECC Head of Traf. Eng, and other organisations consulted
B
Local Scheme Decision
report
proceed
defer
recommend to defer or reject
Local Decision
Scheme - proposed for FWP
Future Work Programme
case file progressed
funding and design secured
MT Financial Plan
report template for JPC
formal scoring
Comms review
Feasibility (26 weeks)
Joint Committee
report
defer
reject
N.F.A
JPC Scheme Decision
proceed
C
Formal Decision
Scheme - Approved
case file progressed
funding and design budgeted
report JPC to library
added to work programme
Consulting Eng. briefed
Scheme - Work Programme
formal consultation starts
Consulting Eng. instructed
scheme working drawings
legal notices - advertising
Consultation (29-31 weeks)
scrutiny
Inquiry
refer
any objections
D
proceed
Scheme - Work Programme
Implement TRO: Made
Civils works - lines & signs
ParkMap updated
TPT Certification
Office/CEOs updated
Web and info updates
Procedure Order Making (42-51 weeks)
NORTH ESSEX PARKING PARTNERSHIP
June 2012 rev. Oct 2013 (timeline)

Any questions or comments?

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Barts Health NHS Trust

Whipps Cross University Hospital

Quality Report

Whipps Cross Road
Leytonstone
London
E11 1NR
Tel: 020 8539 5522
Website: http://www.bartshealth.nhs.uk/our-hospitals/whipps-cross-university-hospital/

Date of inspection visit: 12, 13, 14, 23, 30 November 2014
Date of publication: 17/03/2015

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.

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Inadequate
Medical care	Inadequate
Surgery	Inadequate
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Inadequate
End of life care	Inadequate
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Whipps Cross University Hospital is part of Barts Health NHS Trust and provides acute services to a population of approximately 350,000 living in Waltham Forest and surrounding areas of East London and Essex.

The trust employs around 15,000 whole time equivalent (WTE) members of staff with approximately 836 nursing and midwifery staff working at Whipps Cross University Hospital.

We inspected this location as a direct response to concerns raised from a number of sources, stakeholders, patients, local politicians and indicators which we consistently monitor. We spoke with over 185 patients and relatives, and 400 members of staff.

Overall, we rated this hospital as 'inadequate'. We found urgent and emergency care, medical care (including care for older people), surgery, services for children and young people, outpatients and diagnostic imaging and services for those patients requiring end of life care were inadequate. Significant improvements are required in these core services.

We found that maternity and gynaecology and critical care require improvement.

We rated this hospital as inadequate for safe, effective, responsive and well-led and rated caring as requires improvement.

Our key findings were as follows:

- There was a culture of bullying and harassment and we have concerns about whether enough is being done to encourage a change of culture to be open and transparent.
- Morale was low. Some staff were reluctant to speak with the inspection team, when staff did some did not want the inspection team to record the discussions in fear of repercussions.
- The decision in 2013 to remove 220 posts across the trust and down band several hundred more nursing staff has had a significant impact on morale and has stretched staffing levels in many areas. We observed the reorganisation had a damaging impact on staff and the service provided.
- Staffing was a key challenge across all services and the environment was not conducive to recruitment and retention and the sustainability of services.
- The implementation of IT systems had impacted on patient safety and care. The trust recognised there had been issues and were attempting to resolve them. However patients were struggling to get appointments and be recognised as needing care and treatment.
- Patients, staff and stakeholders including Commissioners, MPs, Royal Colleges, Health Education England and local branches of hHealthwatch continue to raise concerns about the quality of the service provided.

Safe:

- There were not enough nursing and medical staff to ensure safe care was provided.
- Handovers between medical staff were unstructured and did not ensure relevant staff were aware of specific patient information or the wider running of the hospital.
- There was limited learning from incidents. Staff did not have the time to report incidents, were not encouraged to report incidents and were not aware of any improvements as a result of learning from these incidents. Some senior staff were unaware of serious incidents and action plans that involved them leading the required change.
- There were low levels of compliance with mandatory training. It was not always evident that learning from the training was embedded.
- Medicines management required improvement in some areas including, but not limited to the storage and administration of medicines. There was an inconsistent use of opioids across wards.

Summary of findings

- Patients nearing the end of their life were not identified, and their needs therefore were not always assessed and met.
- The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied. The use of an early warning system was embedded within the surgery, while in A&E and medical care areas, its use was inconsistent. the National Early Warnings System had not yet been implemented in the hospital.
- Theatre ventilation was not adequately monitored.

Effective:

- The use of national clinical guidelines was not evident throughout the majority of services. An end of life pathway to replace the existing Liverpool Care Pathway had not been introduced. National guidance for the care and treatment of critically ill patients was not always followed.
- Medical patients pain relief was managed.
- The management of patients nutritional and hydration needs varied. In the National Care of the Dying Audit patient's' nutrition and hydration requirements being met was rated worse than the England average.
- Patient outcomes in national audits were similar to or below the performance of other hospitals.
- We were told that actions had been taken to raise staff awareness of the Mental Capacity Act 2005 and deprivation of liberty safeguards. Records showed mental capacity was recorded and families were involved however we found most staff we spoke with lacked an understanding of the Mental Capacity Act and deprivation of liberty safeguards.
- The trust was working towards seven day working. Job planning for medical staff had started. Access to fundamental diagnostic and screening tests out of hours was limited. There was no critical care outreach team after 5pm or at weekends.

Caring:

- Improvements were required to ensure staff were always caring and compassionate and treated patients with dignity and respect at all times.
- In September 2014, 194 of 210 (92%) respondents to the friends and family test were 'extremely likely' or 'likely' to recommend the inpatient service.

Responsive:

- The average bed occupancy for from May to October 2014 was 91%. This impacted on the flow of patients throughout the hospital. Patients were cared for in recovery, or transferred out of critical care for non clinical reasons.
- Patients well enough to leave hospital experienced significant delays in being discharged because of documentation needing to be completed. During our inspection an estimated 30 patients were well enough to leave hospital but remained because their continuing health care assessments had not been completed. Staff that previously completed this paperwork were no longer in post because of the restructure.
- Operations were often cancelled due to a lack of available beds.
- The average length of stay (ALOS) was high, the trust recognised this issue was impacting on patient care and had taken some action to address it.
- The hospital was persistently failing to meet the national waiting time targets. Some patients were experiencing delays of more than 18 weeks from referral to treatment (RTT). The trust had suspended reporting activity to the department of health and had started a recovery plan.
- Many patients experienced delays in their treatment as a result of lack of planning to introduce the electronic patient records system or when transport arrangements had changed. Patients complained that they were unable to get in touch with the hospital.
- Capacity issues within the hospital led to a high proportion of medical "outliers" (patients on wards that were not the correct specialty for their needs) . The result of this was that patients were being moved from ward to ward on more than one occasion, this impacted on their treatment, delayed their stay in hospital and were on occasion transferred late at night.

Summary of findings

Well-led:

- Staff told us that the executive team were not visible.
- Morale was low. The 2013 NHS Staff Survey for the trust as a whole had work related stress at 44%, the joint highest rate in the country for an acute trust. 32% recommend it as a place to work, which is third lowest in the country.
- Nursing staff who were previously supernumerary to the shift were no longer there to provide leadership and guidance.
- There were a number of vacant managerial posts and interim staff in post making it difficult for staff to be well-led.
- The application of clinical governance was varied, with some services lacking any formal, robust oversight. Risk registers were poorly applied in some clinical areas which led to some risks not being recorded and or escalated.
- The trust was £13.3 million off its financial plan at the end of September 2014, the year end forecast outturn was revised from £44.8 million to a deficit of £64.1 million. £2 million additional costs were specifically associated with the deployment of IT systems at Whipps Cross University Hospital as the deployment had been unsuccessful and it had been necessary to invest significant resources to address problems in outpatients booking and scheduling.

We saw some areas of outstanding practice including:

- Pain relief for children and adults was effectively managed.
- The Great Expectations maternity programme had led to a reported better experience for women. There had been a reduction in complaints regarding staff behaviour and attitude and an increase in women's satisfaction of the maternity service.

However, there were also areas of poor practice where the trust needs to make improvements.

The hospital must ensure:

- Safety and effectiveness are a priority in all core services
- Services are be well-led.
- Adequate steps are taken to meet the fundamental needs of patients.
- There are appropriate levels and skills mix of staffing to meet the needs of all patients.
- Bank and agency staff are fully inducted to ensure they can access policies, be aware of practices and provide care and treatment in the areas they are required to work in.
- Complaints are investigated in a timely manner and patients are involved and action taken.
- Robust assessment and monitoring of the quality of the service.
- Patients leave hospital when they are well enough. Average length of stay was higher than medically necessary.
- Procedures for documenting the involvement of patients, relatives and the multi-disciplinary team 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times.
- Accurate records are available for the majority of patients attending outpatient appointments.
- Safeguarding procedures are improved and followed.
- All staff understand the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Equipment is ready for use and appropriately maintained.
- The environment is adequately maintained to protect patients.
- Medications are stored safely.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	There was no clear vision for the department and monitoring arrangements were not always effective and did not promote improvements from shared learning. We found that the access and flow did not work well, recognising this was partially linked to the availability of beds throughout the hospital. We saw that there were delays in patients being assessed and in handovers taking place for patients who arrived by ambulance. Incidents were not always managed effectively in terms of reporting and improving patient outcomes. We also saw examples of patients who had received sub-optimal care during their time in the department. Due to the high volume of agency and locum staff, there were inconsistencies in the application of trust processes and protocols. Although most of the patients reported that staff were caring, we made some observations and saw some documentation which indicated patients did not always receive fundamental care and treatment which respected basic rights or their dignity.
Medical care	Inadequate 	Safety was not a sufficient priority. There were frequent staff shortages and a reliance on agency and locum staff that increased the risk to patients. The handovers did not cover all aspects of patient care, or ensure that staff were aware of how the service was performing. The medical services were not responsive to patient needs. Patients did not always leave hospital when they were well enough and bed occupancy was regularly over 85%. Patients with complex needs were not always identified, or given access to specific services to cater for these needs. Performance was between average and poor in national audits. There was a lack of local audits in some areas and a lack of seven-day working. Although patient feedback was mostly positive, there were concerns with patient involvement in a number of areas and patient survey results were variable.

Summary of findings

The medical services were not well-led. There were gaps in the governance arrangements at a middle-management level and the strategy to achieve the vision was unknown.

Surgery **Inadequate**

The service did not protect patients from risks of avoidable harm and abuse.
We identified high numbers of outstanding nursing vacancies, the poor skills mix throughout wards, a high volume of agency staff usage and a high patient volume that had a negative impact on the service. Some wards often relied on recently qualified, or agency staff.
Some agency staff did not have full access to the electronic record-keeping systems, which presented challenges in caring for patients and reporting incidents. We found inconsistencies in incident reporting throughout the service. Staff told us they did not have time to report incidents and that they would not escalate issues of inappropriate staff skills mix of staff shortages, due to fears of repercussions from senior staff. They had rarely received feedback from the incidents they reported to senior staff. Staff commented that they were not sufficiently supported by their seniors. Daily consultant-led care was not embedded.
We found inadequate surgical and medical cover whichthat resulted in some unnecessary delays in obtaining some pain relief and clinical reviews, which had an impact on patient discharges.
Patients who had undergone surgery were being cared for in the recovery area for extended lengths of time, because of due to a shortage of surgical beds on the wards. Patients were occasionally transferred to clinical areas that were inappropriate given the complexity of their patients' needs.
Patient flow within the service was poorly managed, which often led to operation cancellations, delays in treatment, and patients being cared for in inappropriate clinical areas.
Operating data was collected in a number of ways by different staff, including handwritten lists, diary notes, theatres lists, and via an electronic system. There was no process to coordinate this information meaningfully in order to monitor the impact of frequent cancellations, or delays, on patients' clinical outcomes.

Summary of findings

			We found that a number of medical patients were cared for on surgical wards, surgical patients were cared for on non-surgical wards and we identified that this was common practice. The lack of relevant meaningful and accurate data and undeveloped governance systems within surgical services meant senior managers did not have a grip on the day-to-day running of the service.
Critical care	**Requires improvement**		There was poor access and flow within the department and no designated area for patients who required high dependency care, although there was a business case in place for this. Surgical procedures were frequently cancelled and occupancy levels higher than the England average. There were no clear arrangements in place for learning lessons and meetings were not well attended. Staff did not feel well supported and there was a high use of agency nurses who did not always report for their shift. The majority of medical records had been updated and recorded relevant information although nursing records were not contemporaneous notes and instead only recorded variations to expected standards of care. Restraint guidance was not clear and not always applied in line with legislation. Staff reported low morale and it was their perception that there was a bullying culture within the trust.
Maternity and gynaecology	**Requires improvement**		We found committed staff and examples of good practice, such as close multi-disciplinary working. There had been improvements since our last inspection, but further work was needed. Maternity and gynaecology services had taken action to address challenges in meeting the demand for their service. This included improvements to induction of labour and elective caesarean section procedures. Further action was needed to understand the demand for inpatient maternity services and how to make the best use of resources to meet this demand. There were times of staff shortages in inpatient areas. The process for escalating concerns at these times was not always implemented effectively. The

hard work and commitment of midwifery staff helped keep women safe, but this meant that midwives sometimes did not take a break in their 12 hour shift.
The change of patient record software earlier in the year had resulted in difficulties in accessing accurate data about activity in the maternity unit. There was manual verification of some data to make sure key performance indicators were reported accurately.
There was a focus on learning from serious incidents and complaints in women's services and staff of all professions and grades reported incidents. There had been improvements in the way that complex complaints were dealt with to ensure that people were kept fully informed about investigations. Serious incidents were investigated and actions identified. The response to incidents not categorised as serious, and the process for monitoring the implementation of actions, required further work.
The women's and children's healthcare CAG was developing its clinical governance processes. This had promoted shared learning in women's services, but attendance at trust meetings reduced the presence of senior managers at the site. Guidelines were being reviewed and updated, and there were regular audits, the results of which were shared with staff. Risk registers were regularly reviewed, with responsibility for actions allocated and monitored.
The women using the service said doctors and midwives gave them the information they needed when they attended antenatal appointments. We were told the midwives on the birth unit were "caring and compassionate" and one of the women who had given birth on the labour suite described her midwife as "brilliant". A woman told us of the poor level of support she had received in recovery following a caesarean section.
The newly refurbished emergency gynaecology unit (EGU) was providing a responsive service to women, but the service was not open at weekends. Women undergoing gynaecological surgery did not always receive post-operative care from appropriately experienced staff.

Summary of findings

			A values and behaviour programme had been launched in maternity services at Barts Health NHS Trust to improve the way staff interacted with women and with each other and to improve the standard of care. Feedback from women using the service indicated that there had been improvements in patient experience. However, changes to staffing implemented by the trust, such as changes in the management structure, had lowered morale and some midwifery staff did not feel their voice was heard.
Services for children and young people	**Inadequate**		Parents and children were generally satisfied with the care and felt they had been kept well informed. They told us staff were compassionate and caring. There were concerns about how incidents were reported and acted upon and how learning was shared. Risks were not appropriately managed. Patients on Acorn Ward did not always receive responsive care because of a lack of registered trained and experienced staff. Beds had been closed to make the service safer, however this was impacting on the rest of the hospital. Services were not planned or delivered in a way that met the needs of children and young people. There was a lack of designated areas for children in areas they would visit across the hospital. There were avoidable delays in some treatments and transport between services. There was no evidence of learning and sharing from complaints, which would help other areas improve their practices. While senior staff responsible for the care of young people, children and neonates had a vision for delivering high quality care to their patients, the service was not seen as a priority for the trust board.
End of life care	**Inadequate**		While we found that staff were overall caring and committed to providing good care to patients at the end of life, we had concerns in all domains and rated this service as inadequate overall. Staffing issues had a major impact on the service's ability to provide good care and we found examples where patients receiving end of life care were not being properly supported. The service was not able to understand how complaints or incidents might relate to end of life care, and the hospital was not measuring the quality of services delivered to

patients receiving such care. Limited action had been taken in response to the 2013 review of the Liverpool Care Pathway (LCP) and at the time of the inspection the pathway had not been replaced. 50% of 'do not attempt cardio-pulmonary resuscitation (DNA CPR)' forms we reviewed had not been fully completed. We found a number of concerns that related to this service being well-led, with end of life care having no influence within the clinical academic group (CAG). There was a lack of strategy and resources that compromised the service's sustainability.

Outpatients and diagnostic imaging	**Inadequate**	There were no effective systems for monitoring quality of the services and risks associated with its delivery. The hospital was unable to assess and respond to patients' risk as the data collection was unsatisfactory and the system used for monitoring patients' referral to treatment times and cancellations did not work effectively. The hospital was persistently failing to meet the national waiting time targets. Staff felt disempowered and that they were unable to take initiative in order to improve the hospital's performance. We observed lack of leadership which led to staff feeling demotivated. Many of the patients experienced delays in their treatment as a result of lack of planning when changes were introduced. There were problems with access to information as patients' medical records were not delivered in a timely manner to outpatients clinics. Although, we observed patients were treated with compassion, dignity and respect, patients did not always feel fully involved in decisions about their care and treatment.

Whipps Cross University Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Contents

Detailed findings

Background to Whipps Cross University Hospital

Whipps Cross University Hospital is in Leytonstone, east London, and serves a diverse population of more than 350,000 people from Waltham Forest, Redbridge, Epping Forest and other areas. It provides a full range of general inpatient, outpatient and day case services as well as maternity services and a 24-hour emergency department (ED). The hospital serves an area with a wide variation in levels of deprivation and health needs, ranging from the most deprived 5% to among the most affluent 30% of electoral wards in England.

The hospital has 690 beds across 34 wards.

Whipps Cross University Hospital is part of Barts Health NHS Trust established in 2012. It is the largest NHS trust in England. It has a turnover of £1.25 billion, serves 2.5 million people and employs over 14,000 staff. The trust comprises 11 registered locations, including six primary hospital sites in east and north-east London (The Royal London Hospital, Newham University Hospital, Mile End Hospital, St Bartholomew's Hospital, The London Chest Hospital and Whipps Cross University Hospital) as well as five other smaller locations.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector, Care Quality Commission (CQC)

Head of Hospital Inspections: Siobhan Jordan, CQC

Inspection Lead: Hayley Marle, CQC

The team of 45 included CQC inspectors and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics, palliative care medicine, anaesthetist, physician and a junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses', physiotherapist, an imaging specialist, outpatients manager, estates, facilities, dementia care, child safeguarding, a student nurse, CQC non- executive ; and experts by experience.

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 always inspects the following core services at each inspection:

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCGs), NHS Trust Development Authority, Health Education England, General Medical Council (GMC), Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN); NHS Litigation Authority and local branches of Healthwatch.

A number of organisations, members of the public and current staff raised concerns about the quality of the service being provided at the hospital.

We carried out an announced visit between 11 and 14 November 2014 and unannounced visits on Sunday 23 and Sunday 30 November 2014. We observed how people

were being cared for and talked with patients, carers and/or family members and reviewed personal care or treatment records of patients. We held focus groups with a range of staff in the hospital including doctors, nurses, midwives, allied health professionals, and administration staff. We interviewed senior members of staff at the hospital and at the trust. A number of staff attended our 'drop in' sessions to talk with a member of the inspection team.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Walthamstow on 11 November 2014, when approximately 30 people shared their views and experiences of Whipps Cross University Hospital.

Facts and data about Whipps Cross University Hospital

Whipps Cross university hospital

1. Context

- Whipps Cross University Hospital is one of six hospitals run by Barts Health NHS Trust which is the largest NHS Trust in the country.
- Whipps Cross University Hospital provides a full range of general inpatient, outpatient and day case services, as well as maternity services and a 24-hour Emergency Department and Urgent Care Centre.
- The hospital serves a diverse local population of more than 350,000 people from Waltham Forest, Redbridge, Epping Forest and further afield.
- The main commissioner of services is Waltham Forest Clinical Commissioning (CCG).
- The area has a wide variation in levels of deprivation and health needs.
- Deprivation in Waltham Forrest is higher than average and about 28.3% (16,000) children live in poverty. Life expectancy for both men and women is similar to the England average. Statutory homelessness in the area is amongst the worst in England. In Year 6, 22.9% (603) of children are classified as obese, worse than the average for England. Smoking prevalence (adults), recorded diabetes, incidents of TB and acute sexually transmitted infections are worse than the England average. Alcohol related hospital stays in both under 18's and adults are marginally better than the England average. Infant mortality is worse than the England average
- The health of people in Redbridge is varied compared with the England average. Deprivation is lower than average, however about 23.0% (13,900) children live in poverty. Life expectancy for both men and women is higher than the England average. In Year 6, 21.3% (713) of children are classified as obese, worse than the average for England. Statutory homelessness and violent crime are worse than the England average. Recorded diabetes and incidents of TB are worse than the England average.
- The health of people in Epping Forest is generally better than the England average. Deprivation is lower than average, however about 15.6% (3,600) children live in poverty. Life expectancy for both men and women is higher than the England average. In Year 6, 16.9% (155) of children are classified as obese. Statutory homelessness and violent crime and better than the England average. Recorded diabetes and incidents of TB are better than the England average. The percentage of people killed or seriously injured on roads are worse than the England average.

- The hospital has a total of 641 beds - 299 general and acute beds and 97 maternity beds,
- The hospital employs 835 staff members, 582 nursing and 253 other staff. The workforce was supported by 9% bank and agency staff against a national average of 6% in the last financial year (2013/14).

2. Activity

- Inpatient admissions: 26,899 (2012-13)
- Outpatient attendances: 1,370,000 (Aug 2013-July 2014)
- A&E attendances: 143,700 (93,000 A&E + MIU 50,700) (Oct 2013-Sept 2014)
- Births: 1,415 (October 2012-November 2013)
- Deaths in hospital (including deaths in the hospice, The Margaret Centre): 1141 (Apr/13 - Mar/14); 263 (Apr/14 - Jun/14) and 350 (Jul/14 -Jul/14)

3. Bed occupancy

- Average bed occupancy: 91% (May to October 2014)

Detailed findings

4. Incidents

- Zero never events were reported in the period 01/01/2014 – 09/01/2015
- 208 serious incidents requiring investigation were reported from 01/01/2014 – 09/01/2015.
  - 138 incidents relate to pressure ulcers grade3, 16 to pressure ulcers grade 4 and 4 to slips trips and falls.
  - 16 maternity related incidents were reported: 2 intrauterine deaths, 1 maternal death, 3 unplanned admissions to ITU, 9 unplanned admissions to NICU and 1 unexpected neonatal death.
  - 3 incidents regarding child deaths and 2 incidents relating to unexpected patient deaths were reported.
  - Allegations against health care professionals accounted for 6 incidents reported
  - 6 incidents relating to sub – optimal care of the deteriorating patient were reported
  - 5 delayed diagnosis incidents were recorded
  - 12 incidents relating to various types of incidents were reported

5. CQC inspection history

- The hospital was inspected as part of Barts Health NHS Trust inspection in November 2013 under the CQC's new inspection methodology. The trust was not rated. We issued four compliance actions:
- Care and welfare of people who use services. Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.Improvements are needed to ensure that patients receive appropriate levels of care and welfare. This relates to the issues with the way patients were cared for on the medical and surgical wards and the delays to their care and/or discharge from hospital.
- Safety and suitability of premises. Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.Improvements are needed to ensure that the patient environments (or 'premises') are safe and meet patients' needs. This relates to the environment in the Margaret Centre, outpatients and on some medical wards.
- Safety, availability and suitability of equipment. Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.Improvements are needed to ensure that equipment is appropriately maintained and available for use. This relates to a lack of low-rise beds on medical wards, bedside oxygen on one ward, oxygen flow meters and suction on the surgical wards, equipment in maternity, ensuring resuscitation equipment is fit for use and the lack of a spare ventilator trolley in ITU.
- Complaints. Regulation 19(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Improvements are needed to ensure that patients know how to make a complaint and those complaints are dealt with appropriately.

6. Key intelligence indicators

Safety

- For the period 01/01/2014 – 09/01/2015 no never events were reported and a total of 208 serious incidents requiring investigation were recorded.

Effective

- Hospital Standardised Mortality Ratio (HSMR) indicator – no evidence of risk for the trust as a whole.
- Summary Hospital-level Mortality Indicator (SHMI) – no evidence of risk no evidence of risk for the trust as a whole.
- Data not available specific to the hospital.

Caring

- NHS Friends and Family test (July 2014) – average score for urgent and emergency care was 59, which was slightly better than the national average of 53. The response rate was 33.5%, which was better than the national average of 20.20%.
- The average Friends and Family score for inpatients was 63, which was worse than the national average of 73. The response rate was 22.04%, which was worse than the national average of 38%.
- The average Friends and Family score for maternity (antenatal) was 33, which was worse than the England average of 62. The average score for maternity (birth) was not recorded seeing that no responses were received. The average score for maternity (postnatal) was 33, which was worse than the England average of 65.
- Cancer Patient Experience Survey (2013-14) – the trust as a whole had an 82% rating for 'Patient's rating of care' as 'excellent'/'very good'. This was same as the threshold for the lowest 20% of trusts. Data not available specific to the hospital.

Detailed findings

- CQC Adult Inpatient Survey – One risk was identified in the trust as a whole to the question 'Did nurses talk in front of you as if you weren't there'. Data not available specific to the hospital.

Responsive

- A&E, four-hour target – Did not meet the 95% 4 hour target for the period Sept 2013- Oct 2014 on average 91.13% of patients were seen within 4 hours.
- Referral-to-treatment times – the trust stopped providing this data beyond August 2014.

Well-led

- Staff survey 2013, for Barts health NHS Trust, overall engagement score (trust as a whole): 3.63. Slightly worse than the England average of 3.73.
- The results of the 2013 NHS Staff Survey demonstrated that for Bart's Health NHS Trust, the majority of scores were as expected in line with the national average over the 28 key areas covered in the survey, which included:
  - as expected in 24 key areas
  - better than average in 2 key areas
  - worse than average in 2 key areas
- The response rate for the staff survey 2013 was lower than the national average with a response rate of 46% compared to 49% national average
- Data not available specific to the hospital.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Medical care	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate
Surgery	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Critical care	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
End of life care	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate
Outpatients and diagnostic imaging	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate

Notes

<Notes here>

Urgent and emergency services

Safe	Inadequate
Effective	Inadequate
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Inadequate
Overall	Inadequate

Information about the service

The emergency department (ED) provides a 24-hour service, seven days per week to the local population. It sees around 120,000 patients per year. The ED had a major refurbishment in 2012. Patients present to the department either by walking into the reception area or arriving by ambulance via the ambulance only entrance.

Patients transporting themselves to the department report to the streaming pod located inside the entrance of the ED. The streaming pod is part of the main reception area in the ED is run by the Partnership of East London Co-operatives (PELC). PELC is commissioned by Waltham Forest Clinical Commissioning Group. Patients are assessed and streamed in accordance with their clinical need and are booked in by reception staff to the relevant area of the ED.

The department consists of a majors and minors areas, with a separate paediatric area for children and young people under the age of 16. There is a resuscitation area which had six beds; one of which is primarily for children. A second resuscitation bed can be created if required, by flexing one of the adult beds.

Patients attending the ED should expect to be assessed and admitted, transferred or discharged within a four-hour period in line with the national target. If an immediate decision cannot be reached, a patient may be transferred to the Clinical Decision Unit (CDU) for up to 12 hours or admitted to the Acute Assessment Unit (AAU), for up to 48 hours. The AAU formed part of the medical speciality.

We spoke with 32 patients, 52 members of staff, including doctors, nurses, administration staff, allied health professionals, paramedics as well as clinical, nursing, governance and managerial leads within each specialty. We also reviewed over 19 patient records, we reviewed items of equipment and observed care and treatment being provided.

Urgent and emergency services

Summary of findings

There was no clear vision for the department and monitoring arrangements were not always effective and did not promote improvements from shared learning.

We found that the access and flow did not work well, recognising this was partially linked to the availability of beds throughout the hospital. We saw that there were delays in patients being assessed and in handovers taking place for patients who arrived by ambulance.

Incidents were not always managed effectively in terms of reporting and improving patient outcomes. We also saw examples of patients who had received sub-optimal care during their time in the department.

Due to the high volume of agency and locum staff, there were inconsistencies in the application of trust processes and protocols.

Although most of the patients reported that staff were caring, we made some observations and saw some documentation which indicated patients did not always receive fundamental care and treatment which respected basic rights or their dignity.

Are urgent and emergency services safe?

Inadequate

Safety arrangements for emergency services were inadequate. There was a high use of agency nurses and medical locums within the department, as high as 50% of the workforce on some shifts. Many of the temporary staff members were unfamiliar with the department and the policies and procedures they should work to. Incidents were not always reported in line with trust policy and lessons were not being consistently learned from and actions were consistent and sustained. Safeguarding arrangements for children and vulnerable adults were in place but there were examples where these had not been followed.

Incidents

- During the period January 2014 and September 2014, a total of 110 serious incidents were reported which related to the ED. We saw that 100 of these related to patients identified with a pressure sore on arrival as part of ED assessment process.
- We were told that there had been no never events reported by the trust in the 12 months prior to our inspection. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented. We noted through review of incidents reported by the ED that one incident related to a patient who had a wrist band on which had the name of another patient. This had been reported and approved as a low risk incident internally.
- We were provided with a spreadsheet of all incidents reported by ED between 18 August and 23 October 2014. A total of 301 incidents had been reported during this period, 57 of these categorised as low harm or near miss were still awaiting approval, some dated back to August 2014.
- All of the staff we spoke with had access to report incidents and told us that they were confident in how to report. However, we noted from our review of a small sample of incidents that some contained insufficient detail, some had been incorrectly categorised, and others had taken a long period of time to be reported.
- One incident, classified as 'no harm' reported that a child who required critical care, could not be transferred

to the paediatric ward because there was an inadequate staff and poor skills mix. The child was transferred to the adult Intensive Care Unit (ITU). The recorded action was to improve capacity issue for children requiring ICU, we saw no evidence that any action was being taken.

- Another patient had been transferred to an area of ED which was unsuitable to care for their clinical need. This had been raised by staff within the unit, but overruled by other colleagues. The patient's condition deteriorated.
- We noted several examples where incidents had been categorised incorrectly.
- Of the sample we reviewed a total of 13 incidents had taken more than three days to be reported, two of these had taken over 100 days to be reported and had been identified through other means, in one case because a complaint had been made. For most of the incidents where a delay in reporting had occurred, there was no recorded cause or explanation for the delay.
- Although staff all told us that they had access to report incidents, some of the staff we spoke with told us that they did not always have time to report incidents because the department was too busy. There was a lack of evidence that changes happened as a result of incidents being reported which affected staff willingness to prioritise reporting incidents.
- Many staff told us that they received updates on lessons learned from incidents within the department and the wider hospital and trust and some gave us examples of these. We were told that learning took place as part of their team meetings. We requested evidence of this, but it was not provided.
- We were told that agency nurses and locums who worked regular shifts at the hospital were invited to attend the team meetings. Some agency nurses told us that they did not have time to attend the meetings but they would receive feedback from through the communication book when they next worked a shift.
- There was a weekly teaching session for trainee doctors within the department and the session was used as a forum for disseminating learning from incidents. The locum doctors we spoke to, told us that they did not regularly attend this session. A significant portion of the middle grade doctors were non-permanent staff. Therefore there was a risk, that learning from incidents was not reaching a significant proportion of doctors. We questioned staff, including management about a particularly serious incident which had occurred the previous year. None of the staff we spoke with were aware of this incident or changes made to processes as a result.
- We also highlighted another incident; where one of the recommendations was for staff to notify the team who cared for patients with a learning disability when a patient with learning disabilities accessed the department. Staff we spoke to were unaware of this procedure and their responsibility to notify the specialist team.
- We requested copies of the investigation report and action plans for two recent serious incidents, as well as evidence of where learning had been shared and evidence of implementation of actions. The investigation reports stated the incident, the outcome for the patient and provided a clear chronology of events, with an action plan which specified the changes that were required. The action plans we were given did not demonstrate any actions which had actually been delivered and some actions were not due to be delivered until 2015. Therefore no evidence of shared learning, timely action and implementation of changes taken as a direct result of the incidents.
- We requested copies of the notes from the mortality and morbidity meetings but these were not provided.

Cleanliness, infection control and hygiene

- We observed that the department appeared visibly clean on the day of our inspection and the staff we spoke with did not report any infection control issues. Although, we did note that the floor in the relative's room required cleaning.
- We saw staff wash their hands and use hand gel between attending to patients. 'Bare below the elbow' policies were adhered to. Staff wore minimal jewellery in line with trust policy.

Environment and equipment

- We observed that staff had access to medical equipment required for an ED and the staff we spoke with reported that there were no concerns regarding equipment.
- We reviewed the incidents reported between August and October 2014 and noted a small number of incidents related to equipment had been reported but there were no themes emerging.

- We observed that resuscitation trolleys had the requiredment items which had been regularly checked, however we did note on inspection that the trolley in the paediatrics area of department had not been checked for two days.
- We noted that there were not enough computers for staff to access as and when they required . All patient record information was updated electronically, therefore computers were required. Manual records were not maintained unless the electronic system was not working. Each member of staff used a smartcard to access and update electronic records. Some of the cubicles had a portable computer, not all of these were in working order. Computers could also be accessed at the nursing station but there was limited access.
- When recording, for example, a patient's blood pressure or heart rate, the member of staff needed to record these details, or other clinical updates on a piece of paper and then transfer this information to the computer at a later time when a computer was available. Transferring the information from paper to computer, increases the risk of incorrect information being recorded or it not being recorded at all. If a computer was not immediately free, it was also possible the member of staff may forget to update the patient's record we were told.
- During our inspection, we observed that one member of agency nursing staff was unable to work effectively and refused to remain in the department and complete her shift because of issues with smart cards, she left the department.
- We also noted that a serious incident had been taken place which resulted in a patient death. Although the investigation had not been fully completed at the time of our inspection, one of the contributing factors referred to the computers not working and as a direct result information was not readily available about the patient.

Medicines

- Medicines and controlled drugs were stored correctly in locked cupboards. Storage arrangements met legal requirements. We noted that the outer door of the medicines cabinet in the paediatric area of ED was locked, however it needed improvement to ensure it was sufficiently secure for storing Schedule 3 and 4 controlled drugs. The pharmacy department were aware of this. There were strict controls in place for handling the keys and accessing medication.
- A controlled drugs register was maintained to record the administration of controlled drugs. All medication we reviewed had been recorded as received or administered in line with requirements. We saw that this was regularly audited by the pharmacy department as well as ED staff.
- We observed that a hard copy guidance for intravenous (IV) injections was out of date and being referred to by staff. We saw that up to date guidance was available on the intranet but we were told that this was not being referred toreferenced.

Records

- Most records within the department were stored electronically, with exception of records in CDU. We observed that patient records in CDU were stored on desks on the nursing station which were freely accessible to anyone member of staff, patient or member of the public in the unit.
- Staff were issued with 'smart cards' to enable them to access and update patient records on the IT system. We were told by staff that there were often issues with using the smart cards and that sometimes they did not work, or they had to share cards. Smart cards were registered to individual members of staff, therefore if a card had been used by another member of staff; they would need to change the details on the system to record who had updated the patient's record. If this did not happen, the system would record the card owner as the person who had updated the patient's record. Sharing cards in this manner is a breach of information governance. There is a requirement that information is kept securely at all times and that care is taken to avoid unlawful processing or access.
- During our inspection we observed a number of technical issues in using smart cards, which delayed access to vital information and also caused delays in updating patient conditions which could change rapidly. This was raised with the management team, and during our un-announced re-inspection, we were told that new cards has subsequently been issued to the staff.

Urgent and emergency services

Safeguarding

- We saw that the majority of staff had completed level 2 safeguarding training and that only 30% of nursing staff had completed level 3 children's safeguarding training. There was no evidence nursing staff had completed level 3 adult safeguarding training.
- We requested evidence of medical staff safeguarding training at level 3 this was not provided.
- The ED had arrangements in place to report safeguarding concerns. There was a trust wide lead for safeguarding children and a trust wide lead for vulnerable adults.
- To report a vulnerable adult concern a telephone call was made to social services and followed up by sending a secure email to the social services vulnerable adults safeguarding team.
- For children, a phone call was made to social services and this was followed up with a faxed referral. Following a serious incident in 2013, additional measures had been put in place, for example, all children's safeguarding referrals were recorded in the department's diary and checked by the Health Visitor Liaison Officer (HVLO) employed by the trust and we saw evidence that this had happened.
- For children on the child protection register, a flag was on the electronic system, to alert staff members.
- The staff we spoke with were all familiar with the trust's safeguarding arrangements. We spoke with both permanent as well as agency staff. However, it is important to note that there was no induction process for agency staff. Furthermore, they were responsible for ensuring their own mandatory training was up to date. We saw that there was high usage of agency staff and locums and therefore there was an increased risk that they may be unaware of the procedures which must be followed to report safeguarding concerns.
- We reviewed a sample of patient records and found one record where it was appropriate to make a safeguarding referral and we found that trust processes had been followed appropriately and the referral was made.
- We had requested additional patient records for specific conditions, for example, patients who had presented due to self-harm so that we could review them and ensure safeguarding referrals had been made if appropriate. However, we were not provided with the reports requested.
- We were made aware of a serious incident which had occurred in 2013 relating to a Non Accidental Injury of a child. We saw that an action plan had been developed which included a number of recommendations. One recommendation was that the report be shared with all ED staff to disseminate the learning from this case. However, we spoke to staff and management within the department and none of the staff or managers we spoke with were aware of this incident or the actions taken as a direct response.
- We also asked staff about completion of body maps, which was one of the recommendations from the incident. We were told by nursing staff that hard copy body maps, used to record marks, such as bruises or injuries, were complete for children. There was no body map for adults and as all documentation was electronic, staff were required to record in typed format details of any injuries and where they were located on a person's body. One of the doctors we spoke with was unaware of the use of body maps and informed us, they would refer any concerns to a paediatrician.
- From review of the incidents reported, we noted that not all safeguarding referrals were reported on the hospital's electronic reporting system. For example, we saw that a total of three children safeguarding incidents had been reported between August and October 2014. We had identified through general review of the safeguarding diary that a significantly higher number of safeguarding referrals had been made during this period.
- We also noted that one of the incidents reported that two members of staff had failed to recognise the safeguarding alert flag for one child who had attended ED. Subsequently, the child was discharged without recognition of the risk or assurance that it was safe to do so. This incident had also been categorised as 'no harm'. A second incident also identified failings in following safeguarding procedures for another child.
- We saw some examples of safeguarding issues being identified and reported, for example, the department were good at identifying and reporting pressure ulcers on arrival into the department.

Mandatory training

- All new members of permanent staff were required to attend a trust induction and were also given a period of orientation within the department during which they were supernumerary.
- We were told there was no induction arrangement in place for agency nurses or locum doctors who made a

significant proportion of the emergency department team. However the executive team stated locums employed on a fixed-term basis attended the medical new starter induction.

- All permanent members of staff are required to complete the trust's mandatory and statutory training. The staff we spoke with were satisfied with the standard of training provided.
- Agency nurses and locum doctors were required to source their own mandatory training, although we were told they could access some trust training if they requested to do so, but that this was not offered routinely.
- Statutory and mandatory training included, although was not limited to, privacy and dignity, reporting of incidents, infection control, safeguarding (Level 1), dementia awareness and information governance.
- We noted that statutory and mandatory training was generic and had not listed training required according to staff needs. For example, staff were required to attend safeguarding training for both adult and children at level 1. However, there was no information regarding requirements of paediatric staff requiring safeguarding training to level 3. Therefore this was not reported on at a trust wide level.
- From review of data provided by the trust we saw that the majority of permanent medical staff had completed their mandatory and statutory training, nursing staff had completed mandatory training and between 75% and 85% of nursing staff had completed their statutory training, this varied according to the area of ED they worked in.
- We were provided with a separate spreadsheet evidencing the percentage of nurses who had completed life support training at intermediate levels for adults and paediatrics. Overall this was 93% and 54% respectively with 92% of paediatric nursing staff having completed paediatric intermediate life support. No evidence was provided of staff who had attended advanced paediatric life support training (APLS). In accordance with the Royal College of Nursing guidance, at least one nurse per shift should be trained in APLS.
- We requested the same information for medical staff but were not provided with this.

Assessing and responding to patient risk

- Patients who transported themselves to the ED were required to report to the nurse or doctor at the streaming desk. The nurse or doctor undertook an initial assessment of the patient and issued them with a coloured card. The colour of the card was used to inform the receptionist which area of ED the patient needed to be directed to. If the patient's condition was sufficiently serious, we were told that they would be escorted directly to the relevant area. The streaming pod was run by PELC.
- Patients directed to reception provided their details and waited in the main waiting area, before being directed to paediatric ED, minor injuries, majors or urgent care (Urgent care was also managed and run by PELC). Reception staff were employed by PELC, although during busy times, a receptionist assisted in booking patients.
- There were two separate areas within the Majors section of ED, Early Assessment (EA) and Initial Assessment (IA). IA is for patients who arrive by ambulance and require early investigations in order that a diagnosis can be made. This operates during the day and is consultant led. EA is for patients who have been transported themselves to the ED and been triaged. .
- Outside of these hours, the beds are still used and patients prioritised according to clinical need, however, the distinct EA/IA pathway was not followed during this time.
- There was a process in place to assess all patients arriving by ambulance within 15 minutes. We spoke to some paramedics who were waiting to handover patients. They told us that this process generally worked well but that sometimes they had to wait longer than 15 minutes.
- We reviewed the ED dashboard which indicated that patients transported by ambulance, for the year to date (1 April to 9 November 2014) 44% had received their initial assessment within 15 minutes, against a target of 85%. 92% of patients had received their initial assessment within 30 minutes against a target of 95%. The dashboard reported that 11 patients had exceeded the target handover time of one hour. This conflicted with data provided to us on a separate spreadsheet which aimed to record and summarise investigations of such incidents where ambulance handover exceeded one hour; this reported that such incidents had not occurred during 2014/15.

- During one shift, we observed that that the EA Rapid Assessment process was unable to function appropriately and there was over a two hour delay to see an ED doctor. There were four doctors absent due to sickness for this particular shift.
- We reviewed a sample of patient notes and found that the majority of cases, patient risk had been responded to appropriately. However, we noted one patient with an emergency condition, which required immediate assessment by a doctor and an emergency CT scan to be arranged. Despite the seriousness of the patient's condition, they had not been assessed following arrival into the department for over three hours. We also noted that the notes for one child who had sustained a head injury did not record what advice had been given to the child's parents prior to discharge.
- We observed a delay in a patient being transferred from the A&E waiting area through to the main department, the patient appeared to be very unwell and their relative attempted to raise awareness amongst staff. Staff did not appear to respond promptly to the patient's needs and manual handling procedures were not followed.
- Review of incidents reported between August and October 2014 included some incidents which indicated patients had received sub-optimal care. For example, for one patient, there had been a delayed diagnosis and implementation of trauma pathway resulting in delayed critical intervention. The patient subsequently died. It was agreed by the Mortality Review Panel that this had a negative effect on the patient's outcome. Another incident described the difficulty, during the weekend to get access to an urgent scan for a patient with a serious condition that required the scan in order to accurately diagnose the condition and commence treatment.
- Staff gave inconsistent accounts for identifying and reporting pressure ulcers as part of the assessment process and managing pressure area care. Some staff told us that patients identified as having a pressure ulcer, or at risk of developing one, were ordered a pressure relieving mattress if they were expected to be in ED for any length of time. Other staff told us that mattresses were not ordered for at risk patients. We observed and spoke with three elderly patients who had been in the department between nine and 11 hours who either had a pressure ulcer, or were at increased risk of developing one. These patients had remained on the ED trolley during this time and a pressure relieving mattress had not been ordered.
- We saw that the ED did not have a suitable system in place to respond to the deteriorating patient. The IT system used by the department was not able to record early warning scores in a way to monitor any deterioration over a period of time. Reliance was placed on reviewing the patient observations recorded and supporting information. This increased the risk of an incorrect medical opinion being formed about a patient's condition.
- We asked if an audit was available to ensure the effectiveness of monitoring the deteriorating patient, however, we were informed it was not available.

Nursing staffing

- Recognising the significant workforce issues with the emergency department we requested a copy of the ED's recruitment strategy but this was not provided.
- We requested details of a staffing needs assessment undertaken for both nursing and medical staff, to ensure the trust had adequately assessed the number of staff needed to work in the department to meet patient demand. However, we were not provided with a copy.
- We were told by the matron that there was a high vacancy rate within the department and that agency nurses were being used to cover most shifts. We were told that the trust had recently undertaken a recruitment event abroad and similar events were planned to take place over the next few months.
- We were told that there was no documented protocol which linked staffing levels to acuity and that staff were allocated to each area within ED according to available skills and patient demand. There was no formal process for making these decisions. Reliance was placed on the shift leader to assign staff to each area.
- The staff we spoke with had mixed opinions on whether staffing was adequate. Only a small number of staff we spoke with perceived that staff arrangements met the needs of the department. However, it was the perception of most of the staff that staffing arrangements were not suitable. Staff reported that there was a high number of agency nurses working in the department and that the skill mix did not reflect the needs of the patients. A high number of experienced nurses had left over the previous two years. We were told it had been difficult to recruit and that staff recruited were newly qualified with limited experience.

- It was the perception of some of the nurses we spoke with that a high use of agency nurses and newly qualified nurses impacted on the care provided to patients because, they did not always have the skills needed for the emergency department. For example we were told that some agency nurses were unable to triage patients or give IVs. We were also told that the senior nurse often had to check work undertaken by nurses who worked the shift, which took their time away from patients.
- We were told that the paediatric area of ED did not always have a paediatric qualified nurse on duty and we saw evidence of this. One of the night shifts had been staffed by four agency nurses until 2am and then two agency nurses until 8am. All four nurses were trained to care for adults only. In accordance with Royal College of Nursing standards there should be a minimum of two children's nurses at all times.
- In addition to the assessment bays in paediatric ED, there was a Clinical Observation Unit, this was used for paediatric patients who still required monitoring. This unit was not staffed separately and therefore reliance was placed on nursing staff checking on patients periodically. We were told that as these patients were not a priority, reliance was placed on parents to look after their children and staff made checks as and when they could.
- We reviewed a sample of daily allocation sheets and found that there was a high usage of agency nurses, particularly on the night shift, day shifts also frequently had up to 66% of nursing cover provided by an agency nurses.
- We observed that some shifts did not have the required number of nursing staff and we were told that if staff members called in sick at short notice, which they did, it was often difficult to replace them.
- Most of the staff we spoke with told us that they would not complete an incident form if they were short of staff, because if the shift was busy, they would not have time to do so. We reviewed the incidents reported between 18 August and 23 October 2014 and found that only seven nursing staff incidents had been reported between this period, two shortage of staff and five due to skill mix. There were four staffing incidents reported due to workload.
- Most of the staff we spoke with told us that they rarely had time to take a break during their 12 hour shift.
- We observed one of the nursing handovers and found that this was effective and concerns regarding individual patients or general issues affecting the department were discussed.

Medical staffing

- We requested a copy of the ED's recruitment strategy but this was not provided.
- We were told by the staff we spoke with that some shifts were short of the required number of doctors and that there was a high percentage of locum doctors working in the department. However, many of the locums worked regular shifts at the trust.
- We reviewed a sample of rotas and found that this supported what staff told us, we saw that the majority of shifts were covered by approximately 50% locums for middle grade doctors.
- The expectation was that consultant cover was provided for 16 hours per day, seven days a week and we saw evidence of this in the rotas.
- There had been a small number of incidents reported regarding a lack of consultants and middle grade doctors. There were also some examples in the ward escalation summaries where there had been a shortage of doctors.

Major incident awareness and training

- The trust had a major incident plan which was last updated in September 2014. The latest version included an update on lessons learned from previous exercises as well as changes as a result of the merger. The plan set out roles and responsibilities, example scenarios had been included within the plan.
- We were told that regular major incident training took place and all of the permanent staff we spoke with told us that they had attended major incident training. All permanent staff talked confidently about what to do for certain major incidents and where they could access equipment and clothing and how to apply this.
- We were provided with a copy of a debrief report for a recent major incident exercise. The report outlined the event, what worked well and what could be improved. An action plan had been developed. We noted that not all areas identified for improvement had been transferred into the action plan, for example, the report stated, 'Whipps Cross phones were not situated effectively and should have speakerphone capability and that, red phones at Whipps Cross were not seen as fit for purpose as their design inhibited the functional

use'. But this had not been referred to in the action plan. We also noted that although each action had a deadline and nominated person / team responsibility to implement, confirmation of the date each recommendation had been achieved was not recorded.
- There was a designated room which was used to store equipment for major external incident, including decontamination suits for example.
- We were provided with evidence that the majority of permanent nursing staff had completed major incident training. However, it was unclear when the training had taken place and we were not provided with the same information for medical staff even though this had been requested. We received no evidence that agency staff had participated in this training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Inadequate

Patients did not consistently receive care and treatment in line with national guidance. Not all of the staff were competent to provide the care required. We were not provided with evidence of any recent audits or learning from this. We were unable to fully assess multidisciplinary working arrangements because requested evidence was not provided. Nursing staff were not empowered to make decisions about capacity, or act on their concerns. Patients did not always receive nutrition and/or hydration while in the department, despite having spent a considerable amount of time there.

Evidence-based care and treatment

- We reviewed a sample of notes for patients who had attended the ED. From the sample we reviewed, most patients but not all had received care in line with national guidance. For example, for the notes we reviewed we saw that patients who presented with chest pain, children with asthma, head injury had received care in line with the relevant National Institute for Health and Care Excellence (NICE) guidance. However, we noted any discharge advice given for the patient with a head injury had not been documented.
- We also witnessed examples of poor care, guidance for appropriate care for a patient with an Abdominal Aortic Aneurysm had not been followed. The College of Emergency Medicine guidelines states that these should be "expedited" and done "without delay". The patient we saw had not received an initial assessment from a doctor for over three hours.
- One patient who should have been treated in accordance with NICE guidance for management of sepsis had not been administered antibiotics for approximately three hours after. Antibiotics should have been administered within one hour. We also noted that this patient had been admitted to the Clinical Decision Unit (CDU) when it was inappropriate to do so as she did not meet the criteria which could have posed a risk to her health.
- We also saw examples of a number of incidents reported where patients had received sub-optimal care, including one where the patient had been inappropriately admitted to CDU despite the staff escalating concerns, informing the nurse in charge that the patient should not be admitted there.
- Policies were available on the intranet for staff to follow; however, nursing staff working in paediatric area of the ED referred to hard copy guidance which were out of date. We also noted the resuscitation guidance displayed in the resuscitation area was out of date.

Pain relief

- The ED had an electronic scoring tool to record patients' pain levels. Pain was scored from 0-10, adult patients were asked (where this was possible) what their pain rating was. This was documented by the nurse on behalf of the patient as hard copy tools were not available. We also noted that there was no pain scoring tool for younger children or for patients with a learning disability.
- The patients we spoke with told us that they had received pain relief and we saw evidence of this through review of patient notes.
- We did see one example of a patient who did not receive analgesia promptly.

Nutrition and hydration

- During the first day of our inspection we spoke with four patients who had been on the department for more than four hours and during at least one mealtime. Some of these patients had been on the department for over

10 hours. Each of the patients told us that they had not been offered anything to eat or drink. We reviewed their notes and there was no medical reason why they were not offered food or drinks.

- The relative of one patient told us, "I asked the nurse if my daughter could have something to eat, the nurse told me that they don't provide food in ED". This patient had been in the department overnight. Another elderly patient told us, "I had to keep asking for food and they kept ignoring me, "I had to ask five times before I got a cup of tea". This patient had been in the department for 11 hours.
- We were told by staff that patients who were on ED for more than four hours were offered toast or cereal at breakfast and a sandwich at other meal times. We were given contradicting accounts about how frequently drinks were offered. One member of staff informed us a tea trolley was regularly circulated every two hours another told us this only happened at meal times.
- We observed that patients did not have any food or drinks unless a relative had purchased this for them. We raised this with the matron at the end of the first day of inspection. On the second day of our inspection we observed patients being offered drinks and something to eat.
- We saw that patient complaints had been received about the lack of food and drink offered in the department and action had not been taken.

Patient outcomes

- We were provided with a copy of the clinical audit plan for 2013/14 and 2014/15. We saw that each of the plans included audits required nationally, for example audits required by the College of Emergency Medicine (CEM) as well as the National Institute for Health and Care Excellence (NICE).
- The hospital did not submit to the College of Emergency Medicine (CEM) in 2014/15.
- We noted there were 13 audits planned for 2014/15 of which four had an agreed start and end date. There was no evidence that audits were underway or that any audits had been completed for the year to date.
- We reviewed the clinical audit plan for 2013/14 and saw that of the 17 audits listed; only one was recorded as completed.
- We requested evidence of the two most recent completed clinical audits with details of action plans as well as minutes from the presentation forum. However, this evidence was not provided.
- We noted that the clinical audit plans listed trust record keeping as an audit title. During the inspection we asked management whether audits on record keeping took place but we were informed that they did not.
- We requested a copy of the nursing audit plan but were not provided with one. We were provided with some ad-hoc nursing audits. A recent ED compliance audit concluded some minor improvements were needed but that overall staff and patients were satisfied. It was noted the staff interviewed as part of the audit had raised concerns about the skills mix within the department but this had not been addressed in the conclusions or action plan.
- Other audits provided were not from the current year and some over two years old and were, therefore not relevant.
- We saw that unplanned re-attendance rates were significantly below the national average. The national standard is 5% with the England average above 7%. The trust's re-attendance rate for the year to date as at 9 November 2014 was 0.2%. We asked whether the data was validated or audited, but it had not been. We asked why re-attendance was significantly lower than the England average and were told that 'it was a grey area' to determine whether a patient's re-attendance related to an attendance within the preceding seven days. National comparisons on re-attendance data was not available at the time of our inspection.

Competent staff

- The trust had systems in place to ensure professional registration of permanent employees was maintained and up to date and we were shown evidence of this.
- The staff we spoke with told us that they had received an appraisal within the last year and had found this process helpful. We saw that most nursing staff had received an appraisal in 2014.
- We requested details of appraisal data for medical staff but the data provided was trustwide and not specific to the hospital; therefore data could not be considered as part of this inspection.

- The junior and middle grade medical staff we spoke with told us that they felt supported by the consultants and there were specific 'open door' sessions each week should a doctor wish to discuss any issues / concerns with one of the consultants.
- We were told by some of the staff we spoke with that not all of the agency staff who worked within the ED had the required skills, for example, some agency nurses were unable to triage or insert an IV cannula.
- We also saw two incidents which had been reported which raised concerns regarding competencies. For example, one incident reported that there were no staff on duty for a particular shift to fit a collar, or to safely move a patient in the department who had a spinal injury. A second incident reported that a member of staff working in the resuscitation area of ED had not received training to use the machines in resuscitation and had not been issued with the relevant codes required.
- We also saw examples of incidents which reported that the skill mix was inadequate on five shifts.

Multidisciplinary working

- Most of the staff we spoke with told us that multidisciplinary arrangements worked well and communication with staff working on the Acute Assessment Unit (AAU) worked particularly well. The hospital had an Ambulatory care team, who aimed to provide diagnostic tests amongst other things for patients who do not need to be admitted.
- Patients who presented at the department with mental health needs were treated for their immediate clinical needs and a referral was also made immediately to the crisis team for adults and the child and adolescent mental health team for children. We were told that relations had improved and that response times had improved but there were often delays in getting a psychiatric review, particularly for children.
- Data provided by the trust demonstrated that between September and October 2014 there were between 4 and 14 patients each week who waited in the department for more than four hours because they were waiting to be seen by a mental health specialist. It was unclear as a percentage how many mental health patients who attended the department waited more than four hours or for how long and there was no audit to assess this. It was noted that the data provided also conflicted with other data provided by the trust which indicated there were no patients who had presented with mental health issues who had breached the four hour target during the same period.
- We requested some patient notes for both adults and children who had presented at ED with mental health concerns, but these were not provided. Therefore we were unable to assess the timeliness of ED staff making referrals to the psychiatric teams. We noted there had been some incidents reported regarding delays for paediatric patients waiting to be seen or waiting to be transferred. We also noted on occasions patients breached the four hour target because they were waiting for the mental health team or for a bed.

Seven-day services

- Pharmacy services were available during the day and on-call arrangements were in place out of hours.
- We were told by the staff that radiology arrangements did not always work well as there were often long waits for patients to undergo CT scans.
- We reviewed the reason patients remained in the ED for more than four hours in September and October. A patient who waited longer than this, or 'breached' because they were waiting for diagnostic tests was reportedly a small percentage each day.
- There was an occupational therapy and physiotherapy service Monday to Friday that they could refer patients to if necessary. This service was not available out of hours.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We talked to staff about the Mental Capacity Act 2005 and consent. The nursing staff we spoke with had an understanding of capacity but reported that they had not received any training. They told us it was usual that medical staff would assess a patient's capacity. We were told that nursing staff used to have a form they could use to assess a person's capacity but that the new electronic system did not allow for this. Medical staff had access to hard copy forms to complete mental capacity assessments.
- The nursing staff we spoke with reported that they would not restrain a patient under any circumstances.

We were told that if an incident occurred with a challenging patient that they would do their best to calm the situation, call security and then the police as necessary.

- We were told that there was no specific training for staff on mental capacity. The training undertaken as part of learning disabilities included an element of mental capacity. However, this did not include competency and capacity assessment for children or for people who were incapacitated for reasons other than a learning disability, for example, if they were unconscious or intoxicated.

Are urgent and emergency services caring?

Requires improvement

The ED required improvement in caring for people. Most of the people we spoke with were satisfied with the care they had received. However, we observed some examples of poor care and patient's privacy and dignity was not always adequately respected.

Compassionate care

- Most of the patients we spoke with told us that staff were kind and caring. However, we were told of some examples where patients and / or their relatives had not been satisfied with their care. For example the mother of one patient told us, "while my daughter was in CDU one of the nurses was very abrupt with her, which made her anxiety worse. The staff here know she has a history of anxiety".
- We observed staff supporting and treating patients in a caring manner, although we made one observation where a member of staff rushed a patient's care and did not show compassion in assisting the patient.
- The 'Friends and Family' test gauges patients perception of the care they received and how likely they would be to recommend the service to their friends and family. Feedback from patients through the friends and family test is above the England average.
- We were given mixed information about whether hourly comfort rounds took place. Comfort rounds are undertaken to ensure patient's' needs were being met, for example whether they were comfortable, needed assistance to the toilet or needed a drink. Some of the staff we spoke with told us this did happen every two hours but that this was not recorded. Other staff we spoke with reported that there was no such arrangement in place. The patients we spoke with told us that staff had not performed comfort rounds.
- Each assessment area within ED had private cubicles or bays where curtains could be pulled around the patient to ensure their privacy and dignity was respected.
- The IA and EA area of majors did not have toilet facilities. This meant that if patients needed to use the toilet they had to exit into the majors waiting area. Re-entry to the department could only be gained with the assistance of staff. While in IA and EA some patients wore a hospital gown, which we observed, kept the patient fully covered. We observed one elderly patient wearing only a hospital gown and underwear who had returned from the toilet in the waiting area. The patient waited for a member of staff to let them in, who then proceeded to shield them and assist them back to their cubicle.
- The relative of another patient told us how their relative had also had to access the toilet wearing only their hospital gown. We asked nursing staff if they were offered any other means of covering themselves while accessing the toilet, one member of staff told us, "They have blankets on their bed, and they could use those, but they chose not to".

Patient understanding and involvement

- Most of the patients we spoke with told us that they were satisfied with the level of involvement and communication from staff but they had been waiting in the department for a long time. The relatives of one patient we spoke with were not satisfied with the communication from staff and had not felt listened to when attempting to seek staff understanding about the seriousness of their relative's condition.
- We undertook an inspection during the night. We observed at 11:45pm an 83 year old patient, who appeared to be sleeping, was taken to CDU by the porters because she was awaiting patient transport to take her to her care home. The patient's relatives were angry that they and their mother had waited so long and it was so late at night. The relatives said they would take her themselves or that their mother should remain in ED until morning when it would be less disruptive for her. We observed that the nurse responded in a calm

manner encouraging them to wait for the patient transport to arrive. However, concerns about discharging a patient late at night did not appear to have been listened to.

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

(for example, to feedback?)

Requires improvement

The Emergency Department was not always responsive to patient's' needs. We saw that the access to the department and flow through it, did not work well and some patients, higher than the national average, were in the department for over 10 hours. A significant proportion of patients waited much longer than they should for an assessment from a doctor. Furthermore, there were delays in handovers taking place for some patients who arrived by ambulance. The complaints system was unclear and the evidence of lessons learned from complaints was insufficient.

Service planning and delivery to meet the needs of local people

- Senior staff told us about individual plans regarding admission avoidance and ambulatory care as well as trust wide attempts to reduce the length of stay. Causes of the delay were monitored daily, weekly and monthly. However, although causes were monitored, there was no cohesive review or plan which brought everything together or which attempted to identify and understand the reason behind the causes, for example, delay in ED. The assessment process was a significant contributor but we were not told about, or provided with evidence of how this was being addressed.

Access and flow

- The national target for patients attending ED to be admitted, discharged or transferred within four hours is 95% of all patients. We saw that for the year to date, as at 9 November 2014, the hospital's achievement stood at 93.081%, this was significantly lower for 'type 1' patients at 89.11% for the same period. Type 1 patients are patients who attend the majors area of ED. Concerns about the accuracy of recording time spent in ED were shared with the inspection team. We raised these concerns with the executive team who took immediate action.
- The ED dashboard reported that the 15 minute and 30 minute handover for ambulances was only achieved 44.1% and 93.2% of the time, for the year to date. It was also recorded on the dashboard that there had been 11 ambulance waits to handover to A&E staff, which had exceeded 60 minutes. The 60 minute handover data was inconsistent with the separate spreadsheet we had been provided with on ambulance handover delays exceeding 60 minutes, which indicated there had been no reports of such incidents.
- We saw that the longest wait time averaged for the year to date as 11:36 hours and on occasions this had reached 12 hours.
- Data from the same dashboard reported that 5% of patients brought in by ambulance waited for long periods to have their initial assessment by a doctor. The year to date figure was not reported, but during the week ending 12 October 2014 over 5% of patients waited more than 11 hours to be assessed and week ending 19 October 2014 over 5% of patients waited more than 10hours and 48 minutes. Results varied week to week, with the lowest being week ending 24 August at five hours and 42 minutes.
- The data provided also indicated that patients who left the department without being seen was 2% significantly lower than the target of 5%.
- We were told by staff that the department was frequently busy and that workloads were very demanding. Staff told us that it was their perception that the team worked well together and this helped. We were told that there were a number of factors which impacted on the flow through ED; this included accessing beds in the hospital for patients who needed to be admitted, waiting for test results or specialists from other departments to assess a patient. It was the perception of staff that the high usage of agency nurses and medical locums impacted on the efficiency of the department due to some of their work needing to be checked (depending on whether they were short term / long term agency/ locum workers). This was compounded by lack of access to smart cards to enable temporary staff to access the trust's electronic recording systems.

- We reviewed data provided which recorded the reasons patients had exceeded the four hour wait in ED between 1st September and 2nd November 2014. It showed the main causes for breaching the target were due to, patients waiting for a bed (51%), patients waiting for an ED Assessment (27%) and patients with clinical needs accounted for (10%) of delays (which meant they were waiting some form of treatment or waiting for a specialist to assess them).
- We were told that the closure of some beds on the children's ward had also impacted on the flow within the department. Although we were unable to assess the impact of this as figures on delays were not reported on or monitored separately for children.
- We were told that patients were assessed by specialist departments during their time in the ED, for example patients would be seen by an orthopaedic or paediatric specialist. However, there were frequently delays in patients being assessed by the relevant specialty which impacted on the length of time a patient remained in the ED. We reviewed the seven day breach analysis report between 1 September and 2 November 2014 and saw that overall, 4% of patients exceeded the four hour target due to waiting for a specialist.
- One member of staff told us that there could be significant delays in patients being reviewed by specialists within the A+E. Decisions to admit were taken by the A+E department in order to expedite movement to ward beds, however patients could end up waiting post the DTA for specialty review. We were told, the patient was moved within 12 hours of the DTA.
- For example, we were provided with a screenshot of the system for a given point in time and saw that one patient had remained in ED for in excess of 10 hours, a bed had been booked for the patient three hours previously but the patient was still waiting for an assessment by a urologist.
- The CDU formed part of ED; patients could be admitted to the CDU for up to 12 hours. The CDU accepted transfers from the ED for short stay patients as well as accepting GP referrals directly. Specific criteria had to be met for patients being transferred to CDU. We saw that the majority of patients who were in CDU, it was appropriate for them to be there. However, during the unannounced inspection we noted that one of the five patients on the unit was not suitable according to the agreed protocol and had a higher level of care needs. We saw that an incident had also previously been reported where a patient had been inappropriately admitted to CDU despite opposition from some medical staff. Subsequently there was deterioration in the patient's health.
- ED were also able to refer patients to the Acute Assessment Unit (AAU) for patients who required further medical assessment. AAU was run by the medical directorate and had over 70 beds, we were told that the beds were often full and could not always be accessed as required. In addition, the trust had two contingency wards. These wards were designed to be open during peak periods only, for example during the winter when there is usually extra demand on health services. However, we were told that at present they were permanently open due to constant pressure with patient flow.

Meeting people's individual needs

- Support was available for patients with dementia and learning disabilities. Most of the permanent nursing staff we spoke with had received training in dementia awareness and supporting people with a learning disability and this was supported by training records. The trust had a learning disability specialist, who could be called during the week if needed.
- It was noted that agency staff did not routinely attend trust training courses unless they made a specific request to do so.
- A recent incident had occurred where a patient with a learning disability failed to have a fracture diagnosed because they were unable to communicate their pain to staff. One of the recommendations was for staff to ensure they informed the learning disability team that a patient with a learning disability was in the department. There was no evidence that learning from this had been communicated to ensure people's individual needs are met.
- Not all of the staff we spoke with were able to tell us who the hospital lead was for learning disabilities, but they were aware that there was one and that they could find the contact details on the intranet. We saw a protocol in the ED for supporting people with a learning disability. Part of the protocol included notifying the trust's learning disability team that a patient was in the department. However, the staff we spoke with were not aware of this and told us that they would only notify the learning disability team if there was a concern or the patient needed support.

- A translation telephone service (Language Line) could be accessed for patients whose were unable to communicate adequately in English and staff reported that this worked well when necessary.
- There were information leaflets about specific accidents / injuries / emergency conditions within the department. However, all leaflets were in English only. We asked management what the top three languages were, spoken by people who lived locally, but they were unable to provide this information.
- Some leaflets were out of date and referred to the hospital before the merger in 2012.
- A standard communication sheet was available for people who were unable to communicate verbally. This included basic pictures of types of pain, body parts, and different drinks, for example. The communication sheet also included some basic sign language. There was no communication aide for a person with a sensory impairment who may want to read using braille.
- We observed that there was a quiet, private room within the department, which was used by relatives who needed some time to themselves, or for staff to discuss bad news with relatives.

Learning from complaints and concerns

- Patients could contact PALS via the telephone or email if they wanted to make a comment or a complaint. We were told that patients could also be given the telephone number of the governance team and that this information was available to patients on PALS leaflets. We observed some posters promoting the PALS service.
- There had previously been a delay in responding to complaints but we were told action had been taken and complaints were now being dealt with promptly.
- We reviewed the complaints received about ED during September and October and noted that 15 complainants had received a response and the complaints had been closed. This had taken between 11 and 45 days. There were 16 complaints outstanding, mostly received in October, two complaints, unresolved at the time of our inspection in November, had been received in early September.
- The information we were provided with did not record details of whether the complaint had been upheld or not. Action needed to improve the service was not always recorded. Complaints typically related to the standard of care provided, staff attitude and length of wait. Some relatives raised concerns about delays in diagnosis.
- We were provided with details of 'lessons learned' for one complaint. The complaint related to a patient being discharged late at night. We saw that the agreed action was for staff to take into account patient's individual circumstances before discharging them late at night. The agreed action was to raise this at the sisters meeting for cascade to all staff in October 2014. We were not provided with evidence that this had been discussed. During the inspection we observed that two elderly patients who were deemed well enough for discharge late at night. One was kept in overnight for discharge in the morning as they lived alone. The other elderly patient, who lived in a care home, had patient transport arranged. They were still awaiting transport at 11:45pm.
- Three of the complaints we reviewed may also have needed to have been reported as incidents but we were unable to see evidence that they had. We requested additional information from the trust but this was not provided.
- We also saw examples of patients / relatives who had complained that the patient had not received food or hydration. This had been discussed at a committee but there were no agreed actions and we saw patients were not routinely offered food and drink in the ED.

Are urgent and emergency services well-led?

Inadequate

The delivery of high quality care was not assured by the leadership, governance or culture in place. There was no clear vision or strategy.

Managers within the department were new to the posts and there did not appear to be an understanding of inherited issues having been handed over and resolved. Management were aware of some of the issues, but not all and effective action was not always evident.

Not all committee or team meeting minutes requested were provided and the discussion recorded in the minutes

shared with us did not demonstrate that clear decisions had been made or that terms of reference had been followed. Staff had mixed views about leadership and how well supported they felt.

Vision and strategy for this service

- We were told that there was no cohesive vision for the ED although there were ad-hoc plans in place aimed at improving the flow through the department, for example, opening a special ward for patients who required to be discharged back into the community and required care.
- We requested a copy of the ED annual business plan but were not provided with this.

Governance, risk management and quality measurement

- Monthly governance meetings were held. A quarterly report was presented at the Emergency Care and Medicine (ECAM) Quality and Safety Committee (QSC). Serious incidents were also shared with the trust wide Serious Incident committee (SIC) which met weekly. The ECAM QSC and SIC were direct sub-committees of the trust board.
- All serious incidents should be investigated within 45 days. The hospital often did not meet this requirement and in the past the commissioners had intervened with reviewing a backlog of serious incidents. There was no system to ensure the sustainability of reviewing serious incidents within timescales and ensuring adequate investigations.
- We reviewed the most recent set of minutes available for the ECAM QSC, July and April 2014 and found that, the number of incidents reported during the quarter were commented on as well as the volume overdue. However, individual content nor trends were not considered in accordance with its terms of reference. It was agreed at one of the meetings that new ways to share learning from serious incidents and complaints was needed, but did not record how. The minutes also recorded that new risks had been discussed, risk themes were recorded, and that the risk management committees continued to monitor risks, but it did not report how.
- We were provided with a copy of the Emergency Medicine Department and Acute Assessment Unit Clinical Improvement Group (CIG) minutes for November and October 2014. We were not told about this particular group during the inspection and it was unclear from the committee structure and minutes provided what the reporting lines were for this group.
- We saw that the CIG minutes evidenced the number of clinical incidents which had occurred during the month were discussed. It was clear that skill mix and high agency usage remained an outstanding concern, but there was no evidence of discussion as to how this would be addressed.
- Complaints were also discussed, but solutions to concerns raised were not consistently recorded. For example, the November minutes reported that patients had complained about food/refreshments not being available. Rather than considering whether concerns were justified, it was noted in the minutes that refreshments were available day and night, but it was not stated how this had been verified or followed up. Early morning discharges were also reported as a concern. It was stated that all patient discharges were treated on an individual basis, but the risks were higher when discharging a patient at night. Again, solutions were not discussed.
- The ED maintained a risk register. High level risks were transferred to the trust wide risk register. The ED risk register was reviewed and discussed at the quarterly risk register meeting. This was a trust wide meeting.
- We reviewed the risk register for ED which had a total of 12 risks recorded. It did not reflect all the risks the inspection team found or what staff told us. The main risk was meeting the four hour target due to bed capacity. High usage of agency staff due to 25% vacancy factor, impacting on skill mix within ED was also classified as a high risk.
- There were additional risks we identified during the inspection which had not been factored in, for example, privacy and dignity risks had failed to consider the lack of toilets in the majors area. Recent serious incidents had not been considered or included on the risk register, as well as the risk of a major incident, infection outbreak and Ebola outbreak. Overall although the risk register supported some of the concerns we found through the inspection process, it had not considered all significant risks.
- We requested copies of the risk management committee meeting minutes but these were not provided.

Urgent and emergency services

Leadership of service

- Most of the senior management positions were filled by members of staff who had been newly appointed from external organisations. They were aware of some but not all the issues effecting the service provided to patients as there was a lack of continuity in management and contingency planning.
- Within the ED there was a nurse in charge of the shift and within each separate area of ED, e.g. minors / paediatrics the most senior nurse who worked the shift reported to the nurse in charge who in turn reported to the Matron.
- We noted from discussions with staff and review of the daily allocation sheets that the nurses leading a given area, for example children were not always a permanent member of staff.
- Medical staff reported to the Consultant, when on shift and to the registrar in charge out of hours.
- We spoke with senior managers about the concerns raised with us by staff and they told us that they had recently held a 'brainstorming' exercise for staff to suggest ideas about how to tackle the problem. We requested a copy of the brainstorming exercise but this was not provided.

Culture within the service

- The staff we spoke with had mixed perceptions about the culture within the service. Most of the staff we spoke with were satisfied with the culture and told us that they worked well together.
- We were told that a significant number of experienced nurses had left following the merger and that they had either not been replaced or many had been replaced with more junior nurses. We were told that there was a negative feeling as a result of this. It was reported to us that some of the nurses who had left were not permitted to work as agency nurses on the department because they had left the organisation.
- Some staff reported that they had felt bullied at times but had not reported this because they did not feel it would make any difference. Other staff reported that they did not feel they would be listened to by senior managers if they raised any concerns about how the department was run and so they did not share their concerns.

Public and staff engagement

- A friends and family notice board was displayed in the majors waiting area. There were some positive and negative quotes from patients displayed on the board but there was no feedback of action taken. It was unclear when the quotes had been obtained. Staff training attendance data was also displayed on the same notice board and this dated back to July 2013.
- The recent CQC A&E patient survey reported largely positive feedback from patients although it was noted that negative findings were reported that they did not feel reassured by staff if they had felt distressed while in A&E. However, results for this survey were trust wide and not specific to the hospital A&E.
- We were told that staff contributed to team meetings and could raise issues as part of their annual appraisal. We were not provided with evidence of team meetings. Some of the staff we spoke with perceived that there was no benefit in raising concerns as they did not feel listened to.

Medical care (including older people's care)

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The hospital provided a range of inpatient medical services, including older people's care, endocrinology/ diabetes, cardiology, stroke, haematology, rehabilitation, gastroenterology, respiratory, acute medical care, ambulatory care and general medical care totalling 384 beds at full capacity, as well as surge wards.

The service was provided over 22 wards and we visited 16 of these over three days, as well as two night visits. Other than haematology, we visited wards across all the specialties, including isolation and surge wards. The medical care service admitted just over 30,000 patients a year, which were mostly emergency, or day cases. Most patients were older people or there were patients that required general medical care, such as gastroenterology.

We spoke with over 30 patients, 100 members of staff, including doctors, nurses, administration staff, allied health professionals (such as pharmacists and therapists), as well as clinical, nursing, governance and managerial leads within each specialty. We also reviewed over 50 patient records and over 30 items of equipment.

Summary of findings

Safety was not a sufficient priority. There were frequent staff shortages and a reliance on agency and locum staff that increased the risk to patients. The handovers did not cover all aspects of patient care, or ensure that staff were aware of how the service was performing.

The medical services were not responsive to patient needs. Patients did not always leave hospital when they were well enough and bed occupancy was regularly well over 85%. Patients with complex needs were not always identified, or given access to specific services to cater for these needs.

Performance was between average and poor in national audits. There was a lack of local audits in some areas and a lack of seven-day working.

Although patient feedback was mostly positive, there were concerns with patient involvement in a number of areas and patient survey results were variable.

The medical services were not well-led. There were gaps in the governance arrangements at a middle-management level and the strategy to achieve the vision was unknown.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Safety was not a sufficient priority. There were frequent staff shortages and a reliance on agency and locum staff that increased the risk to patients. The handovers did not cover all aspects of patient care, or ensure that staff were aware of how the service was performing.

There was an inconsistency in recording assessments, and staff told us records often could not be located. Some of the Safety Thermometer results were worse than the national average.

Staff were aware and able to report incidents but did not have the time. There was a lack of feedback on incidents that had been reported and sharing of any learning.

Incidents

- Although there were 101 serious incidents reported in 2013/14, we were provided information by the hospital which suggested the most recent serious incident reported was in July 2014, which involved a pressure ulcer deteriorating from a level 2 to a level 3. The trust had taken action to address this by employing an additional tissue viability nurse and staff were positive about the support this nurse was now giving. However, some staff who worked on the ward on which the incident occurred were not aware of the incident.
- While we were on site, we were informed of three possible serious incidents. One involved a patient who had been prescribed penicillin when they were allergic to it. Another involved a deteriorating pressure ulcer to a level 3. Another patient was prescribed incorrect medicines after their condition deteriorated. Staff told us they had reported these incidents. The investigations were pending at the end of our inspection.
- Most of the staff we spoke with were aware of how to report incidents and were able to show us how to report an incident using their incident reporting system. However, some staff told us they did not report near misses, as they did not have the time and agency staff were not always able to report incidents, as they did not have access to the computers.
- Staff on two wards told us about safety huddles, or debriefings, to discuss incidents. They were able to describe the outcome of an investigation that resulted in a recommendation that staff should check the documentation of skin bundles from the previous shift. However, most staff told us they either did not receive feedback from the incidents they reported, or they could not gives us examples of learning from incidents that had occurred on their ward. Senior leads acknowledged that learning from incidents needed embedding.
- Incidents were not always graded appropriately. We saw a number of incidents that had been graded as low harm such as a grade one pressure ulcer when it was a higher harm grade 3.
- We were told moderate harm incidents and above were reviewed by the governance leads, but those of low harm, or below, were reviewed by ward managers.
- Mortality and morbidity meetings took place monthly, which included junior doctors attending to learn from deaths.

Safety thermometer

- Safety thermometer results were visible on every ward we visited, with safety crosses in place showing how many falls, pressure ulcers, inadequate staffing, infections and incidents had occurred.
- Some of the Safety Thermometer results were worse than the national average. There were higher than average pressure ulcers reported, with between four and eight reported each month and a total of 80 grade 3 and 4 pressure ulcers in 2013/2014. Results for one care of the elderly ward showed although there had been a reduction of pressure ulcers in the summer. They had recently risen again to previously high levels.
- The trust had recently started tracking to see if pressure ulcers had developed before admission, rather than being acquired after the patient was admitted to the hospital. Most of the recent pressure ulcers were being reported as being 'on admission', although there was an incident during our inspection where a pressure ulcer had deteriorated.
- Records for patient skincare showed pressure ulcers were being well managed with appropriate mattresses and turning charts. Two tissue viability nurses were conducting audits for pressure care. Link nurses were in place for pressure ulcers. Roles and responsibilities for managing pressure ulcers were displayed in one ward. Patient notes we reviewed showed appropriate follow-up care for those patients with skin integrity concerns.

- Reporting of urinary tract infections was low, with between zero and two reported each month on the safety thermometer across all of medicine.
- Reporting of falls was variable, with between one and four reported each month. There was a high amount of falls on Blackthorn ward and there had been two falls on Syringa ward in November. Patients who were at risk of falls had been given falls cushions and non-slip socks to use. Patients were initially risk assessed. However, there was no record of a reassessment after admission. There was also no falls outreach team.

Cleanliness, infection control and hygiene

- All the areas of the wards we observed were visibly clean, although infection audit scores and results from October 2014 showed multiple issues with storage of equipment, Aseptic Non Touch Technique (ANTT) training, MRSA screening, general cleanliness and infection control.
- These audits also showed multiple issues with waste bins and we confirmed these findings as sharps bins were either incorrectly placed on the floor, or their temporary lids were not closed in most wards. In addition, one ward had black bin sacks hooked onto each patient's bed for general waste.
- However, more recent audit results displayed on the wards showed that there was 95% to 100% compliance and there had been staff meetings to discuss the results, including any learning gained.
- We observed that infectious patients had been placed in side rooms with their doors open and, although we were told one patient was claustrophobic, there was no reason given for any of the other patients, as to why their doors were open.
- On most wards, we observed staff complying with infection control guidance, such as washing their hands between patient beds and wearing personal protective equipment when entering a patient's room who was infectious.
- Both the MRSA and C. difficile targets were worse than the national average with 7 C. Ddifficile cases and 2 MRSA bacteraemias since April 2014. One ward had a patient who had a hospital acquired C. difficile the day we inspected it.
- The hospital had a specific infection ward, but some wards had no side rooms for patients with infections.
- We were told by staff that the renal units had previously had a cockroach infestation, which was now being dealt with weekly by pest control. However, staff told us pest control had only got involved a week before our inspection despite the problem being more longstanding.

Environment and equipment

- Equipment checks were variable. This included resuscitation trolleys. Some were clean and had labels within the last 24 hours.
- We reviewed evidence of checks for resuscitation trolleys for the four weeks prior to our inspection but staff were unable to locate records of these prior to that period.
- We observed that the process for changing linen and replacing bed curtains was in place. Linen was appropriately stored.
- Sluice rooms were being used for storage. We observed walking frames and drip stands in the sluice room, although they were kept clean.
- Some of the doctors' offices were cluttered with records and documents in various places and there was limited room for staff to work, or move.
- Nurses reported that pressure-relieving mattresses were arriving within 12 to 24 hours, in most instances.
- Topping mattresses were available on the ward in the interim. Most staff reported that equipment was obtained in a timely manner from the equipment library.
- A ceiling on Cedar Ward had been leaking for two weeks. The bed underneath the leak could not be used. It had been reported.
- Doctors and Allied Healthcare professionals told us that there were delays with support from the IT provision and, as they were not on site, the provision of service from this team was unsatisfactory. Staff told us that computers in the different areas of the hospital had different programs loaded, which meant delays in accessing the information they needed.
- Staff complained that IT issues were causing delays with pathology results for renal patients which meant patients treatment was delayed, particularly if they were a patient due to receive dialysis the same day.
- There was a lack of working electrocardiogram (ECG) machines and there had been an incident of a patient's blood results being delayed by several hours.

- We observed that there was a lack of piped oxygen for each bed space in the isolation ward.
- Equipment was not standardised throughout the hospital. For example, hoists in one ward were different from others.

Medicines

- Drugs fridges were locked and, although some were at the correct temperature, there was inconsistent recording of maximum and minimum temperatures.
- Medicine cupboards were locked when they were not in use, although we observed one with the keys left in it and a set of keys in an unlocked drawer. Two medicine cupboards had medicines stored in a disorderly fashion. This was despite it being identified in recent medicine audits as a concern.
- We observed on multiple wards that appropriate medicine administration, with checks and explanations given to the patient beforehand.
- Guidance for administering IVs was followed, such as cleaning the patient's skin at the site of the IV insertion, including flushing and preparing the vials appropriately.
- Some pharmacists told us that the lack, and the unstable nature of the nursing workforce due to the high use of agency staff meant drug errors were occurring. Some pharmacists were also not aware of the fact that there was an emergency drugs cupboard on site.
- Most drug charts were complete and up to date, with signatures for medicines being recorded.
- The medicine audits we checked had the correct balances and records were completed.

Records

- Most of the patient records we checked had risk assessments that were complete, such as those relating to nutrition, falls and skin.
- There was inconsistency in use of recording assessments. Some patients had separate assessments carried out on separate sheets of paper. However others had a nursing assessment booklet. Nurses reported being confused as to which form was to be completed. Doctors confirmed that some assessments such as VTEs were being completed in multiple places.
- We noted incomplete assessments. One MRSA assessment had no record when it had been undertaken. Another two had not been completed at all.
- We observed patients had bed rails in use without on-going needs for the rails being assessed. Bed rails in one ward were in place without an appropriate assessment if they were subjectively chosen to do so, such as, if a nurse thought there was a safety issue. However, no criteria for this had been set out.
- Some fluid balance charts were not totalled.
- Three admission booklets had not been fully completed and two patients with a recent fall had no falls assessment.
- We observed that some patient records were loose leaf and most records were left in a trolley in the corridor, rather than in a secure area. We also observed that some had been left out on desks.
- The trust had been served a recommendation by the coroner in April 2014, following the death of a patient who had three separate patient records, none of which had contained the patient's whole medical history.
- We observed patient records that were kept separately, with some in a file, while other parts were stamped together, but not kept in the same file. Other records were kept separately, as patients had been given a Barts Health NHS Trust number when they already had a Whipps Cross University Hospital number – these were not always merged together.
- Ward clerks told us that it was sometimes impossible to track and trace notes.
- Some staff reported that notes were held in a number of locations for storage, which also made it difficult to find them.
- Staff reported to us that, on a weekly basis, up to 25% of notes could not be found.
- There was no access to Wi-Fi on some wards, which meant it was difficult to obtain the electronic records.

Safeguarding

- A safeguarding team was in place that included executive team support and some staff were able to show us the safeguarding adults alert form.
- However, many staff were unaware of how to report a safeguarding incident, other than via their incident reporting system. When staff did know about the safeguarding team, they reported that the team appeared to be under resourced although we did not see further evidence of this during our inspection.
- Safeguarding training for both vulnerable adults and children were variable. Although some wards and services had a completion rate of on or above 90%,

others had much worse completion rates. For level two children safeguarding, Acacia Ward nurses was at 60%, Bracken Ward nurses at 67%, neurology medical staff at 67% and Mary Ward nurses at 64%. For both children and adults safeguarding training, care of the elderly, respiratory and gastroenterology medical staff were below 75% completion. For safeguarding adults training, Wavell Ward nurses had a completion rate of 67%.

Mandatory training

- All the staff we spoke with were complimentary about the mandatory training they had received. This training took place yearly, other than moving and handling, which was two yearly. Early warning scores and dementia awareness training took place every three years. However, some staff told us they had no training regarding falls.
- The mandatory training rates for staff were variable. The trust had a target of ensuring 90% of staff were trained in each area. Although some areas and wards were achieving this, there were areas and wards that fell far below this target. These included:

1. Acacia Ward in which nurse training completion rates were only 70% in a number of training modules including venous thromboembolism assessments, conflict resolution, dementia, early warning systems, fraud, complaints resolution, and privacy and dignity;
2. Bracken Ward in which nurse training completion rates were only 33% in infection control and basic life support and 67% in most other areas
3. Care of the elderly in which medical staff training rates were below 90% in all but two training modules with rates as low as 58% for dementia, 42% for infection control, and 50% for fire,
4. Gastroenterology in which medical staffing training rates were similarly low to care of the elderly,
5. Nightingale Ward in which most nurse training rates were below 80%,
6. Respiratory in which medical staffing training rates were similar low to care of the elderly and gastroenterology; and
7. Wavell Ward in which nursing training rates were 67% or below .

Assessing and responding to patient risk

- Commissioners had raised with the trust and us before the inspection that they had concerns about patients conditions deteriorating and this not being escalated and managed appropriately.
- Early warning scores were being completed for patients, however most were not being escalated. Patients who required additional monitoring when they became a 'yellow' risk, such as those who exhibited signs of brachdycardia (slow heart beat), mild hypothermia and hypotension, were not observed within the required hour after the risk arose, their conditions were not being escalated, or a doctor was not called. When we asked staff why this was the case, they said they did not always follow the early warning score guidelines, as they felt some did not require additional escalation, or the situation did not fall outside the range of expected parameters for specific patients.
- Some staff told us they had not received the full roll out of early warning score training, whereas others said there had been a full one day training course on deteriorating patients.
- The cardiology team were auditing their early warning scores and this showed 100% compliance in November 2014, but 90% compliance during the week of our inspection.
- Patients' swallowing could not be assessed on site, due to unavailable equipment such as a videofluroscopy or endoscope. This meant that there was a risk that these patients could aspirate (this means that a foreign substance, such as the gastric contents, could be drawn into the patient's respiratory tract during inhalation) .

Nursing staffing

- Staffing levels for medical wards were established to ensure at least a ratio of 1:7 nurses to patients and a skills mix of 65% registered nurses, 35% unregistered nurses. However, this was not being met in many instances.
- Multiple wards had a high number of bank and agency staff on shift, particularly on Mary ward and Bracken ward. Specialities that had percentages of bank and agency staff above 15% included respiratory, cardiology, gastroenterology, stroke with thee worst being acute medicine at 34.6%. On the isolation ward, they were filling 10 of 16 shifts a week with bank staff, with agency filling the rest of the shifts. There remained four vacancies on the gastroenterology wards after the loss of five staff in recent months.

- During our unannounced inspection, which took place around 8pm at the start of the late shift, eight wards reported nursing shortages. We observed site managers trying to get replacement staff, moving staff to ensure safety and escalating the situation. We were told that this was not uncommon and was a low number of staff compared to most days.
- Vacancies were high in some areas, with nearly 10% being in acute medical, 26.2% in cardiology, 29.7% in care of the elderly, 13.6% in gastroenterology, and 42.9% in rheumatology. It was reported that there were not enough bank staff to cover the unfilled shifts and, as the trust was cutting down on agency usage, this meant shifts were left unfilled at times. On the isolation ward, they had three vacancies. There were 5.5 vacancies in the AAU, but these had all been recruited and were due to be filled by December 2014. There remained four vacancies on the gastroenterology wards after the loss of five staff in recent months.
- A number of wards reported low levels of staffing, with safety crosses and rotas showing they had been below establishment levels up to ten times each month. We were contacted by multiple staff members regarding their concerns about staffing numbers and a feeling of being over worked and over stretched, with night staff complaining that they were unable to take breaks. Most patients said there was a lack of staff, with some staff commenting that call bells were left waiting many minutes, or were not answered at all.
- When we checked the staffing acuity tool, although an acuity and dependency score had been completed, staffing numbers did not reflect this. One ward had only stable, but fully dependent patients, yet additional staff had not been provided to reflect this. We saw one ward that was established at four registered nurses and two unregistered for 26 beds, which could add an additional unregistered nurse, despite being a care of the elderly ward, where the sister had recognised that 22 of the patients had either a diagnosis of dementia, or had the signs of it and were fully dependent on staff to support them. The skills mix audits based on acuity and dependency were completed weekly.
- In addition, patients who may have required one-to-one care, as they often wandered and/or could pose a risk to themselves or others, were either not provided this support, or it was provided by an untrained nurse. Although there was a trust policy which agreed to untrained nurse supporting patients one to one, the situations we observed this showed this was not the correct competency for the individual patient due to the high dependency of their support needs.
- Electronic rostering was planned, but had not been fully rolled out.
- Nursing handovers did not ensure safety as a priority for patients. In two wards, there was no team handover, with individual nurses handing over to each other. There was always a detailed description of the patient's' nursing needs for the next shift. However, there was very little discussion, or questioning, going on between the nurses during handover.
- The Sir Robert Francis report recommended wards be staffed with at least a band seven supernumerary nurse to help train, supervise and educate nursing staff. Although the trust told us all wards had a supernumerary band 7, only one ward we visited had a supernumerary nurse and they were not a band seven. This same ward also had frequent nurse shortages, so the supernumerary nurse would therefore take on clinical duties. This meant they could not fulfil their supernumerary duties.

Medical staffing

- There was only one permanent acute medical consultant covering the AAU. Therefore, other specialties covered both the on-call, take (reviewing the newly admitted patients and on site shifts. This meant the AAU was not always covered by a consultant trained in acute internal medicine although they were trained in general internal medicine. In addition, doctors reported shifts being unbalanced, with sometimes one specialty only covering the AAU. This meant that their specialist ward(s) were not fully covered medically. Senior leads told us that there was currently work being undertaken to review consultant job plans in order to improve consultant cover.
- A high number of patients, particularly those who were elderly, spent time in the AAU. Two consultants cared for acute medical patients from 9am to 5pm. This included caring for triage and patients needing admission. Out of hours, one registrar and a junior doctor cared for patients in the unit.
- Medical staffing records showed a high use of locums in some specialties with over 10% of shifts filled by locums in respiratory and gastroenterology, over 20% in diabetes, and over 40% in acute medicine.

Medical care (including older people's care)

- Medical staffing vacancy rates were also high with over 10% vacancies in gastroenterology, over 20% in diabetes and care of the elderly, and no substantive staff in dermatology or stroke although the stroke service was permanently staffed during our inspection. The trust told us dermatology and stroke services were staffed by cross site doctors. In addition, some doctors told us that locum shifts were left unfilled so junior doctors had to act up.
- There was no consultant to consultant handover at the end of their rota.
- There was an appropriate ratio of two junior doctors to 16 patients in cardiology, with an additional junior doctor to cover non-medical wards.
- Consultant ward rounds were conducted twice-daily in the AAU. These ward round occurred on a variety of days on the other wards, depending on the specialty i.e. once or twice a week. These rounds would normally take place around 9am. We observed that a ward round included a full medical review by the consultant and any additional issues the patient wanted to raise were answered. A nurse accompanied the round, so they were aware of any medicine changes.
- The medical handovers we observed did not ensure the safe handover of patients' care and treatment. They were led by a middle-grade doctor and doctors often attended late. There was no discussion about the capacity or of the bed occupancy. There were no nurses, or social workers involved, despite discharges being discussed. There was no discussion about patients that should be a priority. There was no input from surgical or critical care staff. On one handover, the on-call consultant was still doing their round, so the doctors may not have had all the information on patients in the hospital that they needed to be aware of.
- Despite surgical patients being treated in the AAU, surgical doctors did not attend the board round meetings.
- There was a lack of doctors out of hours, with only two junior doctors covering all the medical wards.
- The renal consultant worked part-time and patients were dissatisfied with the fact that they hardly saw a renal doctor.
- Most of the patient records we checked showed they had been seen by a doctor every 24 hours. However, this was not the case at the weekend. AAU doctors acknowledged that not all patients were seen daily. At weekends, only new patients and potential discharges were seen.

Major incident awareness and training

- Business continuity plans were in place for each specialty, which graded the impact of the service being closed depending on how long it was closed for. They also included mitigation and procedures for what to do in the event of five different emergency situations, such as relocating services, or moving staff to other areas.

Are medical care services effective?

Requires improvement

National audit performance was variable, with outcomes scores of average, or below average in most audits. There was a lack of local audits in a number of areas to assess performance and patient outcomes.

Patient pain relief and nutrition and hydration needs were being met. There was a lack of seven-day and multi-disciplinary working and staff competency had not always been assured.

Evidence-based care and treatment

- Policies and procedures we reviewed were mostly up to date and mostly were in line with national guidance. However, some staff told us these policies were not accessible, such as the pain management guidelines, and some staff felt the intranet guidance was out of date. We saw one paper version of a medicine guideline for intravenous injections that was out of date.
- There was no patient pathway for patients to avoid admission via the ED for patients already diagnosed with chronic obstructive pulmonary disease (COPD).

Patient Outcomes

- The trust took part in most relevant national audits. Outcomes Scores were either average, or below average in most of them.
- The national heart failure audit results were variable with , below average in six areas, two areas around the average and above average in three areas. When we asked what the action plan was to improve these results, part of the action was that the new heart attack

centre was to be opened at another site. However, tThe only other action mentioned was to improve staff awareness of the pathway for cardiology patients from the A&E and AAU to ensure cardiology was referred to.

- Results for the national stroke audit were similar to most trusts (score D which is the second lowest score out of an A to E range). The main issues scores that required improvements were occupational therapy and speech and language therapy input. We were told that this was due to a lack of staff in these specialties, which were being recruited to.
- The national myocardial infarction audit was above average for patients receiving secondary medicines, but worse than average in all five other areas. When we spoke with senior staff, they were aware of the better results for the trust as a whole, but not those which were specific to the hospital.
- There was no evidence of audits of echocardiographythe echocardiograms, although we were told by senior leads that the service was performance monitored in their clinical governance meetings.
- The National Diabetes Inpatient Audit (NaDIA) showed that results were variable with ten scores better than average, but eleven scores that were worse than average. There had been no diabetes local audit, as staff reported to us they did not have time, money or resources to do so, so we were unable to ascertain if there had been an improvement since the national audit. There were no 'ThinkGlucose' electronic referrals in place in the ward for patients with diabetes.
- The national cardiac arrest audit showed that there was a high amount of arrests with a worse than average survival rate. We saw evidence of actions in place, particularly in the cardiology wards, where results of cardiac arrests were displayed and how staff could mitigate both the amount of arrest calls and improve the survival rate.
- The national acquired pneumonia audit showed variable results, with worse than average length of stay, deaths, time between admission and antibiotic, chest x-rays undertaken, and antibiotics given in line with guidelines.
- However, they were better than average for chest x-rays being obtained before antibiotics were given and timeliness of senior review.
- The national audit for seizure management had variable results. In 12 areas, the hospital was above average, including record of epilepsy, senior review in the ED, tests conducted within the ED and advice being sought from the neurologist.
- However, they were worse than average for recorded care plans, seeing a specialist, temperature checks within 20 minutes, completion of neurological observation chart within four hours of attendance, and post-discharge outpatient appointments.
- The national non-invasive ventilation audit had variable results. The hospital was worse than average for six areas including out-of-hours admissions, excess oxygen given, recording of ventilation plans prior to starting ventilation, recording of ventilators used, the failure rate of non-invasive ventilation, and deaths post admission.
- However, they were better than average for four areas including length of stay, recording of plans for if non-invasive ventilation failed, family involvement, respiratory follow up and pulmonary rehabilitation within 12 months. When we asked doctors about their thoughts regarding the audit, they were unaware of its results and whether any actions had been taken.
- All the results for the renal audits, including fistulas and dialysis efficiency showed improving results.
- The national inflammatory bowel audit showed variable results, with better than average results in six areas including mortality, being seen by a specialist nurse, stool samples sent for testing, heparin prescriptions, transfers to a gastroenterology bed and the timeliness of follow up.
- However, they were worse than average in four areas including nutritional screening, referral to dietician, prescription for bone protection, and maintenance of Anti-tTumour Necrosis Factor Alpha (anti-TNfa) on discharge.
- The national dementia carer audit showed that most carers felt supported at the hospital, but were not offered external support. Carers had made recommendations, such as having specific dementia wards, better communication and increases in staffing. An action plan was in place and it included a specific care plan for people living with dementia, having more surveys, ward champions and information leaflets. However, most of these had only been partly completed

at the time of our inspection, and we saw no use of a dementia-specific care plan. In addition, when we spoke with nurses, they told us there had been no local audit regarding dementia care for at least nine months.

- The hospital results for the national learning disability audit were variable, with better than average results in eight areas including identifying learning disability patient systems, completed swallowing assessments, completed discharge summaries, having a learning disability specific nurse, mobility assessments, records of seizures, records of needs post discharge, and learning disability input into training.
- However, they were worse than average in ten areas including recording how to communicate with patients with learning disabilities, training in learning disabilities, recording of body mass index, risk assessment of epilepsy, best interest meetings, patient and family involvement in 'do not resuscitate' (DNR) orders, reviewing of psychotropic medicines, including prior to discharge, signposting for assessments post discharge, and involvement of patients with learning disabilities in induction training.
- There was no average score published for other aspects of learning disabilities, but the hospital scored over 50% in most areas including staff awareness of patients with learning disabilities having additional needs, communication being appropriate with patients with learning disabilities, carers satisfied with their involvement in developing communication with staff, carers satisfied with their involvement in ensuring the patient was comfortable, that questions raised were easy to answer, that doctors and nurses helped patients to understand what was happening, staff checking the patient understood the information given, staff checking the patient could make a decision, patients satisfied with their overall involvement, patients support to make decisions, patients satisfied with the planning of their discharge, patients satisfied with when they were discharged, patients spoken to about getting support, staff friendliness, staff listening skills, staff treating patients with dignity and respect and overall satisfaction with the service received.
- However the same scoring showed the hospital was below 50% for staff being trained in learning disabilities and patients having a health passport.
- Trust mortality rates were better than the national average for each specialty and the overall mortality for the hospital measured by was 0.9 against the summary hospital-level mortality indicator (SHMI), was 0.9, which was also better than average, although the risk of mortality was higher at the weekend.
- There was limited therapy audits taking place, but there were audits on speech and language therapist (SALT) compliance, regarding patients who had had swallowing difficulties and elderly patient's who had fallen. Patients in stroke rehabilitation were being assessed on their balance, using the Barthel Index (which measure activities of daily living) and the Ashworth Scale (which measures spasticity).

Pain relief

- Patients reported their pain was well managed and pain was monitored and recorded to ensure patients received the appropriate amount of pain relief, as needed.
- Patient records showed pain medicines were given appropriately after a vital signs assessment.

Nutrition and hydration

- Patients had mixed views on the food, some saying it was either OK, or good, and that they received a choice. However, some were not happy with the choices offered. In November 2014, the board were congratulated on the improvements to the quality of the food by the House of Lords.
- Most patients who required support to eat were identified with red trays and received the support they needed using a red tray system.
- We observed staff ensuring that patients were in the correct position to eat before they ate or drank.
- Protected meal times were in place and signage for these was displayed and we observed these being observed to by staff.

Competent staff

- New staff were supernumerary during their induction and were positive about the supervision they received. However, some new nursing students were paired with other nursing students despite it being their first day at the trust and there had been a delay in them receiving mentors.
- Senior leads acknowledged that having locum consultants in gastroenterology may have led to a poorer induction for the junior doctors this year.

- Appraisal rates were 42% in acute medicine and there was no reported appraisal rate for cardiology. This was despite an education and training committee at clinical academic group (CAG) level reviewing training and appraisal rates. However, nurses across the wards were positive about their appraisals, which included discussions about study days and professional development.
- There was a lack of competency education of staff in the care of patients with diabetes and staff were struggling to complete online training due to issues with accessing IT and lack of time.
- Plans were in place to ensure staff on the cardiology ward were cardiac trained but this had not yet occurred.
- Cardiology doctors were generally positive about the training they received and we observed a consultant-led ward round, which included a teaching element for the junior doctors when they were reviewing each patient. However, some junior doctors told us they felt the training they received did not give adequate information.
- There were some complaints about the amount of study leave consultants received, which senior leads acknowledged they had not communicated effectively about, due to a reduction in funding. Senior leads told us study leave was being agreed if it was relevant, or important to their role.
- Competency training was being completed in two separate ways, some by using a booklet, whereas others were online. However, they duplicated some courses so there was not always clarity of whether a staff member had been trained or not.
- We viewed a number of agency nurse orientation records and all these showed that agency staff completed an orientation before they worked on the ward.
- Some patients reported not feeling confident in the competency of the staff. One patient told us a nurse was unable to dress her pressure ulcer – a junior nurse had been left to complete it. This nurse had never done it before. Staff on the stroke ward felt the agency staff they sometimes used were not competent to care for patients with swallowing issues. It was also reported that some staff had not been able to use the hoists on the ward so they requested physiotherapists for support.
- Some locum doctors told us they had no local induction and we could not find records of an induction for them.
- When we spoke with therapy staff, they told us their probation period was not completed correctly due to delays in having formal meetings, so this had led to their probation period having to be extended.

Multidisciplinary working

- We observed partly effective multidisciplinary working with therapists, nurses and doctors involved in patient care and in patient meetings, as well as on ward rounds. However, there was no nurse presence at any of the medical handovers we observed. Although social workers from local authorities were invited to board rounds, they were not encouraged to be involved and we found many patients who could have had social worker input were not being referred.
- We were given examples of meetings with occupational therapists being continually cancelled and were told there were currently seven occupational therapist (OT) vacancies. This was 25% of their staff, although two were being covered by locum staff. There was also a dietician vacancy and a 0.5 whole time equivalent (WTE) SALT vacancy. Therapy staff commented they did not have enough assistants.
- Staff were complimentary about the support they received from physiotherapy, occupational therapy and speech and language therapy, including their quick responses to referral.

Access to information

- Although discharge summaries were communicated to GPs, doctors told us these could be delayed due to the lack of time registrars and consultants had to review the summaries to sign them off and this could mean a delay of a number of days.
- In addition, we were informed doctors were unsure of the process of signing off discharge summaries as some were being signed off by junior doctors to reduce the delay in sending them whereas others said the policy was for only registrars and consultants to sign them off.

Seven-day services

- There was a mixed view from staff about whether out of hours facilities and staffing were appropriate.
- The trust had not yet developed seven-day working, but planned to have it in place for frontline services within three years and in place on the AAU over the winter period. Consultants were not on site at the weekend and doctor numbers were reduced. Senior leads in

acute medicine told us they had an ambition to adjust the weekend rota so consultants worked from one in 20 weekends to one in 10, but this was still in consultation with the consultants.

- One single cardiologist covered all the trust sites at the weekend but was based at Royal London. There were two junior doctors covering nine medical wards at weekends. Cardiology weekend ward rounds were conducted by a general medical registrar.
- There were no on site diagnostic services at the weekend, such as echocardiography or occupational therapy for medical patients.
- There was no physiologist to complete echocardiograms, although there was at least one other doctor accredited to complete the test in acute medicine.
- Physiotherapy was available seven days a week for respiratory and rehabilitation patients. This aspect of the service was covered by three physiotherapists and the pharmacy was open Sundays but not Saturdays.
- The renal dialysis service was open 7.00am till 10.30pm, Monday to Saturday.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Most staff lacked understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, with staff giving us incorrect descriptions of when an application for Deprivation of Liberty Safeguards needed to be made.
- Mandatory training only included training for Mental Capacity Act 2005 and Deprivation of Liberty Safeguards for medical staff, not nursing or other staff. We were told this was covered in their safeguarding training.
- None of the assessments we checked included a check on the mental capacity of a patient and we saw variations in how the Deprivation of Liberty Safeguards applications were completed. Some wards were completing Deprivation of Liberty Safeguards for every patient, whereas others did not complete them when they were required to, such as when they felt they needed to restrain someone.
- All of the patient records we checked had a completed consent form for any procedures, or surgeries.
- Most of the patients that had been identified as needing a psychiatric assessment were still awaiting one. The waiting times these patients had experienced ranged from hours to many days. We identified one patient who had waited two weeks.

Are medical care services caring?

Requires improvement

Patient survey results were variable, most patient comments were positive, apart from some regarding their involvement in their care. Most staff we observed displayed compassionate care, although there were issues at times regarding privacy and dignity. Emotional support was variable and some patients were not offered any cultural or religious support.

Compassionate care

- Friends and Family test results were variable. Scores were above the national average in cardiology, Nightingale, Faraday, Blackthorn and Conifer but below average scores in Curie, and Cedar. Scores had varied both below and above average for Chestnut, Acacia, and Birch wards.
- The inpatient survey showed above average scores for Acacia ward and Syringa although Syringa only had one patient who completed the survey last month. Only one patient in ten on Cedar ward recommended it in the last inpatient survey. 75% recommended Nightingale ward in October on a high response rate. On Blackthorn ward, only 40% would recommend it on a 34% response rate. On Chestnut, there had been 19 responses with 53% recommending it. Overall, the hospital had an average score in 28 questions and worse than average in 22 on a 35.3% response rate.
- Most of the patients we spoke with gave us good experiences of their care. One patient said of staff "all of them are angels helping me". Another said staff were "like a family". However, some patients told us that nurses said they would help them or answer their call bell, but then did not give them the support they requested. We also received a few patient comments where they told us they did not get the support they needed and reported staff as having poor attitudes.
- One of the handovers we observed did not give privacy and dignity, as it was conducted in the bay corridor.

Although staff were trying to keep their voices down, patients could overhear the handover on each side of the bay. In addition, none of the handovers we observed included patient interaction. We also observed nurses discussing a patient's end of life care over another patient.

- We observed some good patient and staff interactions outside of handovers with time given to the patient for explanations and consent to take blood pressures or check breathing. Patients who were anxious were reassured in a kind manner. Patients were also called by their preferred name.

Patient understanding and involvement

- Although most patients told us they were involved in their care, there were a few patients who told us they had not been involved in their discharge planning, or their treatment. We received particularly poor comments on the stroke ward and Cedar ward.
- Those patients that were positive about their involvement told us they were asked how much information they wanted to know.

Emotional support

- We saw evidence of emotional support being provided to patients. Members of the palliative care team provided support to patients that were not near their end of life, but who had complex conditions. In addition, comments and advice from previous patients with similar support was available, such as patients who had suffered a heart attack.
- Some patients told us they were not offered any cultural, or religious support.

Are medical care services responsive?

Inadequate

The service was not planned, or delivered, in a way that adequately met patient needs. The flow of patients through the hospital was not managed well and many patients were well enough to leave hospital, but remained. There was a lack of bed capacity and occupancy was commonly well above 85%. The environment was not suitable to patient needs in a number of wards.

Patient needs, particularly for those living with dementia, were not well met. Their needs were not always identified and services were not always in place to ensure their care was appropriate. There was not always an awareness of complaint concerns and some patients were not responded to in a timely manner.

Service planning and delivery to meet the needs of local people

- The rehabilitation ward for the care of the elderly did not take or treat acute patients. Although this meant it was easier for the ward to admit patients within target timescales, it meant patients were often transferred into and out of the ward if they deteriorated. They also did not have an activity coordinator, which staff felt was required to help reduce length of stay and no business case had been put forward.
- The environment on Blackthorn Ward, Conifer Ward and Cedar Wards were not appropriate for the needs of the patients on those wards. These were set up as 'nightingale ward' where the beds were not separated into bays apart from one bay of four beds. This meant patients could be and were being easily disturbed. Conversations were not able to be confidential, and this included conversations during medical ward rounds. Patients reported most of the wards as being noisy.
- One ward had a bath, which only mobilising patients could use, when most patients on the ward could not mobilise without support.
- One of the toilets was out of order and we observed a window that was broken that required repair. At the time of our inspection, the requisition to repair had not been made as staff reported they did not have the time.
- Most beds had access to a telephone, television and internet.
- The cardiac care unit was mixed sex, despite not having high dependency patients being treated there. This is in contrary to national policy where all non critical patients should be in single sex bays. In addition, the trust was not declaring these as breaches of single sex areas, which is also contrary to national guidance.
- The trust understood it would need to change to meet additional demand, particularly as they expected demand from younger people to increase by as much as 20% and an increasing elderly care demand.
- Patients were triaged and vetted before they were admitted to ambulatory care to ensure they were not acute and were likely to be able to be discharged

straight home. This meant patients who only required one night or a few hours stay, could be cared for without being admitted to a general or acute medical ward and so reduced their length of stay.
- However, some members of staff told us patients were transferred from A&E to the stroke ward or AAU without being seen by a doctor, so the four-hour wait target was not breached. This also meant records for them were either incomplete or non existent.
- We were told, and we observed, that there were a lack of porters, so clinical and managerial staff had to transfer patients themselves at times.
- A winter pressure plan was in place to improve avoidance of admissions, streamline patient pathways and improve discharge through a range of measures although this was either not in place or only partly in place.

Access and flow

- Staff reported concerns with continuing care assessments as the assessments were long and time consuming to complete. Reports showed the hospital had numerous delays with discharge and most of these were reported as delays with the assessments.
- We also observed multiple patients with a recorded, planned discharge date that had been missed.
- We saw evidence of a patient that had been incorrectly identified as needing continuing care, when they required a nursing home placement and their stay had been six weeks longer than necessary, due to the continuing care paperwork constantly being refused.
- Most of the social workers were locums. Senior staff told us they were due to recruit additional staff to complete and support with continuing care assessments to reduce the delays, but acknowledged these were their biggest delays for discharge. Patients who were long stayers at the hospital were the subject of a meeting.
- Nursing staff that used to carry out the assessments were no longer in post, due to the nursing consultation and restructure. However we were told the complex discharge team supported staff to conduct the continuing care assessments.
- At the time of our inspection, approximately 90 patients at the trust were well enough to be discharged, but were waiting for a continuing care assessment. It was unclear how many of these patients were at Whipps Cross University Hospital, but it was estimated by commissioners that it was at least 30 patients.
- One possible cause for delays with discharges within the hospital was the length of time staff and patients spent waiting for medications. Staff told us these could be delayed if discharge summaries had not been completed. An audit had not been completed to identify if discharge summaries were completed.
- Average length of stay was mostly above the England average, particularly elective cardiology, clinical haematology and emergency elderly care and neurology. The longest lengths of stay were for rehabilitation (92.43 days, neurology (34 days), stroke (36.33 days), nephrology (30 days), care of the elderly (12 days) and endocrinology (11.374 days). The stroke length of stay was against a national average of 14 days. Staff felt the average length of stay on the respiratory ward was four days. One nurse told us that the length of stay for elderly patients could vary from five days to eight weeks. Senior staff told us they were often caring for patients in the AAU for longer than their 48-hour target. Length of stay on the isolation ward was around two weeks. Overall length of stay had increased from 2013/14 by 10.3%.
- Fifty per cent of discharges were made out of hours.
- Staff gave conflicting views on the procedure for signing GP summaries. Some doctors told us junior doctors could sign them off, even if they were not their own patient, which meant there was a risk the information would be inaccurate. However others said they should be signed off by someone of least at registrar level, which is the appropriate procedure. When we spoke with senior staff, they acknowledged there may be confusion as some locum consultants may have given conflicting advice to the new intake of junior doctors in August.
- We were told there had been no audit of whether discharge summaries had been written by 3pm, so patients could be discharged the next day and we were told the target was rarely met.
- Across medicine as a whole, readmissions were better than average, but readmissions were high for elective respiratory, gastroenterology and emergency general medicine, care of the elderly and respiratory. We reviewed multiple patients, who had been readmitted multiple times in 2014 (one patient up to ten times). The readmission rate for those admitted to the AAU within seven days was 5% in October 2014, which equated to 86 patients.

- Bed meetings occurred at least four times a day, with the last being at 5:00pm. We observed a bed meeting, which was not appropriate. Patients were admitted and transferred based on by where there were vacant bed spaces rather than the ward that would suit their medical needs. This meant patients were more likely to be cared for on wards that did not meet their specific needs. We observed a number of patients on the wards we visited that were not on the ward appropriate for their condition. In addition, staff on one ward told us that two patients had arrived for admission, which they had not been told about. However all the patients on an incorrect ward were seen by a doctor specialising in their condition every 24 hours.
- We observed an effective board meeting where there was multidisciplinary input and discussions regarding social care were evident. However, no surgical input was given on the AAU, despite surgical patients being admitted there. Engagement with social workers was limited at these meetings. In addition, the board rounds on the diabetes ward were not appropriate, as we were told they were ad hoc, informal and only had junior doctor presence.
- The majority of patients experienced at least one bed move after admission and over a third experienced two bed moves. 5% experienced three bed moves and 2% experienced four or more. One patient had been moved five times during their admission when we inspected.
- The hospital was on a 'black alert', which meant they did not have any beds. There was pressure to discharge, so more patients could be admitted. There were particular pressures in the diabetes ward, AAU and elderly care rehabilitation wards. Over the weekend that we inspected the hospital, a consultant took the role of 'discharge consultant' who focused on discharging patients in AAU and the wards. If care was assessed, planned and delivered appropriately there would not be a need for a discharge consultant. Bed occupancy Capacity was around 90% when we inspected, when evidence suggests patient care can become compromised at 85%, or above. The last six months showed occupancy capacity had regularly been at this level, or worse higher since June 2014 in most wards.
- Most of the patients we checked either did not have a displayed planned discharge date, or they hit had already gone past itsed.

Meeting people's individual needs

- There was a high referral rate for patients living with dementia patients to the dementia nurse to receive the additional support they required. However, many patients that required screening for dementia were not being screened. Those that had been identified as having dementia, or where there were concerns regarding their capacity, had not had a capacity assessment. We reviewed records where consent had been obtained from the family when no capacity assessment had taken place to ascertain if the patient themselves could have consented. Many patients were waiting for a psychological assessment to determine their capacity, despite being admitted many days, or weeks, previously. When dementia was diagnosed, the type of dementia was not recorded.
- Dementia training rates for staff were variable with some wards and areas at 100% but others failing to meet this target. This included Acacia at 70%, Birch 88%, Bracken 67%, Chestnut 94%, care of elderly 58%, Elizabeth 94%, gastroenterology 60%, Mary 90%, Nightingale 91%, respiratory 63%, Syringa 88%, and Wavell 67%. However, most staff told us the training was not helpful and the training had not been audited for its effectiveness.
- There was no flagging system for patients living with dementia. There was a dedicated dementia nurse.
- The wards for older people participated in voluntary quality mark for elderly friendly hospital wards which assesses whether the wards listen to the views of its patients. However, no award had been given at the time of our inspection.
- There was a flagging system in place for patients with learning disabilities and a learning disability nurse that staff were aware of. Hospital passports were supposed to be in place, but we did not see any.
- The hospital and the trust senior members of staff understood the hospital had a diverse population with a large ethnic background with a variety of different languages spoken. We were shown that infection control related leaflets were available on the internet in up to seven other languages that staff could print off if a patient requested or needed one. However, very few of the leaflets we viewed that were on display in the wards were translated into another language, or directed signposted patients to other language versions.
- There was a variety of leaflets regarding specific conditions in specific wards, such as cardiac, stroke and respiratory conditions. Some leaflets were out of date and referred to the hospital pre-merger in 2012.

- Translator services were available and nurses told us they were normally available when required. However, we did observe a ward round where a patient required a interpretertranslator, but none had arrived for them. Another patient told us no pictures were being used to help them communicate and there was no evidence to suggest staff had been trained in non-verbal communication skills.
- Some patient records had been completed so that patients would be able to read them. For example, one record had explained what atherosclerosis was.
- The trust used volunteers to support patients to eat, particularly dementia patients.
- Visiting times were restricted on most wards from 2.30pm to 8.00pm and no children under the age of 12 were allowed to be admitted into a ward. However, patients told us these restrictions were flexible, such as a granddaughter being able to visit after visiting hours on the cardiology ward.
- Staff told us the gym and its equipment were not ideal for the stroke and rehabilitation patients, as there was not enough equipment, such as a resistance machine or treadmill.

Learning from complaints and concerns

- There was no recording of informal complaints that were resolved on the ward so no trend or learning could be made from these complaints. Senior leads acknowledged these needed to be recorded.
- Sixty-two per cent of complaints were answered within the agreed timeframe with the complainant. Stakeholders reported that it was sometimes difficult for patients to receive a response to complaints.
- A report regarding trends of complaints was shared quarterly in a trust-wide newsletter.
- We reviewed five complaints regarding medical care. Appropriate actions were proposed to remedy the concerns raised in the complaints, such as changes to processes or protocols. However, some of the language used in the responses was were medical and would not necessarily be understandable for most members of the public.
- We reviewed summaries of nearly 50 formal complaints that were reported between October 2013 and September 2014. They covered a range of wards, but mostly were regarding poor care, the poor attitude of staff, lack of information and discharge. When we asked senior staff about what they felt the trends for complaints were, they initially did not acknowledge early discharge was one of them. However, they agreed that setting expectations with patients, their family and friends was an area they needed to improve.
- Stakeholders had concerns that it was difficult for patients to know how to register a formal complaint and most wards did not have leaflets on how to complain displayed. We spoke with two patients who both said they had complained and neither had received a response to their complaints. Some of the leaflets we saw were over three years old, as they related to the previous trust. The up-to-date leaflets had the appropriate information on how to complain, including what to do when English was not your first language, which was available in ten different languages.
- Compliments and 'thank you' cards were displayed in each of the wards we visited.
- A customer service manager was in place for acute medicine who dealt with concerns regarding care, attitude of staff, communication, and lost property before they escalated to a formal complaint.

Are medical care services well-led?

Inadequate

Although visions and strategies were in place, there was not an awareness of these at ward level. There was a gap in the governance structures between ward level and the CAGs, which meant staff did not always feel supported. Risk registers were only trust and specialism based. There was not always an awareness of performance at ward level. Leadership was not always visible. The culture of the services was poor with allegations of bullying and a disconnect between the leadership and ward staff. There was poor staff and public engagement.

Vision and strategy for this service

- Most staff at ward level were not aware of the vision and strategy of their services. They were only able to tell us that the focus appeared to be on other sites, such as the new heart attack centre and the Royal London Hospital. The only ward level staff that were able to report on a local visions and strategy was on the

cardiology wards where they were aware of the aim to decrease cardiac arrests by early detection of a deteriorating patient. However, they were not aware of the audit this strategy had come from.
- Business cases had been submitted for the new heart attack centre and there was a plan to rotate cardiology nursing staff between sites in March 2015 on a four-monthly basis, so they all received experience in receiving patients both at initial admission and post stabilisation.
- The senior leads in the acute medicine and older people CAGs had a vision of admission prevention and earlier discharges, such as initiating a hospital at home team, so care could be continued at a patient's home that would normally be at the hospital. The vision also included working with the local authority to reduce the amount of hospital admissions from falls. They planned to introduce 'hot clinics' and have more day case work. A strategy to fulfil the vision was not yet in place.
- Therapy staff raised the issue that there were too many trust initiatives and not enough strategic planning. They felt management was reactive, rather than proactive.

Governance, risk management and quality measurement

- Although there was a clear reporting structure for staff to raise issues and for incidents, complaints and risks to be discussed, including discussion in multidisciplinary meetings, there were few staff within this structure that were hospital-specific leaders. For example, although there was a matron and hospital director, there was no clinical governance or nursing lead for the medical specialties that solely covered Whipps Cross, as they were cross site.
- Senior staff believed the hospital was strong in some clinical specialties, such as when it came to being able to deliver efficiencies, having a stable structure, having a strong workforce and leaders, good education for staff and having a clear vision and strategy.
- These staff felt the hospital's weaknesses lay in its financial ability to deliver its services, some of its operational performance, having separate cultures at its sites, the distance between its sites, the complexity of the trust, patient experiences and perceptions and the education facilities. However, our inspection found these were not the key weaknesses of the hospital.
- The acute medicine CAG had governance leads within each specialty and smaller governance meetings were held in medical specialty meetings. These all fed up to the Quality Safety Committee. Governance meetings occurred monthly. However, the last recorded Quality Safety Committee minutes we received for acute medicine was July 2014 and they had a trust-wide view with little site-specific discussion.
- Items on the trust-wide risk register relating to medical services reflected some of our concerns including safeguarding, staffing capacity and their skills to treat deteriorating patients, infections, cost-improvement plans including their effect on the workforce, emergency care capacity, data quality, high use of bank and agency staff, infrastructure, staff compliance with best practice and its engagement, informatics infrastructure, and staff engagement particularly regarding reporting of incidents and issues.
- The CAG risk register for acute medicine only included two Whipps Cross University Hospital related items for older people – length of stay relating to continuing care assessments and the environment.
- The board assurance framework did not recognise the hospital specifically, only trust level. It had actions for its highest risks, but its highest rated risks were financial - the PFI cost inflation at another site, and underachieving cost improvement plans
- The trust did have actions in place for issues we identified in medicine such as agency staffing usage, emergency capacity, infection control, overall organisational capacity, investment in infrastructure, the staffing review decreasing quality of care, cost improvement plans and the impact they have on quality, lack of seven-day working, and insufficient medical equipment. However, we did not see the impact of these actions in these areas.
- When we spoke with the senior leads within cardiology, they were unaware of some of the audit results at the hospital that related to their performance. They also did not have actions on how to improve the cardiology service other than the move towards a heart attack centre at another site. Some of the leads told us they did not get a regular performance dashboard.
- Cardiology leads felt there were weaknesses in some of their pathways and that these had been an issue regarding the failure to rescue (crash calls leading to deaths), although they felt these weaknesses had

improved. Senior leads across the CAGs acknowledged learning to the wards from incidents was not always robust, so had implemented a monthly discussion for wards regarding incidents.

- Due to lack of permanent staff, and the fact that there were not enough staff at many weekly or monthly meetings to discuss quality and governance, actions that were supposed to happen did not occur.
- Ward staff briefings took place daily to discuss issues such as pressure sores, nutrition, and incontinence guidance and performance. Overall, ward meetings occurred monthly, which discussed key performance topics, such as patient harm prevention, staffing levels, complaints and nutrition. However, other than AAU, most minutes did not record if there was an open discussion with staff about any other issues and there was little recorded discussion about incidents, or complaints at these meetings. These were mainly discussed at a clinical improvement group that was hospital specific, but only involved senior clinicians and only focused on timeliness of responses. In addition, although ward meetings were scheduled monthly, some wards did not have a meeting for six months.

Leadership of service

- Staff were aware of the weekend visits that the executive team made and they were positive of the support provided by the hospital director and matron. The acute medicine CAG director said they met with clinical directors once a month and it was open to consultants to attend as well.
- Other than the above, staff at all levels reported that senior leadership was not visible or supportive. They felt the leads within the CAGs were not available or supportive. CAG lead nurses told us they could only be on site for half a day, once a week, to meet the ward managers, or sisters, due to the amount of sites they covered.
- We found a number of ward manager posts were vacant. Some wards were operating without a ward manager, whereas others had ward sisters acting up into the role on a rotational basis. This meant there were additional burdens on the sisters in many wards.
- Therapy staff felt well supported by both their CAG and appreciated by other CAGs.

Culture within the service

- The last NHS staff survey showed a worse than average score for bullying and harassment of staff. Some of the staff we spoke with, as well as feedback we received from stakeholders and staff prior to the inspection, indicated that there was a perceived bullying culture. Particularly as they felt their concerns were not listened to, which was leading to low morale.
- Doctors said they were working over shift hours on a constant basis. Some students told us the nurses were rude and commandeering and that there were sometimes cliques of different bands of staff. Most nursing staff commented that the change to the banding system had caused morale to drop and it was still low.
- When we spoke with senior staff, some told us they felt there was either not a culture of bullying or a perception of bullying that was mainly a result of changes the trust had implemented that staff were not willing to accept, such as: the direct matron line management not being on site and the debanding of staff grades. They agreed morale was low.
- The trust had commissioned an external review on staff perceptions of bullying, which showed issues were with line management, the working environment, workloads, poor behaviour tolerance, and ineffective strategies to deal with the issues.
- A staff reward scheme had been implemented called 'Barts Health Heroes', which had recognised some staff, but we did not get told about this from ward staff. However, there was awareness that ward staff on the older people's wards were shortlisted for a Health Service Journal award.
- Overall, sickness was 3.23% and turnover was 12.2%. However, in acute medicine, turnover was high, at 25.3%, 18.9% in cardiology, 15.7% in care of the elderly, 31.2% diabetes nursing 28.6% gastroenterology medical, and 33% allied health professionals in therapies. Actions were in place to do retention questionnaires, staff rotating, buddying staff, skilling up nurses, creating a talent management scheme, preceptorships and education groups. There was also high sickness rates for nursing cardiology at 6.9%, and 7.6% in medical gastroenterology.
- Most ward staff reported good team working within their own wards, particularly on Acacia Ward and in therapies where there had been team-building exercises. Therapists also commented that there was cross-site learning and training to share good practice.

Medical care (including older people's care)

Public and staff engagement

- Many wards had a worse than average response rate to the friends and family and inpatient surveys, although Acacia ward had a better than average response rate. FFT was gathered using cards, which included an online form signpost as well.
- The NHS staff survey showed that engagement with staff was below the national average, but average for acute medicine. Pulse surveys were mostly below average. There used to be a ward manager's meeting, but this had stopped.
- There was a patients' panel that reviewed wards and fed back to the hospital on its findings, with recommendations. The panel had raised with the hospital and us that staffing levels were inadequate, morale was low, the impacting of re-banding of staff, and they felt less involved in discussions than before the merger.
- The CAGs terms of reference required that there was a patient panel representative at some of their meetings but this had not happened. There have been continual changes in the CAGs structure and staff were often late for meetings because they were having to travel across sites.
- A stroke club operated on the premises every two weeks, allowing for stroke patients to get, and offer, support. However, other than providing the premises, there was no interaction, or signposting between the trust and the club.
- One ward had a communication book in place for staff to pass on information between each other and between shifts. This included priorities for the ward, such as cleanliness, listening to patient feedback, and NHS Friends and Family Test results.

Innovation, improvement and sustainability

- In 2013, 14 wards of the older people's service across the trust participated in learning hubs that developed engagement, multidisciplinary team working to improve the quality of care for older people. An initial analysis of the Older People's Improvement Programme had concluded that positive changes had been made to the service. However, the impact of this was not evident.
- The older people's and the stroke service were looking at adding a virtual ward service to reduce length of stay.

Surgery

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The hospital provided a range of elective and emergency surgical services to the local population, including orthopaedics, general surgery, vascular surgery, colorectal surgery, urology, trauma, ear, nose and throat (ENT) and ophthalmic surgery. Sixty per cent of cases were day case procedures, 26% were elective and 15% were emergency cases. In the 12 months prior to the inspection 16,236 operations had been carried out.

There were ten main theatres, two of which were specialist orthopaedic theatres and one designated trauma theatre which ran 24 hours a day, seven days per week. There were two ophthalmic theatres, which were used for specialist eye surgery. We reviewed theatres as part of this inspection.

The surgery service was part of the surgery and cancer clinical academic group (CAG) that operated across the trust. The CAG was created in July 2014. At the time of our inspection, there were approximately 142 surgical beds in the designated surgical wards and 29 patients could be accommodated on the surgery day case ward. We visited Hope Ward (elective assessment), Poplar Ward (elective surgery), Primrose Ward (head and neck, general surgery and urology), Sage Ward (orthopaedic), Sycamore Ward (orthopaedic), Plane Tree Ward (surgery day case) and Rowan Ward (gynaecology, surgery and urology) wards.

During our inspection, we were also guided by concerns that had been raised with CQC by patients and staff before the inspection. These concerns related to the high incident of pressure ulcers, the quality of care delivered, staffing levels and discharge delays. We spoke with 28 patients, observed care and treatment and looked at 21 care records. We also spoke with 77 staff members at different grades, including Allied Healthcare professionals, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. We received comments from our listening event and from people who contacted us to tell us about their experiences. In addition, we reviewed performance information about the trust and undertook an unannounced inspection to surgical areas on the evening of Sunday 30 November 2014.

Surgery

Summary of findings

The service did not protect patients from risks of avoidable harm and abuse.

We identified high numbers of outstanding nursing vacancies, the poor skills mix throughout wards, a high volume of agency staff usage and a high patient volume that had a negative impact on the service. Some wards often relied on recently qualified, or agency staff.

Some agency staff did not have full access to the electronic record-keeping systems, which presented challenges in caring for patients and reporting incidents. We found inconsistencies in incident reporting throughout the service. Staff told us they did not have time to report incidents and that they would not escalate issues of inappropriate staff skills mix of staff shortages, due to fears of repercussions from senior staff. They had rarely received feedback from the incidents they reported to senior staff. Staff commented that they were not sufficiently supported by their seniors. Daily consultant-led care was not embedded.

We found inadequate surgical and medical cover that resulted in unnecessary delays in obtaining some pain relief and clinical reviews, which had an impact on patient discharges. Patients who had undergone surgery were being cared for in the recovery area for extended lengths of time, due to a shortage of surgical beds on the wards. Patients were occasionally transferred to clinical areas that were inappropriate given the complexity of the patients' needs.

Patient flow within the service was poorly managed, which often led to operation cancellations, delays in treatment, and patients being cared for in inappropriate clinical areas. Operating data was collected in a number of ways by different staff, including handwritten lists, diary notes, theatres lists, and via an electronic system. There was no process to coordinate this information meaningfully in order to monitor the impact of frequent cancellations, or delays, on patients' clinical outcomes.

We found that a number of medical patients were cared for on surgical wards, surgical patients were cared for on non-surgical wards and we identified that this was common practice. The lack of meaningful and accurate data and undeveloped governance systems within surgical services meant senior managers did not have a grip on the day-to-day running of the service.

Surgery

Are surgery services safe?

Inadequate

We identified inadequate staffing levels and skill mix which had a significant effect on patients' safety within the service. We also identified some concerns relating to a lack of consistency in clinical incident reporting and feedback mechanisms. Staff told us they did not report all incidents due to staff shortages on surgical wards.

Although nursing recruitment was being undertaken there was acknowledgement that this was impacting on the skill mix on some wards and acuity tools were not used consistently to plan staffing levels. Daily consultant led care was not embedded, which was not in line with national or best practice guidance.

Annual maintenance checks of theatre ventilation were not being carried out. Infection control was monitored in most areas, though we noted hand hygiene rates for some theatres were not routinely audited. There was poor compliance for MRSA screening of all inpatients. A trust audit identified concerns with storage of medicines, though actions had not been taken to meet the requirements of the audit.

Incidents

- Staff used an electronic incident reporting system to report incidents. However, they told us that feedback from incidents reported was rare and that they were unable to fulfil their duties to report incidents, due to staff shortages. One staff member summarised the view of the majority of staff we spoke with when they said, "Staff will not raise incidents if concerned about pressures on staff, including if numbers are short on the ward." Agency staff also told us that they would not report incidents. They felt this had led to an incomplete and inaccurate profile of incidents, which did not reflect issues staff faced. Furthermore, there was no uniform approach to the reporting or learning from incidents throughout the directorate. Staff were unable to give us specific examples of learning from incidents. This was particularly apparent where surgical wards had vacancies at ward manager level.
- 118 incident reports of 'no harm' to 'moderate harm' were overdue for investigation at the end of October 2014 in the CAG. Senior staff told us they had been asked to prioritise investigation of incidents, though no other support had been offered.
- Twenty-six serious incidents were reported in 2014, 18 of which were grade 3 or grade 4 pressure ulcers. We saw that the investigation reports had been completed with actions identifiedstated, although it was not clear how these actions had improved the care and safety of patients. Senior staff told us that one action was displaying graphs representing the numbers of pressure ulcers, known as run charts, on walls of the surgical ward. Managers told us they were to assist staff to understand causes and learn from reported incidents. We spoke with staff on the wards about these charts and they told us they were put in place within the month prior to our inspection. However, they were unclear about their purpose, or how they would prevent or improve care for patients with pressure ulcers.
- Some staff reported that two serious incidents requiring investigation reported in theatres were downgraded to a lower level of risk within 2014. The trust did not provide further details to demonstrate why this decision was taken, or how these incidents would be lused for learneding.
- A weekly review of incidents was undertaken by a senior nurse and the consultant patient safety lead. Staff we spoke with could not see the impact of these meetings and it was not clear if all incidents within the surgical directorate were discussed and actioned.
- Although a number of surgical specialties held monthly audit meetings, which included a review of morbidity and mortality; wider care issues, such as delays in recovery, were not captured. Learning points were not identified and shared across specialties. Dedicated time was available for clinical audit meetings. This time was often used for staff training, and there was limited evidence of coordinated audit activity. We noted that not all clinical areas were reviewing morbidity and mortality. In August 2014, the trust-wide mortality group identified that these meetings were not approached uniformly, nor were they minuted to clarify how learning had been disseminated across the teams.

Safety thermometer

- The surgical areas we visited were not able to demonstrate how routine data was collected for the

NHS Safety Thermometer. Senior managers told us this information was available, but senior nurses were reliant on informal conversations with ward sisters to gather ward performance information.

- We saw some information that would be routinely submitted for the measures of the NHS Safety Thermometer were displayed and updated by ward staff. We saw that safety cross boards were used to note staff shortages, if patients had fallen or incidences of pressure ulcers.
- During our inspection, we noted staff shortages were recorded on all wards on the boards for, notably for 10 of the 13 days on Rowan Ward and 9 of 12 days on Primrose Ward in November 2014. Senior nurses we spoke with told us they were aware that staff had reported these issues and were asking staff to manage on a day-by-day basis.
- The trust failed to provide us with the data to show the rate of venous thromboembolism (VTE). We saw that surgical wards had a VTE audit folder to review the numbers of risk assessments undertaken, but, in most cases, this was not updated within the six months prior to the inspection. The local commissioners reported that VTE screening had fallen below the 95% trust target. Due to a change, from a paper-based to an electronic recording system, activity was not being recorded. We did not find any changes made to rectify this.

Cleanliness, infection control and hygiene

- We observed the hospital and the theatre areas to be clean and that staff in these areas adhered to local and national infection control policy and procedures.
- Each surgical ward had a ward-based cleaning team, and we saw that daily cleaning audits were displayed in wards. Cleaning rotas in theatres were visible in each room, were up to date and checked daily, including weekends.
- Hand wash basins and alcohol hand sanitising gel were available at ward and theatre entrances and the gel was mounted by each bed, or on the wall.
- Senior nurses told us that an infection prevention and control dashboard was sent to them on a weekly basis for information.
- We saw that equipment was regularly cleaned and labelled to identify that it was ready for use.
- The hospital and trust benchmark for MRSA bacteraemia was zero. One case had been reported between April 2014 and October 2014 within the surgery service and an investigation had been completed.
- Hand hygiene results were reported to be routinely 90%, or above, for all surgical wards and theatres. We were not assured that all data was being collected, as required, as the audit did not cover hand hygiene practice in theatres 5 – 10.
- An infection control nurse practitioner was allocated to review surgical patients throughout the hospital. Surgical ward staff told us they felt well supported by the infection control nurse practitioner, who was visible, provided expertise and often provided direct care to patients if wards were short of nursing staff.
- Throughout our inspections of the surgical wards, we witnessed that the isolation rooms had clear precaution signage and open doors. We also noted that side rooms for patients with infections did not have en suite facilities and commodes were not visible in patient rooms. It was unclear how these infection control risks were managed.
- We saw that some infected patients were nursed on open wards. Some staff we spoke with were worried about risks, and their ability to ensure that the protocols were being followed for these patients. These problems occurred most notably on wards where there were staffing shortages.
- We noted that, although mandatory infection control training had been provided, no specific infection control training had been offered to surgical wards.
- Surgical site infection rates were not counted, or reported. In theatres, a surgical site infection audit was undertaken monthly. However, the results were not shared widely.
- A campaign to raise the profile of sepsis among staff was in place ('STOP – Sepsis Treatment Optimising Patients').
- The trust MRSA screening policy requires inpatients be screened within 24 hours of admission. Compliance was audited by reviewing 10 patients each month on each surgical ward. Results showed poor compliance and variability, with most wards screening only six of the 10 audited patients on average, and there were some months where only three or four patients were

screened. Between April 2014 and October 2014, this had been achieved on three occasions across surgical ward areas for the ten patient's screens. The trust could not assure us of actions taken to address this.

- At the unannounced inspection, we noted that the waste room door on Rowan Ward was unlocked and open. Three full sharps bins had been left on the floor and two bags of clinical waste were left on top of a closed waste trolley. This was not in line with trust policy.

Environment and equipment

- We were told that the hospital operated a central equipment library. Ninety-one per cent of high risk items of medical equipment had had planned maintenance within the 12 months prior to our inspection.
- We saw surgical wards had working hoists and that they were well maintained.
- Ward staff told us they had access to pressure-relieving equipment when required, and direct support from the tissue viability team.
- We saw that most resuscitation trolleys were checked. On Primrose Ward records showed the trolley was not checked on Mondays and Fridays throughout October 2014, and not on Monday 3 November 2014, or Friday 7 November. We also saw that the trolley was not tagged as having been checked. Staff told us this was because they did not have time to do this.
- In theatres, the contract with the company that was responsible for maintaining and checking equipment had been stopped in mid-2014. Though this was identified as a risk on the risk register, measures were not yet in place to address this and it was unclear if high risk equipment was being serviced.
- Some staff we spoke with told us that obtaining equipment often proved problematic and that they experienced delays in getting the items they required. Concerns were raised about traceability and a lack of pain-controlled analgesia and epidural pumps in theatres.
- We received information that recovery did not have the appropriate monitoring equipment available. When recovery was full, staff told us that managers asked them to place patients in what they described as a 'holding bay'. The area was not appropriately equipped, as there was no portable oxygen, or suction machines. While we did not see a patient who required continuous monitoring in this area during the inspection, we had concerns that patients requiring constant monitoring of their condition were cared for in an unsafe environment with staff who did not feel competent to meet their care needs.
- During our inspection, we identified that theatre ventilation had failed, while surgical procedures were being carried out. Staff were unaware that this had occurred, as there was no mechanism for alerting theatre staff when ventilation had failed. We made the trust aware of this issue, as soon as we identified our concerns and issued the trust a notice to confirm sufficient measures were put in place to ensure that the operating theatre ventilation was safe.
- Annual maintenance and revalidation checks of operating theatre ventilation were not being carried out, which was of significant concern when it came to operating theatres 1, 2, 3 and 4. Evidence of suitable microbiological sampling of the theatres was also lacking. The trust confirmed that their approach to the issues in these operating theatres was to reduce the level of surgical interventions undertaken within these theatres to that of low complexity and to monitor postoperative infection rates.
- There was no evidence that suitable checks were being carried out to ensure operating theatre ventilation was safe for patients undergoing surgical procedures in operating theatres 1,2,3 and 4. The trust confirmed the upgrade of operating theatres 1,2,3 and 4 was planned, though this plan had yet to be confirmed by the NHS Trust Development Authority (NHS TDA). We were advised, should this funding not be approved, the trust would need to reschedule the capital programme to accommodate replacement operating theatres. There was insufficient evidence to assure us that a safe, clean, compliant environment for surgical procedures was provided within operating theatres 1, 2, 3 and 4, in line with relevant regulations (Building Regulations 2000, England and Wales, approved document F1: Means of Ventilation and Heating and ventilation systems: Health Technical Memorandum, 03–01: Specialised ventilation for healthcare premises, A, HTM03/01 B, Health and Safety at Works Act 1974.).

Medicines

- During our inspection, we found that medicines were stored in locked cabinets within surgical wards and staff raised no concerns with us in relation to medicines management.

- After the inspection, we looked at the audits on safe storage carried out by the trust's pharmacy department. They had identified concerns over maintaining cold storage to protect the effectiveness of the medicines and had issued an action plan. They had also identified unlocked medicine cupboards and cupboards that were being used to store the patients' own drugs. But action had not been taken at the time of our inspection.
- We looked at the recording of controlled drugs in theatres and on one ward. All balances were correct and entries complete. Daily checks and regular audits were carried out. We saw the audits carried out by the pharmacist and heard how the pharmacist notified the accountable officer of the trust of discrepancies and incidents.
- We identified no concerns with the management of medicines in theatres. Senior staff told us theatres was compliant with the trust-wide controlled drug audit, though we were not provided with evidence of this.

Records

- Concerns regarding the electronic patient record keeping system, were raised with us prior to commencing the inspection. A number of patients received letters for the wrong treatment and patients were booked in for the wrong treatment within the surgery directorate, which resulted in operations being cancelled. We were not made aware of a process to verify how many had been affected, although we were told the trust had implemented a series of measures to address these issues.
- In surgical preassessment, preoperative assessments were undertaken and recorded prior and during consultations before the day of the procedure. Staff told us the assessment was valid for a maximum of three months in case procedures were delayed or cancelled.
- Patients had their care needs risk assessed and appropriately recorded in all the clinical areas we visited. These assessments were stored securely in all areas.
- From records we reviewed, hourly nurse rounding was in place. However, some staff we spoke with told us they were expected to complete hourly rounding forms, irrespective of whether or not this took place. This provided a false assurance.
- Some staff told us they regularly stayed past their allocated shifts on the wards to complete notes, risk assessments and charts.
- We noted that, although body maps were used for patients who were at risk of developing pressure ulcers, they were not routinely sent to theatres along with the patients' notes.
- Records were transferred internally and externally between departments. They were also tracked on the electronic patient record-keeping system. However, some administration and clinical staff expressed concerns about the difficulties and extended delays in obtaining patient notes, as notes were not always tracked.
- Records were transferred internally between CAGs and externally and tracked on a computer system. However, some administration and clinical staff expressed concerns about the difficulties and extended delays in obtaining patient notes.

Safeguarding

- The training data provided by the trust for the service suggested a completion rate of 90% for level 1 and level 2 adult safeguarding training. Only one area had been identified as falling below the trust's training compliance rate target of 90%, with a reported rate of 67% for administrative staff on Rowan Ward. The records indicated that the completion rate for safeguarding children at level 1 and level 2 was also 90%. Nonetheless, these reported rates contradicted our findings on the wards. Staff told us they did not have face-to-face training for safeguarding and were expected to read standardised trust-provided literature. Ward staff we spoke with could not, therefore, be assured that the training was understood, or used in practice.
- A number of staff we spoke with during the inspection could not describe a safeguarding alert, or identify a safeguarding concern. We found an example of poor practice in one clinical area regarding a safeguarding concern that related to a patient with learning disabilities in which an agency nurse had omitted a dose of epilepsy medication and a safeguarding concern was not raised.
- On a number of surgical wards, when we asked to review safeguarding referrals we were told that no adult safeguarding referrals were kept on wards and that few had been made. Senior staff told us they would contact the safeguarding team if they had concerns on a case-by-case basis.

Surgery

Mandatory training

- Training records were provided by the trust, with most areas in the surgery CAG reported to achieve an over 70% training compliance rate. However, when we spoke to ward and theatre staff, it was difficult to identify if the training provided was effective. This was because almost all mandatory training had been provided through a training booklet. Ward managers had to ask staff if they had completed the booklet. During the inspection, when we asked for evidence of these completed booklets for permanent and agency staff, we were not provided with them. Staff told us that they undertook their training, but many could not recall specific details regarding safeguarding, health and safety, or infection control outlined in the training manual. Some staff told us they preferred to have face-to-face sessions, rather than have all their training through a booklet.
- Staff received face-to-face training for basic life support. While most theatres and Primrose Ward nursing staff were reported to have completed this training, compliance on the other surgical wards was lower, with only 46% to 69% completing the required training. We also noted particularly low uptake on Rowan Ward for non-qualified staff, which included healthcare assistants, at 13%.
- Staff told us managers sometimes made offers to relieve staff to undertake mandatory training, though this did not always happen in practice.

Assessing and responding to risk

- The surgical wards used the national early warning score (NEWS) system for standardising the assessment of acute illness severity. We found clear directions for escalation and staff were aware of the appropriate action to be taken if patients scored higher than expected. Completed charts demonstrated that staff had escalated correctly, and repeat observations were taken within necessary timeframes.
- Staff described their roles and could identify the necessary steps to take in the event of a clinical emergency. They were able to identify the location of emergency equipment and how to access the crash team.
- Although staff reported no concerns about accessing medical input when required, we noted there were no outreach services after 5pm, or at weekends. The Hospital at Night team would arrange for medical input to surgical wards and theatres if contacted by the ward staff, but site managers told us they were concerned that surgical staff were not always proactive in contacting the Hospital at Night team due to staff shortages, training and skills mix on the wards.
- Pre-assessment information was valid for three months, and had to be repeated if patients were not seen within this time frame.
- We observed that no risk assessments were in place for two patients with complex needs on Primrose ward. Staff told us these patients required one-to-one care. Staff told us they had escalated these concerns in the past and an extra healthcare assistant was provided for a short time, but this was not sustainable. Staff told us they did not have time to complete risk assessments, due to the evident staffing shortages.
- We noted that surgical risk of patients was not being asked for and recorded on the booking form, or on the theatre computer system.

Nursing staffing

- As part of the consultation restructure a surgical nurse coordinator post had been removed from the surgical wards. This post had oversight and responsibility for the ward, nurses were now responsible for caring for patients within their bays (up to six beds). This meant that a nurse did not have oversight of the ward staffing issues. We were told that, recently, a patient had fallen from their bed while the nurse assisted with controlled drugs in another bay. The fall was reported as an incident. This was a task that the surgical nurse coordinator used to carry out.
- Throughout our inspection, we found there were regular gaps in staffing establishment. There was a significantly high rate of unfilled vacancies at the time of the inspection. Three of the six surgical wards did not have a ward manager for up to three months. There were six nurse vacancies on Primrose Ward and eight nurse vacancies on Sage Ward at band 5. Three senior nurse posts on the wards had been vacant until the three weeks prior the inspection. Staff had been recruited from the Royal London Hospital to these posts. We were also made aware of 16 band 5 scrub nurse vacancies in theatre and three anaesthetic vacancies. There was an ongoing rolling recruitment programme, but there were difficulties in recruitment. Senior managers we spoke with were unable to provide us with accurate percentage fill rates for nursing shifts.

- A number of posts had been removed from each band level, nurse staff and healthcare assistants were re-banded one level lower and, overall, there had been a decrease in substantive nursing staff following a recent consultation. A number of experienced staff left the hospital during this time. This had a significant impact on nurse staffing levels and morale across the surgical wards and in theatres. Almost all staff we spoke with spoke of their concerns about low nurse staffing levels.
- The wards used a staffing acuity tool developed by The Association of UK University Hospitals (known as AUKUH), but we found this was not consistently in use on the surgical wards we inspected to assess staffing requirements. Also, not all senior staff we talked with were aware of this tool. At the inspection, we were told that the trust intended to maintain staffing above the minimum levels recommended by the National Institute for Health and Care Excellence (NICE), at a ratio of 1:7. However, we saw that wards were routinely not staffed at this level and neither could we be assured that this ratio was appropriate for the case and skills mix on each surgical ward on any given shift.
- The staffing tool used in theatres was the Association for Perioperative Practice (AfPP) guidelines. We reviewed off duty rotas and lists identified that the skills mix was planned in order to adhere to these guidelines.
- We were told that staffing levels on surgical wards should have been four registered nurses and two band 2 healthcare assistants with a supernumerary band 7 ward manager for the early shift on every inpatient surgical ward. On Rowan Ward the band 7 post was being covered by a band 5 member of staff and by a band 6 on Primrose Ward. Staff who were acting up into these ward manager posts were not supernumerary. We saw these staff routinely carried clinical caseloads of a bay of six patients. Occasionally, they also had to supervise when agency staff were late, or shifts were not filled.
- We were concerned that only one nurse, at band 5, was allocated to Plane Tree Ward, covering 15 beds.
- We were told that the hospital had successfully recruited more staff with a targeted overseas recruitment drive and that the trust had recently employed 15 newly qualified band 5 nurses from Spain, Portugal and Poland.
- The hospital employed a high number of agency staff to fill the existing staff vacancies. Staff spoke of controls in place to monitor agency usage and managers told us a new contract with a single agency had compounded circumstances, which meant that shifts that were planned to be covered by agency staff regularly went unfilled. We witnessed an agency nurse arrive at 10.00am for an early shift, which commenced at 8.00am. This meant that some staff had to cover more than their designated area. For example, staff told us a band 6 nurse worked between two theatres and a band 5 nurse covered two patient bays.
- Electronic rostering for clinical shifts was introduced a short time before the inspection and linked to the nurse bank. Ward managers were given eight weeks to fill shifts, but staff were still moved around on a shift-by-shift basis. Staff spoke of problems adjusting to electronic rostering and told us this was taking up clinical time doing administrative duties at band 7.
- Due to the difficulties in ensuring safe staffing numbers on the wards, senior managers often had to try to move staff from other trust sites, or within the hospital. One staff member summarised their working experiences when they told us, “Everyday is like a game of chess.” Managers told us this was done to ensure patient safety, although we could not be assured that the staff that were moved had suitable competencies to work safely on these wards.
- We were provided with information from the trust that suggested sickness rates were over 25% for some areas, including general surgery nursing. However, although managers told us these rates were inaccurate, they were unable to confirm what sickness levels were, or assure us that they were being monitored. We saw that staff sickness was 2% in theatres.
- Staff on the wards told us they rarely had time to take breaks, often working over their allocated shift hours to ensure patients did not come to harm. Staff in theatres told us that they regularly worked late to cover when lists ran over, and that it was not possible to get the time back, or be paid for working extra hours.
- Handovers occurred twice a day, and senior nurse managers led board rounds. Staff told us these discussions were heavily focused on identifying patients that could be discharged.

Surgical and medical staffing

- Staff we spoke with told us on-site cover between 8am and 5pm, five days a week, as well as an on-call service at weekends. The same named consultant covered weekends, but Monday to Friday there was a different

consultant each day. After the inspection, the trust told us the consultant group provided 24/7 consultant cover with same consultant covering from Monday to Thurs day and Friday to Sunday and that a different consultant was on call out of hours.

- Senior managers told us the consultant of the week model was in operation across most surgical specialties. Despite this, during the inspection we found this was not the case. Staff coordinating theatres were unaware of who the surgeon of the week was during our inspection. This was not in line with recommendations for safe handover and consultant-led care for surgical staffing, as stated in the British Medical Association (2004) 'Safe handover: safe patients. Guidance on clinical handover for clinicians and managers,' for example.
- There was limited surgical cover at night. Rotas confirmed that one senior house officer (SHO) provided night-time cover for theatres, surgical wards and A&E and one registrar. For almost half of the nights in November 2014, the registrar post was covered by a locum. Surgical staff did not always attend the Hospital at Night team meetings. We observed two Hospital at Night meetings and the surgical SHO did not attend.
- Rotas we viewed showed that there were four SHO vacancies that were being covered by locums.
- Nursing staff and junior doctors told us they felt there were not enough doctors to provide cover for the service.
- Anaesthetists provided input to patient care at the preassessment stage.
- There was an orthopaedic medical liaison on orthopaedic wards and the trust employed two consultant orthogeriatricians.

Major incident awareness and training

- There was a documented major incident plan, which listed key risks that could affect the provision of care and treatment.
- There were protocols for deferring elective activity to prioritise unscheduled emergency procedures. Staff we spoke with were not aware of the plans and did not describe the appropriate action they would take.
- Emergency planning training was mandatory for all staff.

Use of the 'five steps to safer surgery' procedures

- The theatre staff completed safety checks before, during and after surgery as required by the 'five steps to safer surgery' procedures – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist. They also demonstrated an understanding of the procedures. However, staff told us there were no "observational" audits undertaken to verify staff adherence to the 'five steps to safer surgery' procedures. Theatre staff carried out a surgical safety checklist audit against paper records and audited 10 cases per month. 16,236 operations were carried out in 12 months. Ten audits were conducted per month, 0.7% of operations were audited.
- We were told that the results were reported to the theatre user group and shared with recovery staff. Staff we spoke with were unaware of the audit results, or identified learning. We were told that an action plan had started in September 2014, though the trust failed to provide us with this. We could see the audit results highlighted issues with the debrief and sign out stages, though no improvements had been made in response. Audit results were not reported to any other committee, or group. Therefore, the hospital failed to use it for shared learning across the division.
- Overall, the risk of unsafe surgery was not mitigated. Compliance with the 'five steps' was described, as well embedded, despite the very low sample size used in the audit, or which cases were included. It did not highlight the very recent introduction of the 'five steps to safer surgery'. The trust was, therefore, provided with false assurance for surgical safety.

Are surgery services effective?

Requires improvement

There was limited evidence of improvements to services following participation in national audits. Although we found some evidence that services were aware of the requirements of the National Institute for Health and Care Excellence (NICE) national guidance, there was no consistent programme of delivery and learning guidelines from local audits. The lower than average trust-wide hospital mortality ratio was used as assurance or evidence of good outcomes for patients, though this was a crude measure and not specific to surgical services. Staff were unable to describe the impact of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards on their patients.

There was timely and consistent pain relief provision and the pain team used local auditing tools effectively.

Evidence-based care and treatment

- The hospital participated in national audits. These included audits of surgical-site infections, hip fractures, emergency laparotomy and bowel cancer operations.
- National Institute for Health and Care Excellence (NICE) guidelines were managed corporately, with a clinical lead assigned to each guideline, national and local audits were managed by the CAGs.
- National audit results were compiled. The hip fracture audit in 2013 showed that the trust performed better than the England average in seven of the 15 best practice measures, which included all patients having a falls assessment and a senior geriatric review within 72 hours. Of note, 20% of patients were admitted to an orthopaedic ward within four hours, which was below the national average of 40%, and the mean length of stay was 25 days compared with a national average of 19 days. We asked for, and were not shown, evidence that the neck of femur fractures time to theatre, which should be a maximum of 36 hours, was being regularly monitored.
- Senior managers told us national audit results for bowel cancer were good. Results from the National Bowel Cancer Audit in 2013 showed that, of 24 best practice measures, seven were better than the national average. For example, the hospital scored better than the England average for showing that all patients were discussed at multidisciplinary meetings. However, a number of best practice measures were worse than the national average and these included patients having a reported computerised tomography (CT) scan in line with NICE guidance, being seen by a clinical nurse specialist, and the adjusted 90 day mortality rate, which was 11.4%, significantly higher than the national average of 4.5%.
- The results of the Lung Cancer Audit in 2013 showed the trust performed in line with the national average on four of nine measures.
- The national emergency laparotomy audit showed that the hospital met a number of key recommendations for the provision of safe care for emergency general surgical patients, which was in line with the national average. However, the hospital did not have a fully staffed operating theatre 24 hours per day, seven days a week. It had not audited emergency theatre provision within the previous two years, and did not have explicit arrangements for review by elderly medicine and could not provide for the admission of high-risk patients to a critical care unit, following surgery.
- It was not clear that the results of these national audits were being used to drive local quality improvement programmes.
- We asked for further evidence of how NICE guidelines and evidence-based care influenced practice. The trust did not provide us with this information when requested. We reviewed reports from the patient safety committee, clinical effectiveness committee and the surgical division board. There were no reports of compliance with NICE guidelines shared with these committees to show to what extent evidence-based care influenced practice.
- When we asked staff about their involvement in local audits, most told us they were unaware of any local audits. We asked for evidence of the impact of a local audit on care. We were told that audits were presented to surgical staff at the academic half day and that staff had protected audit meeting times. Recent audits included prophylactic antibiotic prescribing in colorectal surgery and a urology audit. These examples were used to demonstrate instances of good practice, which led to improvements in standards. However, there was no evidence that learning from these audits had been undertaken, or shared.
- The hospital had excellent upper gastrointestinal (GI) results and colorectal figures had improved year on year. From this, staff had developed the colorectal strategy.
- There had been no audit of the acutely-ill patient. This had been identified as a requirement by the acutely-ill patient subcommittee.
- Senior nurses had commenced audits of nursing documentation, called clinical staff reviews in October 2014. Five patient records were audited across surgical wards in October 2014. The results of the audit highlighted missing falls assessments and VTE prophylaxis. We were told that the results of the audit had been shared with ward managers. However, it was not yet evident that this audit programme covered all aspects of care, or if it had been undertaken to improve care.

- There was no evidence provided that the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) theatre utilisation was being audited, or that patients were being cancelled, due to lack of theatre time.

Pain relief

- A specialist pain team provided direct support to surgical wards and undertook pain reviews, supported by the outreach team and on-call anaesthetists. The dedicated pain team worked across inpatient sites at the trust, as well as with patients in the community. Two clinical nurse specialists were designated at the hospital, and provided direct support daily to staff and patients on surgical wards. The service was provided to both medical and surgical areas by means of a referral system.
- The pain team worked to evidence-based protocols, and had developed local guidelines for patient-controlled analgesia for postoperative and acute pain. We saw the Abbey Pain Scale, for measuring pain in patients who cannot verbalise and cognitively impaired adults, was in use in patient records.
- Staff held bi-monthly pain teaching sessions and held a recent chronic pain study day. The team held 'drop in' sessions for patients to prevent admissions and unnecessary interventions.
- We were made aware of a number of vacancies in the service at senior nurse specialist level, which the service had carried out for over two years. More recent attempts to recruit to these vacancies were yielding success.
- The pain team had an audit programme, which was shared across senior nurses. The team undertook an audit in July 2014, which involved 100 patients across medical and surgical wards. They found 26% of patients did not have a formal pain assessment by means of using a validated tool and there were no specific tools in place, or that were being used sensitively to assess pain in patients with cognitive impairment. In response to the findings, the team have standardised the pain assessment tool across the trust. This plan is due to be implemented in December 2014.

Nutrition and hydration

- Patients who were able to eat and drink told us they were given a choice of food and drink.
- Where patients had a poor nutritional intake, we were told they were risk-assessed and fluid and nutrition charts were used to ensure they received adequate food and drink. Access to the nutrition team was sought by referral.
- Where necessary, a dietician assessment was undertaken and specific interventions recommended.
- There was no evidence of auditing nutrition and hydration. There were no recent audits of nil by mouth times, or fasting. The last preoperative fasting knowledge of guidelines of nurses on surgical wards was undertaken in 2011, and there were no actions, or changes stated within the audit, nor evidence of learning.
- Patients in recovery who had no ward bed were given sandwiches only, as hot food was not available in recovery. Patients were observed eating and drinking while they were being brought into recovery or while they recovered. Recovery staff informed us, and we observed, "We have no patient bed tables, so patients have to eat their food from a theatre instrument trolley."

Patient outcomes

- The Summary Standardised Hospital Mortality Indicator (SHMI) – which compares the expected rate of death in a hospital with the actual rate of death at the hospital – was 65, which is significantly low statistically, showing that fewer patients died than expected.
- Revision rates submitted between 1 April 2014 and 31 August 2014 for hip operations was 0.8% within three years and knee operations was 0.5%, which were significantly better than the national average.
- The risk of readmissions for elective procedures was 108, compared to the national average score of 101, which was slightly worse. For general surgery this was worse, at 116. For trauma and orthopaedic surgery the score was at 129.
- The relative risk of readmission was worse than average for non-elective ENT and trauma and orthopaedic surgery.
- Patient Reported Outcome Measures (PROMS) showed that the majority of patients undergoing knee replacement operations, hip replacement procedures and groin hernias were generally worse than reported as England average.

Competent staff

- At the time of the inspection, two senior nurses and one matron who were new in post had yet to be given access to appraisals and statutory and mandatory training data. They told us they were aware that staff were not up to date because of the pressures of work.
- Competency-based training and further education programmes were available to staff. The medical education unit offered a range of courses related to further education for clinical staff.
- Staff told us it was difficult to access further training and development as their areas were often short staffed. Staff shortages made it difficult for staff to access further, often necessary, training.
- Staff in charge of wards were concerned that they were not informed about the agency staff competencies.
- Critical care staff had to cover the recovery area, but were not trained to do so and staff had not accessed suitable training. For safety, an anaesthetist covered emergency patients and had to stay overnight if there were no beds for patients to be transferred back to, in the wards. Recovery staff had not had critical care training.
- Nursing staff told us they were not trained in discharge planning.
- Band 2 healthcare assistants provided complex care to patients, including care of tracheostomies and complex dressings. Staff we spoke with told us they were trained to give this care, though we were not provided with training records to confirm this when requested. Furthermore, the acutely-unwell patients subcommittee reported in August 2014 that tracheostomy training days were still not achieving the number of delegates that need to access training.
- Senior staff told us that every scrub nurse was assessed for competencies by band 7s and that scrub nurses revalidated yearly, although we were not provided with evidence to confirm that this was the case.
- In theatres, recovery staff had undertaken anaesthetic modules at London South Bank University, although we were not provided with evidence to confirm this was the case.
- We saw records showing that over 60% of staff had received an appraisal in 2014. We asked for a breakdown of this data by surgical specialty and ward area, but they were not provided with this information. The majority of staff we spoke with told us they had not received a recent appraisal and did not have regular supervision meetings with their manager.
- We were told by senior managers that surgical staff engaged in the appropriate revalidation processes.

Multidisciplinary working

- There was daily support on the wards from a housekeeper, a ward clerk, a phlebotomist, a ward physiotherapist and an occupational therapist.
- At board rounds, we saw that discharge planning was discussed with an occupational therapist, physiotherapist, the nursing team and discharge coordinator.
- We identified a positive approach to multidisciplinary working with the pain nurse specialist and anaesthetists and theatre team.
- There was regular input from the practice development nurse in theatres.
- We were told that there was fragmented communication between the surgical departments and the bed management team, which meant that that there were a number of patients on surgical wards who required input from the wider multidisciplinary team.

Seven-day services

- Staff told us out-of-hours imaging and pharmacy support was available when required.
- Seven-day therapy services were available. Physiotherapy and occupational therapy teams provided a service to the inpatient wards between 8am and 6pm, and on call rotas were in place since April 2014 to ensure the seven-day service was adequately staffed.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff we spoke were not able to explain the impact of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards on the patients they cared for.
- Staff told us Deprivation of Liberty Safeguards training was not available to most staff at the trust, at the time of the inspection.

Surgery

Are surgery services caring?

Good

The majority of staff we observed interacted compassionately and did their best to make patients comfortable given the demanding and difficult environment in which they worked. Feedback from the majority of patients we spoke with was positive. The results of the NHS Friends and Family Test highlighted that surgical services were not always in line with the England average.

Compassionate care

- Most patients spoke of positive experiences of care. We saw most staff deliver caring and compassionate care to patients. Patients and relatives told us "the staff are all very good" and "all doctors and nurses are like a family and they are really nice".
- The patients and relatives we spoke with were complimentary about the nursing and medical teams and the care they delivered. However, they also commented on the workload and stress they witnessed staff having to endure. Some people told us "the ward is tremendous considering the pressure they are under" and "hard to tell who people are during ward round". They also said that there was sometimes "poor communication" following cancellations.
- The ward rest time for patients, which took place between 1.30pm – 2.30pm each day, was enforced by nursing staff on Rowan Ward.
- Surgical wards in the hospital performed below the England average for the monthly inpatients NHS Friends and Family Test, with some variable results across the hospital. On Poplar Ward, scores since January 2014 had worsened from 80 to 38 in March 2014, and, in July 2014, were at 48. This was similar on Sycamore Ward, which scored 73 in January, and lower between May, June and July 2014 with scores of 46, 35 and 45. Primrose Ward results were around the same as the England average for most months in 2014.

Patient understanding and involvement

- Most patients we spoke with understood their care options and were given enough information about their conditions.
- Patients and their families were involved in decision-making about their care and support. They had been given the opportunity to speak with the consultant looking after them prior to their operation.

Emotional support

- A number of clinical nurse specialists supported ward-led care, including colorectal, palliative and stoma specialist nurses. We were told by staff that there were vacancies in some specialist roles, including an oncology specialist nurse vacancy, which staff felt was impacting on patient care. This had been escalated to the commissioners, as it was felt the trust had taken no action.After the inspection, the trust told us the oncology nurse specialist post was not vacant.
- We were not made aware of any specific counselling or support services available to patients with regards to clinical care.
- Registered mental health nurses were sometimes required to provide direct support to patients with specific needs. However, there were some reports that they were not always available when required.
- The chaplaincy service, which was available during the week, provided an on-call service to both patients and relatives.

Are surgery services responsive?

Inadequate

Surgical services were not responsive and there were significant demands on the surgical department's capacity to manage its routine workload and emergency service provision, due to the shortage of beds throughout the hospital. Priority was given to whichever patient required a bed, which had a knock-on effect on the provision of appropriate surgical care. Surgical patients were triaged to the acute assessment unit (AAU), but surgery staff did not review, or handover, patients who were triaged this area. We saw inappropriate areas used for patients who needed overnight stays. The trust had reported that referral to treatment time data was inaccurate and had escalated this to the commissioners. There was no meaningful, accurate data collected on the long delays experienced in returning patients to wards, cancellations of operations, theatre utilisation and productivity, or surgery patients on medical wards, which meant senior staff had limited control on the

services. We were told that patients were routinely returned to holding wards until a more appropriate bed became available. This was not conducive to producing a positive patient experience or continuity of care.

Service planning and delivery to meet the needs of local people

- There was limited evidence to indicate the service was planned to meet the needs of the local people. The local population spoke 120 languages, ranged in age and had high rates of glaucoma. There was also a high trauma workload.
- Significant capacity issues were highlighted, but formal plans to address this were not yet in place.
- The surgical wards did not reflect recommendations for delivery by the Royal College of Surgeons (RCS). Emergency and elective care were not separated and the level of postoperative care required following elective surgery was not factored into ward repatriation.
- The access and management policy did not ensure services had been planned to meet the most urgent needs of local people. A patient that required urgent treatment had been cancelled at least four times. We escalated our concerns to the executive team.

Access and flow

- There were noted difficulties with the delivery of the surgical service. Staff remarked, “The wheels could come off at any moment,” and, “Everyday is crisis management.”
- Managers told us that a surgical assessment unit was encompassed within the acute admissions unit, and that there were 10 surgical beds. We found this was not accurate in practice and there was no surgical cover on AAU, nor was there a surgical presence at the AAU handover. Patients were transferred from A&E to AAU without being clear which team had accepted them and, therefore, were unclear as to who was responsible for care.
- There was no surgery presence during handovers for the Hospital at Night team, and site managers did not receive information proactively about surgical patients who may have been at risk of deterioration.
- Surgical lists commenced at 7am. Children and vulnerable people were prioritised and were often seen first on the list, and there were no afternoon lists for children. There were no staggered admissions.
- Theatre scheduling took place two weeks in advance and were monitored weekly. Theatre lists were coordinated by a consultant anaesthetist and a theatre coordinator. The booking sheet used for theatres did not cover NCEPOD or surgical risk profile.
- The Department of Health monitors the proportion of cancelled elective operations and the hospital was not an outlier when compared with other trusts. However, when we asked for theatre utilisation information we saw that a number of theatres routinely had less than 40% utilisation. When we asked for clarification, managers told us this information was inaccurate and lists had to be manually checked for accuracy. When we requested data on theatre utilisation, we were provided with a report that stated ‘knife to skin’, or surgical time, was measured. Managers told us that the figures were wrong, as they were not based on the cases carried out.
- Cancellation and repeat cancellations were not meaningfully measured. The theatre coordinator manually checked utilisation, cancelled operations and adjusted data accordingly, though cancellations were not shown. This system meant that the coordinator had to manually review records the day after to feedback on theatre performance. During our inspection, we were made aware of a patient who had their operation cancelled four times. We escalated our concerns to the executive team and were informed the patient would be treated the next day.
- Many staff reported instances of patients staying all night in recovery, due to lack of bed availability on the wards. Figures on frequency of occurrence were not monitored by managers, and there was a reliance placed on staff to report clinical incidents, although staff told us they did not report all incidents of this nature.
- Managers told us Sycamore Ward was for emergency orthopaedics and Sage Ward was for elective orthopaedics. However, during the inspection, there was a mixture of patients on both wards from a number of surgical specialties, medical care patients and emergency and elective orthopaedic patients were found to be on both wards. This could have increased their risk of infection.
- During our inspection, we saw that one patient had been nursed in recovery for two days and did not have access to washing or toileting facilities, as the public toilet for recovery was in the corridor. Hot meals were not provided in recovery and staff tried to find sandwiches for patients. We observed a patient being

kept in recovery for over four hours, due to no beds being available on the wards. At our inspection in November 2013 we raised with the trust our concerns at routinely using the recovery area inappropriately.

- Staff told us recent examples of incidents that had not been reported, including a patient at the end of life who had been brought to theatre as there was no bed, and there were no washing facilities, or privacy and dignity for the patient or their family. Despite trying for several hours to transfer the patient to a more appropriate setting, the patient died in theatre.
- We were told that patients were regularly cancelled, due to lack of high dependency and intensive care facilities. The trust had plans in place to open a six bed unit in 2015.
- The admission criteria for emergency patients was not clear and the policy provided limited details.
- On surgical wards and day surgery there were separate wings for male and female. We were made aware that there had been two reported mixed sex breaches in the surgery division in 2014. This was due to bed shortages across the hospital.
- The trust was persistently not meeting the national waiting time target of 18 weeks for non-admitted pathways (95% referral to treatment target [RTT]). Those are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital. The trust performed worse than the England average between September 2013 and September 2014. It achieved an average of 91% between March 2014 and October 2014. Some of the worse performing specialties were neurosurgery (August 2014; 76%), gastroenterology (77%), neurology and general surgery (82% each). The trust suspended reporting on all 18 weeks RTT waits in September 2014 and did not expect to be able to resume until 2015.
- The trust was persistently not meeting the national waiting time target of 18 weeks for incomplete pathways. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month (RTT of 92%). The trust achieved an average of 81% between March and October 2014. Trauma and orthopaedics (69% of all patients treated within 18 weeks), general surgery (81%), urology (83%) and neurology (83%) were among the worst performing specialties across the trust in August 2014.
- The trust reported a lack of confidence in the data it held for referral to treatment times and backlogs, which it had escalated to its commissioners. The trust had been granted 12 months to review and the improvements in data were being overseen by a weekly task force meeting. We requested, but did not receive, evidence of these meetings. Senior managers could not assure us that they were aware of the extent to which cancellations, backlogs and delays in treatment were affecting patients.
- The configuration of surgical wards did not reflect best practice for delivering surgical services, due to the shortages of beds and arrangements for management of the bed base. Wards that were designated for certain surgical patients had a range of complex cases, for example, Primrose Ward should take general surgery, urology and ENT patients. Staff told us that, “The reality is, the unit takes anything,” and we found that there were long stay medical patients, orthopaedic, surgical, ENT and urology patients on the ward, during our inspection.
- Staff told us that difficulties with identifying available beds within the trust also had an impact. Staff gave us examples of a patient with a complex condition who was best suited for tertiary care at the Royal London Hospital who had to be treated at Whipps Cross University Hospital, due to trust-wide bed shortages.
- We were made aware of long-staying patients on Sage Ward, Rowan Ward, Poplar Ward and Primrose Ward, some of whom were admitted in February 2014 with no clear plan for discharge. The numbers of patients who were well enough to leave hospital, but remained, were checked at daily bed meetings, though this information was collected locally by the site management team and not shared with senior managers of surgical services.
- We were made aware of surgical patients that were being cared for on medical wards, though the trust did not provide us with this information data when it was required.
- We were told there were often patients who were scheduled for elective procedures without beds available for them to be transferred to. On 13 November 2014, there were 19 elective patients without beds.
- Staff told us patients were sometimes moved between wards for non-clinical reasons, without clear rationale. Managers told us they had no policy on moving patients between wards for non-clinical reasons.

Surgery

Meeting people's individual needs

- The hospital had clinical and support staff who also worked as translators and thereby offered instant access to language support. There were also agreements in place for external translators to provide support for patients if an appropriate member of staff was unavailable.
- We noted that snack packs were given to patients discharged at meal times, which had been introduced as a local initiative on Rowan ward.
- There were a number of patients that staff had identified as being confused and requiring further support. We did not see any specific dementia specialist initiatives available to support staff who were delivering frontline care. A recent dementia specialist post had been removed from the trust structure and staff were not clear on who they now spoke with specifically about dementia, other than peers or line managers.
- We spoke with the family of a patient with a learning disability. A nurse had omitted medications to control epilepsy during their stay. The patient had suffered a subsequent epileptic fit. We noted there was no medical review of this patient, no learning disability clinical nurse specialist involved in the patient's care and staff failed to raise this incident as a safeguarding concern. We highlighted this to the executive directors board of directors on the day we discovered this concern.
- We saw a number of doors to patient consultations rooms on Hope ward were open during patient consultations. Patients were advised to bring reading material as they would spend up to four hours in the waiting area and we noted there were limited facilities available.

Learning from complaints and concerns

- There was a backlog of complaints responses, which had been escalated to the board in September 2014. Senior managers told us the backlog had since been addressed in October 2014. However, a report dated 7 November 2014, showed there were 113 open complaints within the surgery CAG, across the trust. At the time of the inspection we requested, but were not provided with, a breakdown of the number of PALS and complaints or further details. After the inspection, the trust told the 113 complaints referred to were open but not overdue for the Surgery and Cancer CAG. They also told us the CAG undertakes a thematic analysis of complaints, PALS, and /or GP service alerts each quarter, selected either by topic, service, speciality or theme.
- Senior staff described local resolution meetings with patients and relatives that complained, so that they could offer face-to-face apologies and describe actions taken to improve care. They told us they held 11 of these within the last year.
- Some patients at the listening event expressed concerns about how staff within the surgical wards communicated with them when a concern was raised informally or formally. People told us they thought formal complaints were not handled well, and some were not even responded to.
- The Parliamentary and Health Service Ombudsman had reported on five cases relating to the surgery directorate at the hospital. Four cases did not identify any learning for the trust. One case, shared with the trust in September 2014, highlighted concerns with the management of acutely-ill patients and recommendations had been made for the trust to implement. Since the inspection the trust told us that action plans were developed by the CAGs for any PHSO investigated complaint upheld or partially upheld and that in two Surgery CAG PHSO cases published in this time frame, one had a financial redress recommendation only and the other was not upheld.

Are surgery services well-led?

Inadequate

The service was not consistently well-led. Many senior management posts remained vacant for significant periods. The governance processes were described by staff as 'immature', and it was clear that senior staff did not have an oversight of the care issues affecting patients and frontline staff. Non-managerial staff reported a disparity with management support within the directorate and felt they were neither listened to, nor did they have their concerns addressed. Staff told us "nothing changes" despite raising concerns with their immediate line managers. The impact of the staff consultation meant

trained and skilled staff had left the organisation, and the process by which the rebanding of staff to lower grades was communicated and carried out continued to have a significant effect on staff morale.

We were encouraged to see that an executive group director had been recently appointed. They had made early attempts to improve the visibility of patient safety issues at board levels and supported senior colleagues in doing so. However, due to the limited dedicated time the director had to undertake this post, staff told us the CAG director was not visible at the Whipps Cross site.

Vision and strategy for this service

- We asked for evidence of a strategic vision for surgical services, but were told development of some services, including urology, had been discussed with local commissioners, but had not yet been formalised in a report. There was no evidence of a unified vision for surgery services being shared with staff and stakeholders.
- The trust's integrated business plan for 2014 to 2016 had plans to reconfigure the capacity to undertake more complex arthroplasty operations at the hospital.

Governance, risk management and quality measurement

- The governance and risk management arrangements within the surgery and cancer CAG were undeveloped, and we could not be assured that senior managers had an oversight of the concerns affecting front line staff and patient safety and experience. This meant that concerns and risks that needed escalation and action were not dealt with, and often not known.
- The trust's October 2014 governance structure showed that services were divided into five clinical academic groups (CAG) which reported activity and performance of all trust locations, including Whipps Cross Hospital. Despite transitional weaknesses in the governance arrangements for cancer, the CAG was merged for surgical services in July 2014. Throughout our inspection we found governance arrangements were not well understood by senior staff within the CAG, and some senior staff described different structures that did not correlate. Reports shared through the committee structure did not separate incident, complaints, risks and performance activity by location and therefore the trust board had neither full information nor oversight of issues affecting surgical services delivered at the hospital.
- In a short time, the Executive Group Director had worked closely with the interim Executive Operations Director to identify strengths and weaknesses in the governance arrangements within the CAG, though noting this was in the early stages and could not evidence the outcome of these findings. Six senior staff attended a patient safety conference run by the Institute of Healthcare Improvement in Boston, USA. The Director acknowledged a lack of metrics and a loss of operational oversight.
- We were told that governance was aligned to risks reported through the service lines, i.e. each specialist surgical area had their own local governance arrangements, the hospital wide patient safety group and the trust wide surgery and cancer services CAG board. Several risks, including staffing shortages, were not identified and escalated through these committees. We also noted regular poor attendance by surgical leaders.
- We were told there were plans for the creation of a governance board for the CAG to be attended by clinical leads and senior nurses for each service.
- Backlogs in reporting on serious incidents and complaints had been reported throughout the summer months in 2014. Whilst the backlog had been addressed in order to meet requirements set by local commissioners, learning and change following these investigations was not taking place. Managers admitted "there is a need to develop a cascade of learning." The governance team last sent a newsletter out in the summer to the CAG to disseminate information identifying themes and trends, but no staff we spoke with were aware of this.
- Managers were confident that most incidents were reported as the hospital was a high reporting site for incident prior to the merger in 2012.
- Ward and theatre risks were not all captured and escalated. In relation to reporting risk, one staff member remarked "we just look after the patients that get sent to us, that's all we can manage." Senior staff acknowledged there were missing risks from registers, though concerns with financial implications were always escalated. Some ward managers were unaware of surgery risk register.

Since the inspection, the trust told us theatre governance meetings take place monthly across all sites. They also have weekly reviews of incidents, risk, etc. within theatres across all sites.

- There was no oversight on local governance procedures within the service lines, and we were not provided with any evidence that these measures worked in practice. For instance, we saw the significant referral to treatment time issues were not on the surgery local risk register. Managers told us performance reviews were held regularly and service lines were responsible for presenting cross site data though we were not shared any evidence to confirm that this occurred.
- We noted there were no theatre governance meetings, and local incident discussions were informal and not recorded.
- Evidence of lack of the integrated governance was shown in the managing acutely unwell patients group September 2014 meeting minutes for deteriorating patients.
- The Central Alerting System report; which highlights safety alerts the trust must take heed of and action; which went to the October 2014 board, showed the CAG failed to respond and we requested but were not provided with evidence to demonstrate how this was followed up.

Leadership of service

- Leaders within the trust had did not demonstrate they had an understanding and oversight on surgical services provided, which was impeded by unreliable reporting and a lack of visible leadership at the hospital. The CAG worked across the trust's sites.
- There was no site specific lead for surgery at the hospital.
- The CAG was led by an executive group director (medical/surgical lead), an executive nurse director and an executive operations director, and these senior managers were responsible for overseeing all trust locations. The executive group director for surgery commenced in their post in July 2014 and the executive operations director post was vacant and had been filled temporarily on an interim basis since August 2014 and was due to end in February 2015.
- The executive group director had a large portfolio to deliver, but insufficient non-clinical time to order to achieve this.
- Most leaders and managers were new in post, and a number of posts within the CAG had not been appointed. A proportion of managers were interim workers, and were given short-term contracts that lasted less than 12 months. Most had not received a handover from previous staff, and it was unclear who had been responsible for surgical wards and departments prior to their appointments.
- Staff spoke about 'clinical Friday's, which occurred once a month, in which senior clinicians assisted frontline staff. However, as there had been a number of senior roles which had not been filled for some time, the benefits of these sessions had not been felt by staff we spoke with.
- Theatre staff reported that non-executive directors and directors did attend, but received no feedback.
- Many nursing staff told us that managers and leaders were not supportive, and they felt concerns raised about staffing levels and the impact on patient care were ignored. The trust told us they were advised to review staffing levels across all locations, due to the impact on trust finances. The executive nurse director told us the 1:7 ratio was based on a mixture of acuity, evidence-based, an internal nursing workforce plan and local and national benchmarking. They also said ward staff would need to provide a risk assessment review on whether more staff were required. This was due to compromised patient safety caused by measures that had been put in place to prevent overspending. However, this contradicted concerns raised by staff through incident reporting in relation to staffing ratios and did not assure us that nursing leaders understood the impact of nursing staff shortages on patient care.
- A few members of staff told us when they had raised concerns that newly qualified band 5 staff were being given significant responsibilities, they were told that their concerns were not valid.
- Clinicians we spoke with felt managers pressured them into making decisions about care and treatment that focused solely on discharging patients from beds.
- Some managers and leaders told us there were no issues with bullying and harassment despite the findings of the trust-wide report published in October 2014. Executives and some senior staff were named as being 'bullying' and 'aggressive' by surgical staff we spoke with.

Surgery

Culture within the service

- The culture within the service left staff demoralised. Staff were committed to the hospital and their roles, despite difficult circumstances, but cognisant of pressures and concerns about lack of managerial support to target patient safety issues. It was remarked by a staff member, "The whole culture at Barts and Whipps Cross University Hospital is a bullying culture and the people responsible are the senior management."
- A number of staff we spoke with were in tears and were visibly distressed by their recent experiences of working in the hospital. A staff member shared "every day for the past two weeks I have cried".
- Staff shared many examples of poor behaviour they felt had been 'normalised', as well as concerns regarding the instability of the organisation of the workforce.
- The impact of the merger in 2012 and the nursing consultation in 2013 continued to have a detrimental effect on staff morale, and remained fresh in the memory of those nurses and support staff that were directly impacted.
- There was a consensus that the nursing staffing review undertaken as part of the trust consultation was poorly handled, staff morale continued to be affected. We were told that this led to the exodus of experienced nursing staff and a number of experienced band 6 nursing staff we spoke with were planning to leave, as they are at the end of pay protection.
- The majority or nursing and medical staff did not support the changes and told us they were not listened too during the consultation process.
- There was entrenched bullying and harassment. Staff members told us they felt uncomfortable about speaking openly and exposing known poor practice, as they feared that retribution would follow from senior staff. One said, "If inspectors could wave a magic wand, I would want the culture of blame and lack of openness resolved," and another staff member said, "It's not a nice place and I'm worried about my nursing registration." Another worried nurse said that the culture meant "staff lose sight of what is acceptable and unacceptable".
- Exit interviews that were completed showed that a proportion of staff on the surgical wards left as they were worried about patient safety concerns.

Public and staff engagement

- Patients' views of surgical wards were being sought through the patient panel and the NHS Friends and Family Test.
- Staff did not feel engaged and struggled to influence senior managers over decisions affecting their work.

Innovation, improvement and sustainability

- There were a number of innovative techniques being used in surgery, including the tertiary referral centre for complex abdominal wall hernias and reconstruction with research studies presented at international meetings and awaiting publication. The hospital was the first centre in the world to introduce collagen paste for the treatment of anal fistulas and were the leading centre for the only clinical/scientific trial on this new method of treatment.
- The senior management team acknowledged that the sustainability of the service needed review, in the light of the undeveloped governance framework and lack of oversight on the quality of the service provided to patients.

Critical care

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Inadequate
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Intensive Care Unit (ICU) had nine beds. It provided general surgical and medical critical care support for the local population. It had seven level 3 beds and two level 2 beds. Patients who had a potentially life-threatening illness could be admitted to an intensive care bed; they received one-to-one nursing care, or those patients too ill to be cared for on a general ward and required higher levels of care and more detailed observation/intervention for a single failing organ system or require post-operative care could be admitted to a level 2 bed. If capacity was exceeded, the ICU used theatre recovery as part of the escalation policy. The unit had around 500 admissions per year.

There was no designated critical care outreach team, a service was provided from 08.30 to 16.30 by a nurse consultant who was available to support deteriorating patients, out of hours cover was provided by the clinical site managers (CSM) who assisted with the management of critically ill patients on wards and departments across the hospital. There were 2.6 whole time equivalent (WTE) CSM who worked between the hours of 20.00 to 08.00 hours. An early warning system was used to monitor patients, promoting early detection and intervention if a patient's condition deteriorated and triggered the requirement of support from medical and nursing staff.

We spoke with, four relatives of patients being cared for on the ICU, 34 staff including, nurses, doctors, consultants, senior managers and support staff. During the inspection we looked at care and treatment, we also reviewed care records. We received comments from our listening event, and from people who contacted us to tell us about their experiences. Before and during our inspection we reviewed performance information from, and about, the hospital.

Critical care

Summary of findings

There was poor access and flow within the department and no designated area for patients who required high dependency care, although a business case to resolve this issue had been submitted to the board. Patients requiring surgical procedures were frequently cancelled and occupancy levels higher than the England average.

There were no clear arrangements in place for learning lessons and meetings were not well attended.

Staff did not always feel well supported as senior staff had significant roles and responsibilities and were not always present.

The majority of medical records had been updated and recorded relevant information although nursing records were not contemporaneous notes and only recorded variations to expected standards of care.

Restraint guidance was not clear and not always applied in line with legislation.

Are critical care services safe?

Requires improvement

Incidents were not consistently reported and there was no evidence that learning from incidents took place.

There was a 12% vacancy rate for nurses and medical staffing arrangements were adequate.

The unit was clean and infection control and hygiene policies were adhered too.

Medical records were completed however nursing care planning and evaluations completed were difficult to track progress or review progress of the patient's condition retrospectively. Nursing records were not contemporaneous.

Incidents

- There were no Serious Incidents (SI) reported for critical care services in the year preceding our inspection.
- There was an electronic incident reporting system in place to report near misses or adverse events, there was variation in incident reporting, staff we spoke with did not follow a consistent pattern about what incidents were reported.
- We were told the day before our inspection clinicians had closed and signed off 100 incidents. It was unclear about the method for closure and what discussions took place with the entire team and how and what feedback mechanisms took place to ensure learning from the incidents.
- We reviewed eight incidents recorded on the electronic reporting system during the inspection. Actions had been assigned and had been completed but not within the required timeframe.
- During the inspection there was an issue about the number of times that a patient's operation was cancelled due to lack of bed availability. Staff did not routinely report this as an incident on the electronic incident reporting system. Each time a cancellation occurred there was no incident report completed; staff seemed unconcerned by cancellations and the impact on patients. The patient we refer to had his surgery cancelled on five occasions.
- The ICU held monthly Mortality and Morbidity (M&M) meetings; combined with this was a practice and

learning meeting. We reviewed six mortality and morbidity meeting minutes; the minutes reviewed covered a period from January 2014 to October 2014 but not consecutive months.

- The minutes were circulated to ICU consultants and senior nurses. The format of the minutes was brief, there was no standardisation in the recording of the patient's details, diagnosis or treatment plans. Action plans were also brief, no date of completion identified and confirmed as being completed except through comments such as 'done'. There was no time limit on actions for minutes nor any arrangement for ICU M&M to be escalated and reported at a higher level to provide a governance cross check and auditable trail.
- Minutes recorded in June 2014 and September 2014 identified that there were problems in being able to access patient's notes to review; this was caused by changes in the electronic records system. In one instance only 3 out of 14 notes were available to review.

Safety Thermometer

- The ward assurance performance dashboard information was displayed on a noticeboard in the corridor outside of the ICU. Information displayed on the dashboard included the occurrence of pressure sores, cardiac arrests and Safe Staffing details. The information was visible for relatives and visitors to the unit to see.
- The dashboard information showed that in both September 2014 and November 2014, there had been two pressure ulcers acquired on the unit. The mechanism for discussing and investigating the occurrence of pressure ulcers was unclear.

Cleanliness, infection control and hygiene

- All staff we saw during the inspection adhered to the 'bare below elbows' policy, as well as using appropriate protective equipment, such as gloves and aprons to carry out procedures and personal care activities. However, the aprons in each bed space were the same colour making adherence to bed space with protection nearly impossible to oversee.
- Saving lives and hand washing audits were carried out monthly and sent to the infection control team.
- The infection rates for the unit, as reported through the Intensive Care National Audit and Research Centre (ICNARC), were low, as with most similar critical care units in England.
- MRSA screening compliance for the ICU was audited from April 2014 to October 2014. Ten patients screening compliance were audited at random each month; the trust policy was that all patients should be screened within 24 hours. The results of the audit showed a compliance rate of 90% to 100% over this period.
- The unit was clean and tidy; dedicated staff explained the cleaning schedules and the use of different coloured mops and buckets for cleaning different areas to reduce the risk of cross infection.
- There was a sink and hand-gel available at the entrance of the unit, staff were observed following hand washing protocols.

Environment and equipment

- Security on the ICU was good; the unit was locked and accessed by a secure intercom system that visitors to the unit had to use. Staff had a swipe card system that was unique to them.
- The ICU was based in a traditional converted nightingale ward, the bed areas were cramped which impacted on the privacy of patients.
- There was a side-room on the ICU, this could be used for isolation but again was limited as was not purpose built to be able to provide negative/positive pressure ventilation/ air lock or even double doors for barrier nursing.
- The environment did not conform to modern ICU building standards in that there was no negative pressure in the only side room on the unit.
- The equipment store was tidy; the equipment was labelled and ready for use. It was not clear who was responsible for checking equipment.
- There was an arterial blood gas machine (ABG) this machine was shared by theatres. Issues had been raised about the number of non-related ICU samples that had been processed; clotted blood samples had caused damage to the ABG machine. This ABG machine had no lactate measurement facility which would be expected in managing severe sepsis. There was an issue specifically about the number of non ICU staff who entered the unit to use the blood gas analyser and the potential for breach of confidentiality as well as infection control.
- On the resuscitation trolley a piece of equipment - Laryngeal Mask Airway had expired. A tracheostomy emergency flowchart 2010 did not have a review date.

There was no cardiac arrest audit form, as well as an out of date British National Formulary, a pharmaceutical reference book that contains information and advice for prescribing and pharmacology.

- The ICU does not have a rolling repair and renewal programme for equipment. Senior nursing staff met with the medical devices department regularly; 45 new intravenous fluid pumps were due to be rolled out for use on the unit. We were told there would be a teaching programme for all staff to familiarise them with the equipment. Staff did not feel involved in the replacement programme and expressed safety concerns with the equipment which was implemented.

Medicines

- The critical care pharmacist attended the unit daily to review each patient and their medications to ensure that they were suitable and within prescribing guidelines. The ICU had no daily top up service from pharmacy. The senior nurse had the added responsibility to her role to ensure that stock levels were maintained.
- Sterile fluids were kept in an unlocked storage area, this could potentially increase the risk of contamination of the fluids.
- All controlled drugs (CD) checks were completed by two members of staff at each shift change; there was an audit trail of completion at the rear of the CD book.
- Six prescription charts were reviewed, on all prescription charts reviewed where antibiotics had been prescribed; there was no stop date, no indication for use, this demonstrating a lack of antibiotic stewardship.
- Arterial and central line flush solutions were not consistently prescribed, which was an National Patient Safety Agency (NPSA) requirement.
- The ward fridge had a temperature display log that had been recorded.

Records

- Staff told us that a new IT system that had been introduced was difficult to use and there was poor IT support from the company. During the inspection we observed that two computers had been left open and unattended with SMART cards in place allowing anyone unauthorised access to information.
- We reviewed three ventilated patient's' observation charts who were was receiving one to and one nursing care. The staff member showed awareness of guidelines and protocols and were was able to demonstrate knowledge about tracheostomy and ventilator acquired pneumonia (VAP) care bundles. Included setting daily aims of care for the day and a management plan.
- Two sets of notes we reviewed had detailed documentation in the patient record of the time and decision to admit the patients to the ICU. We tracked one patient who had been referred to the ICU for admission, but had not been admitted. The notes showed a clear discussion had taken place with the ICU consultant and referring team, supportive treatment was initiated. There was also recording of detailed discussion that had taken place with the patient's family, which included acknowledgement of family perspectives of treatment options. There was evidence of a multidisciplinary team approach in reviewing patient's condition and treatment options.
- We reviewed medical notes of a patient on ICU, this patient had a 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) order in place. The DNA CPR order had been completed signed and dated by an ICU consultant. There was also evidence of a clear discussion recorded with the family in the medical notes. Consent forms, daily review notes, and comprehensive physiotherapy notes and assessment were completed and signed.
- The nursing care planning and evaluation was recorded on the reverse of the patient's ICU charts, this format makes it difficult to track progress or review progress retrospectively. Nursing documentation was undertaken on the basis that unless otherwise stated there was no variance to the care planned. This made it impossible to assess whether there had been anything to document or it had been omitted or forgotten. Documenting variance to care on the reverse of the chart made it difficult to have a contemporaneous view of the patient's progress. This also had the effect of isolating nursing issues from the rest of the MDT as they were unlikely to review the reverse of a large chart, the remainder of the MDT wrote their clinical records in the medical notes.
- The process in place to review the ICU charts and ensure that they had been completed appropriately was Ad hoc spot checks which were carried out by the matron and education lead.

Safeguarding

- There was a Safeguarding Protection of Adults at Risk of Harm Policy; however we were not able to access it on the intranet system when we asked to look at policies. Staff reported that they had difficulty accessing relevant policies on the intranet; they also felt that some policies were not specific to the Whipps Cross site.
- We were told that there were new safeguarding teams, staff could telephone for advice and there was also a designated email address to send completed scanned risk assessment forms to.

Mandatory training

- New staff attended a trust induction programme; the education lead had a meet and greets session with new staff which included orientation and induction to the ICU environment. There was a trust local induction check list to be completed for permanent staff.
- Mentorship training was provided we saw that a register of mentors was kept, this included mentor status, with dates for both mentor updates and triennial review.
- Compliance with mandatory training for ICU nursing staff was recorded as being 75% of staff who were fully up to date with training in November 2014 up to the date of the inspection. We spoke with the lead nurse for education who explained how students and new members of staff were allocated mentors with whom they worked, and this allowed their development and learning to be monitored and supported.
- After reviewing the data provided by the trust we saw that the anaesthetics medical staffing rate for mandatory training was 87.61%, for statutory training the rate was 80.45%.
- We were told that there had been issues with mandatory training with changes in delivery, previously within critical care training had been delivered face to face. A new mandatory training booklet had been introduced; staff felt that there was some conflicting information about practices between different sites and the new corporate approach from Barts Health NHS Trust did not feel specific to the ICU at Whipps Cross.
- Access for new staff to the IT system we were told took up to eight weeks, we were told this impacted on staff being able to access e-learning modules in a timely manner.

Assessing and responding to patient risk

- There was a nurse consultant who was the lead for managing the deteriorating patient pathway. The nurse consultant was the link person between ICU and the wards during the day.
- The trust had implemented the early warning score (EWS) for any patient deemed at risk of deterioration; the system standardised the assessment of acute illness severity, and indicates when senior staff should be contacted. Referrals were made predominately to the medical team who was responsible for the patients care and the nurse consultant and clinical site managers liaise with the critical care and work closely with the unit.
- There was handover of patients monitored on the early warning system at the 20.30 Hospital at Night team meeting for the clinical site managers and clinical staff. Staff told us there was no robust system in place to track patients, patients can be moved and not utilising technology that ensures the system is joined up.
- The national cardiac arrest audit showed that there was a high number of cardiac arrests with a worse than average survival rate.

Nursing staffing

- The ICU had a band 8 matron who covered two sites. Some senior nursing staff were rotating to the other unit to support the matron, we were told that this was impacting on consistency of support for staff.
- There was a 12% vacancy rate for the nursing establishment for the ICU. Currently 70% of total nursing establishment of registered nurses on the unit had a post-registration critical care course. This was better than the 50% recommended by the core standards for Intensive Care Units (2013).
- Nurse to patient ratio was 1:1 for level 3 patients, with 1:2 for level 2 patients.
- The total combined bank and agency nurse hours for September was 935 hours and for October 2014 the total was 850 hours. The combined agency and bank hours were to cover sickness, maternity leave and the vacancy rate. The unit was not complying with the core standards from the Faculty of Intensive Care Medicine and was sometimes using more than 20% of bank and agency registered nurses on any one shift.
- A new e-roster system was used to set the rotas, we were told that there had been issues with rotas' being produced that were not covering the shifts with regard

to skill-mix and working patterns. The senior nurse producing the rota had been using previous system to produce a rota to support the needs of the service. All staff did internal rotation.

- Staff told us that they felt under pressure with staffing levels, the use of agency nurses had increased on shifts, but as some nurses did not turn up for booked shifts this also had a significant impact. There was an induction sheet for agency nurses that had to be completed, this included orientation to the unit environment.
- There was a standardised handover procedure at shift change for all nursing staff. After this staff were allocated to a specific patient and received handover at the bedside for each individual patient they would be caring for.

Medical staffing

- Care was consultant led; there were eight consultants who covered the unit, one of the consultants worked within the A&E department but provided cover for the ICU one day per week. They provided 24 hour cover on a fixed weekday rota, two consultants alternate on Monday-Wednesday and weekend cover from Friday to Sunday was provided by the same consultant.
- Consultants were present from 07.30 to 18.00, but stayed to provide cover to the unit if necessary outside of these times. In line with the core standards of the Intensive Care Society a consultant was available to attend within 30 minutes and undertake twice daily ward rounds.
- The ICU complied with the Faculty of Intensive Care Medicine in the requirements to support trainees undertaking training in Intensive Care Medicine. Junior doctors that we spoke with were positive about their teaching opportunities and the support they received from the consultants.
- During the inspection we were able to observe the handover between the consultant night trainee and day trainee. There was a daily ward round note completed during the handover. The handover sheet was detailed and used an SBAR communication record. SBAR – stands for situation, background, assessment and recommendation.
- The consultant to patient ratio was 1:8 which was within the range as recommended by the core standards of the Intensive Care Society.

Major incident awareness and training

- Staff were able to tell us about major incident planning, within the last 12 months there had been an exercise on evacuation of the ICU.
- The ICU had a comprehensive Business Contingency Plan in place that set out the framework for how the critical care service would respond to situations that arose outside the parameters of normal procedures. The policy timeframe was current and due for formal review in February 2015.

Are critical care services effective?

Requires improvement

Overall we observed that patient outcomes were similar to other units and there was evidence that patients received adequate pain relief and nutrition.

The application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards required strengthening and recording.

Staff appraisals were up to date and support from other teams largely met requirements. Although we noted that there was not a consistent appropriate from specialist teams when patients were discharged to other areas of the hospital and we observed some staff caring for patients were not suitably experienced.

Compliance with the latest guidance was not monitored and some guidance being used was out of date.

Evidence-based care and treatment

- NICE guideline CG83, 2009 – rehabilitation after critical illness was adhered too. Patients on the ICU were seen and assessed by the dedicated ICU physiotherapist. The first assessment for rehabilitation needed following critical illness occurred after 24 hours of admission to the ICU.
- Intensive Care Society and the Faculty of Intensive Care Medicine guidelines with regards to level of senior staff and consultant cover were followed.
- The unit had a specialist nurse and lead consultant for organ donation, we were told that there was a quarterly potential donor audit; the information was not on the local surgery CAG register.

- A new National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, "On the Right Trachh?" was published in 2014, recommended best practice for caring for patients with a tracheostomy. We did not have any information about compliance with the guidelines, minutes we reviewed from the ICU practice meeting in June 2014 showed at that time the areas that were not compliant were for percutaneous tracheostomies to have a surgical checklist, consent form and be sutured in place. On the day of the inspection there was an airway scenario simulation training session being run on tracheostomies management.
- We noted that in the bedside resource folders that some protocols such as the Bowel Care bundle were out of date, this protocol was created in 2007 with no review date or ratification date. The Eemergency tracheostomy protocol had a review date of 09/September 2012 not as awaiting approval. We were told that protocols were stored in the photocopier; this was a local solution if they could not be accessed on the IT system. Another protocol was the Palliative Care Bundle, created in 2007 with no review date or ratification date.

Pain relief

- We reviewed three pain relief charts and there was evidence of pain assessments conducted.

Nutrition and hydration

- The ICU observations charts recorded intravenous infusions and parenteral nutrition and the patients' fluid balance, enabling staff to monitor the patients' nutrition and hydration status.

Patient outcomes

- The data provided to the Intensive Care National Audit and Research Centre (ICNARC) from 1st January to 30th June 2014 showed that, when compared to similar units, rates for patients readmitted to the unit were low. The readmission rate (within 48 hours of being discharged) was 1.8%.
- The unit mortality rates were comparable to other similar units, at 0.9 for the six month period from 1st January to 30th June 2014.

Competent staff

- The ICU had a designated educational lead for nursing staff; there was a local induction programme for newly appointed staff, as well as an induction check list for agency staff working on the unit.
- We observed band 4 staff caring for patients without adequate supervision.
- Newly appointed staff to the unit had a period of between four to six weeks supernumerary status. There was a critical care competency document that newly appointed staff nurses and assistant practitioners who were band 3 had up to one year to complete, signed off by their mentor. For band 5 staff nurses completed competences formed part of the criteria for them to access a critical care course.
- The appraisal cycle for staff was from November to January, we were told that for 2013 the completion rate had been 100%; we saw paper records that identified the dates that appraisals had been completed.
- The ICU have assistant practitioners, the role was developed with support from the nurse consultant and a local Higher Institute of Education.
- Registered nurses on the unit with a post registration award in critical care nursing was 70%, the unit supports students undertaking the post registration course.
- Junior medical staff had an educational supervisor, and those that we spoke with had teaching /training opportunities.

Multidisciplinary working

- There was a multi-disciplinary clinical ward round which occurred daily, including weekends. This was attended by consultants, junior doctors, nursing and Allied Healthcare professional including pharmacist, physiotherapy and dietician. With some consultants seeing
- There was not an integrated approach from all specialist teams when patients were being discharged from the unit, some teams would see their patients on ICU while others did not. This was a parallel approach, rather than an integrated one.
- There was locum cover for the microbiology service during the week with a daily ward round, but there was no Saturday cover. The microbiology department had moved off site from the hospital.
- There was a designated ICU pharmacist who attended the unit daily; there was an out of hours on-call service.

- There were designated physiotherapists attached to the ICU, who followed patients throughout their stay until discharged to the ward. They discussed weaning plans and mobilisation and rehabilitation for patients. Physiotherapists were available also at weekends.
- There was no designated critical care outreach team, a service was provided from 08.30 to 16.30; there was a nurse consultant was available to support deteriorating patients. Out of hours cover was provided by clinical site managers who were available to assist with the management of critically ill patients on wards and departments across the hospital. An outreach team was a recommendation jointly of the Faculty of Intensive Care Medicine and Intensive Care Society core standards.

Seven-day services

- There was a consultant on call to the service out of hours. Consultants worked on rotation and were responsible for ensuring the unit had adequate clinical cover from junior doctors at all times when a consultant was not on duty on the unit.
- There was locum cover for microbiology; there was a daily round but inconsistent advice from locum changing; there was no Saturday cover.
- There was a weekly meeting with radiology services and on call provision at the week end.
- There was consultant cover for patients in the unit during the day from 07.30am to 6pm and an on call service out of hours.

Access to information

- Information systems to support staff to deliver effective care have been reported as being difficult to access in a timely manner. There was a standardised handover procedure for discharging patients from critical care that included both written and verbal feedback to ward staff.
- Staff we spoke with repeatedly expressed frustration at the difficulties they experienced with the IT system. There had been issues around notes not being retrievable to review that had been documented in the M&M minutes; this was caused by changes in the electronic records system.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- There was a designated lead for Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There also provided a monthly open access teaching session that staff could attend. However, we were unable to verify the number of staff who had undertaken training within the ICU as part of their mandatory and statutory training.
- Recently two patients had been physically restrained. We observed one patient who was being physically restrained with wrist and ankle restraints. We were told the risk assessments were completed in accordance with the trust policy. We asked for but were not provided with any documentary evidence that the policy was followed.
- We looked at the records and found that there were differences when restraints were used one team wrote as required, another team did not mention the use of restraints at all. It was unclear in the medical notes whether the patient was documented as not having capacity. There was no counter signature by the safeguarding team as required by their own policy document.
- When looking into the process we came concerned that it was not clearly recorded that action was being taken in the patients best interests and that there may have been a conflict of interest with a member of staff in the governance aspect of physical restraint. We raised our concerns with executive team.
- We were told that the Restraint and Containment Policy was under review but there were problems accessing the document on the intranet. We saw that there were ICU action cards for restraint and we were told that they were the pre-existing legacy policies, reviewed in 2013. They had been stored on a local intranet page up until the new IT system began. There had been discussions with the safeguarding lead including reviewing practice; elements of the legacy policy had been implemented into the new trust restraint policy.

Are critical care services caring?

Good

Staff were kind, caring, and compassionate. Staff approached people in a person centred way and families said they were involved in the care of their relative.

Critical care

The ICU did not have a systems to gain feedback from patients or relatives about their experiences or satisfaction of the service.

Compassionate care

- We observed care being delivered where patients' privacy and dignity was preserved. Nurses and healthcare assistants were talking to patients and their relatives with kindness and compassion.
- The staff and relatives we spoke with demonstrated that communication and keeping the patient, Friends and Family Test updated and informed was important.
- It was not possible to talk directly with patients during the inspection due to the nature of their conditions. The ICU did not partake in the Friends and Family Test, they also did not have systems in place through feedback through a patients or relatives satisfaction survey. It was unclear how they measured how they were performing against patient satisfaction.

Understanding and involvement of patients and those close to them

- One relative said the consultant caring for the family member was very caring and attentive, keeping the family involved and ensuring that they understood what was happening with their relative. The relative felt that the visiting times were not long enough, to be able to spend time with their family member.
- Another relative told us that there had been good communication between the clinical staff, they were kept fully informed about the referral that had been made to a specialist team with regard to the treatment plan for their family member.

Emotional support

- There was a good system for post discharge follow up for patients who had been a patient in the ICU. Follow up after discharge is a recommendation from the Intensive Care Society's Core standards 2013 and NICE CG83 2009. ICU physiotherapist supported patients post discharge from the unit to the ward.
- The unit did not utilise a system such as a 'patient diary' to enable patients to have a record of their experiences and progress and friends and family to record their visits or significant events.
- Another relative felt that she had been well supported when difficult news had been broken to her about the family member who was acutely ill on the ICU.

Are critical care services responsive?

Inadequate

Occupancy levels in the unit were higher than the national average and surgical procedures frequently cancelled without adequate forward planning arrangements.

There were two HDU beds and no high dependency unit in the hospital which meant that patients who would normally receive specialist HDU care were cared for in wards or the theatres recovery area. We identified in November 2013 that the recovery area was being used to care for patients and this practice was continuing. Staff were not always suitably trained to care for patients with such high needs.

There was no designated facilities for relatives to stay overnight.

Service planning and delivery to meet the needs of local people

- There were two HDU beds in the hospital and no high dependency unit. At busy times patients that would normally be cared for on a HDU were cared for on wards or in the theatre recovery area. There were a number of transfers to reprioritise the clinical needs of patients because there was no HDU.
- There was a relative's room on the ICU for private discussions in private, although it became crowded at visiting time while relatives were waiting to go onto the unit.
- There were no separate facilities where relatives could stay overnight, if for example, if their relative was very unwell or was unstable. We were told that there were fold up beds that could be used in the relatives room, there were no separate washing facilities.
- Relatives that we spoke with were satisfied with the visiting policy, only one person said that they found it difficult not being able to bring their children to the unit to visit.

Meeting people's individual needs

- To meet the needs of patients or relatives who did not speak English as their first language, if ICU staff spoke

the relevant language they would translate for and to patients. There was a telephone translation service (Language Line), which staff could access for patients or their relatives to ensure that they were understood.

- We observed that there were no information leaflets available in any other language apart from English. It was unclear what options staff had if they required written information in an alternative form.
- Nurses provided support to relatives if they suffered bereavement on the ICU, the matron had sourced a job plan for a psychology assistant to be able to provide support on the unit. There was no date as to when this post/service would start.
- There was a relative's room on the unit, this was also used for staff-handover which would normally be outside of visiting hours. There were limited facilities for relatives to be able to stay, although the unit had access to fold-up beds.

Access and flow

- Bed occupancy in September and October 2014 was from 88% to 91% which was higher than the national average. On 19 occasions from September 2014 to the first week of November 2014 surgical procedures were cancelled because there was no ICU bed available.
- NICE guideline CG50, 2007 - acutely unwell patients in hospital: recognition of, and response to, acute illness in adults in hospital were not fully adhered too. Part of the guideline states that patients should not be transferred from the unit at night. However, data that we saw demonstrated that 9% to 12% of admissions over a two month period had been transferred from the ICU to another ward between 10pm and 7am. This was due to pressure on beds, for example, if a patient required admission to the unit either from another ward or A&E, they were given priority.
- Non clinical transfers routinely took place because of bed capacity. This practice was not in line with best practice and was not recorded as an incident.
- There was a diary system operating on the ICU for booking beds each day three spaces were available for adding patient's names that were undergoing a surgical procedure. On each occasion that a cancellation occurred there was no forward planning with regards to ensuring a cancellation would not had to be made again.
- The admissions policy was followed. Admissions could only take place under the care of the ICU consultant being aware with the exception of patients referred from A&E.
- When a bed was not available, patients were cared for in the recovery area of theatres. This option was part of the unit's escalation plan, however this impacted on recovery staff who were not ICU trained, as well as ICU and anaesthetic staff at night-time.
- In October 2014 there were three out of hour's discharges from ICU, the reasons for late discharge from the unit included shortage of ward beds, awaiting ambulance and shortage of staff on ward.

Learning from complaints and concerns

- The ICU matron told us about the process for patients or relatives wanting to make a complaint. If the patient or relative wanted to make an informal complaint, they would speak to the shift leader. We were told about families that had been spoken with by the medical staff with regard to why their relatives had not been admitted to ICU, they had wanted to understand the decision process.
- If the issue or concern were not resolved satisfactorily they were directed to the Patient Advice and Liaison Service. If the issue or concern was still unresolved, the person would be advised how to make a formal complaint.
- We reviewed two complaints from data that had been submitted from the trust from 1st October 2013 to 30th September 2014, both specific to ICU. One complaint had been resolved and an action plan completed. The other complaint did not have an action plan to clarify how it was resolved.

Are critical care services well-led?

Requires improvement

Staff recognised they needed a HDU and had submitted a business case to the board, that was subject to funding. Risks were known and managed.

Critical care

It was staff perception that local leadership was diluted because of the number of areas management were responsible for. There was poor attendance at meetings and the unit was not currently part of a critical care network although this was being given consideration.

Vision and strategy for this service

- The aim was to develop a high dependency unit (HDU) and establish the workforce to provide care for patients. All staff we met were committed to high quality, compassionate and safe care and treatment but recognised a HDU would ensure the ICU being used appropriately. A business plan had been provided to the board.

Governance, risk management and quality measurement

- There was a critical risk register in use specific to the hospital ICU, there were four entries recorded on the risk register, including a descriptor controls in place to mitigate risk. The issue of bed capacity was recorded on the register, with a red rating.
- Clinical governance meetings for the CAG were held monthly. We reviewed the minutes from six Patient Safety Committee meetings held from, but not concurrent between April 2014 to October 2014. There was representation from the Nurse Consultant for Critical Care and the clinical lead (Safety) from ICU; we noted that there were often more apologies of non-attendance from senior staff. Apart from accessing the minutes for information it was unclear what other feedback mechanisms were in place.
- There was a data co-ordinator, as well as a band 7 nurse in post who collected data and submitted it to ICNARC. Senior staff were aware of the latest Intensive Care National Audit and Research Centre (ICNARC) data results.
- The ICU was not of a part of a critical care network; we were told that an inaugural meeting was to be held with the formation of a new network from 15 hospitals in the region. Four representatives from the trust would be attending the meeting, but we were not given a date to confirm when it would be held. The mechanisms of sharing best practice outside of the trust were unclear.

Leadership of service

- The ICU was part of the Surgery and Cancer CAG; information from the CAG was disseminated by the CAG Group Director through governance to the Clinical Director, Service Head, General Manager, Clinical Lead and to the Matron.
- The unit was led by a band 8 matron, a consultant clinical lead; and a nurse consultant. The matron recently had to take the lead for another similar sized unit within the trust. Responsibility for both sites had impacted on her availability and accessibility for staff.
- Staff we spoke with did not know the corporate nursing team; they felt they were 'invisible'.

Culture within the service

- Most of staff felt that the merger in 2012 had not led to any benefits for their service.
- We were told about the impact that the recent re-banding of staff had had on the service and the morale of the team as well as individuals within it, the effect was that some staff felt that they could not speak out as they wanted to 'might not bring up issues if they want to keep their job'.
- Some staff reported that the way they were spoken to by senior members of staff could be improved. There was a perception of a bullying culture.
- Some staff felt that there was a culture of pressure, rate of change in roles and responsibilities make any progress difficult to assess, plan or manage. The critical care service had been part of two CAGs in two years.

Public and staff engagement

- Due to the nature of critical care there was no general public involvement with how the service was run; patients and their relatives did not have access to patient satisfaction surveys as they were not conducted on the unit. Relatives we spoke with during the inspection gave positive feedback in their comments about the care their relatives were receiving while on the ICU.
- Not all staff that we spoke with felt they had a voice and their opinions were valued.

Innovation, improvement and sustainability

- The lead for the deteriorating patient's pathway, was co-ordinating the introduction of a new system the National Early Warning System (NEWS) in January 2015. The NEWS would replace the previous EWS track and trigger system that identified patients at risk that

necessitated promoting early detection and intervention if the patient's condition warranted a higher level of support from medical and nursing staff. Nursing staff would be trained on using the new system, in order to be able to identify those patients requiring more support if they became acutely unwell.

- Due to capacity issues with ICU beds that were recorded on the critical care risk register; a business plan had been put forward to open a HDU at the hospital. The benefits of the HDU would be that acutely unwell patients requiring level 2 care would be cared for in an appropriate environment. It would also increase the flexibility and responsiveness of the ICU to meet patient's needs.

Maternity and gynaecology

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The services were provided on the maternity unit and in the community. Community midwifery services delivered antenatal and postnatal care for low risk women in the catchment area. Specialist antenatal clinics were run by obstetricians, specialty trained midwives and other health service staff, such as dieticians. Ultrasound scans were carried out next to the antenatal clinic by sonographers and midwives trained to carry out ultrasound scans.

Antenatal, induction of labour and postnatal care were provided in a 44 bed ward (Mulberry Ward). An area of the ward was used for transitional care, where babies could be cared for alongside their mothers. Women were assessed prior to admission in a 24-hour triage area, next to the labour suite, and a day assessment unit, open from 8am to 8pm on weekdays. There was a midwifery run birth centre, with five rooms currently in use. The labour suite had 10 delivery rooms and two high dependency beds, with two adjoining obstetric theatres with three recovery beds. The small homebirth team was supported by the community midwifery service. There were 4,861 births in 2013/2014.

Gynaecology services ran an emergency gynaecology unit (EGU) on weekdays for women with pregnancy and non-pregnancy related acute gynaecological complications. The hysteroscopy clinic carried out diagnostic examinations of the womb and procedures such as the removal of coils and polyps (womb growths). There was a multidisciplinary clinic for women with chronic pelvic pain. Women having gynaecological surgery were cared for postoperatively in non-specialist surgical wards.

The services were part of the women's and children's health clinical academic group (CAG). There were clinical and nursing/midwifery leads for maternity and gynaecology at the hospital, who reported to the CAG leads.

We spoke with 15 women and more than 40 staff, including maternity support workers, midwives, nurses, doctors of all grades, administrators and senior managers. In addition, we held meetings with midwives, trainee doctors, consultants and administrative staff to hear their views. We reviewed information provided by the hospital.

Maternity and gynaecology

Summary of findings

We found committed staff and examples of good practice, such as close multi-disciplinary working. There had been improvements since our last inspection, but further work was needed.

Maternity and gynaecology services had taken action to address challenges in meeting the demand for their service. This included improvements to induction of labour and elective caesarean section procedures. Further action was needed to understand the demand for inpatient maternity services and how to make the best use of resources to meet this demand.

There were times of staff shortages in inpatient areas. The process for escalating concerns at these times was not always implemented effectively. The hard work and commitment of midwifery staff helped keep women safe, but this meant that midwives sometimes did not take a break in their 12 hour shift.

The change of patient record software earlier in the year had resulted in difficulties in accessing accurate data about activity in the maternity unit. There was manual verification of some data to make sure key performance indicators were reported accurately.

There was a focus on learning from serious incidents and complaints in women's services and staff of all professions and grades reported incidents. There had been improvements in the way that complex complaints were dealt with to ensure that people were kept fully informed about investigations. Serious incidents were investigated and actions identified. The response to incidents not categorised as serious, and the process for monitoring the implementation of actions, required further work.

The women's and children's healthcare CAG was developing its clinical governance processes. This had promoted shared learning in women's services, but attendance at trust meetings reduced the presence of senior managers at the site. Guidelines were being reviewed and updated, and there were regular audits, the results of which were shared with staff. Risk registers were regularly reviewed, with responsibility for actions allocated and monitored.

The women using the service said doctors and midwives gave them the information they needed when they attended antenatal appointments. We were told the midwives on the birth unit were "caring and compassionate" and one of the women who had given birth on the labour suite described her midwife as "brilliant". A woman told us of the poor level of support she had received in recovery following a caesarean section.

The newly refurbished emergency gynaecology unit (EGU) was providing a responsive service to women, but the service was not open at weekends. Women undergoing gynaecological surgery did not always receive post-operative care from appropriately experienced staff.

A values and behaviour programme had been launched in maternity services at Barts Health NHS Trust to improve the way staff interacted with women and with each other and to improve the standard of care. Feedback from women using the service indicated that there had been improvements in patient experience. However, changes to staffing implemented by the trust, such as changes in the management structure, had lowered morale and some midwifery staff did not feel their voice was heard.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Action had been taken to address challenges in meeting demand. Nevertheless, maternity services did not demonstrate a coherent approach to meeting demand when there were staff shortages. Midwifery staff were often under pressure and sometimes did not take a break in the 12 hour shift.

The portakabin used by community midwives to see women for their first antenatal booking was not fit for purpose. Theatres and wards were clean and there were adequate supplies of equipment.

There had been improvements to the incident reporting process. Serious incidents were investigated and actions identified. Staff met with families to answer questions and keep them informed of the investigation and its outcome. The monitoring of the process was not yet fully in place.

There were processes in place to assess and manage risk, which were promoted by close multi-disciplinary working. This included systematic antenatal assessment of women at risk and the use of team briefings and checks in obstetric theatres.

Mandatory training was up to date and included multi-professional team training in obstetric emergencies.

Gynaecology surgical patients were not always being cared for post-operatively by appropriately qualified staff.

Incident reporting

- Staff from all professional backgrounds and grades told us they entered incidents on the incident reporting system. We looked at the women's services reports for the two months prior to the inspection and saw that incidents, such as a shortage of staff, failure to inform a patient of results, and drug errors, were appropriately reported. Reporting levels in maternity were increasing and there had been 270 incidents reported in the four months to October 2014. There had been a focus on a shift to a culture of being open and learning. Staff were encouraged to report 'near miss' reports and were thanked for being open about an error. Trainee doctors who reported most incidents received an accolade and when an incident was well managed staff received a letter of commendation.
- There was an agreed trigger list of serious incidents (SIs) for maternity services reported to NHS England, such as the unexpected admission of a baby or mother for intensive care following the birth. There had been no Never Events reported in the previous year in maternity services. (Never Events are largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented).There had been 18 serious incident (SIs) reported, in the year to September 2014.
- The clinical governance lead and nursing/midwifery managers were automatically sent details of incidents reported, and primary responsibility was allocated to one of them to review the incident and feedback to the reporter. There was a local weekly multi-disciplinary risk forum each week in both gynaecology and maternity services to review incidents and complaints and to identify potential SIs or other incidents requiring consultant involvement. A supervisor of midwives attended the maternity meeting and took part in the investigation of complaints and incidents when appropriate. Other staff were encouraged to attend the meetings.
- There was a 90% feedback rate to staff in maternity services at the trust who submitted incident reports. Staff told us of the action and feedback in response to their reports. Some midwives we spoke with, however, such as those who reported a shortage of staff, said they had not received feedback, or they said the response did not address their concerns. Others said they did not report concerns about staffing because nothing happened as a result of these reports. There was a perception among staff that there the response to incident reports varied depending which manager dealt with the report and/or which member of staff made the report.
- Staff told us that regular discussions about incidents and complaints took place at ward meetings, for example on Mulberry Ward and the emergency gynecology unit (EGU). Gynaecology services circulated a list of SIs to staff, who signed to indicate they had read them.
- The CAG had introduced a standard operating procedure for responding to serious incidents, which

was now being adopted throughout the trust. The quality assurance process had been streamlined to improve the timeliness of the investigation and to follow up on actions agreed following the investigation. The procedure promoted adherence to the duty of candour. In addition to a meeting with the consultant at the time of an adverse event, families were given a named person to contact after they went home. They were invited to attend a meeting with a senior midwife/nurse and the consultant at a later date, which was documented. If there was an investigation, they were asked to contribute the questions they wanted answering.

- The format of the investigation reports was appropriate, with a timeline and a section for other contributory factors. We looked at six reports and these all focused on the time line and clinical records. The opportunity was missed to explore the factors, such as staffing and communication, from which the service might have learned lessons. This had been recognised and there were plans to hold a master class in the appropriate recording of contributory factors.
- A restructuring of risk management in the CAG had been agreed with the appointment of a risk midwife at the hospital and increased administrative support to monitor adherence to processes. At the time of our inspection, information on implementing actions and meetings with families was not always monitored.

Midwifery and nursing staffing

- Maternity and gynaecology services had reviewed staffing levels and we found evidence in some areas of action to address the challenges of meeting demand. However, at the time of our inspection there were frequently staff shortages. Medical and midwifery staff told us women were kept safe on the labour suite and in triage because of the commitment and hard work of midwives.
- The midwife to birth ratio was 1:32, worse than the recommended ratio of 1:28. We were informed that because of a recent fall in activity the current ratio was 1:30. Bank and agency staff were being used to fill gaps in shifts while additional staff were recruited. Nevertheless, we were informed of occasions in the months immediately prior to the inspection of midwifery staff shortages and/or inappropriate skill mix on labour suite, including triage, and on Mulberry Ward, the inpatient antenatal/postnatal ward. We asked about monitoring of the escalation policy, but were told there no information on the number of times 'amber alert' had been used or what action had been taken. (Amber alert is used when there was a risk that staffing levels were too low to provide safe care).
- The trust safer staffing submissions recorded the nursing/midwifery staffing establishment on each ward and whether this was met on each day. These submissions, however, which had a 'green', 'amber' or 'red' rating depending on actual staffing levels compared to the establishment (agreed staffing levels), did not take activity or acuity into account and did not reflect the maternity services escalation policy, which defined amber and red ratings differently. The National Patient Safety Agency intrapartum scorecard was sometimes used to monitor activity on the labour ward retrospectively. However, we were not clear that there was a robust approach to predicting demand in inpatient areas or to responding efficiently when demand was high. We were not informed of an assessment of tasks on the labour suite, such as cleaning beds and equipment between patients, which was done by maternity assistants, or answering phones, which was done by midwifery staff out of hours.
- According to information displayed on the labour suite, the number of midwives on had been below the establishment on seven of the previous 13 shifts. We were informed that the coordinator and the pager holder on the labour suite, who were expected to be supernumerary, were regularly undertaking clinical duties. Staff reported difficulties in meeting demand on the labour suite and triage. This included delays in planned induction of labour, and delays in moving women who were in established labour to the labour suite from the antenatal ward and triage area. One-to-one care of women in established labour was prioritised, but there was a risk that other women did not receive appropriate care.
- There were two high dependency beds on the labour suite and three beds, one of them for high dependency care, in the recovery area of theatres. Midwives from the labour ward were responsible for caring for women in these beds. A woman told us she had been in a recovery bed for 24 hours following a caesarean section. She said she had often been left alone, unable to reach the

buzzer to call a midwife or to reach her baby's cot. Another woman, who stayed on the labour suite waiting to be reviewed by a doctor, told us she was left without being checked by midwifery staff for over two hours.

- There were plans to increase the number of staff trained to care for women in recovery and/or who needed high dependency care. Theatre nurses had undertaken training and worked shifts in recovery at the Newham University Hospital obstetric theatres in order to improve their skills. However, the plan of how these nurses would be used to support midwives was not in place and we were not clear that there were sufficient checks at the time of our inspection to ensure appropriate care was being provided to these women.
- The triage area, which was open at all hours and was located next to the labour suite, was staffed by one midwife, who requested medical review from junior doctors when this was required. If a woman was at risk, the midwife pressed the emergency bell and labour suite staff provided immediate assistance. However, the midwife did not receive support on the day of our announced inspection to assist with high demand. On that day, there had been delays in seeing women and some women left the hospital without being seen because of the long waits. We observed a triage midwife asking for assistance to deal with the workload, but this was not forthcoming. There was a clerk on duty during the day, and an agency clerk was sometimes on duty at night, to assist the midwife by booking women and answering telephone calls. At the time of our unannounced visit on Sunday evening there was no clerk on duty. A woman we spoke with said the telephone had not been answered on the occasion she called triage at night.
- On our unannounced inspection, we saw that the coordinator of the labour ward had put the names of staff on the whiteboard to check that they had taken a break. Midwives on the labour suite and on triage, however, told us it was "the norm" for midwives not to take a break during their 12 hour shift. One midwife gave two examples in the last two weeks when they had not taken a proper break or had anything to eat, because they were they were providing care and no one relieved them. It was difficult for midwives to have a drink when it was busy as it was the expectation that they would not take water into the labour room. A woman we spoke with expressed concern that her midwife had not had a break while she was caring for her in labour. When health care staff are tired, hungry and thirsty, they are more likely to make errors that put patients at risk.
- The Mulberry Ward safer staffing submissions for October recorded 10 shifts when midwifery staffing was lower than establishment levels. Action had been taken to reduce the pressure on staff when activity was high. Maternity assistants confirmed that they had been provided with training to enable them to take on additional tasks and increase their level of responsibility. Staff gave examples of improved team working, which had raised awareness of pressure points and the need to help each other out. Ward staff had been consulted about reorganising beds to improve efficiency.
- Some women we spoke with said they had been well supported with breastfeeding on Mulberry ward, but one woman we spoke with said there had been low staffing levels and that midwifery staff had been dismissive when she asked for advice. Prompt discharge of women and their babies was challenging at times of high activity. This sometimes resulted in delays in transferring women from the labour ward to the postnatal ward because of the lack of beds.
- Some community midwives had recently retired and the commissioned report on midwifery staffing had identified the need for additional midwives because there was an unusually high number of women who only used the service for postnatal care. There was a rolling recruitment programme to increase team sizes, with the intention of recruiting experienced midwives.
- Antenatal clinic services were at the agreed staffing levels. Good teamwork and contingency planning in the screening department enhanced service delivery. Annual leave was planned in advance, and a handover period was in place when the coordinator of the screening service went on maternity leave.
- There was a shortage of sonographers, which affected both gynaecology and maternity services. This is a recognised problem nationally. In maternity services some midwives had been trained in sonography, and agency staff were used to fill gaps in the rota. In gynaecology services it had been proposed that they should train their own nurses in sonography, and there were arrangements being put in place to cross cover across Barts Health NHS trust locations when the lead sonographer was on leave.

- Gynaecology services were responding to increased levels of demand and nursing staff on the emergency gynaecology unit worked hard to meet the high standards expected. The service had identified a risk of these standards not being maintained if activity continued to increase.
- It had been identified that women cared for on Rowan Ward, following gynaecology surgery, had received inconsistent care. This had been documented on the risk register and to mitigate the current risk a training package was being developed for nursing staff on the ward with no experience caring for gynaecology patients.
- Sickness rates were very low in gynaecology services and had fallen in maternity services in 2014. From April to September 2014 there had been no nurses leaving gynaecology services. The turnover rate for midwifery staff had been high in the previous year, but had fallen to 10% in 2014. Vacancy levels were low in gynaecology. Additional midwifery staff were currently being recruited.

Medical and theatre staffing

- Obstetrics and gynaecology consultants were present during the week and there was a rota for medical cover of maternity and gynaecology wards. There was a 74 hour per week dedicated obstetric consultant presence, fewer than the 98 hours proposed by the Royal College of Obstetricians and Gynaecologists (RCOG) for a unit this size. However, there was good access to medical staff out of hours. The on-call consultant attended on weekend mornings and saw women on the labour and ante/post natal ward who required consultant review. Midwifery, nursing and trainee medical staff told us consultants were always available for advice and would come to the hospital when appropriate.
- At night there was a middle-grade doctor on duty for obstetrics and one for gynaecology, in addition to a trainee doctor.
- Medical staff attended gynaecology patients appropriately during week days, consultants saw their patients post-operatively and a registrar carried out ward rounds each day. Trainee doctors were available by pager. However, at night the patients might be seen by an on-call trainee doctor from a different specialty. Consultant surgeon out-of-hours cover for gynaecology patients on Rowan Ward were often from a different speciality.
- There was a dedicated theatre team on duty at all times and a dedicated anaesthetist and obstetric consultant for the elective caesarean section lists. There was access to a consultant anaesthetist at other times. Main theatres usually provided staff when the second theatre was needed; sometimes midwifery staff were used. We were told of occasions when a maternity assistant who was not theatre trained assisted in theatre.
  Midwives took on the theatre nurse role if necessary, which put additional pressure on the labour ward at busy times.

Assessing and responding to patient risk

- There were well embedded protocols in place to deal with obstetric emergencies such as postpartum haemorrhage (PPH).
- The lead midwife in each inpatient area was responsible for assessing staffing levels. She contacted the maternity services manager or (out of hours) the site manager to authorise the deployment of bank staff when there was staff sickness or leave.
- When the lead midwife assessed that there was still insufficient staffing to meet demand safely, she contacted the pager holder. The escalation policy specified the action the pager holder should take if there was a risk to mothers or their babies. This included requesting authorisation for agency staff, closing the birth centre or asking community midwives to assist staff at the hospital. The pager holder was a lead midwife, usually on labour suite, but we were told she was sometimes unavailable because she was undertaking clinical duties, such as attending theatre. We were told sometimes requests for agency staff were turned down, or no agency staff were available. This meant the escalation policy was not always implemented effectively to reduce the risk of poor or unsafe care at times of high demand or staff shortages.
- The pager holder had previously been a member to staff with specific responsibilities for overseeing activity in the maternity unit. There had not been appropriate consideration of the impact of the changes to the arrangements for the pager holder at the time it was made. Lead midwives were now being asked to contribute to discussions about how this role should be carried out.
- The risks to women undergoing surgery were reduced by multi-disciplinary engagement in pre-list briefings and the steps of the WHO surgical safety checklist. There

had been a hospital programme to support the embedding of the checklist in practice. Obstetric theatre staff told us the WHO surgical safety checklist was integral to the way the team worked. It was used in all procedures except grade 1 emergency caesarean section.

- We observed an elective caesarean section pre-list brief in obstetric theatres, at which all theatre staff and the labour suite coordinator were present. Following introductions, the obstetrician and anaesthetist discussed each patient, any potential risks and the way that the risks were being addressed. This included confirmation of the use of cell salvage (cell salvage is a process that collects blood from an operating site) for a woman who had refused a transfusion and a discussion about additional equipment for a woman with a high body mass index. The order of the list was changed, with the new order read out and confirmed. All theatre staff, therefore, were well prepared and there was less likelihood of unexpected glitches during the list.
- Theatre nurses told us they made sure that everyone was paying attention at each step of the WHO surgical safety checklist. They were able to tell us of near misses when harm had been avoided because of the checks.
- Three of the four sets of notes we looked at of patients who had undergone surgery contained a completed checklist. One set of notes for a patient who had undergone an emergency caesarean did not contain a checklist. Staff we spoke with were not aware of any audit information on the use of the five steps to safer surgery.
- All inpatient women were monitored using the modified early obstetric warning score (MEOWS) to record observations. When required, midwifery staff completed observations on babies and recorded these on the neonatal early warning score (NEWS) charts. We reviewed some of these observations and found they were appropriately completed. Staff were able to describe at what point concerns were escalated to the lead midwife or medical staff. Midwifery staff used a tool consisting of standardised prompt questions to ensure that they shared focused information with medical staff when escalating concerns about mothers or babies. We saw a copy of the tool next to the phone in the labour suite.
- Maternity services across the Trust had taken action to reduce the risk of inadequate management of pathological cardiotocography (CTG), a recognised risk in maternity services. This had included additional training for staff who did not demonstrate competence, and reviews of cases of babies admitted to the neonatal intensive care unit (NICU).
- Staff had access to emergency trolleys in the event of an obstetric emergency.
- There was evidence of a systematic response to patient safety alerts issued by NHS England. For example, the use of connectors for epidural anaesthesia was on the risk register and there was an action plan in relation to implementing recommended changes.
- The risk of not following up on women who did not attend antenatal appointment had been identified and a new policy put in place. The midwife made a phone call and if there were two failed appointments, they would make a home visit. There were also processes to address the needs of women who attended the unit in labour who had not had antenatal appointments. This included ensuring virology screening and the introduction of additional training and diagnostic packs.
- The maternity service had identified a risk of women who were hepatitis B positive not accessing appropriate assessment by a hepatologist. They had put in place interim arrangements while liaising with commissioners for additional funding.

Cleanliness, infection control and hygiene

- The areas we visited were clean and tidy and we saw evidence of adherence to cleaning schedules. Standards of cleaning met the national specification of cleanliness. The birth centre and obstetric theatres were appropriately designated as very high risk areas and audited weekly. Other wards were designated as high risk areas and audited at least once a month. The records for October 2014 indicated that targets of 98% were exceeded in theatres and the targets of 95% were met, on average, in other areas. The community midwifery facility was also regularly audited and met targets for cleanliness. There was a weekly audit of cleanliness in the antenatal clinic, completed by the lead midwife with the cleaning supervisor. The target of 95% of tasks undertaken was generally met, although on the week of our inspection this was 93%.
- The hospital infection prevention and control audit of the delivery suite in September 2014 found compliance with all aspects of hygiene and infection control.

- Staff commented on the improved cleaning regimes in the last year. There were weekly meetings between senior management and the cleaning supervisor to discuss any issues that had arisen with cleaning schedules.
- Theatre staff explained the cleaning schedule for theatres. They described how "everyone pitched in" to make sure the theatre furniture and floors were cleaned between procedures. On the day of our inspection, we observed theatre staff discussing action taken to address their concern that the cleaning had not been sufficiently thorough. The cleaning supervisor had come to theatres and had undertaken to ensure that the cleaners understood their responsibilities in the cleaning of bodily fluids.
- There were 'I am clean' stickers with the day's date in all the areas we inspected to indicate an item was ready to be used again.
- Staff followed 'bare below the elbows' guidance. We observed staff using personal protection equipment, such as gloves and aprons. Hand sanitising gel was available within the clinical areas.

Harm-free care

- There was a white-board in inpatient areas with a 'safety cross' completed for the month, which gave an easily understandable overview of care, adapted from the national Safety Thermometer (a tool for measuring and monitoring patient harm and harm-free care), but which was relevant to maternity services. These indicated that there had been no incidents of hospital acquired infections, that audits had found cleaning and hand hygiene standards exceeded targets and that one-to-one care of women in established labour had been provided during the month.

Medicines

- Medicines were stored safely and there were systems for maintaining appropriate levels of stock.
- The inspection team reviewed medicine storage on the labour ward and in theatres. Medicines were kept securely in a locked room. Controlled drugs and high risk drugs were stored in locked cupboards in the room.
- When medicines required storage at a low temperature, they were stored within a specific medicines fridge. Temperatures were checked and recorded daily, and were within the expected range.
- Staff on the labour ward and in theatres demonstrated the process for checking stocks and for doing the monthly checks for expired drugs.

Environment and equipment

- Community midwives saw women from the local catchment area for their first antenatal appointment in a Portakabin on the grounds of the hospital. We visited the cabin and found that it was not fit for purpose and there was a risk to women and staff because of poor security and the absence of a fire exit. The cabin was separate from the main building and although there was an alarm button, we were told that security had failed to respond promptly to this when the alarm had been tested. The area lacked space and did not ensure confidentiality for women. There was only one toilet. A woman we spoke with found the facilities "chaotic". She was happy about the rest of her care, saying, "When you don't have to go to the hut, it gets better."
- The labour suite had been refurbished and provided high quality ensuite facilities for women in labour. There were plans to build a new birth centre and it was recognised that the existing facilities did not meet current expectations.
- Equipment checks on the wards had improved since our last inspection. Staff were allocated to check resuscitation equipment in inpatient areas and there was an audit of the daily checks. This indicated the checks were nearly always completed.
- During our previous inspection there had been concerns about access to equipment. During our recent inspection staff told us there was adequate equipment and there were stores of surplus CTG scans and other equipment for use when needed. A manager had been allocated responsibility to liaise with the hospital engineer to make sure equipment was replaced and/or repaired in a timely way.
- The theatre suite had been rebuilt recently in line with current expectations of design, airflow, equipment and safety. There was no toilet in the theatre suite, staff and women in recovery had to go through two sets of doors to access the toilets in the labour ward.
- Theatre staff demonstrated the automatic checking process for anaesthetic equipment and the logs of these checks. The theatre store rooms had an adequate stock of sterile instruments and consumables. Theatre staff gave examples of action taken to address the occasional

problem with supplies of instruments, such as introducing single-use instruments so they could be sure that each pack contained the items needed for procedures.
- Entry to the inpatient wards was controlled by swipe card access for staff. Patients and visitors attending wards and departments out of hours were greeted by security staff.

Records
- Women carried their own pregnancy-related care notes in hand-held-records given to them at their first booking. Women took the notes with them when they went to the maternity unit, or for examinations with their community midwives. All the women we spoke with said that the health professionals they saw completed entries in their care notes.
- The inspection team looked at six sets of hand-held notes and found that the notes, including the intrapartum notes, were completed. In one set of notes we did not find the blood and scan results.
- The electronic patient record system had been introduced in May 2014 at Whipps Cross University Hospital. Staff told us they had been well supported in its introduction and most were positive about the advantages of the system. The electronic system had not yet been implemented in community midwifery services and this limited the information available electronically.

Safeguarding
- All permanent staff providing direct care to pregnant women had a day's level 3 safeguarding training. Staff without direct contact completed level 2 training on line. There was training for first year trainee doctors on perinatal mental health and safeguarding.
- There were systems in place to identify women at risk. GPs and the midwives who saw women antenatally had criteria to guide them in making referrals to the safeguarding midwife. The midwives we spoke with demonstrated a good knowledge of the action to take when they identified a vulnerable woman. For example, when a woman arrived at triage who was not known to the service, the midwife checked with the hospital at which the woman was booked and referred to the safeguarding midwife. If a woman who was unknown to the service arrived at the weekend, she would not be discharged until an appropriate assessment had been made.
- There was multi-agency working with other agencies to safeguard the unborn child and a rolling audit process to check that there was appropriate contact with the mother. There had been recent improvements in assessing the needs of women, with a care plan in place for all those assessed as vulnerable. There was also contact with adult social services to address the needs of women with learning disabilities.

Mandatory training
- Mandatory training was updated in the four mandatory study days attended by staff each year, and completion of training was monitored by their line manager and the practice development midwife. The training database highlighted when training was due. Attendance at mandatory training in the period April to August 2014 for health and safety training was nearly 100% and for safeguarding training level 3 was 82%.
- There was well established mandatory multi-professional team training (MOTT) for CTG assessment and 'skills and drills' to rehearse obstetric emergencies. There were six unannounced drills each year at the hospital. Every member of staff was given a copy of the Practical Obstetric Multi-Professional Training (PROMPT) manual. The attendance rate for MOTT was nearly 100% in the period April to August 2014.

Are maternity and gynaecology services effective?

Good

There were regular reviews of guidelines. There was a programme of audits and the results of these were presented to staff, with action points identified. Gynaecology services had a strong record of participation in research.

Outcomes for women and their babies in maternity services were within expected limits.

Women received antenatal and postnatal care in community settings, in addition to antenatal appointments at the hospital when appropriate. There were clear pathways for high-risk women.

There was effective multidisciplinary working in maternity and gynaecology services.

Maternity and gynaecology

There had been noteworthy developments in training and support for midwifery staff. Trainee doctors were well supported and rotas were adjusted so they were able to take up opportunities for learning.

Evidence-based care and treatment

- Clinical guidelines were developed and reviewed with reference to the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) and other relevant bodies.
- The obstetric governance lead for maternity at the hospital had taken a lead in overseeing guideline development for the CAG. Each guideline to be reviewed and updated was allocated to a consultant and a registrar. Seventeen updated obstetric guidelines had been ratified for use across the trust at the CAG audit committee. Senior midwives, including the supervisor of midwives, also played a role in developing guidelines, such as the guideline on female genital mutilation.
- There had been agreement that there would be a separate link on the intranet for maternity guidelines. There were delays at trust level, however, in uploading the guidelines and they were not yet available on the intranet. Medical staff told us they accessed current NICE or RCOG guidelines when up to date local guidelines were not available and demonstrated how they did this. We looked at the file on the labour ward of 'High Risk Guidelines', and saw that sections were out of order and the majority of the guidelines were not dated or were overdue for review. We were told these were being phased out because medical staff, including locums, were able to access the guidelines on line.
- We saw evidence of regular audits of guidelines, the findings of which were disseminated with actions identified. There was a monthly audit meeting in maternity and in gynaecology services. Clinical duties, such as elective caesarean lists and antenatal clinics were rescheduled to enable staff to attend and midwifery/nursing and medical staff told us that information of audits was emailed to them. Continual audits in maternity services included postpartum haemorrhage (PPH). A recent audit had found the management of these cases followed good practice, but there had been delays in alerting porters and other relevant staff. The results had been disseminated to staff and action identified.
- In gynaecology services audits of guidelines included management in early pregnancy of ectopic pregnancy and miscarriage. The findings were presented to an audit meeting and this had led to changes in the choices given to women for follow-up checks.
- There was an active research programme in maternity and gynaecology. Barts Health NHS trust contributed data to the Neonatal intensive and special care programme (NNAP) and to the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK).
- There were regular morbidity meetings in gynaecology and joint monthly perinatal morbidity and mortality meetings.
- The implementation of the induction of labour programme had resulted in a more effective pathway for women. The standardised approach had been disseminated through training, meetings and emails, so that all staff, including trainee doctors, understood their role and the expected standards.
- Transitional care was provided on the postnatal ward, following good practice guidelines, so that babies were able to stay with their mothers. Transitional care is provided to babies who need treatment such as antibiotic medication, but do not require intensive care. Midwives who had received additional training were supported by a neonatal nurse to provide the care during the day, and provided the care on their own at night and at weekends. Because of the importance of timely administration of medication staff sometimes found it challenging to provide the level of care required as well as responding to other demands on the ward.
- Some midwifery staff had been trained in the examination of the new-born, with the expectation that they would be able to discharge babies instead of relying solely on paediatric services. There had been no agreement on how this change would be implemented at the time of our inspection.
- There were plans to increase the length of appointments to the National Screening Committee recommendation of 30 minutes from January 2015. The regular scan appointments were currently 20 minutes. Action had been identified to mitigate the risk of failure to identify fetal anomalies, such as arranging a further scan.

- Care bundles had been introduced in maternity triage to promote consistency of care provided for women presenting with symptoms such as vaginal bleeding, ruptured membranes, and reduced fetal movements
- The maternity service had the certificate of intention to implement the UNICEF UK Baby Friendly Initiative, which was promoted by the World Health Organization to promote good care for new-born babies. The newly appointed infant feeding co-ordinator was introducing sessions for new mothers and improved monitoring of breast-feeding 89% of women were breastfeeding when they left the hospital, better than the national average.

Access to information

- Most women we spoke with who were receiving maternity or gynaecology services said midwives and doctors had made clear verbal explanations and had given them written information. We did not see leaflets in languages other than English, but we were told these could be downloaded from the intranet. We were told that interpreters or telephone interpreting services were used, in particular when there were issues of consent, but were not informed of any monitoring to ensure that these services were used appropriately. We observed a husband interpreting for his wife during our inspection.
- Women were given an information pack when they were booked for maternity services. They were given a comprehensive discharge pack, which included advice on breastfeeding and how to identify a sick baby and guide to services on.
- Written information was given to women when they were discharged from gynaecology services, with the telephone number of the ward in case they had any queries.

Patient outcomes

- The introduction of new patient record software earlier in the year had resulted in difficulties in accessing accurate data about activity in the maternity unit. We were given data during our inspection, but we noted that some of the information, such as caesarean section rates, did not reflect Hospital Episode Statistic (HES) data. Maternity services had put processes in place to manually verify some key performance indicators, but were unable to assure us of the accuracy of other data items, such as information on babies receiving transitional care.
- The emergency caesarean section rate for April to June 2014 was 18% compared to a national rate of 14.8%, and the elective caesarean rate was 10%, similar to the national average. The overall figure of 28% was worse than the national average of 26%, but not significantly worse. The number of women who were high risk, for example because of previous caesarean sections, was higher than average.
- In the CQC maternity outlier programme, the maternity services has not been identified as an outlier for puerperal sepsis, maternal readmissions, or neonatal readmissions.

Multi-disciplinary working

- We found examples of effective communication between professionals and teams in each area we visited.
- The screening team reported that consultants worked closely with them and were available for advice, if needed. There were quarterly multi-disciplinary, recorded meetings of the screening steering group which discussed any issues with the screening process, and proposals for improving pathways for women.
- There was multidisciplinary handover between shifts on the labour suite. We observed the night handover to the day shift, at which each patient was discussed and outstanding action identified. The discussion included the attendance of doctors from other specialties for women who had a medical need. A computer terminal was available to access individual women's case notes.
- Obstetric theatre staff spoke of the good multi-disciplinary working, which promoted safe and responsive care. Nurses said they were listened to and felt able to speak out if they had any concerns.
- Links between maternity services and paediatric service enhanced the care of new-born babies, but it was sometimes difficult to access appropriate support out-of-hours. A neonatal nurse worked with midwifery staff to care for babies requiring transitional care. Midwifery staff told us that the neonatal paediatrician with links to maternity services was accessible and provided support and advice when needed. Midwives on the labour suite also reported good working relations with paediatric medical staff, who came promptly when there were concerns about an unborn baby's condition. Trainee and middle grade doctors from the paediatric department came to the maternity unit to review babies prior to discharge, but we were told that out-of-hours there were often delays because the doctors were also covering A and E.

Maternity and gynaecology

Pain relief

- The full range of pain relief was available to meet the individual needs and preferences of women. These included epidural analgesia, opiates, nitrous oxide (gas and air), paracetamol. There were waterbirth facilities on the birth unit and a portable pool had recently been introduced in one of the rooms on the labour suite. Most women (88%) taking part the feedback exercise earlier in 2014 said they had been offered the choice of pain relief they wanted.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women told us they fully understood the choices they made and had consented to, such as the options for screening or the reasons for elective caesarean section.
- There were appropriate processes for termination of pregnancy, with the completion of forms with two doctors' signatures. We found that the service was not consistently sending the form to the Department of Health, as required. When the inspection team pointed this out, immediate action was taken: forms were ordered, teaching arranged for the following week and the other women's services in the trust were contacted.
- The joint work with social services departments on assessing the needs of women with learning disabilities included discussions about capacity. Midwives had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

Competent staff

- Midwives, nurses, maternity assistants, theatre staff and administrative staff told us their training and appraisals were up to date. Appraisal rates were at 85% in July 2014, already higher than the 2013/2014 rate of 75%. Training was delivered by workshop, e-learning and on the floor.
- We received many positive comments about the work of the practice development midwife in supporting training and development. We looked at some of the recently introduced initiatives, such as a bespoke programme for midwifery support workers that specified a code of conduct based on best practice principals, minimum skill set expectations and an assessment framework for those expectations. Midwifery assistants had been given additional responsibilities in some parts of the service, but on the labour suite they felt they were not able to develop their skills in undertaking specific tasks relating to the support of women because they spent their time cleaning and checking stocks.
- A student midwife told us that mentors were very supportive and that there was an individualised plan for each student. However, another student midwife did not know who their mentor was and experienced staff commented on the additional work required to support students and newly-qualified midwives.
- Recently recruited midwives were newly qualified and the challenges of providing appropriate support for them had been recognised. A nine-month preceptorship programme had been developed and additional specialist midwives had been appointed to support the programme.
- Trainee, middle-grade doctors and consultants told us they had good access to training and study leave. Junior trainee doctors received an induction leaflet that describes common procedures. Trainee doctors praised the teaching and support they received and the willingness of the service to adjust rotas so that they were able to take up opportunities for learning. A trainee gave an example of spending a week on the emergency gynaecology unit after they had attended a training module so that they were able to put the learning into practice. One of them said "This is one of the very few hospitals that really supports teaching."
- Sonographers carried out all types of pregnancy scans in order to maintain their skills.

Seven-day services

- Antenatal and scanning clinics were offered from Monday to Friday. Additional scanning clinics were scheduled at weekends when there was a need.
- The emergency gynaecology unit was not open at weekends. This meant that appropriate treatment for women attending at the weekends was delayed. At the weekend, emergency cases requiring immediate treatment, or care, were admitted through the emergency department to a surgical ward and waited until Monday for specialist review.

Are maternity and gynaecology services caring?

Maternity and gynaecology

Good

Women who gave birth on the birth unit said midwives were “caring and compassionate”. Several women praised the midwives on the labour ward, saying that the midwife stayed with them. One of them described her midwife as “brilliant”. Feedback from women using maternity services had demonstrated an increase in confidence in the staff providing care during labour.

Bereavement support for women with pregnancy loss was sensitive and compassionate.

Women were positive about the caring service they received from staff on the emergency gynaecology unit (EGU).

Compassionate care

- The inspection team observed nursing, midwifery and administrative staff interacting with women with kindness and understanding, even when they were under pressure. Staff demonstrated an awareness of the importance of maintaining women’s dignity and privacy. For example, the midwife on maternity triage spoke quietly to ensure that their conversation would not be overheard.
- A woman who gave birth in the birth centre said she found the atmosphere calm and relaxed and the midwives attentive and kind. She said “I got the birth I wanted: 10 out of 10.” Another woman told us midwives on the birth unit were, “Caring and compassionate”. Several women praised the midwives on the labour ward, saying that the midwife stayed with them throughout labour. One of them described her midwife as “brilliant”. She said that her care on the postnatal ward was very good and staff always came when she pressed the bell. We received some negative comments about the availability of staff on the postnatal ward.
- Women receiving care and treatment at the EGU praised the compassionate and caring staff. A gynaecological patient on the surgical ward said nursing staff on the ward responded promptly to calls, both night and day. However, we were informed there had been complaints from other women about the care provided on the ward.
- Bereavement services for women with pregnancy loss were sensitive and appropriate. There were two single rooms for women who had a stillbirth, or a pregnancy loss, providing comfortable facilities for both parents. These could be reached from a separate entrance from the labour suite.
- There was a monthly pregnancy loss clinic run by the bereavement midwife and a consultant obstetrician. The bereavement midwife provided a service to families whose babies had died, including visits to women in their homes. When there was an adverse event, there was a named link for the family involved, who was either the bereavement midwife or a supervisor of midwives. Staff commented on the importance of the work of the bereavement midwife and how this had improved the support for both women and midwives when a birth did not have a good outcome.
- Recent feedback from women demonstrated improvements in the confidence in maternity services staff. The results for Barts Health NHS Trust of the national survey of women using maternity services in 2013 had been worse than average some on questions relating to care in labour. Poor staff attitude had been a common theme in complaints in the previous year. The results of feedback from 102 questionnaires completed by women discharged from the maternity unit from July to September 2014 at Whipps Cross University Hospital found there had been improvements in satisfaction. Ninety-five percent of women indicated they felt fully supported by their midwife during labour and 91% said they had confidence in doctors and midwives. The number of complaints about poor attitude had fallen. There were also many positive comments about the friendliness and kindness of staff in the free text completed by women on the questionnaire.

Patient understanding and involvement

- There were many comments on how well doctors and midwives explained the care and treatment at antenatal appointments and answered any questions they had. Women also commented on the good level of support provided on the postnatal ward. The results of the 2013 national maternity survey found that Barts Health NHS Trust scored close to the national average on the question about the kindness and understanding of staff after the birth. We also received positive comments about the care on the postnatal ward. However, we were given an example of an abrupt response to a request for support on the ward.

- Women reported that doctors had explained their care and treatment fully and encouraged them to ask questions.

Are maternity and gynaecology services responsive?

Requires improvement

Women were able to discuss the type and place of birth they wanted pregnancy antenatal appointments. Normal birth was encouraged and consultants worked with midwives to extend that choice to women who were not low risk. However, there had been occasions when the birth centre closed and home births were cancelled and this had reduced women's choices.

There had been a number of initiatives in women's services at Whipps Cross University Hospital to improve the responsiveness and effectiveness of treatment and care.

Women were assessed at their first appointment and allocated to an appropriate pathway, with access to specialist clinicians. Most women we spoke with said they had found the service responsive and flexible and they were given a telephone number to call. There were persistent problems, however, for women who tried to reach the service through the switchboard. Women who attended specialist clinics did not always get an opportunity to discuss their birth plan with a midwife.

Service planning and delivery to meet the needs of local people

- Women talked about their preferred place and type of birth on booking. This was reviewed throughout the pregnancy. Normal vaginal deliveries were encouraged and were offered in the labour suite, as well as the birth centre. There was a small home birth team, supported by the community midwifery service, which cared for women in the last month of their pregnancy, and after the birth, in their own homes. Consultants worked closely with the birth centre midwives to facilitate the choice of women who were higher risk, such as those with a high BMI, or who had diabetes, so they were able to have a normal delivery if possible. There was a midwife allocated to women with previous caesarean section who were planning to have a vaginal birth. Women were transferred appropriately from home when the birth did not go according to plan. The birth centre had rapid access to medical staff and appropriate transfer of women to the obstetric led unit. The labour suite offered midwifery-led births and had recently installed a portable birthing pool in one of the labour rooms.
- During 2014 the birth centre had been closed at times of high demand and women who wanted to have a home birth were sometimes unable to do so, because of pressures on the service. The number of births at home had decreased during 2014 to less than five a month from May to October 2014. We were told that transfer rate to the hospital was higher on the three days a week when the home birth team are not on call and the community midwifery team took calls from women in labour. The inspection team were not provided with data on the frequency of women not having their choice of birth place. Only 68% of women having their babies who provided feedback between June and September 2014 said they were offered a choice, a lower rate than at the other two hospitals at Barts Health NHS Trust. Some women we spoke with who attended specialist clinics said they did not have the opportunity to talk to a midwife about their pregnancy or to discuss a birth plan.
- The new EGU had been built in response to the business case, which presented evidence of suboptimal care from an audit of 600 patients. The unit was delivering a one-stop service, with a full range of medical and surgical treatment options available for the management of miscarriage and ectopic pregnancy so that women could be offered a clinically appropriate choice of care. The team of nurse specialists, consultants and sonographers worked effectively together to provide a responsive and effective service. Patient feedback was very positive.
- A dedicated list for elective caesarean sections was being piloted in obstetric theatres, with a second theatre used for emergency cases . Data was being collected on its effectiveness and initial results indicated the introduction of the list had improved efficiency of the list and planned procedures were less likely to be cancelled.
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Access and flow

- 70.61% of women were booked before 13 weeks in 2013/2014, well below the target percentage of 90%. Late referrals accounted for 55% of late bookings. This was not on the risk register and we were not informed of action to improve this rate.
- Women referred to the service from outside the area were seen at the antenatal clinics in the maternity unit. Low risk women living within the catchment areas were seen by a community midwife for their first booking at the hospital and then allocated to a community midwifery team located at a GP surgery or children's centre near their home. One woman said she preferred to have a named midwife; another said she was happy about having contact with different members of the team. Several women commented on the flexibility of the service when they wanted to rearrange an appointment.
- The majority of women got call backs from the community midwifery team. A small number of women were not given a specific number to call and if they tried to reach the service via the switchboard they encountered persistent problems.
- Scans were carried out in the maternity building and all women were offered 12 week and 20 week scans. There had been additional sessions on the weekends to ensure scans were done within the expected time scales.
- There were a range of specialist consultant clinics for women in the area and for those referred from other parts of North London. These included clinics for women with medical conditions, women with female genital mutilation or third degree tears, women with previous miscarriages, and women with reduced fetal movement.
- There was a well-established multidisciplinary approach to providing appropriate care to women at risk. Women with infectious diseases such as HIV attended appointments at the sexual health clinic, with a multidisciplinary team supporting them which included maternity staff, a dietician and a pharmacist. There was a meeting prior to the birth with the consultant and midwife to make a plan for delivery. Women who are newly diagnosed with diabetes attended a group talk by the midwife and dieticians. There was prompt referral to the multi-disciplinary diabetic clinic, which was staffed by diabetic and obstetric consultants, a specialist diabetic nurse, a specialist midwife and a dietician. There were also clinics run by a consultant and midwife with special interest in mental health for women with mental health needs.
- There had been a shortage of rooms and women had to wait to be seen for some clinics. Waiting times had been audited in May 2014 and, as a result, clinic sizes were changed to balance the number attending and the need for rooms. Further work was underway to improve the efficiency of the diabetic clinics by increasing the number of low risk women seen at midwifery led clinics.
- The day assessment unit, which was open 8am to 8pm seven days a week with a trainee doctor on duty, was for the assessment of women referred by GPs and triage for monitoring. There was an appointment system for the four sessions attended by consultants so that women did not have to wait long periods to be seen. There had been an increase in referrals to the unit in 2014, which had reduced the number of unnecessary admissions to the antenatal ward.
- Counselling was offered to women whose screening results meant that they needed to make a further decision about diagnostic testing, for example for when the screening indicated that the baby may have Down's Syndrome. We saw that the room where this meeting place took place was appropriate and the screening midwife told us that she gave a full explanation about diagnostic testing and gave her number to them to get in contact if they had further questions. Women were also given the details of charity that offered advice to women about diagnostic testing.
- When fetal anomaly was identified, there was prompt referral to a fetal anomaly consultant. There was also a specialist midwife for fetal medicine, and access to counselling. When there was fetal loss, stillbirth or termination because of fetal anomaly, women were given a full explanation about the choices available to them for the disposal of the baby, or the fetal remains. They were able to attend a hospital cremation or burial if they wished.

Maternity and gynaecology

Learning from complaints and concerns

- Patients and their families were encouraged to provide feedback on their experiences. Complaints and concerns were addressed where possible at the time they were raised.
- There had been improvements in the response times to formal complaints. Complex complaints were now dealt with by arranging meetings with staff and following good practice on being open. When complaints were linked to a serious incident investigation in maternity services, women or their partners were given a named contact there was a process to make sure the family were kept fully informed of the results of investigations. Resolution meetings with senior staff had been introduced successfully in gynaecology.
- There were regular reviews of complaints to identify themes and identify action. The themes were shared with staff. We saw that where complaints had arisen, action had been identified. The nursing and midwifery heads of women's services had recognised the need to improve the monitoring of these actions.

Are maternity and gynaecology services well-led?

Requires improvement

A values and behaviour programme had been launched in maternity services at Barts Health NHS Trust to improve the way staff interacted with women and with each other and to improve the standard of care. Feedback from women using the service indicated that there had been an increase in patient satisfaction. There were developments to meet the trust objective of increasing the proportion of women having a normal birth.

The women's and children's clinical academic group oversaw the monitoring of quality and initiatives to improve women's services.

There had been initiatives to engage staff in contributing to improvements to women's services, but there were difficulties at the hospital in winning the trust of midwifery staff affected by the changes imposed by the trust.

Vision and strategy for this service

- The trust aimed to improve patient experience. A values and behaviour programme was launched in maternity services and staff were invited to take the 'Great Expectations' pledge to improve the way staff interacted with women and with each other and to improve the standard of care. There were initiatives to improve communication with staff, such as weekly newsletters and "hot topics". Staff confirmed that there was an expectation that poor attitudes would be challenged. There had been a measurable improvement in patient satisfaction over the last year.
- There was an overall objective of increasing the number of normal births without medical intervention at the trust. There was recognition that the current birth centre did not meet current expectations and there had been agreement to build a new centre. The home birth service was under review with the intention of developing the service across the trust.
- We were told that the head of midwifery had encouraged staff to contribute to initiatives to meet the objective of improving patient experience and increasing the number of normal births. She was able to make changes to the way the service was run day to day without reference to the CAG directors when no additional costs were involved.

Governance, risk management and quality measurement

- The merger in 2012 had resulted in changes to the way that strategic planning and clinical governance was delivered. In addition to the women's and children's clinical academic group (CAG) board meetings, and clinical governance meetings, there were monthly improvement boards for gynaecology and maternity. The meetings were attended by clinical and nursing/ midwifery heads of the services from each of trust locations to discuss audits, review cost improvement projects and make proposals for future projects. There were also cross-site meetings of leads for services such as the Emergency Gynaecology Units. There were benefits from the links with other hospitals, such as sharing learning and innovation, and enabling staff to work at other locations to develop their skills.
- Women's services at Barts Health NHS Trust had introduced effective processes to review complaints and incidents, and were in the process of increasing the clinical governance resource to embed these improvements.
- The Maternity Liaison Services Committee (MSLC), had not been active during our previous inspection and

there had been no further meetings since then. The head of midwifery told us the commissioners were looking at ways of supporting women who had used maternity services and might be interested in joining the committee.

Leadership of service

- Maternity services had succeeded in their bid to fund cover for consultants, senior midwives and lead midwives to attend away days at a staff college. We were told this had built engagement between the professions and empowered staff to challenge senior colleagues. A training programme for lead midwives had encouraged them to adopt a more considered and active management role. They held a weekly meeting, to which managers were invited, to discuss concerns and ways of managing demand.
- The development of trust wide governance had meant that senior staff based at the hospital attended a number of meetings at other locations.
  They faced challenges in balancing CAG work and providing local leadership at a time of change.
- There was an effective supervision of midwives (SOM) programme. The ratio of SOM to midwives was 1:15, meeting the recommended ratio, but the Local Supervising Authority (LSA) annual report noted that it was sometimes difficult for supervisors to meet the expectations of the role because of the pressures of clinical work. The work of the SOMs in developing good practice was noted in the report. Several midwives we spoke with praised the support they had received from their supervisor at difficult times, such as when they had been verbally abused by a member of the public. A drop in session had been introduced for midwives and students to talk to supervisors. There was a process to address staff grievances, supported by the Human Resources (HR) department.

Culture

- A common theme in interviews with staff was the feeling that the merger with Barts Health NHS Trust was a takeover not a partnership. There had been a series of changes to the management structure, including the down grading of some members of staff, which had resulted in disharmony.
- Staff in women's services told us of the mutual respect between consultant and midwifery/nursing staff and of how well supported they felt when they began working at the hospital. Trainee doctors described helpful and friendly midwifery staff.
- Midwifery staff we spoke with said they were well supported by their peers, and many of them said that teamwork enabled them to cope at busy times. There was praise for local staff who came to the ward to help out when it was busy. However, other staff gave examples of occasions when midwives did not receive support when they asked for it, and there was a perception that some senior staff did not treat midwives equally. There was also a perception that information was not shared with staff, who were left unsure of how issues such as staffing levels were being tackled. Neither the oversight information nor the commissioned report on midwifery staffing levels was shared with staff.

Public and staff engagement

- Medical and midwifery staff gave examples of being encouraged to contribute ideas for developing the service, such as expanding the home birth service. There were initiatives to improve communication with staff, such as weekly newsletters and 'Hot Topics', a summary of current issues displayed on noticeboards and highlighted at handover meetings.
- Receiving regular feedback from women and their partners about maternity services was part of the 'Great Expectations' programme. There was evidence that action was taken to respond to negative feedback and to monitor progress in improving patient experience.

Improvement, innovation and sustainability

- A new electronic patient record system had been introduced from May 2014. There had been robust planning of its introduction into maternity services, with its implementation championed by senior obstetric and midwifery staff. A midwifery manager had worked closely with the software representatives to reduce the impact of its implementation on antenatal appointments. In order to promote electronic record keeping and avoid duplication of paper records, there were mobile computers and maternity assistants had been given access to the system.
- Some women complained that their appointments had been delayed or mixed up, and that they had long waits to see reception staff on arrival. Staff confirmed there

had been problems with appointments for scans and clinics in the summer months during the implementation of the new system. Action was taken to address this, including the replacement of some electronic booking with manual booking and the introduction of a waiting number dispenser for women to see the receptionist in order to be booked into the clinic.

- Gynaecology staff providing emergency treatment and care were passionate about their service and were eager to improve it further. The emergency gynaecology unit was a runner up in the 2014 BMJ emergency medicine team of the year award, which recognises effective multidisciplinary team work. The team was also awarded a trust Barts Health Heroes award in 2013.
- The work to improve the induction of labour process had included three days of consultation with medical and midwifery staff and trainees to contribute solutions. The monitoring of the changes had found reductions in inpatient stays, a decrease in caesarean sections and an increase in patient satisfaction. Maternity services were planning further improvements, such as a 'one stop clinic' for antenatal appointments.

Services for children and young people

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The hospital provides medical and surgical care for children, young people and neonates on an unplanned and planned basis. These services were managed by the women's and children's health clinical academic group (CAG). There was a dedicated 24-hour children's A&E service, which was managed separately by the emergency care and acute medicine clinical academic group (ECAM CAG).

There was a designated children's ward (Acorn Ward), which had 27 inpatient beds. At the time of the inspection, seven of the beds were closed, due to the lack of trained and experienced nursing staff. The beds had been closed since May 2014. There was a 10-bed day surgery unit and a four-bed medical day unit. The surgical day unit was open on specific days for dedicated ENT, maxillofacial and urology surgery.

The hospital had a neonatal unit (NNU) with capacity for 18 cots. The NNU was a level 2 unit, which meant that they could care for 27 week old newborn babies who were at least 1kg at birth.

We spoke with some of the children and young people using the service at the time of the inspection and we also spoke with parents, educationalists, therapists and medical and nursing staff. We observed care and treatment on the children's ward, the day care unit and the neonatal unit and reviewed performance information about the hospital.

Summary of findings

Parents and children were generally satisfied with the care and felt they had been kept well informed. They told us staff were compassionate and caring.

There were concerns about how incidents were reported and acted upon and how learning was shared. Risks were not appropriately managed.

Patients on Acorn Ward did not always receive responsive care because of a lack of registered trained and experienced staff. Beds had been closed to make the service safer, however this was impacting on the rest of the hospital.

Services were not planned or delivered in a way that met the needs of children and young people. There was a lack of designated areas for children in areas they would visit across the hospital. There were avoidable delays in some treatments and transport between services. There was no evidence of learning and sharing from complaints, which would help other areas improve their practices.

While senior staff responsible for the care of young people, children and neonates had a vision for delivering high quality care to their patients, the service was not seen as a priority for the trust board.

Services for children and young people

Are services for children and young people safe?

Inadequate

There was an increased risk of harm, as there was not enough registered nursing staff to safely care for children and young people. Staff did not always find the time to report incidents, and there was no learning from incidents. Some equipment and records in outpatients for children and young people were not available. There was enough consultant cover and staff were trained and aware of safeguarding procedures. Patients were assessed and risks responded too.

Nursing staffing

- There was not a minimum of two registered children's nurses at all times in all inpatient and day care areas. On some occasions one substantive registered children's nurse was caring for patients with six other agency nurses on the 20 bedded children's ward
- There was a 40% vacancy rate for qualified nurses and 16% for unqualified nurses.
- There was a high usage of bank and agency nurses. From January to July 2014, on average, 29% of posts were covered by bank or agency staff. Some nurses told us that, due to the lack of permanent, experienced staff, they worried that safety would be compromised and that they could make a wrong decision, which would lead to them losing their registration. Parents of children receiving long-term care told us it was worrying that "you never saw the same nurse twice" and, on some occasions, this upset their child.
- We were told permanent staff had to spend additional time in supporting bank and agency staff to give intravenous (IV) injections and access IT systems, such as for care planning, as temporary staff did not have the skills to give IV injections, nor did they have access to the IT systems. This meant that permanent staff had less time to carry out their duties.
- An external review on the neonatal unit was conducted in October 2014, following a whistleblower raising concerns regarding staffing experience, knowledge and skills. High sickness rates, and bullying behaviours among team members. An immediate review took place. The report was shared with the staff, an action was developed and a further external review will take place in the summer of 2015 to ensure that all actions have been implemented. We were told this will be reported regularly to the women and children's health CAG. This also led to a temporary senior member of staff being employed to support this piece of work.

Medical staffing

- The service was compliant with the European Working Time Directive and there was full-time consultant cover over 24-hour periods. We were told that 2013 winter pressures monies were used to employ two paediatric registrars in the A&E department, to reduce the number of paediatric admissions to the ward. This had had a positive effect on the reduction of admissions and the two posts continued to be in post. The posts were being advertised on a permanent basis.
- There were nine paediatric consultants at the hospital.
- We spoke with a member of the senior medical staff for children and young people's services, who told us that junior medical staffing had been affected by the reduction of permanent trained and experienced nursing staff. We were told this led to junior doctors being more vulnerable, as they could not always rely upon the expert advice experienced nurses could give them.

Incidents

- There was limited evidence of learning from incidents.
- There had been two Serious Incidents reported though the summer 2014 period. Staff involved in delivering the actions from the learning of the serious incidents were unaware they were responsible. Other staff were not aware of the outcome of the investigations.
- Medical and nursing staff told us that incidents were not always reported, as there was little or no feedback from the outcome of the incident investigations. Some members of the CAG told us there was neither shared learning, nor was there any hospital-wide learning from incidents from other areas in the hospital.

Cleanliness, infection control and hygiene

- There were no cases of MRSA/Clostridium difficile (C. difficile) reported.
- Both the Acorn Ward and the neonatal unit were visibly clean.
- We observed staff carrying out good hand hygiene and saw evidence of adherence to cleaning schedules.
- Single occupancy rooms were available for those requiring barrier nursing.

- We observed staff cleaning clinical areas and also cleaning after the lunch-time meal.

Environment and equipment

- At our previous inspection, there was an issue relating to the lack of pulse oximeters and resuscitation equipment and a lack of equipment checks. At this inspection, pulse oximeters and resuscitation equipment had been purchased. Some had already arrived and were in use. However, there was no resuscitation equipment on a trolley for children in the outpatients department.
- Staff were waiting for pulse oximeters to be delivered. The hospital had plans in place to ensure the service was still safe while awaiting the equipment. We observed that equipment checks were monitored and documented across both units.

Medicines

- Acorn Ward had a designated pharmacist who checked prescriptions to prevent errors in giving the wrong medication and which could contribute to interactions between medicines. Pharmacists had expertise in areas such as paediatrics, oncology and the management of infection.
- We observed the records of controlled drugs on Acorn Ward. All balances were correct and entries complete. Daily checks and regular audits were carried out. We saw the audits carried out by pharmacy and were told how discrepancies and incidents were notified to the accountable officer of the trust.
- We found one medicines trolley unlocked and one medicines cupboard unlocked in an unlocked clinical room. The key to the medicines cupboards was kept in an unlocked drawer. An audit had also identified unlocked medicines cupboards and cupboards storing patients' own drugs. But action had not been taken by the time of our inspection.

Records

- We observed nurses completing care plans and risk assessments for children on the Acorn Ward.
- The quality, safety and innovation group, which met in October 2014, highlighted a severe risk (25) within the Community Paediatric Service, due to the lack of electronic patient records. A working group was set up to implement a paperless system and the newly appointed assistant director of nursing would be reviewing the current system.
- In the outpatients department there were two different systems for identifying patient records, which made pulling the notes for child outpatients difficult, as the location of the notes could not always be verified. Often temporary notes were delivered to clinics with none, or limited information available to doctors at the time of the appointment.

Safeguarding

- Staff on Acorn Ward and the neonatal unit were trained in safeguarding adults and children and there was evidence of links with the designated staff for safeguarding. Most staff were aware of the trust safeguarding policy, the nominated consultant safeguarding lead and the nominated safeguarding nurse for the trust.
- Eighty-six per cent of staff were trained in level 3 child safeguarding.
- Eighty-nine per cent of staff were trained in level 2 adults safeguarding.
- Ninety-five per cent of staff were trained in level 2 child safeguarding.
- Ninety-five per cent of staff were trained in level 1 child and adults safeguarding.
- There was an abduction policy that staff considered not robust enough. This was currently under review.
- The trust were considering the use of an electronic tagging system as part of their review of its abduction policy.
- In outpatients staff were not aware of a 'Did Not Attend' (DNA) policy for children. They were unaware that they all DNAs children should be reviewed by a consultant. The management of DNAs in children was outlined in the access policy that was on the intranet. The bank and agency staff did not have access to the intranet and a hard copy was not available. Following our inspection a hard copy was made available in outpatients.

Mandatory training

- Fifty-seven per cent of medical staff had undertaken mandatory training and 67% had undertaken statutory training.
- Eighty-three per cent of nursing staff had undertaken mandatory training and 49% had undertaken statutory training.

Assessing and responding to patient risk

- The bedside Paediatric Early Warning Score (PEWS) system was used in the assessment in the assessment

and monitoring of children on the Acorn Ward. This was set up in September 2014 and was standardised across the hospital. A research nurse visited the hospital one day a week and reviewed all PEWS charts and feedback, reporting any errors to the staff directly. There was evidence of a high standard of compliance across all areas monitored.

Major incident awareness and training

- The women and children's CAG had its own Business Continuity Plan dated February 2014, which was due to be reviewed in February 2015. This document described how the service would respond to a major incident and how the service would continue to function in such an incident.

Are services for children and young people effective?

Requires improvement

There was no formally agreed programme for reviewing guidelines or undertaking audits. Nevertheless, there were examples of local reviews to monitor adherence to best practice guidelines.

The service contributed to national neonatal audits. Two of the four indicators for neonatal care set by the National Neonatal Audit Programme had been achieved.

Children received effective and appropriate pain relief.

We were told and there was no recorded evidence to demonstrate that appraisals and clinical supervision were always carried out.

Evidence-based care and treatment

- The management of the audit programme in the women and children's CAG had not been formally agreed.
- We were told that guidelines for the care of children were going to be reviewed and the meeting structures for the audit were still to be agreed. We were given a number of examples of audits carried out within the children, young people's and neonatal service, but these were all dated 2013. There was one audit carried out in 2014.
- Staff told us that, in the absence of a formal programme, they carried out audits that identified whether their practice was in line with national guidance, such as: sickle cell audit, neonatal infections, nutrition, sepsis, retinal screening and multivitamin intake. These audits related to 2013 and the implementation of the recommendations had not been re-audited y.
- The neonatal unit used BLISS Baby Charter Audit, as their accreditation scheme, but assessment against the neonatal toolkit was not evident.

Pain relief

- Patient-controlled analgesia (PCA) was introduced a few years ago and its use was embedded in the service.
- Audits had been carried out to introduce different strengths of local anaesthetic in order to reduce the pain experienced postoperation. This had been shared with other NHS organisations through a National Paediatric Conference.

Patient outcomes

- The hospital participated in the National Neonatal Audit Programme undertaken by the Royal College of Paediatrics and Child Health (RCPCH). The latest report was published in October 2014.
- The hospital met two of the four indicators with a set national standards.

1. Sixty-seven per cent of babies of less than 29 weeks gestation had their temperature taken within the first hour of birth (the national standard was 100%).
2. Sixty-eight per cent had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission (below the national average and failing to meet the national standard of 100%).
3. Eighty-three per cent of mothers who delivered their babies between 24+0 and 34+6 weeks gestation were given a dose of antenatal steroids (close to the national standard of 85%).
4. Ninety-five per cent of small/delivered early babies underwent the first retinopathy of prematurity (ROP) screening in accordance with the current guideline recommendations (similar to the national average and close to the national standard of 100%).

Competent staff

- Staff told us that appraisals and clinical supervision were "sporadic" and "opportunistic". Staff were not given the opportunities to develop and discuss their individual practice. We were told there were plans to address this.

- Revalidation for medical staff and job planning was ongoing. The women and children's CAG reported being the second highest performing CAG for their progress on the first level of job planning, which was 64%.

Multidisciplinary working

- Children coming to the Acorn Ward's surgical unit for an operation were predominantly for day case surgery and were placed at the beginning of the theatre list to allow enough time for the children to recover from their surgery and be discharged within working hours. There was no dedicated theatre list for children. We observed ward staff communicating well with surgical staff.
- Physiotherapists visited patients during the week day.
- Speech and language therapists provided a service to the neonatal unit for babies with swallowing difficulties.

Seven-day services

- The service worked predominantly from Monday to Friday.
- Physiotherapists for children were not available at weekends.
- Overnight and weekend services for respiratory conditions were provided by the adult physiotherapy team.

Access to information

- The hospital had issues accessing data and being confident that data was accurate, due to new computer services. This impacted on the children and young person's services.
- The quality, safety and innovation group met in October 2014, to highlight a severe risk within the community paediatric service, due to a lack of electronic patient records. A working group was set up to implement a paperless system and the newly appointed assistant director of nursing was reviewing the current system.

Nutrition and hydration

- We observed lunchtime meals being served on the Acorn Ward. All patients were served quickly and offered support.
- There was a menu that gave options to meet specific dietary requirements and cultural needs.

Consent

- Parents said they felt they were involved in their child's care, were happy with the level of information given to them and were supported throughout their stay. One child told us about how she had been informed about her operation and was talked to first. She was told she was the second patient on the operating list, what would happen to her in the operating theatre and she was given the opportunity to ask any questions.
- New mothers on the neonatal unit told us they were involved and understood treatments before they gave consent.

Are services for children and young people caring?

Good

We observed children and young people being looked after in a caring and compassionate manner. Parents and young people told us about their care and how involved they were with planning their care throughout their stay in hospital. Emotional support was available.

Compassionate care

- Overall, parents and children were happy with the care and felt they had been kept well informed. They talked about compassionate and caring staff. We observed caring and compassionate interactions.
- There was no formal system to collect feedback from the children and young people's service and no monitoring of any improvements. There had been some young people's workshops, with an external research company and the trust produced a national children's NHS Friends and Family Test question, which had been piloted.

Understanding and involvement of patients and those close to them

- Parents said they were involved in their child's care, were happy with the level of information given to them and were supported throughout their stay. We observed children being involved in their care.
- Parents said they were happy to leave their children on the ward if they had to go home and gave examples of where medical staff contacted them during the day to inform them of the treatment their child was receiving while they were away. One parent told us about a paediatrician visiting her while she was on the postnatal ward to put her at ease that her son on the neonatal ward was doing well.

Services for children and young people

Emotional support

- There were bereavement arrangements for both Acorn Ward and the neonatal unit.
- Deaths were very rare on both the Acorn Ward and the neonatal unit. There was a bereavement policy for staff to follow and there was a chaplaincy service, which covered all faiths. The service was provided 24 hours a day. Parents were offered counselling if needed.
- If required, there was a 'memory box' kept on the neonatal unit, which allowed footprints and handprints to be taken of their baby.

Are services for children and young people responsive?

Inadequate

Services were not planned, or delivered in a way that met the needs of children and young people.

There was a lack of designated areas for children in areas they would visit across the hospital. There were avoidable delays in some treatments and transport between services.

Parents were able to freely visit and spend time overnight on the ward in an area with amenities. The children and young people praised the educational service they received while they were inpatients.

Complaints were not responded to in a timely manner and there was no evidence of learning and sharing from a complaint, which would help other areas improve their practice.

Service planning

- The hospital had problems with issuing outpatient letters, as one of the servers had stopped working at the end of June 2014 for a period of two weeks. The letters were not forwarded to the external contractor who was responsible for distributing them. This caused an extensive backlog (approximately 40,000 letters) and resulted in patients missing appointments. This affected a proportion of children and young people's outpatient appointments.
- Not all calls from families calling to rebook outpatient follow-up appointments were answered, and this contributed to a number of appointments being missed. Some staff in outpatients were not aware of a 'did not attend' policy and did not report if children missed appointments. Following our inspection, we've been informed that a hard copy of the policy has been made available to staff to refer to.
- The trust did not collect child-specific data, which related to the referral-to-treatment targets (RTT) – waiting times for patients whose treatment was completed within the set period of time as set by the Department of Health. Overall, the trust consistently failed to meet all of the referral-to-treatment targets. The trust suspended reporting on RTT waits in September 2014, we were told that this was due to inaccuracy in data collection, they did not expect to be able to resume reporting on RTT, until 2015.
- Radiographers told us that children's appointments were planned for early afternoon, which was the least busy time of the day in the main x-ray area. There was no dedicated time for children who needed to undergo a CT scan and they were seen as and when required. Children under five years of age who required an MRI scan were sedated before the procedure. There was one dedicated slot for children booked between Monday and Thursday each week.
- We observed other departments across the hospital where children and young people would visit as part of their care and treatment. The majority of these areas were not equipped to be 'child friendly'. Some areas had no toys or books to keep children occupied while awaiting treatment. Some areas had toys, but these were made of felt, which may be an infection risk, other areas were austere and unwelcoming to children.
- The neonatal unit had four beds on the maternity unit, which were used to provide care for mothers and babies in preparing for discharge.
- We observed that there was no paediatric therapies department and children's appointments were planned on the same day and times as adults. There were also no designated waiting areas for those who attended the therapies department.

Access and flow

- There were arrangements in place for the transfer of critically-ill children to specialist centres by the Children's Acute Transport Service (CATS). We observed staff working with the CATS team to transfer a patient who had been waiting for over six hours in A&E. Staff involved the parents.

- We were told that there were concerns with the transport system between hospitals and some children had to stay for longer periods of time in order to be stabilised. This also affected the neonatal unit, which delayed the transfer of babies from one hospital to another.
- A neonatal nurse worked on the postnatal ward in the maternity unit with babies requiring transitional care. This enabled mothers to stay with their babies.
- Some parents raised concerns with us about the time taken for blood results to come through so that treatment could be commenced. These concerns had been raised, but no action had been taken. Medical staff told us the new computerised system in the neonatal unit was causing problems, as urgent investigations were not on the system and staff had to wait several hours for a test result.
- We spoke with one parent who had to attend with her children on three consecutive days, as there had been mistakes with the blood taken for testing. There were also times when she did not leave the hospital with her child until 11pm, due to problems with a delay in treatment. This was due to the staff not having the necessary skills in dealing with this type of treatment. This was raised during our inspection and a protocol for the management of this type of treatment was being developed and would be shared with staff in order to reduce the chance of this happening again.

Meeting people's individual needs

- Children attending the preassessment clinics had the experience of trying out some equipment used in the operating theatres before having a general anaesthetic and had the opportunity to meet the theatre nurses in order to develop a rapport, which may lead to alleviating any concerns they had about having an operation.
- Parents were given leaflets prior to, and after, their child's operation, so that they were aware of any complications or actions they needed to take, if necessary.
- Children coming to the Acorn Ward's surgical unit for an operation were predominantly there for day case surgery and were placed at the beginning of the theatre list to allow enough time for the children to recover from their surgery and be discharged within working hours. If needed, children stayed overnight on Acorn Ward. Children with complex needs were assessed in good time, so as not to cancel their operations.
- We observed the paediatric recovery bay within the operating theatres: resuscitation equipment for children was up to date and fit for purpose. The paediatric operating theatre was close to the recovery area and recovery staff had been trained in paediatric life support techniques. Although the recovery area was clean and tidy, more could be done to make the area more 'child friendly'. This was the same for the anaesthetic room where children were anaesthetised.
- On Acorn Ward, we observed parents using separate rooms when they had to stay overnight and also, where necessary, some parents had sleeping accommodation in the same room as their child.
- The neonatal unit had a small kitchen for parents to use, with a fridge, kettle and microwave. The microwave was broken, but we were told by staff this was going to be repaired. There were seating areas for parents with sofas and a television and toys for their siblings.
- There was 24-hour visiting for parents and siblings, who were allowed to visit between the hours of 3pm and 7pm. There was a room specifically for mothers wanting to express their milk, areas for breastfeeding, with chairs designed for mothers to breastfeed. There were also en suite rooms for parents preparing for their transfer home. Parents also had subsidised parking while their babies were on the neonatal unit.
- The adolescent communal area of Acorn Ward was sparse and not used very often, we were told that this was because there were televisions on all beds.
- We observed an area specifically for parents to stay in while their child was being cared for on the ward. This room included: a microwave, kettle, cutlery and a shower and toilet.
- The ward was stocked with baby feeds and specialist baby food was available in stock on the ward if a baby was admitted in the night. A stock of routine medicines was also held on the ward, such as: paracetamol, inhalers and spacers to speed up discharge, if necessary.

Educational services

- The Acorn Ward had a school room and playroom. School facilities were provided in partnership with the local authority and was open during term time. The

team included play specialists, qualified teachers and nursery staff. We observed nursing staff informing the team of the health of each of the children due to attend the school that day. The play area was well equipped for all ages of children and adolescents. There was evidence that this resource was highly valued by parents and children. Feedback from children was captured on a comments board which included comments such as: “It helps me socialise,” and, “It makes me forget my pain,” and, “The school room was fab.”

Learning from complaints and concerns

- At our last inspection, we raised concerns about how the complaints process was managed. We were told by staff that complaints for the children and young people's unit was still a concern. Due to the lack of staff to support the complaints process, the team were only just starting to review how complaints were managed. Staff could not give any examples of where lessons were learned, or changes made from the outcome of a complaint.

Are services for children and young people well-led?

Inadequate

The arrangements for assessing and monitoring the quality of the services were insufficient. While senior staff within the women and children’s health CAG could demonstrate a clear vision for delivering high quality care within the Acorn Ward, the services were not seen as a priority for the trust board. Risks were not appropriately managed.

Vision and strategy for this service

- There was a vision for the children, young people and neonatal services. The vision was to change the ward to have two separate functions - an acute assessment area and a day unit to provide a better service.
- The strategy for the restructure had been drafted but there was a of lack of trust board involvement and exposure, so some of these plans have still to come to completion. It was not evident from the recent trust board minutes that the strategy for the children, young people and neonatal services had been discussed.

Governance, risk management and quality measurement

- There were concerns about the quality of data and the timeliness of data submissions, which affected how the women and children's health CAG identified, assessed and managed risks relating to its services.
- Designated posts to support governance and risk management processes had just been established and needed further embedding to ensure people who used the services were safe. Staff told us there was no formalised mechanism for reporting the services performance, such as a dashboard. This was being developed with a view to being presented to the CAG in early 2015.
- The children, young people and neonatal services had a risk register, but this had not been reviewed or updated on a regular basis. Staff confirmed that the risk register had been poorly managed in the past with some risks needing to be reviewed from July 2014. We were told a new governance manager was now in post and the risk register would be reviewed and updated, so that the service would be able to act upon high risks in a more timely manner.
- While the service could demonstrate staff were participating in audits, the management of the programme of auditing in the women and children's CAG had not been formally agreed. We were told the guidelines for the care of children were going to be reviewed and the meeting structures for audit were still to be agreed.

Leadership of service

- Local leadership had developed a vision and strategy but it had not been escalated and taken forward.
- The director of the women’s and children’s health CAG had recently been invited to be a non-voting board member.
- Due to a staffing restructure across the trust, qualified nursing staff had to apply for new roles at a level lower than they were currently working to. We were told that this was carried out by an online interview process. Those staff who were unsuccessful, or who decided to resign from their posts did so with no exit interviews being completed. This meant senior management staff would not receive feedback on how the hospital was performing as a good employer and so would not be able to improve how they look after and support staff in the future.

- Leaders of the service closed seven beds, as there was not enough staff to ensure a safe service was being provided at all times.
- The working relationships between the medical staff and non-clinical managers needed strengthening. Some consultants felt they were not involved in the changes to the service and raised their concerns with the commissioner.

Culture within the service

- A number of staff we spoke with said they were under pressure to deliver high quality care. This pressure had led to some of their colleagues leaving the hospital. Staff who remained felt stressed and undervalued. Some staff did not feel they could express their concerns to senior staff for fear of retribution. Some staff felt that they were not being listened to.
- An external review on the neonatal unit was conducted in October 2014, following a whistleblower raising concerns regarding staffing experience, knowledge and skills, high sickness rates and bullying behaviours among team members. An immediate review took place. The report was shared with the staff, an action was developed and a further external review will take place in January 2016 to ensure all actions have been implemented. We were told this will be reported on regularly to the women and children's health CAG. This also led to a temporary senior member of staff being employed to support this piece of work.

Public and staff engagement

- There was no formal system to collect feedback from the service and no monitoring of any improvements.
- There had been some young people's workshops with an external research company and the trust was set to produce a national children's NHS Friends and Family Test question, which would be piloted soon, but a date had not been set.
- A children's health staff engagement survey in August 2014 showed that staff were slightly more engaged (39%, which increased to 47%) with six out of the nine questions asked of staff being rated as 'green'. The November figures were not completed at the time of the inspection.

Innovation, improvement and sustainability

- Due to the loss of senior nursing staff and low staffing levels across both neonates and children's services, there had been few opportunities to demonstrate innovation. Staff were focused on sustaining a level of service to keep patients safe.
- Reviews of services on Acorn Ward and the neonatal unit were underway, recruitment to more senior nursing posts had started.

End of life care

Safe	Inadequate
Effective	Inadequate
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The hospital palliative care team (HPCT) consisted of two 0.4 of whole time equivalent (WTE) consultant posts and two clinical nurse specialists. 1.6 of whole time equivalent clinical nurse specialist,1.0 of whole time equivalent matron and 1.0 of whole time equivalent palliative care matron posts. A third post was not being covered while the person was on maternity leave. The hospital reported 1,121 patient deaths between April 2013 and March 2014. The number of patient deaths in the first 7 months of this financial year was 672.

The HPCT had a caseload of 771 patients between April 2013 and March 2014. These figures were complicated by the 12-bed hospice that was located on the hospital campus, the Margaret Centre, which was not part of the inspection. There were a further 400 deaths annually at the centre; many of these were of patients transferred from the hospital in the last days of their lives. The Margaret Centre was is due for an inspected ion separately in February 2015.before the end of March 2014.

We visited a number of wards where care was being given to patients at the end of their lives. These included respiratory, gastroenterology, medical escalation, stroke, surgical, acute assessment, renal and care of the elderly wards. There were no specific oncology wards. We spoke with patients and relatives when this was possible. We reviewed medical records and talked with staff from a variety of disciplines. They included porters, chaplains, mortuary staff, healthcare assistants, consultants, doctors, nurses and service managers.

Summary of findings

While we found that staff were overall caring and committed to providing good care to patients at the end of life, we had concerns in all domains and rated this service as inadequate overall. Staffing issues had a major impact on the service's ability to provide good care and we found examples where patients receiving end of life care were not being properly supported. The service was not able to understand how complaints or incidents might relate to end of life care, and the hospital was not measuring the quality of services delivered to patients receiving such care. Limited action had been taken in response to the 2013 review of the Liverpool Care Pathway (LCP) and at the time of the inspection the pathway had not been replaced. 50% of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms we reviewed had not been fully completed. We found a number of concerns that related to this service being well-led, with end of life care having no influence within the clinical academic group (CAG) structure. There was a lack of strategy and resources that compromised the service's sustainability.

End of life care

Are end of life care services safe?

Inadequate

It was not possible to extract end of life themes or issues that had arisen through the incident reporting process, and there had been no learning from incidents that related to end of life care at the hospital. We found examples of patients receiving end of life care not being properly supported. HPCT nursing and consultant staffing was below recommended guidelines. There were consultant sessions that were not allocated to specific activities, and it was not clear how this time was being used. The hospital palliative care team (HPCT) staff were not able to tell us exactly which or how many patients were on their caseload because patient lists were not routinely distributed. There was access to syringe drivers, used to administer regular continuous analgesia. There was no guidance available to staff on the consistent use of opioids, and this left scope for drug errors.

Incidents

- Ward and HPCT staff we spoke with were knowledgeable about the incident reporting process. They confirmed that, to their knowledge, there had been no incidents reported relating to end of life care; nor had there been any 'never events' or serious incidents relating to end of life care.
- It was not possible to extract end of life themes or issues that had arisen through the incident reporting process. There had been no learning from incidents that related to end of life care at the hospital. Although we requested evidence, it was not forthcoming and there was no way to review entries made through the incident reporting system in order to establish if any related to patients receiving end of life care at the hospital.

Safeguarding

- The trust's safeguarding policy was available to all staff through the staff intranet. However, when we asked ward staff on two different wards to show us the policy, it was not accessible because the computers were slow to respond.
- HPCT staff were knowledgeable as to what constituted abuse and how to report safeguarding issues. However, they told us that their training was not up to date.
- We found that ward staff were reporting safeguarding issues by completing safeguarding adults alert forms. One example related to pressure sore treatment for a patient receiving end of life care. The patient's notes said a referral had been made to the tissue viability nurse because it was a grade 3 pressure sore. The notes reported that the tissue viability nurse had made one visit and advised that, because of their workload, they could not say when they would be able to review the patient; in the meantime, they recommended surgical review and referral to physiotherapy.

Medicines

- The hospital achieved its National Care of the Dying Audit in Hospitals (NCDAH) organisational key performance indicator for clinical protocols for the prescription of medications for the five key symptoms at the end of life (score 5/5).
- There was appropriate access to syringe drivers, used to administer regular continuous analgesia. These were available through the medical equipment library and we found examples of when these had been retrieved within five to ten minutes. The syringe drivers used had been standardised in response to a national patient safety alert.
- The HPCT consultant and clinical nurse specialist (CNS) told us that syringe driver training took place on the wards. Ward staff told us they had received training in their use and that there was a syringe driver resource folder available on the wards. However, the information was not easily available to staff at the nursing stations on the wards. One folder we were shown, which purported to contain information about end of life care, had details about how to use a syringe driver but no other information about end of life care. This meant that the information regarding the use of syringe drivers did not specifically support end of life care.
- On a respiratory ward, we were told that sometimes subcutaneous fluids were used in end of life care and oxygen treatment continued until close to the end of life. This meant that staff considered plans for fluids and oxygen and were able to provide comfort care for patients who were dying.
- We found an example on one ward, with a patient receiving end of life care, where drugs had been appropriately prescribed. A syringe driver check sheet had been completed appropriately and all medication for good end of life care was in place.

End of life care

- There was no policy or guideline on the consistent use of opioids. This meant there was considerable scope for drug errors and mis-prescribing when doctors moved between wards and failed to appreciate that the drugs had different potencies when administered by different methods. There was no consistency in the use of opioids, with some wards using morphine and others diamorphine.

Records

- The HPCT staff kept a record of their first assessment and patient details for each referral in their own office location. Details of the initial assessment and all subsequent records were included in the patient's medical notes on the ward, and so available to all medical and nursing staff.

Assessing and responding to patient risk

- Patients were referred to the HPCT for symptom control, pain management and terminal care. There was no breakdown of numbers or types of work done by the team. Patients' dependency was not measured.
- HPCT members were not able to tell us exactly which or how many patients were on their caseload because patient lists were not routinely distributed.
- Patients who were being cared for on the hospital wards and considered to be dying were referred to the HPCT. The HPCT did not have the capacity to 'take over' managing patients' care. The team expected that the ward medical team would remain responsible because the HPCT had only two part-time clinical nurse specialists and no junior doctors of its own to support the management of palliative care patients. They told us they saw their role as advisory or 'executive' in caring for patients on the wards and working alongside ward staff. Referral to the HPCT was through a prescribed referral form sent by email or as hard copy; this form could only be completed by a doctor. The team's aim was to see all new referrals within 24 hours. This was prioritised by risk and patient need. Response times were not measured for quality.
- We found that the end of life care being delivered to patients on the wards was variable. There were examples of when ward staff had considered who might be appropriate for end of life care. For instance, on Syringa Ward, staff would refer a patient to the HPCT when they were no longer to receive active treatment, or sometimes earlier. On another ward, part of the consultant's daily ward meeting was to discuss who might be appropriate for end of life care. On Birch Ward, doctors referred to the HPCT for advice on analgesia and end of life care. One ward consultant said they would refer to the HPCT if the patient was dying and needed symptom control. Staff also told us that they were not aware of any end of life care planning or assessment guides or of any intranet resources, and that there had been no education in end of life care by the HPCT. On Wavell Ward, the daily multidisciplinary meeting discussed end of life needs and involved the families in the patients' care.
- On Mary Ward, there was a lack of involvement from the HPCT when a patient diagnosed with an advanced cancer had complex physical and psychosocial needs. HPCT members were involved but not proactively. They had reviewed the patient 12 days before our visit. This intervention recorded a statement of history but no details of an assessment. On their second visit, there was a brief assessment but no record of the patient's preferred place of care or preferred place of death. There was no aide memoire or assessment for equipment. There was no engagement by the HPCT with clinicians regarding the appropriateness of stenting or an oncology opinion. There was no partner assessment and no advocacy documented. The patient had complex palliative care needs but there was no record of their being considered for the hospice located on the hospital campus. While the patient had previously expressed concerns about going to a nursing home because of their age and symptoms, this appeared from the notes to be the option now being taken forward.
- We found another example of a patient who had been on the acute assessment unit for two weeks and was a known palliative care patient. They had been referred for treatments and scans to other trust locations, but this was no longer thought appropriate because of deterioration in their condition. The patient was clearly in need of specialist end of life care, but there was no acknowledgement on the ward that they had end of life needs and they had not been referred to the HPCT. Limited staff resources meant that the HPCT was not proactive in finding patients; nor had there been any input from the clinical nurse specialist for oncology whom we were told shared their duties across the trust's acute hospital sites.
- On Faraday Ward, a nurse told us that when a patient was referred to the HPCT the ward doctors would

withdraw and hand over responsibility for care to the HPCT. This was not what the HPCT understood as their role, they expected that the ward medical team would remain responsible for the patients. There could be a concerning gap in care because of this misunderstanding.

Mandatory training

- The staff in the HPCT had not kept up to date with their mandatory training. We were presented with training statistics that showed 48% of staff who were up to date with their mandatory training was up to date. The service told us that training for its clinical nurse specialists (CNS) was a year out of date. This was due to a variety of factors that included team members' absence through sickness or maternity leave, and the fact that the HPCT had twice been moved across the trust's CAG structure, which had left them with no managerial process to check whether training was being completed.

Nursing staffing

- HPCT nursing was made up of two clinical nurse specialists (CNS), both working part time. One was 0.6 of a WTE post and the other 0.7. A third CNS was currently on maternity leave but their post was not being covered.
- The hospital reported 1,121 patient deaths between April 2013 and March 2014. The HPCT had a caseload of 771 patients during the same period. There had been no assessment of nursing staffing requirements based on the needs of the service or on patient dependency or acuity levels.
- Levels of nursing staffing had an impact on the level of care that could be realistically offered by the HPCT. For instance, because of the part-time nature of the CNS posts, maternity leave not being covered and one of the CNSs doing training modules, there was often just one part-time CNS to cover the whole hospital.
- The HPCT had two entries on the trust's risk register that were related to how the lack of staffing was having an impact on meeting patients' end of life needs. Both had been there since May 2013. We were told there were no plans to increase the number of staff in the HPCT.
- With current staffing levels, it was a challenge for the HPCT to meet the end of life care needs of the high number of patients or to support ward staff to deliver this care. The service was also affected by the down-banding of nursing grades, management restructure and specialist nursing posts being made redundant, which had meant many substantive ward staff had left. There were fewer permanent staff and greater reliance on bank and agency staff. A major concern of the HPCT was that ward staff were not managing to deliver end of life care sensitively or compassionately because of ward staffing levels and skills mix. For instance on Peace Ward, senior staff told us that the HPCT's role was mostly to advise on symptom control, and that they did not give teaching sessions to the ward staff because of their limited staff resources. On another ward, senior staff told us they had a 40% vacancy rate. On the same ward it was reported that out of 33 band 6 nurses, 50% were down-banded to band 5. Only few of those who had been down-banded were still working at the hospital and morale was very low. On Birch Ward, we were told there was a reliance on bank and agency staff, especially at night.

Medical staffing

- The trust's lead consultant for palliative care reported that the job plans for the hospital palliative care consultants were difficult to manage. There were two consultants in the HPCT. Both were 0.4 of a WTE post.
- An email of concern was written by the lead consultant for palliative care to the CAG director regarding palliative care team nursing staffing levels, which had been on the trust's risk register for two years. Published guidance recommended a palliative care establishment of one consultant and one CNS for every 250 beds. The hospital has 690 beds, which equates to at least three consultants and two CNS working full time. This does not include teaching requirements.
- The level of input to ward patients was low. One consultant led a multidisciplinary meeting one morning a week and did a hospital ward round the same afternoon. The number of patients seen on the ward round ranged from one to six, depending on patient need and consultant time.
- Some consultant sessions were unallocated to specific activities with patients and it was how this time was spent.
- On Syringa Ward, senior staff told us they would refer to the hospice located on the hospital campus for advice because a consultant in palliative care was based there. They did not appear to understand that the HPCT also had palliative care consultants.

End of life care

- We were told by members of the HPCT that a barrier to caring for end of life patients was the difficulty some consultants had in correctly identifying those with palliative and end of life needs. Often junior ward doctors were left to contact the HPCT for advice and to make referrals.

Major incident awareness and training

- The HPCT were rated a 'bronze' service by the trust, which meant 'await further instruction' regarding deployment in the event of a major incident.
- The mortuary had twenty spaces. If there was a need for more spaces this was managed by the bereavement service who had ready access to a much larger mortuary nearby.

Are end of life care services effective?

Inadequate

Limited action had been taken in response to the 2013 review of the Liverpool Care Pathway and at the time of the inspection the pathway had not been replaced. There was a lack of evidence to support the hospital's adherence to national evidence-based guidance. There was no evidence of formalised ways of measuring patient outcomes. Because of a lack of resources, ward staff were not receiving training in end of life care from the hospital palliative care team (HPCT). There were no suitable arrangements in place for HPCT staff to receive clinical supervision. We reviewed twenty do not attempt cardio-pulmonary resuscitation (DNA CPR)' forms. Ten of these had not been fully completed. The HPCT supported ward staff to manage patients' pain at the end of their life. However, there were sometimes concerns about patients receiving pain relief in a timely manner. We found a number of positive multidisciplinary working relationships between HPCT team members and ward teams.

Evidence-based care and treatment

- The hospital contributed to the National Care of the Dying Audit for Hospitals (NCDAH). It had not developed an action plan in relation to this.
- The trust intranet did not have a policy on end of life care for the hospital. It had policies for two other locations, both referred to the Liverpool Care Pathway (LCP). The LCP should have been phased out and withdrawn.
- The trust's end of life care committee was meeting during our inspection to ratify the new end of life care planning documentation and guidance to replace the LCP. The previous committee meeting in September had an action point that the LCP guidelines still needed to be removed from the trust's intranet. This was more than a year after the directive regarding the LCP had been issued by the Department of Health.
- New end of life care planning documentation and guidance had been written but not yet implemented. Draft versions had been made available to ward staff through the intranet and resource folders on wards, but staff had not been familiarised with this documentation or given training in its use, and they were not using it. At the time of our inspection, nothing had replaced the LCP to support patients receiving end of life care.
- We received feedback from a number of wards as to how they were supported to deliver end of life care through evidence-based guidance. On Conifer Ward, senior staff told us there were no policies or guidelines. They felt that the LCP had not been replaced at the hospital. On Wavell Ward, senior staff told us they had no tool to replace the LCP but were aware that there was interim guidance. On Faraday Ward, we were told there was no guidance to follow. A consultant on Conifer Ward told us that, since the LCP had been withdrawn, they did not know of any other care planning, assessment or intranet resources. Senior staff told us there had been no palliative care education since the LCP went. A junior doctor for care of the elderly told us they had no protocols to follow in the care of the dying.
- The trust's lead consultant for palliative care told us they wanted HPCT nurses to pilot using the new documentation at the hospital, but there had been a lack of senior nursing management support for doing this.
- We saw documentation, first drafted in July 2013, which included care planning and guidance. We were told that this documentation had "got stuck at committee stage for a year". It was modified in November 2014 and was being discussed for approval.
- We reviewed the new documentation. We found it needed some improvement because it did not reflect

the detail of the guidance issued by the Leadership Alliance for the Care of Dying People (LACDP). For instance, there was no clear statement to identify the responsible consultant or whether the consultant was aware that a care plan was being started. It did not record whether the patient, family or carers were aware of the plan, or whether reversible courses of action had been considered. There was no note of who had led discussions or been present, and space for recording discussions was very limited. It did not record consideration of capacity issues, lasting power of attorney, advance decision to refuse treatment, advance care planning or preferred place of death. There were no allowances for daily review or for changes to the care plan.

- An HPCT consultant and CNS told us they had discussed implementing the AMBER care bundle (this aims to improve the quality of care of patients who are at risk of dying in the next 1–2 months). However, after the merger with Barts Health NHS Trust in 2012, this did not happen.
- There were no specific governance arrangements for complying with National Institute for Health and Care Excellence (NICE) or other evidence-based guidelines. One of the HPCT consultants and CNSs told us there had been no recent commissioning for the quality and innovation indicator (CQUIN).
- There was no evidence of any further guidance documents or policies to show that practice followed evidence-based care and treatment.

Nutrition and hydration

- The trust's NCDAH score for reviewing patients' nutritional requirements was 53%. This was better than the England average of 41%.
- The trust's NCDAH score for reviewing patients' hydration requirements was 63%. This was better than the England average of 50%.
- The HPCT saw its role as prompting symptom management, which included nutrition and hydration needs. This was done by checking that end of life care needs were being met appropriately. The team discussed processes with ward staff around naso-gastric feeding. It provided advice and information to family members regarding hydration and nutrition in a patient's last days and hours of life.
- On Syringa Ward, we found that discussions took place at registrar and consultant level around care planning issues such as feeding at the end of life. There was also multidisciplinary discussion regarding nutrition and hydration needs during patients' end of life care.
- A protected meal times policy operated, which meant that all ward staff helped out without distraction. However, on Birch Ward, we found an elderly palliative care patient whose eating and drinking had been recorded in their notes as declining. We observed a bowl of porridge left untouched by their bed an hour after breakfast had ended, although it was not clear if this patient had been offered assistance and had refused it.

Pain relief

- The hospital scored 64% in the NCDAH for 'as required' prescribed medication for the five key symptoms that might develop during the dying phase. This was better than the England average of 51%.
- The HPCT saw its role as prompting symptom management, and this included pain management. Advice was given to ward staff in relation to managing patients at the end of life. The ward staff also contacted the HPCT for pain symptoms management advice.
- The lead HPCT nurse told us there was a good relationship with the hospital pain team and that they sometimes did joint visits. Ward staff told us that they could also refer to the pain team for managing difficult symptoms, but that they would generally go to the HPCT first.
- There did not appear to be a trust-wide policy or guideline on managing pain available to staff. On Faraday Ward, the acute pain folder in the nursing office did not contain any prescribing information. We were told this guide would also be used for palliative care patients.
- Ward doctors and ward nurses told us they had a good collaborative working relationship with the HPCT and would contact the team for advice about pain management. This included referral for symptom control to help patients at end of life or for advice on analgesia, and to discuss aspects such as pain management with a patient's family.
- We met with a relative who was with their parent in the last days of life. They told us about their experience of admission and care. They explained that, on arrival their parent had waited one and a half hours for pain relief in

the accident and emergency department (A&E); then, once admitted to a ward, they experienced a similar situation that was only resolved once the family became upset and more demanding that their relative should receive pain relief.
- On Birch Ward, a doctor told us they felt that the HPCT was helpful. When a palliative care decision had been taken, they would often consult the team early to discuss the patient's progress. Staff felt they received help with managing pain control.

Patient outcomes

- In the NCDAH, the hospital scored 67% for reviewing interventions during a patient's dying phase. This was better than the England average of 56%. The hospital was also better than the England average of 82% for reviewing the number of assessments undertaken in a patient's last 24 hours of life (96%).
- There was no evidence of formalised ways of measuring patient outcomes. HPCT staff told us they were doing this but on an individualised basis, and that the results were reported at their multidisciplinary team meeting.

Competent staff

- End of life care was not part of mandatory training for all staff. There was an end of life care group that was working towards getting end of life care onto the mandatory training schedule. This was an action that had resulted from the NCDAH.
- The hospital did not achieve its NCDAH organisational indicator for access to specialist support for care in the last hours or days of life (score 1/5).
- The trust did not achieve its NCDAH organisational indicator for continuing education, training and audit (score 0/20).
- There were three oncology CNSs across the trust who rotated across the acute sites but were based at the St Bartholomew's hospital site. Ward staff told us they were there for advice in emergencies but not generally present at the hospital.
- The HPCT band 7 CNSs were not receiving clinical supervision. The band 8 HPCT CNS received external supervision. We were told by the trust's lead cancer nurse, with responsibility for palliative care across the trust, that they were putting arrangements in place for clinical supervision to be given to both bands 7 and 8 HPCT nurses from a band 6 complementary therapist.
- Ward staff had not been trained in using the new end of life care planning documentation that had been made available to them. There had been no education in advance care planning. There was no plan to roll out any teaching programme to the ward staff on using the new documentation. The HPCT wanted to be included as part of the staff mandatory training schedule, but the team had not been involved in this since the merger in 2012.
- Although there was no formal training of ward staff, the HPCT nurse lead told us they liked to see every interaction with patients as educational and informative for ward staff. There were no resources to support ward teams in any other way.
- Four times a year there was a morning session with newly qualified nurses about death and dying, which covered attitudes, self care and end of life processes.
- A system of link nurses for palliative and end of life care was in operation before the merger more than two years ago. However, since then, many staff had left. Because of staffing issues, this system had largely fallen into abeyance and was proving difficult to re-establish.
- Members of the HPCT contributed to foundation year 1 training sessions. The chaplaincy contributed to both student nurse induction and foundation year 1 training. The chaplain told us that death, supporting families and dealing respectfully with a deceased's body were all covered.
- Ward staff told us they had received training in the use of syringe drivers and that there was a syringe driver resource folder available on the wards. However, all the clinical information on the wards about syringe drivers had to be retrieved from an office, which took some time. It was not easily available to staff at the nurses' stations. One folder we were shown had details about how to use a syringe driver but no other information about end of life care.
- A CNS was doing pain and symptom control training modules, it was organised as needed and only when time allowed. We were told there was no formal career development framework for HPCT nursing staff, and no development posts available.

Multidisciplinary working

- We found a number of positive multidisciplinary working relationships. On one ward, there was a daily ward meeting in which a consultant, social worker and

nurse took a multidisciplinary approach to meeting patients' end of life care needs. A care of the elderly senior house officer told us that the HPCT nurses were very supportive with medication and symptom control advice, and would also liaise with hospice and community services. On another ward, Peace Ward, there was a 'board-round' meeting twice a week and HPCT nurses attended if they felt this was needed. Otherwise, they were contacted by the ward to assess patients with end of life care needs. We also found examples of the HPCT working alongside the stroke team and working to involve patients' families. A ward doctor told us they felt that the HPCT made a good contribution to the multidisciplinary working of the ward. They felt able to call the team in when a palliative care decision had been taken, in order to discuss the patient's progress and the various aspects of palliative care. We were told that complementary therapies were available from two volunteers to patients receiving end of life care. Psychological support was also available from two support workers. HPCT staff were not able to tell us exactly which or how many patients were on their caseload because this was not routinely distributed. We were told this was the responsibility of an administrative assistant who was neither managed nor supervised. HPCT staff felt they had no authority to direct the staff responsible and that they had only limited involvement with the task.

- Although there was a 0.7 of a whole time equivalent (WTE) occupational therapist, 0.5 WTE of a social worker and 0.5 WTE psychological support available to the HPCT, these were shared with two other services; the hospice based on the hospital campus and the community palliative care team. Therefore, these WTEs were not exclusive to the Whipps Cross HPCT establishment as reported, and there were too few of these multidisciplinary resources to meet patients' needs.
- Patients were able to access social workers and complementary therapists through the ward-based teams. An HPCT consultant and CNS told us they would refer to the hospital social work team to help patients with complex needs.
- One of the two 0.4 WTE consultants led an HPCT multidisciplinary team meeting one morning a week during which hospital patients with complex needs were discussed. We were told joint working between the HPCT and the wards depended on HPCT's relationships with the wards' nursing and medical staff.
- One of the two HPCT consultants told us there were no plans for any joint hospital and community multidisciplinary team meetings because "it would be too big". Every inpatient was discussed with whoever was around at a weekly HPCT meeting before the HPCT ward round took place.
- An HPCT consultant and CNS told us the team had trialled attending daily morning meetings at the acute assessment unit to pick up referrals, but this had not proved very successful. The HPCT had also recently met with a care of the elderly consultant to discuss joint management of patients, although we were unaware of the outcome of this. The HPCT attended the motor neurone disease multidisciplinary team meeting.
- An HPCT consultant felt there was goodwill and excellent relationships with many medical teams. This was echoed by one of the gastroenterology consultants who told us that, if they ever had a problem with a patient who had palliative care needs, they knew they could always phone the palliative care consultant.
- We met with a family member who was with their parent in the last days of life. They told us that reflexology, massage and counselling were all offered to them by the HPCT.

Seven-day services

- There were no seven day services available from the HPCT and no plans at present because of the lack of staff resources. 24-hour consultant cover was available through an on-call rota. All the HPCT consultants for the trust joined together for the on-call rota. We did not see evidence on the wards of how to contact them. Nursing staff told us they would contact the hospice on the hospital campus for advice.

Access to information

- The hospital achieved its NCDAH organisational indicator for access to information relating to death and dying (score 5/5).
- The HPCT lead nurse told us there was a 'communication form' that was generic across

North-East London. This gave details of the specialist input with palliative care that is shared across services, and is sent to district nurses, GPs and community support services on patients' discharge.
- The HPCT staff kept a record of their first assessment and basic patient details for each referral in their own office location. The initial assessment and all other further records were written and shared in the medical notes on the wards.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Some patients receiving end of life care had been identified as not for resuscitation, 'do not attempt cardio-pulmonary resuscitation' (DNA CPR). They had the appropriate form in their file so that staff were aware of what action to take in the event of cardiac or respiratory function ceasing. The form identified those patients who would not be resuscitated in the event of an arrest and who had competently refused this treatment option.
- A doctor told us that DNA CPR was decided soon after admission and that a consultant or registrar would complete the form after discussion with the patient or their family.
- A DNA CPR audit had been completed by the trust between April and June 2014. Data presented to us demonstrated that, apart from the numbers of forms audited at the hospital during this period, all other data was trust wide, involving six hospital sites. It was therefore not possible to extract information from this audit to measure the performance of the hospital, nor was there any plan of action resulting from the trust-wide summary.
- We reviewed twenty DNA CPR forms. Ten had been completed appropriately in that there had been discussions with the patients' families and multidisciplinary discussion, and consultant signing forms.
- The standard of the other ten DNA CPR forms was variable. For instance, we found forms with no documentation of consultation with the patient's family even though notes showed that the family had been involved. In one case there were two DNA CPR forms in one file and it was not possible to tell which one was current. We also found forms that were nowhere near completion.
- There was nowhere on the DNA CPR form to indicate patient capacity. It was therefore down to the person completing the form to be aware that this needed documenting. In some cases, there was no statement of capacity and no confirmation of a decision. One form had written on it 'no formal capacity/best interests paperwork'. On others the issue had simply not been addressed.
- The HPCT lead nurse told us that part of the HPCT's role was to advocate for a patient, elicit the views of the family and arrange for a capacity assessment if there was any doubt about the patient's capacity. They would also advocate for patients in situations when the ward staff might be over-influenced by the wishes of the family.
- A person who was with their parent in the last days of life told us how, on admission to A&E, a doctor spoke to them about resuscitation and the patient's wishes not to be resuscitated were recorded.
- On Faraday Ward, we asked senior ward staff to explain how the medical teams decided that someone was dying and needed end of life care. The process described was encouraging; if the patient had capacity, the consultant would suggest that they had a private conversation off the ward with another member of staff present. If the patient lacked capacity, the consultant would talk with the next of kin instead, but the actual decision regarding end of life care would be made by the consultant in discussion with the clinical team.
- With regards to mental capacity, we found there were variable levels of understanding and implementation of process. For example, on some wards, there was confusion over how to assess capacity. Nursing staff told us they used a mini-mental state test. A ward sister identified the mini-mental state documents on the ward (part of the London Health Needs Assessment), as being those used to assess mental capacity. We noted that they did not refer to the Mental Capacity Act 2005.
- On one ward, the daily multidisciplinary meeting discussed end of life DNA CPR and involved the family of patients when capacity assessment needed to be completed. On another ward, capacity was assessed at the initial screening process.
- On care of the elderly wards, staff told us they had "just been told" they had to complete deprivation of liberty safeguards (DoLS) assessments for all patients with dementia. They did not have any further rationale or training on this directive. The assessment amounted to

a uniform statement that had been placed in the file of every patient with dementia. This was in response to the new DoLS ruling in early 2014 about preventing patients with dementia leaving the wards. A consultant psychiatrist for older persons' services and the Mental Capacity Act 2005/DoLS medical lead told us the hospital had been 'playing catch up' with this ruling, which had meant just getting the forms filled in without ward staff understanding the rationale or having any training. They stated this was not ideal but pragmatically led. It was acknowledged that there was a general teaching gap and a lack of knowledge regarding capacity and deprivation of liberty on the wards.

- There were easy-to-read booklets for relatives and patients that described what DoLS meant for patients, families and staff. We found a DoLS laminated flow chart on the ward that included in one of the stages 'identify patients without capacity – an MDT task'. There was, however, no current training for nursing staff on the Mental Capacity Act 2005 and DoLS assessment, and the nurses told us it was always done by the doctor.
- Discharge coordinators had specific capacity assessment forms for patients being discharged.

Are end of life care services caring?

Requires Improvement

The majority of relatives told us they felt staff were compassionate and caring, and we found examples of staff providing sensitive care to end of life patients. Ward staff were committed and cared about delivering care that was compassionate, but they felt they were not always able to give patients who were dying an appropriate level of care and attention. Staff recognised they were not always able to deliver end of life care sensitively or compassionately because of staffing levels. Staff focused on the task, rather than treating people as individuals, because they had limited time and resources.

Compassionate

- The hospital did not achieve its National Care of the Dying Audit in Hospitals (NCDAH) organisational key performance indicator for clinical provision/protocols promoting patient privacy, dignity and respect, up to and including the death of the patient (score 5/9).
- Staff issues had had a negative impact on patients receiving end of life care. Ward staff felt they were not able to give patients who were dying the care and attention they wanted. For example, we found a patient with advanced cancer who was receiving end of life care but whose mouth care had not been taken care of. Staff focused on the task, rather than treating people as individuals, because they had limited time. We were told, "it is sometimes humiliating for staff to try to deliver sensitive compassionate care with the environment and context they are being asked to deliver care in". This was further compromised by staffing issues within the HPCT, which limited the amount of support that could realistically be offered to wards. It was widely reported that morale among nurses had been low since the trust's restructuring, and this had had an impact on patient care. They told us dignity and compassion were compromised because there were too few resources.
- We found examples of staff providing sensitive care to end of life patients. We met with a relative who was with their parent in the last days of life. They told us the staff had been "lovely" and helpful throughout. They felt this was very special because they could see how busy and hard working the staff were.
- On one ward, a nurse told us about a patient who had died the past week. The family had come from another country and were very complimentary about the service. The nurse also told us that staffing reduction meant that there were sometimes other, less positive examples of care.
- In all our conversations with the HPCT staff, they showed that a caring and compassionate approach to working with patients and families was a priority. A junior doctor told us they found the attitudes of the HPCT very good, kind and caring towards their patients and their relatives.
- We saw HPCT nurses giving support to families with sensitivity and compassion. For instance, we observed conversations with family members that were sensitive and reassuring, with questions answered in a helpful way. One relative told us they had received a lot of help and care from the HPCT, which had been essential to them at a challenging time.
- Staff continued to treat patients with dignity and respect after their death. Mortuary staff referred to the deceased

person in a respectful manner and explained the process they went through with relatives when they accompanied them on mortuary viewings. This showed consideration for the sensitivity of the situation.
- The mortuary staff provided training for porters in the transportation of deceased patients. Deceased patients were taken from the wards to the mortuary in specific concealment trolleys via a basement corridor that was not accessed by the public.
- A relative told us that the conversation informing the family that their parent was dying had been conducted in a ward corridor by a junior foundation year 2 doctor who was reprimanded for this by their registrar. On a separate occasion when a family were informed that their parent had cancer, they were told this by a ward consultant in a private room and in the presence of a Macmillan nurse. However, the family felt it was told to them in an insensitive way by the consultant who left the Macmillan nurse to pick it up in a more sensitive and compassionate manner.

Patient understanding and involvement

- The hospital scored 78% in the NCDAH for the indicator for health professionals' discussions with both a patient and their relatives or friends about their awareness that the patient was dying. This was 11% better than the England average.
- The hospital achieved its NCDAH organisational indicator for formal feedback process regarding bereaved relatives' or friends' views of care delivery (score 1/4).
- The death registration office told us they always listened to the family, explained processes to them and recorded their choices, such as cremation or burial.

Emotional support

- The hospital's score in the NCDAH for assessment of the spiritual needs of a patient and their nominated relatives or friends was 50%. This was better than the national average of 37%.
- We met with a relative who was with their parent in the last days of life. They told us about their experience of admission and care. They said reflexology, massage and counselling were all offered to them by the HPCT.
- A relative told us they had met a chaplain who had offered them support. We were told they did not have any spiritual needs or specific requests but found the offer of support helpful and said that they were spoken to in a sensitive and kind manner.

Are end of life care services responsive?

Requires Improvement

Ward staff found the hospital palliative care team (HPCT) to be helpful, supportive and responsive to their needs. We were told that HPCT staff would usually attend within 24 hours of a referral being made, although response times were not measured. Rapid discharge took a minimum of four days.

People's cultural and spiritual needs were met through an on-site chaplain. There was a lack of information available on the wards about chaplaincy services that were on offer to people. There was also a lack of information available on the wards regarding the HPCT's role. Due to resources, the HPCT was a reactive service rather than a proactive one, and awaited referrals from doctors rather than picking up referrals through general ward engagement. There was no method to extract from hospital data details of complaints that related to end of life care. There were a number of patients who remained in hospital although they were well enough to be cared for in the community. Single side rooms were available to patients receiving end of life care and visiting was unrestricted. However, there was no access to facilities such as tea and coffee making or food preparation.

Service planning and delivery to meet the needs of local people

- HPCT staff told us it was hard to deliver a service plan because it was difficult to get clinical academic group (CAG) leadership to engage with this. The culture within the service made it very hard to move anything on.
- Parking vouchers that entitled relatives of end of life patients to receive free parking were issued by the wards. We met with a relative who had been given parking vouchers by ward staff. However, they had been given a parking ticket despite having the correctly displayed voucher that entitled them to exemption from charges.

End of life care

- A family member told us they had been in the hospital with their loved one for three days. They had lived off sandwiches from the hospital shop; this had been okay for a day but not enough for a longer period. They had brought in a microwave meal but were not permitted to use the microwave themselves because of health and safety regulations. The kitchen on the ward was locked so they were unable to make their own tea or coffee. Staff did ask them if they wanted tea or coffee.
- HPCT and ward staff told us they now saw fewer chaplains on site because their working practices had been changed and they worked across all Barts Health sites. There was one chaplain based on site four days a week for bereavement support. There were always three chaplains on call, one Roman Catholic, one Muslim and one generic. There were also Christian and Jewish chaplains who visited one day per week and a Sikh volunteer one day a week. We were told that the chaplains would routinely visit the wards, interact with patients and staff, and engage with people on a variety of issues including spiritual needs at the end of life.
- The chaplain's office, death registration office, bereavement office and the registrar for deaths from the local authority were all conveniently located along one small corridor off the main hospital corridor.
- We met with a relative who was with their parent in the last days of life. When their parent was transferred from the assessment unit to the ward where they now were, the family were not informed of the move. They only found out when they came to visit and found their parent gone from the bed they had previously occupied.
- Ward staff told us they sometimes got requests for night-time ward transfers of end of life patients. It was not policy to move patients at night-time but this seemed to be overridden by the bed and site managers. Upholding this policy was sometimes down to the "strength of personality" of ward shift leaders on duty at night-time to refuse. Admissions could be any time of the day and night.
- The HPCT sent out a bereavement letter to relatives six to eight weeks after a patient's death; this included details of the support available.

Meeting people's individual needs

- One of the two 0.4 WTE consultants led a multidisciplinary team meeting one morning a week when patients with complex needs were discussed. Patients who had recently died were also considered. Bereavement risks were discussed; these included isolated patients, patients with cultural needs and complex relatives' needs. The same consultant who conducted the morning meeting carried out a ward round the same afternoon.Ward staff told us that the environment posed different challenges when it came to meeting patients' individual needs. For instance, there was nowhere to hold sensitive conversations with families. Ward and HPCT staff said they tried to accommodate patients receiving end of care in single side rooms for their privacy and dignity, but that it was not always possible.
- A family member told us they had not been home for three days because of the critical situation. They told us staff were helpful and welcoming, and they had slept in the ward's single room where their loved one was being cared for.
- The need for interpreters was met through over the phone translation service. Interpreters were available on site for face-to-face translation within 24 hours from when the request was made.
- There was no service leaflet for patients or relatives. The lead HPCT nurse told us one used to exist but it had become obsolete when the hospital merged with Barts Health NHS Trust over two years ago. It had not been replaced.
- There was a lack of information available on the wards to patients and their families regarding the chaplaincy or how to contact them. Chaplaincy services told us that information placed on wards tended to get removed and replaced with other information placed by ward staff.
- The death registration office managed the registration of deaths and gave priority to those who needed burial or cremation within 24 hours such as Muslim and Jewish deceased. The office managed the process of writing death certificates with doctors and checked on referrals to coroners. Family choices such as cremation or burial were recorded and explanations of processes were given to families.
- The multifaith area was located off the main hospital corridor and had a quiet, peaceful and calm atmosphere. It had a good standard of décor with clean floors and fresh flowers. There were information leaflets and posters on different faith initiatives such as prayer day and Sikh meetings. There was a separate Muslim prayer room.

End of life care

- A relative who was with their parent in the last days of life told us that the Macmillan cancer support centre had helped the family to organise benefit applications and council tax exemption. We were also told that the Macmillan person was only on site one day a week and covered the whole trust.
- The bereavement officer worked for external funeral services and managed the mortuary. They gave advice on funerals, managed release of the deceased for funerals, and carried out contract funerals and burials.
- The mortuary was categorised as a 'holding' mortuary and had twenty spaces. If there was a need for more spaces, this was managed by the bereavement service, which accessed a larger mortuary nearby, also managed by the external provider. At weekends, mortuary services checked on numbers with the porters. If there were fewer than ten spaces available, bodies would be transported to the second mortuary location. There was also a facility for bariatric deceased patients at the nearby mortuary. There were no post-mortems carried out at Whipps Cross.
- Porters were also trained by the bereavement service in the use of hydraulic trolleys. They could access the mortuary out of hours through the mortuary duty team. Viewings could also be arranged out of hours through the same process.
- The mortuary viewing area was clean, light and well maintained.
- The trust took responsibility for the maintenance of the mortuary but not for cleaning it. Before the trust's merger, the mortuary area was part of the hospital's cleaning schedule. This was a now a contentious point between the trust and the bereavement service. It meant there was uncertainty as to who took responsibility. The bereavement officer had taken on all cleaning responsibilities to ensure that cleaning was done. This included safe disposal of clinical waste.

Access and flow

- To be considered for support from the HPCT, a referral form needed to be completed by a doctor. This was then forwarded to the team by email or in paper form. Nurses could not refer to the HPCT directly and there were no telephone referrals; this could result in a delay in patients receiving HPCT support. However, we were told that advice would be given over the phone and the HPCT was responsive when new referrals were received.
- Ward staff found the HPCT to be helpful, supportive and responsive to their needs. For instance, they told us they generally had a good response from the HPCT and a good relationship with the CNSs; however, the palliative care consultants were only there if needed and generally not proactive.
- The HPCT aimed to see all new referrals within 24 hours. This target was not measured.
- Staff felt under pressure to transfer patients to the Margaret Centre (a hospice on site) and many of these patients had a short length of stay before death. Staff were aware of patient flow problems in relation to discharging patients from the hospital and into the Margaret Centre. We were told a new policy was not being followed correctly by bed or site managers. This resulted in inappropriate referrals of some patients because the centre had an empty bed, and a failure to refer others who would have been appropriate. On-call palliative care consultants did not have a say on admissions to the hospice. We were given examples of inappropriate hospital outliers being placed there by hospital bed managers because there was a bed, while complex end of life patients were not picked up for referral there. This was often because senior medical staff did not recognise that a patient had complex palliative care needs. The Margaret Centre often had empty beds because of this.
- The medical lead for palliative care, as well as HPCT nursing staff and consultants, believed there was a lack of oncology support at the hospital that prevented the HPCT from becoming involved with cancer patients' care at an earlier stage. It also meant that patients sometimes lacked an understanding of their prognosis or the progress of their illness. There was no general oncology opinion and the visiting oncologist responsible for the hospital did not always have the specialisation or interest for the site of the patient's cancer.
- In discussion with the discharge coordinator, we learned that there were 94 patients in hospital currently awaiting a community healthcare placement. Arranging additional funding could take 24–48 hours to be approved but then 2–3 weeks to arrange services if the patient had special needs.
- Wards reported issues with fast-track discharge for end of life patients. The discharge team dealt with these and it could take a week or more to arrange everything. They also reported it could take 3–4 weeks from referral to

community healthcare to placement. Some patients had waited two months after being well enough for a community placement. Wards also reported they were going to weekly meetings where prolonged stays were discussed; these would include discussion on the provision of continuing care, which normally took 3–4 weeks but was currently taking up to two months because of a backlog in the community. This was attributed to arranging equipment for home, establishing carers to visit at home or finding a placement in suitable nursing or residential home.

- A patient had been fast tracked for continuing care but was still in hospital a month after the application had been made. The ward sister told us there was a backlog for routine continuing care that affected people getting their preferred place of care. Rapid discharge took four days minimum and ordering a bed took two days. Care packages could take a week to put in place.
- It was also reported to us that there was a delay in getting continuing care assessments completed. Ward staff did these but they did not always have time. The HPCT told us they were sometimes asked to fast track referrals but did not have the capacity to do this. They had been asked to organise every aspect of a patient's discharge home: medication, GP input, community support and family concerns, but there were simply not the resources to do this.
- A HPCT consultant and CNS told us they had plans to roll out a rapid discharge audit and it was on their activity sheet as being undertaken. However, when requested during the inspection, no evidence was provided of an audit being either under way or planned. After the inspection, the trust showed us an audit registration form as evidence that is the audit was planned and in progress.

Learning from complaints and concerns

- There was no way to extract from hospital data details of hospital complaints that related to end of life care, in order to improve learning. The HPCT lead nurse told us there were plans to address this through the end of life care board.
- The service told us there had only been one complaint that they were aware of in the past year. We were given information about the complaint, which had been discussed with the patient's relative who had met with the trust's palliative care lead. This was fed into learning about appropriate access to wards, and communication between primary and secondary care, the GP and the hospital; it was then presented to the board.
- The HPCT saw its role as advocating on behalf of patients and relatives when there were issues related to the ward, care or treatment (for instance, access to single rooms, explanation of treatment and access to other support).

Are end of life care services well-led?

Inadequate

End of life care had no influence within the clinical academic group (CAG) structure and there was a lack of both strategy and resources that compromised the service's sustainability. The governance structure was not well supported by the CAG to which the end of life care services belonged. Recently the associate medical director had been assigned to a board link role and had attended the end of life care committee and specialist palliative care board meetings; however, these were in their early stages and were not well attended by those who were not directly linked to the hospital palliative care team. One designated member of staff had overall responsibility for palliative care across the trust. They were not a palliative care specialist, and specialist palliative care was only one part of their very wide role. There were difficult relationships between senior staff that hindered partnership working for the good of the service. There was no programme of audit or quality measurement in place.

Vision and strategy

- The HPCT became involved for symptom control and complex needs. There was no overall trust provision for end of life care patients, which was reflected in the lack of resources and strategy.
- There had been a restructure of palliative care services 18 months before. The aim was to standardise the trust's approach to end of life care. However, there remained a disproportionate spread of HPCT posts across the different acute sites of the trust and Whipps Cross remained under-resourced in comparison.
- The trust's lead cancer nurse, who had responsibility for palliative care across the trust, told us the remit of the

end of life care committee was to standardise the trust's approach to end of life care and provide integrated care between the community and the hospitals. however, we found no evidence of this.

- The trust's lead cancer nurse did not know if there was a trust-wide, or a hospital-specific policy on the national End of Life Care Strategy. The hospital did not have a local end of life care strategy to implement the requirements of the national strategy and the 2011 National Institute for Health and Care Excellence (NICE) guidelines.
- We were presented with a 'Strategy outline for end of life care in Barts Health 2014–19', which was dated November 2014. It identified key priorities that included education and training for ward staff, seven day services, audit, development of care packages and advance care planning. None of these was currently in place and staff were unaware of the new strategy.
- Neither the hospital nor the trust was currently involved in the systematic implementation of any of the enablers outlined in the national transform programme, such as AMBER, rapid discharge, advance care planning, electronic register and end of life care plans.
- There were no action plans and no specific body to take forward individual care plans for dying people. The expectation nationally was that such individual care plans would be implemented in all care settings in line with the five principles set out in the Leadership Alliance for the Care of Dying People (LACDP) report. The end of life care committee had recently been set up with the associate medical director to try to engage consultants with end of life care, but had not yet made progress in rolling out individualised care plans or gaining substantive attendance or support at meetings.
- Trust priorities regarding end of life care had not been identified.

Governance, risk management and quality measurement

- The HPCT had two entries on the risk register, both of which related to how a lack of staffing had had an impact on meeting patients' end of life needs. They had both been on the risk register since May 2013 but remained unresolved.
- The hospital did not achieve its NCDAH organisational indicator for trust board representation and planning for care of the dying (score 1/4).
- Specialist palliative care interests were not represented at board level. This role had been assigned to the medical director but more recently delegated to the associate medical director to take a special interest. For the associate medical director to take on a board link role with specialist palliative care should potentially help to give specialist palliative care services a voice within the cancer and surgery CAG which was trust wide and very large.
- The associate medical director now attended end of life care committee and specialist palliative care board meetings. There was an end of life care committee meeting during our inspection; this was the third time it had met.
- A specialist palliative care board meeting took place monthly. The meeting was attended by palliative care consultants from across the trust, a service manager, the heads of psychological services and complementary therapies, and senior nurses.
- The palliative care leadership within the trust had little influence so palliative care issues were not generally addressed. Specialist palliative care was not represented within the leadership of the cancer and surgery CAG to which it belonged.
- The trust's lead consultant for palliative care reported to the CAG clinical director. It was reported to us that the CAG clinical director had not had the opportunity to meet with their line general manager.
- Specialist palliative care was part of the cancer and surgery CAG within the trust structure. The dominant CAG within the hospital was emergency care and acute medicine (ECAM). This meant that the HPCT were not aware of ECAM's drivers and priorities. They did not coordinate with ECAM on any governance processes, which meant they had no influence. This left the HPCT to build relationships in a more informal way (for instance, role modelling by working with ward staff on end of life issues).
- In addition to the lack of engagement from the CAG, there was a reported lack of influence with the clinical commissioning group. Both the trust's medical lead and the HPCT lead for palliative care told us that a lack of understanding of the national end of life care agenda presented a challenge to delivering end of life care. An example was the use of 'the last two years of life' as a definition of those defined as at their end of life. The General Medical Council's definition is 'patients thought to be within one year of the end of life'. All the national

bodies such as the National Council for Palliative Care and NHS England use the term 'end of life care', so to use 'last days of life' for a two-year agenda was out of step and potentially confusing for specialists, non-specialists and patients.
- End of life care was not currently part of morbidity and mortality meetings within the CAG, which HPCT members felt was far from ideal. This was being addressed through the end of life care board meetings.
- No audits had been carried out. We were told the trust was not organised to measure the quality of services provided to patients receiving end of life care. The trust's clinical lead for palliative care was working on how this could be improved. One of the HPCT consultants was trying to set up an audit programme to cover, for example, rapid discharge, preferred place of care or death and referrals, but currently there was nothing in place.
- There was no action plan from the NCDAH.

Leadership of service

- The leadership role of the hospital's palliative care lead nurse was split between the hospice that was located on the Whipps Cross campus, the community palliative care team and the HPCT. Their role was currently being wholly directed towards the HPCT because the lack of resources.
- It was reported to us from a variety of sources that leadership working relationships could be difficult and not constructive. This was evident during interviews and was detrimental to the service. There were poor relationships between local leads and the trust.
- However, the specialist palliative care medical leadership supported the HPCT nurse leadership. Against a backdrop of reduced nursing staffing within the HPCT and the wards, this had a further impact on the service.
- The trust's medical lead for palliative care told us there was a paucity of management support and the quality was dependent on individuals. She felt the HPCT lead nurse was not receiving enough support or management. She told us it was her opinion that the trust needed an overarching specialist palliative care nurse manager as well as the trust's nurse lead for palliative care.
- The trust's medical lead for palliative care told us that the senior nursing structure did not recognise the established specialist palliative care way of co-leading the service between nursing and a lead clinician, and was making the whole thing "frustrating and painful".
- The trust's lead cancer nurse, with responsibility for palliative care across the trust, was not a palliative care specialist and did not have knowledge of palliative or end of life care; specialist palliative care was only one part of their very wide role. They told us they had been in post for six months. During this time, five senior cancer posts had been lost within the trust. Palliative care sat within the cancer and surgery CAG. They were meant to spend half a day on the Whipps Cross site each week but this did not happen every week because of the other commitments they had to meet.
- Two band 8c nurses with acute oncology experience were managing the whole of the cancer services; palliative care was only a small component of their work. This undermined the recognised role of multidisciplinary working that was essential to effective specialist palliative care. For instance, decisions regarding the nursing within the service were made by the oncology band 8c nurses without any consultation with specialist palliative care medical or nursing staff. However, specialist palliative care nurses had previously been involved in medical consultant interviews set up by the palliative care team lead consultant.

Culture within the service

- One of the two HPCT consultants told us that a lack of senior nurse management within the trust presented a challenge to the palliative care service. Trust finances meant that senior nursing staffing might be cut again.
- The HPCT lead nurse told us it was difficult to deliver a service plan because the CAG leadership did not engage with it. The culture within the service made it hard to move anything on. There was no positive attitude and no dynamism, so there was no planning or movement.
- HPCT medical and nursing staff told us they were constantly fire fighting. They felt they worked in challenging circumstances. Nursing staff told us their way of dealing with this was to get out, work on the wards and do what they could.
- The HPCT nursing staff were perceived by the ward staff as helpful and responsive.
- One ward manager told us morale had 'nosedived' and that 'go to' people were lost through re-banding and

redundancies. This was echoed by a ward consultant who told us that morale among nurses had been low since the trust's restructuring and that this was having an impact on patient care.
- A charge nurse told us budgets were very tight and line managers had to "penny pinch". Staff morale was low due to low staffing levels, in addition senior ward staff were on long-term sick.

Public and staff engagement

- The hospital scored 64% in the NCDAH for reviewing care after death. This was worse than the England average of 59%.
- A bereavement follow-up letter was sent out to relatives 6–8 weeks after a patient's death. 'Have your say' days took place annually for different patient groups.
- 'Have Your Say' days took place. These gave relatives the opportunity to meet with HPCT staff and discuss experiences and outcomes. They were held annually. One was happening at the trust on the day of our inspection.

Innovation, improvement and sustainability

- A consistent message we received from all nursing and medical members of the HPCT was that they were constantly fire fighting and that the service in its current form was not sustainable.
- A charge nurse told us they would like end of life patients to have the attention they deserved, but the reality was that issues with staff reduction meant that some practices could not routinely be done (for instance, checking patients every hour and having a nurse to be with an end of life patient if no relative was there at their death were not always feasible.
- A lack of collaboration made it difficult to bring together all elements of the trust to work positively for the sustainability of the service.
- A system of link nurses for palliative care and end of life was in operation before the merger. However, since the merger, staff redundancies and downgrading of nurses, and the departure of many staff, this had proved unsustainable and difficult to re-establish.
- One of the two HPCT consultants told us, "The organisation is too big. There is an overwhelming feeling of complete disempowerment. We are now attached to our third CAG in three years, there is constant change and dreadful continuity. There is no sphere of influence or control." They added "The biggest risk is that the whole team will stop caring and all will lose empathy."

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

There were over 500,647 first and follow-up outpatients appointments booked at the hospital in 2013/14. Clinics that were held in eight general outpatients' areas in the main hospital site included dermatology, rheumatology, fracture and orthopaedics, urology and gynaecology. There were separate areas for children's outpatients, ophthalmology and cardiology. Obstetrics and physiotherapy were among the most attended clinics, followed by trauma and orthopaedics, ophthalmology, gynaecology and cardiology. The imaging department occupied a number of areas within the hospital and included magnetic resonance imaging (MRI) and computerised tomography (CT) scanning, ultrasound, separate x-ray areas for outpatients, inpatients, oral x-ray and emergency cases. Doctors working in the hospital also provided services in a satellite service at the Silverthorne Medical Centre and Forest Medical Centre. However, on the day of the unannounced inspection, there were no services provided at that location. Therefore we were unable to speak with either staff or patients.

We visited the general outpatients, the breast clinic, oncology, radiology, women and children's outpatient clinics and cardiology department. We spoke with 37 patients and 11 relatives or carers. In addition, we spoke with 73 members of staff, including managers, doctors, nurses, radiographers and radiologists, administrators, receptionists and members of the health records team. We observed care and treatment and looked at care records.

Before our inspection, we reviewed performance information from, and about, the hospital and we requested additional information from the trust after our inspection.

Outpatients and diagnostic imaging

Summary of findings

Outpatients and diagnostic imaging services were not always safe, responsive or well-led. The service required improvements to ensure it was caring.

There were no effective systems for monitoring quality of the services and risks associated with its delivery. The hospital was unable to assess and respond to patients risk as the data collection was unsatisfactory and the system used for monitoring patients referral to treatment times and cancellations did not work effectively. The hospital was persistently failing to meet the national waiting time targets.

Staff felt disempowered and that they were unable to take initiative in order to improve the hospital's performance. We observed lack of leadership which led to staff feeling demotivated. Many of the patients experienced delays in their treatment as a result of lack of planning when changes were introduced. There were problems with access to information as patients' medical records were not delivered in a timely manner to outpatients clinics.

Although, we observed patients were treated with compassion, dignity and respect, patients did not always feel fully involved in decisions about their care and treatment.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Outpatients and diagnostic imaging services provided at the hospital were not always safe. There were systems for reporting incidents. However, it was not apparent that outcomes of the investigations were shared with staff or used for shared learning. Records in the outpatients department were not always stored securely. The hospital was unable to assess and respond to patients' risk because the data collection was poor and the system used for monitoring patients' referral to treatment times and cancellations did not work effectively. There was a variable level of compliance with mandatory staff training and the quality of the training did not meet staff expectations. We noted that the environment was clean and hygienic. Overall, there was a sufficient number of staff to run all the services. Incidents related to safeguarding were appropriately recorded and actions were taken to address them.

Incidents

- Staff had access to an online reporting form and told us that they were confident using it.
- Six incidents were reported for the outpatients and diagnostic imaging services through the Strategic Executive Information System (STEIS) between the financial year 2013-2014. Two of those incidents related to pressure ulcers grade 3, one to imaging reporting backlog, one to delayed diagnosis and two to safeguarding concerns. The incidents were adequately investigated and root cause analyses had been completed with learning points identified. For example, after the incident when a patient's diagnosis of breast cancer had been delayed, the protocol for collecting samples had been rewritten and an investigation undertaken by the trust.
- Incidents handling was discussed during outpatients board meetings. Some incidents were not assigned to the correct 'handler', which caused delays in responding because managers were unable to reassign an incident after it had been allocated to them.

- Thirty incidents related to imaging had been reported via the incidents reporting system used at the hospital. We observed that there were no trends or patterns of incidents occurring within the department.
- Eighty-two incidents relating to various outpatient departments were reported during the same period of time. Most concerned unavailability of records at the time of a patient's visit. Many others were booking related, when an appointment had not been made or was incorrectly booked and a patient's treatment was delayed as a result.
- We observed that, in over 60% of all cases reported through the system (incidents related to outpatients department), there were no clear actions taken in response. In addition, in over 90% of cases, the 'lessons learnt' section was not completed by the person responsible for investigating incidents. This meant that the system for reporting incidents was not being used appropriately, and there were limited opportunities for learning to take place in response.
- Two serious incidents took place within the radiology department in August 2014 and September 2014, but staff were unaware of these. Although both incidents were appropriately investigated, the department had not applied learning from them to prevent recurrence. We noted that the investigation report recommended sharing the incident with other radiology teams in October. However, none of the staff we spoke with about incidents referred to these two incidents.

Cleanliness, infection control and hygiene

- Clinical areas we visited appeared clean, and we saw staff washing their hands and using hand gel between treating patients. Toilet facilities and waiting areas were also clean in all areas we visited.
- We observed that hand sanitisers, although available in most of the areas, were not always easily accessible and there was no standardised way of positioning them. For example, in some areas they were placed on the reception desk and in others on the wall. They were not routinely placed near an exit or entrance to the area, encouraging people to sanitise their hands there and then.
- Personal protective equipment, such as gloves and aprons, was available for staff use in all areas where it was necessary.
- Hospital infection control audits for individual outpatient clinics were led by the decontamination lead and the area lead. We noted that those audits mostly highlighted good practice and that, when improvements were needed, these were clearly recorded and shared with the area lead and the manager of the outpatient department.
- There was no departmental purchasing policy to ensure compatibility and safety, or to address ease of cleaning of the equipment purchased.
- There were no written procedures for decontamination of endoscopy equipment and no decontamination training lead had been identified in the endoscopy clinic.
- We observed that some floors within the diagnostic imaging department had carpets. These could not be cleaned easily. Staff we spoke to were unclear as to how often they were cleaned or the method used. We also noted there was carpet in the entrance and waiting areas in the MRI department.

Environment and equipment

- An audit completed by the decontamination lead in July 2014 showed no evidence of planned or unplanned maintenance for the endoscopes used in the ear, nose and throat clinic. Staff did not follow manufacturers' instructions relating to maintenance or decontamination of rigid endoscopes. In addition, manufacturers' instructions were not easily accessible to staff.
- There was no planned programme for replacing equipment used in the outpatient department. For example, endoscopes used in gastroscopy were not routinely exchanged.
- Equipment used in the diagnostic imaging department had been checked regularly and serviced in line with published guidance.

Medicines

- We observed that medicines were mostly stored securely. They were kept in locked medicine cabinets to which only nurses had access. We observed that medicated ointments were left overnight in the ear, nose and throat clinic in unsecured rooms and on open shelves. This was against the published guidance relating to medication storage.
- All emergency medication and emergency equipment was in place on up-to-date resuscitation trolleys, and it was checked daily.

Outpatients and diagnostic imaging

Records

- The trust aspired to have 98% of medical records available at clinics. The hospital was not meeting this target and some patients told us their records were not available at their appointment. The trust reported that between 4% and 10% of records were not available at the time of a patient's appointment (October – November 2014). This contradicted the information received from nurses and doctors working in outpatients who reported that on some occasions as many as 40% of patients attending the clinics had been provided with temporarily created records only.
- The clinical records kept were a combination of electronic records and paper files. When records were in the outpatient department, they were not always stored securely. There were secure lockable trolleys available for records transfer and storage. However, we observed that these were not always used. For example, in ear, nose and throat departments, medical records were not locked away overnight. We observed patients' lists left on the reception desk and personal files left in individual consulting rooms. There were also records stored on unsecured trolleys in openly accessible areas. Electronic records were available only to authorised people, and computers and computer systems used by the hospital were password protected.
- Numerous nurses and doctors across all clinics told us that patient records were frequently not delivered to them on time, or that they were only given a patient's temporary file that contained very limited information. Nurses and receptionists told us that missing notes could usually be found on the day of the appointment, but this caused delays to patients' appointments.

Safeguarding

- All staff were required to complete the level 1 safeguarding course for children and adults every three years. This course was delivered via a booklet or as an e-learning course. In addition, doctors, nurses and other staff members dealing directly with patients were required to complete level 2 training every three years.
- We noted that incidents related to safeguarding were appropriately recorded and actions taken to address them.
- Staff we spoke to, such as doctors, nurses, healthcare assistants and staff working within the diagnostic imaging department, had relevant knowledge of the safeguarding procedure and were able to promptly access the trust's protocols and policies related to safeguarding.

Mandatory training

- All staff were required to complete mandatory training in health and safety, fire safety, fraud awareness, infection prevention and control, bullying and harassment, and dignity at work. Most of the courses were completed every three years; others, such as information governance, annually. A general manual handling course was to be completed by all staff every five years with clinical and medical staff completing it bi-annually. Fraud awareness and security courses were completed once only, when a member of staff started employment.
- All nurses, doctors and non-medical patient-facing staff were to complete a patients' identification course annually,
- Mandatory training compliance rates varied between 65% for the staff working in dermatology and 89% for those working in the sexual health clinics. The training completion rate provided by the trust before the inspection indicated that the overall training completion rate for the administration teams varied between 75% for those working in medical outpatients' clinics and 97% for the '18 weeks team' (team managing admissions, cancellations and referrals). The trust also told us that 98% of all nursing staff working in the outpatient department were up to date with their training and 80% of nurses working at the Silverthorne Medical Centre. This positive training rate compliance data contradicted information provided by the trust after the inspection that indicated a low compliance rate for infection control training. This varied between 0% for audiology services, 18% for radiology medical staff, 33% for ear, nose and throat medical staff, and 90% for junior medical staff. Similarly, there was a large variance in compliance relating to basic life support training: 100% among staff working in the sexual health clinics, 82% among radiology medical staff, 22% for ophthalmology, 17% for the orthodontic service and 0% for audiology services.

Outpatients and diagnostic imaging

Assessing and responding to patient risk

- There was a rapid access chest pain clinic that provided early specialist cardiology assessment for patients with new onset of exertional chest pain. This was a walk-in clinic for patients who had a referral from their GP.
- There was emergency equipment available to respond in the event of emergency. The equipment was easily available and checked daily.
- The system used for monitoring patients' referral to treatment times to identify those who had waited for a prolonged period of time or whose appointments were multiply cancelled did not work effectively. This meant that patients were at risk of receiving delayed treatment and that their health could potentially deteriorate further. The trust told us that they had written to all the GPs and external organisations working in partnership with the hospital to inform them of the problems and to ask them to get in touch with the hospital if they identified any patients at increased risk.

Nursing staffing

- There was a matron for the outpatient department. However, they were not based at the hospital to manage the day-to-day management of the department. The matron was responsible for all outpatient services run by the trust. There was a nurse lead working at the hospital responsible for overseeing the day-to-day running of the service. They were also responsible for organising the rota and supervising and assisting staff on a daily basis.
- A senior nurse told us that agency and bank nurses and healthcare assistants were used only in an emergency. There was a sufficient number of staff in post to run all the scheduled clinics and extra evening and weekend clinics. The executive team told us that the trust was continuously recruiting nursing staff and looking to fill 95% of all posts across the hospital.
- The sickness rate for the outpatient department was worse than the hospital average of 3.4% (February 2013 to July 2014, including phlebotomy). It was at 6% among allied healthcare professionals 4.2% among nursing staff and 3.5% for administrative and clerical staff. The rates were also worse than the North Central and East London average (varying between 3.1% and 3.6%, February 2013 to March 2014). Similarly, for diagnostic imaging, the rate was worse than the hospital average among administrative and clerical staff (5.4%) and nursing staff (5.5%). However, we noted that it was better for allied healthcare professionals, including radiographers (2.4%). We did not observe absence of staff to have an impact on the care and treatment of the patients who attended the outpatient clinics and diagnostic imaging department.
- Use of agency and bank staff was infrequent in outpatients and phlebotomy in 2013/14 (1.9%), and it was better than the average for the hospital (10.3%). However, we observed that in diagnostic imaging and the nuclear medicine department the use of temporary staff was worse in 2013/14 (approximately 12.7%).
- There was a good level of retention of staff within outpatients. The percentage of employees who left the outpatient department, measured in September 2014, varied between 13% among administrative and clerical staff, 8.4% among nurses, and 0% for allied healthcare professionals. For the diagnostic imaging department, it was recorded at 10.4% for allied healthcare professionals, 12.9% for medical staff and 0% for nursing and administrative staff. The overall rate for both departments was in line with the England average (8.1% between August 2013 and August 2014) and better than the hospital's average (13.4%).

Medical staffing

- Most of the doctors employed by the trust were registrar grade doctors (specialty registrar [StR] 1–6; 46% for medical specialties and 57% for surgery) who worked alongside specialist consultants (29% of all medical and 31% of surgery doctors). The percentage of consultant group was lower than the England average (33% for medical and 40% for surgery); the number of registrar doctors was significantly higher (England average 39% within medical and 37% within surgery specialties). The total number of foundation year 1 and 2 doctors (22% for medicine and 8% for surgery) was in line with the England average for medicine but lower than the England average for surgery (13%). There was fewer middle career doctors (at least three years at 'senior house officer' level or a higher grade within their chosen specialty) when compared with the England average (4% in both specialities compared with the England average 6% in medicine and 11% in surgery).
- Overall, we observed there was a sufficient number of doctors to run all scheduled outpatient clinics.
- The diagnostic and imaging department was heavily reliant on agency locums with 25% vacant posts among medical staff. There was a high medical agency locum

use recorded in 2013/14 (22%), with large variations from one month to another. The highest locum doctors' use was reported in June 2013 (52%) and July 2013 (62%), the lowest in May 2014 and November 2013 (0%). The overall rate for the department was much worse than the hospital average of 11% (February 2013 to July 2014).

Major incident awareness and training

- There was a major incident and business continuity plan drawn up for the hospital in August 2014 by the emergency planning team informed by the commissioning board's emergency planning framework and in accordance with other guidance such as the NHS Commissioning Board's 'command and control' and 'business continuity management framework'. It informed local managers and staff how to act in the event of a major incident, or one that could not be dealt with using regular operational protocols.
- We noted that not all staff were aware of how to act in the event of fire, or of individual staff responsibilities. The responses provided by nurses, healthcare assistants and administrative staff contradicted each other and did not follow the fire safety evacuation protocols.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Suitable clinical guidelines were followed for different patient pathways. Patients consent was sought appropriately. Staff were competent and knowledgeable. However, not all of them had been appraised. There were also problems with access to information because patients' medical records were not delivered in a timely manner to outpatient clinics. There were problems with records storage, and organising and tracking records, which caused delays for some patients.

Evidence-based care and treatment

- There was no dedicated service for a one-stop breast clinic as recommended by national guidelines.
- Although the hospital consistently failed to meet referral to treatment targets, we observed that the access and management policy was up to date and informed by the national access targets, as defined in the technical guidance of the national annual operating framework issued by NHS England. It was a corporate policy developed for all locations managed by the trust.
- A radiation safety survey was completed in October 2013 to ensure compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). Overall, staff showed good awareness of radiation protection requirements. The survey also highlighted areas for improvement, such as protocols that needed to be updated and controlled to ensure that current versions were easily accessible to staff. Staff was also advised to have risk assessments carried out for routine procedures and for specialised procedures. It was recommended that hard copies of exposure charts and standard techniques were made available.
- There was a policy on radiation safety. It was in line with current regulations such as the Medicines (Administration of Radioactive Substances) Regulations 1978 (MARS78), Equipment used in connection with medical exposure. Guidance Note PM77 from the Health and Safety Executive 2006, IRMER and the Environmental Permitting (England and Wales) Regulations 2010 (EPR10). It set risk management strategies and incident reporting procedures. It also highlighted duties and responsibilities of various staff in relation to radiation safety.
- There were clear standard operating procedures set for diagnostic x-ray and nuclear medicine as required by IRMER. These addressed patient identification and responsibilities of individual members of staff, and also set training requirements.

Pain relief

- There was a chronic pain and pain interventions clinic run at the hospital. There was also a rapid access chest pain clinic (RACPC) that provided a quick and early specialist cardiology assessment for patients with chest pain.
- Results of the National Cancer Patient Experience Survey 2013 suggested that patients did not always feel staff did enough to control side effects of radio or chemotherapy, or to control pain in general.

Patient outcomes

- The follow-up to new appointments rate for the hospital varied between 2.1 and 2.5 in 2013/14. This was in line

with the England average (2.253). We were unable to analyse how these corresponded to individual specialties because the trust was unable to provide us with suitable data.

- The trust had been the worst performing trust in London for the quality of cancer staging data collected in 2012/13 (the process of identifying the severity and treatability of a patient's cancer). The trust only recorded data for 30% of cancer patients. In 2013/14, this increased to over 80%. Improving the consistency of staging data was also a local Commissioning for Quality and Innovation (CQUIN) goal in 2013/14 at Whipps Cross University Hospital and this was successfully delivered.
- One of the hospital priorities in 2013/14 was to help reduce the number of patients who smoked. The trust agreed a local CQUIN goal with the local commissioners, under which front-line staff at the hospital would refer 1,770 smokers to stop smoking services by March 2014, including 1,350 outpatients. The hospital had achieved this target.
- The trust scored among the poorest performing trusts in the National Cancer Patient Experience Survey 2013 and a survey run by Macmillan Cancer Support. The trust told us they had set up a steering group to coordinate actions taken in response to this survey. However, members of the local Healthwatch told us the cancer services meeting with patient representatives, which was supposed to inform the improvements and future actions, was cancelled and the trust did not rearrange it. The chief nurse told us there was now improved provision of patient information across the hospital for every type of cancer, and redesigned information for two week wait appointments, diagnostic services, research and clinical trials, and tests and symptoms. Doctors were given checklists to ensure consistency and these were used in outpatient clinics and in diagnostic imaging services. A chemotherapy prescribing system had been rolled out at the hospital in order to increase patients' involvement in managing their own care, improve workflow by providing staff with immediate access to patient records, and improve ordering and pharmacy dispensing.
- There was an eye rapid access clinic and a chest pain rapid access clinic at the hospital Monday to Friday. Both clinics provided a walk-in service.

Competent staff

- In general, nurses, healthcare assistants, doctors and staff working in the diagnostic imaging department were competent and knowledgeable when spoken to.
- The appraisal rate within the clinical academic group (CAG), which included outpatient departments and diagnostic imaging, was 64% (July 2014). The trust had failed to provide us with detailed data relating to staff appraisals. This would have been specific to staff groups working within individual outpatient clinics and modalities within the imaging department.
- The trust did not provide evidence of regular supervision or one-to-one operational meetings and we were unable to confirm that those took place regularly. Some nurses told us that they had occasional one-to-one meetings, but these were not recorded.
- There was a competency framework for new staff to the service, completed within the first 3–6 months.
- There was a teaching programme for staff development. Nurses, radiographers and healthcare assistants told us that, although the trust supported training, it was mostly done using e-learning tools or via a booklet. Statutory and mandatory training booklets were sent to all trainees on their induction day. Nurses told us they did not feel this was effective and that they would prefer face-to-face training.
- A junior doctors' survey organised by the General Medical Council indicated that doctors working at the Silverthorne Medical Centre were satisfied and mostly happy with their clinical supervision. However, they were not always given feedback related to their performance. The survey also indicated that trainee doctors working in the trauma and orthopaedics clinic were not fully satisfied with their induction or clinical or educational supervision. There was an induction planning group that met weekly to discuss the corporate induction programme and issues. An action plan developed in August 2014 indicated that an induction training audit would be completed across all specialties; however, at the time of the inspection, this had not been completed. The action plan did not give a deadline for its completion. Doctors working within dermatology were among the most positive respondents to the survey.
- The staff had introduced a new electronic health records system and asked a number of staff to become a 'care records service champion' so they could support others in learning how to use the system. Staff who were

chosen or who volunteered to be champions told us they had been given no extra training, and they did not feel fully competent and well supported by the trust to fulfil this role.

- Administrative staff working at the hospital told us they did not have regular team meetings and the occasional meetings planned were often cancelled. They complained that there was no opportunity for them to express their views, share experiences, discuss challenges in their day-to-day work or learn from one another.
- Staff working in the call centre dealing with day-to-day patients' queries told us that they had not been given any formal induction. We noted that most of them were employed by an agency and used on 'when required' basis. After the inspection, the trust told us the follow up appointments call centre had 30% agency staff, new appointments had 20% and the 18 week wait and 2 week wait teams had no agency staff at the time of visit.

Multidisciplinary working

- Shared pathways worked well and patients told us that, when external agencies were involved, communication was effective.
- Trust staff told us they had not always managed to report outcomes of outpatient consultations back to the referring GP within 48 hours of the outpatient appointment. The trust told us there were no systems to check how the hospital performed in relation to sending outcomes reports and patient's discharge letters.

Seven-day services

- Most of the outpatient clinics ran from Monday to Friday. They were scheduled to run from 8am to 5pm, but a few of them often overran (notably, the breast clinic or trauma and orthopaedics). The phlebotomy service was not always available to outpatients because it ran Monday to Friday 8am to 4.30pm. Also, patients' calls were only answered until 5pm, Monday to Friday.
- Occasional evening and Saturday morning clinics had been organised in the main outpatients to minimise waiting times. We noted that these were not often enough to reduce a backlog and prevent the risk of breaching the waiting time limits.

Access to information

- The records team were re-labelling the medical notes at the hospital because there were two different systems used for identifying patients' records, and this made accessing notes difficult because their location could not always be verified. Staff also told us that not all nurses and doctors used the tracking system available at the hospital.
- There was an insufficient storage facility at the hospital, which caused further problems with organising and tracking records. The hospital was planning to convert a wheelchair service store and energy store to increase the storage facilities by the end of 2015. However, this was dependent on the funding available and plans had not been signed off by the executive team at the time of our inspection.
- Doctors and nurses told us they had limited time to check whether all medical records had been delivered as requested. Records were delivered on the day of the appointment and, if any notes were missing, those patients were required to wait until the notes were found. An audit of patients' waiting times (waiting time on the day of the appointment) completed in October 2014 indicated that patients waited an unnecessarily long time before their appointment because their notes were not available on time. Doctors and nurses told us that patients often waited for up to two hours before their notes became available. We were also told that often only temporary notes were delivered to clinics, with no information, or only limited information, available to doctors. The trust told us temporary notes included "all available information from the electronic system and any discharge summaries", and they should also "encompass all aspects of the patient's care across all specialties to give a comprehensive view of the patient's treatment". During our inspection, we viewed temporary notes prepared for patients attending various clinics and in many cases the folders prepared were empty. This meant that appropriate information was not available to support clinical decisions made. The trust had developed an action plan in October 2014 to address issues of records availability, and it hoped to recruit extra staff, allocate extra space for storage and organise weekly meetings in which the impact of the improvement plan would be monitored.
- The trust reported that between 4% and 10% of records were not available at the time of a patient's appointment (October–November 2014). This contradicted the information received from nurses and

doctors working in outpatients who reported that on some occasions as many as 40% of patients attending the clinics had been provided with temporarily created records only.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Medical staff were required to complete a one-off course on patient consent. This was informal training delivered during their local induction. Patients told us they were asked for consent to procedures appropriately. They told us staff always spoke to them about any procedure before carrying it out.
- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.

Are outpatient and diagnostic imaging services caring?

Requires improvement

Outpatients and diagnostic imaging services were not always caring. Patients did not always feel fully involved in decisions about their care and treatment, and were not always given information in an understandable way. There was no psychological support routinely available to patients. However, we observed that patients were treated with compassion, dignity and respect. Many we spoke to felt they were offered a kind and caring service.

Compassionate care

- We observed patients being treated with compassion, dignity and respect. This included reception staff being polite and explaining if there was a waiting time.
- Patient consultations took place in private rooms.
- The environment in the reception area of the outpatient department did not allow for confidential conversations. In many of the clinics, the waiting areas were situated in main corridors. Staff were sensitive to the lack of confidentiality; they told us that, if there was a need, they would use a quiet room to discuss confidential matters.
- The hospital started using the NHS Friends and Family Test in October 2014 as required by NHS England. This is a single question survey asking patients whether they would recommend the department to their friends and family. At the time of the inspection, we were unable to compare scores with other hospitals because of unavailability of data at the early stage of the data collection. As indicated by responses gathered during the first month, most patients would recommend the service to their friends and family.
- Chaperones were provided whenever needed. Staff told us that no specific chaperone training had been given to them.

Understanding and involvement of patients and those close to them

- Patients told us they felt they were mostly involved in their care. They said that, if they had any queries regarding appointments, they would contact individual clinics or medical secretaries. However, some of them told us it was difficult to get in touch with the right person and on occasions they were required to visit the hospital in person because they could not get in touch by telephone.
- Results of the National Cancer Patient Experience Survey 2013 suggested that patients did not always feel fully involved in decisions about their care and treatment, or were given full information regarding potential side effects, test results or choice of treatment. The survey also indicated that doctors had not always explained test results fully and in an understandable way, or provided patients with written information that was easy to understand.
- There was written information available for patients. Some of these leaflets had been produced by the trust and other items had been provided by external agencies such as the Royal College of Ophthalmologists.

Emotional support

- There was no psychological support routinely available to patients. The governance manager told us there was a plan to recruit a psychologist in the future; they were preparing a business case but were uncertain of the timescale for it.
- A Macmillan's Cancer Support centre operated at the hospital Monday to Friday. This provided support and advice to patients who had cancer and their relatives and friends. There was a wide range of printed information available (for example, on various types of cancer, how to access financial support, or how to break the bad news to a relative or a friend).
- Results of the National Cancer Patient Experience Survey 2013 indicated that patients were not always told they could bring a friend to hear the diagnosis, for a

follow-up appointment, or when they first received treatment. Only 81% felt they were told sensitively that they had cancer; this was worse than the England average of 93%.

Are outpatient and diagnostic imaging services responsive?

Inadequate

Outpatient and diagnostic imaging services were not responsive. The trust was persistently failing to meet the national waiting time targets. Many patients experienced delays in their treatment as a result of lack of planning to introduce the electronic patient records system or when transport arrangements had changed. Patients complained that they were unable to get in touch with the hospital.

Service planning and delivery to meet the needs of local people

- The management of the hospital did not plan well for the introduction of the electronic patient records system to the hospital in May 2014. This caused issues around patients not receiving letters or not being known to the system, and increased waiting times for appointments. Local Healthwatch members told us patients were phoning up to find out when their follow-up appointments were, but it was difficult to get through and phones were not being answered. Some patients told us they phoned multiple times because there was no response; others said they had to visit the hospital to make a booking. Examples were reported by the patients' panel of how the new system booked appointments with doctors who no longer worked at the hospital, and how patients were coming in for clinics that did not take place on the day of their visit. Patients attended with wrongly generated letters and were sent back to their GP for another referral.
- The hospital had problems with issuing patients' letters because one of the servers had stopped working at the end of June 2014 for a period of over two weeks. The letters were not forwarded to the external contractor who was responsible for distributing them. This caused an extensive backlog (approximately 40,000 letters) and resulted in patients missing appointments. The trust told us this issue had been resolved and we did not find it affecting patients at the time of the inspection.
- The hospital undertook an audit of patients' waiting times in October 2014 (time from patients' arrival at the department on the day of their appointment). This audit indicated that 44% of patients were waiting for longer than 30 minutes. The audit did not indicate maximum waiting times and how these corresponded to the appointment times indicated on patients' letters; therefore it was of limited use in indicating actual performance. Patients often waited for over an hour with maximum waiting times of 4 hours. We observed that, when clinics involved multiple or timely tests, this was indicated on a patient's appointment letter so patients were aware of what to expect on their arrival and could plan their day accordingly. Long waits were experienced in ear, nose and throat (both adults and children), orthopaedics, colorectal and urology clinics with missing notes often being listed as the reason for delay. In each of the clinics there was a board with the name of the doctor working on the day and the waiting time listed next to it. We observed that the waiting times were not always accurate and in some clinics were not updated from one day to another. Patients also told us they had observed staff updating waiting times only when they were aware that an inspector was around.
- We observed that calls from patients were responded to by call centre staff working in an open plan setting. These staff were based behind the busy main outpatient reception desk, an environment that did not allow for private conversations to take place.
- If patients needed general plain film x-rays, they could use the walk-in service Monday to Friday 9.30am to 3.30pm. Other modalities, such as ultrasound, required patients to pre-book appointments.

Access and flow

- The level of 'did not attends' at the hospital (varying between 7% and 8%) was slightly worse across 2013/14 that the England average (between 6% and 7.3%). We observed that this had steadily increased since May 2013 with a major increase in the second half of 2014. The 'did not attend' rate for the first week of November 2014 was reported at above 18%.
- On average, 11% of outpatient clinics' appointments were cancelled by the hospital and 11% on patients' request from April 2013 to March 2014. The trust listed the main reasons for these cancellations in the following order; doctors on annual leave, doctors taking sick leave and appointments booked on clinical audit days. While

it is understood that sick leave could not be foreseen, booking appointments on days when doctors were on annual leave or on days when clinical audits were organised should not take place. There was a policy that required doctors to give six weeks' notice before taking annual leave, to ensure that there was sufficient time to plan appointments around doctors' availability. Doctors we spoke to were aware of this policy.

- The trust was unable to meet the two week urgent referral wait performance target in every month since April 2013 (people seen by a specialist within two weeks from the time when an urgent GP referral was made; all cancers).
- The trust had performed worse than the England average in every month since June 2013 in relation to the 62 days target (percentage of people waiting fewer than 62 days from urgent GP referral to first definitive treatment; all cancers).
- The trust performed worse than the England average and was unable to meet the target related to the percentage of people waiting fewer than 31 days from diagnosis to first definitive treatment (all cancers).
- The trust reported that waiting times and activity for diagnostic tests and procedures were completed mostly within 6 weeks, with 87% waiting less than 4 weeks (September 2014). Overall, 99% of patients were waiting fewer than six weeks and this was in line with the England average. However, there was an insufficient number of appointments available for urodynamic tests and 25% of patients waited longer than six weeks, with a longest wait of elven weeks. There were also longer than expected waits for colonoscopy, cystoscopy and gastroscopy with some patients waiting longer than 13 weeks for the procedure to be completed.
- The computer system used for monitoring referral to treatment targets and patients' attendance was not able to report on patients' appointments that were cancelled more than once. This meant that the hospital was unable to monitor multiple cancellations and, when scheduling appointments, to prioritise patients whose appointment had been cancelled on more than one occasion. A general manager told us this would become part of the integrated outpatient dashboard and was under development at the time of the inspection.
- Not all the calls from patients ringing to rebook follow-up appointments were answered. The trust reported that only 80% of calls were answered, due to an issue with the phone system that prevented callers from getting through.
- Consultants told us they had no control over patient waiting lists and were reliant on the booking system to work effectively and on support from the central appointments manager and service manager. They had no authority to book extra clinics to address issues with long waits. Doctors and nurses told us the hospital's escalation process for when there were no appointment slots available did not work well because, after escalating to the service manager, they waited a long time to hear back from them and have extra clinic slots agreed. We observed that the escalation protocol drawn up in September 2014 required staff to take 'appropriate remedial actions' at various stages of the escalation process, but without describing what these were. Staff could not tell us what the remedial actions the procedure referred to were. We observed that the escalation procedure for when there were issues regarding availability of appointment slots contradicted the processes outlined in the standard operating procedure for urgent referrals (two weeks' wait). This meant that staff could not be clear as to which procedure they should use, and whose responsibility it was to escalate the issue to the general manager.
- Across June and July 2014, there was a backlog of referral letters to be scanned into the electronic patient record system. Clinic outcome forms had not been managed in line with agreed process and, at the time of reporting, this issue was affecting over 10,000 patients. This meant that patients' pathways might have been delayed resulting in poor patient experience and treatment delays. There were assurance meetings held to support the recovery plans and improve the position across outpatients. These were being led by the director of contracts and performance, in conjunction with medical and deputy medical directors. There were no effective systems to identify urgent patients.
- The afternoon breast clinic overran regularly by approximately 2–2.5 hours. Nurses working at the clinic told us no actions had been taken by the management to ensure that appointments were managed more effectively and to prevent delays and clinics overbooking.

- Admissions, cancellations and referrals were managed by different teams. For example, there was a '2 weeks team' and a separate '18 weeks team'. We noted that staff working within these teams were not well supported and did not communicate routinely with each other. Most of the staff were employed via agencies. The service appeared disjointed and lacked oversight, which had an impact on patient flow.

Meeting people's individual needs

- Staff told us that they had ready access to a translation service should they need it. This meant that patients, for whom English was not their first language, could engage fully in their consultation.
- All doctors, nurses and other staff who had direct contact with patients were required to complete a dementia awareness training every three years. This training was provided via a booklet or as a 90-minute e-learning course. The hospital was working towards achieving a target of at least 75% of patients identified as being at risk of dementia to be assessed and referred on for specialist input. The hospital did not achieve this target; most of the data before March 2014 was collected manually and not all the departments were aware of the target. The trust was working towards improving the outcome by "developing robust recording systems that were clinically appropriate and easy to use" as described in the trust's business plan.
- Patients with mobility difficulties, who were dependent on transport being provided by the hospital, experienced major difficulties in June 2014, after the trust had changed the transport arrangements. Patients' representatives reported that a lot of journeys were missed, some patients were not collected from home, others were brought in too late for their outpatient appointment and were then taken home without having seen anyone. In particular, patients who attended the hospital often (for example, those who needed dialysis) were affected by the changes. The planning had been poor; the trust had not prepared an impact assessment to gauge the intended and unintended, positive and negative impact of the changes introduced. This was treated as a serious incident by the trust. The clinical director had met with patients to apologise, and members of the estates team were allocated to deal with organising patient transport at the most critical time. The trust said they would set up a patient reference group in relation to this, but this did not happen. At the time of the inspection, we noted that there were no complaints or concerns reported by patients or staff relating to transport services. The chief nurse told us the transport service had improved and, overall, they have noted improvements in patient pathways and flow.
- There was drinking water and other refreshments available in the waiting areas. There was a regular trolley round when patients could choose from a selection of hot drinks. A senior nurse told us that this was introduced to minimise the negative impact of long waiting times at the clinics.
- We observed that there was insufficient seating in most of the outpatient clinics. Clinics appeared well attended and we observed that in some areas all seats were occupied and patients needed to wait in the corridors where extra seating was arranged. We observed that patients for the sexual health clinic were required to sit in the main corridor underneath the sign 'sexual health clinic', which potentially compromised their privacy.

Learning from complaints and concerns

- Information on how to complain was easily available in the waiting areas.
- Complaints were appropriately recorded and responded to. Complaints and general trends were discussed at the monthly outpatient services board meetings. These mostly concerned patients not being able to get through on the phone and administrative errors (for example, patients being recorded as 'did not attend' incorrectly). There was 257 complaints reported that related to outpatient departments between April and September 2014.
- Forty complaints related to imaging were reported during the same period of time. Most of them related to difficulties in getting in touch with the appropriate department, staff attitudes and other communication difficulties.
- In July 2013, the trust introduced a centralised telephone call hub, so all complaint calls could be managed from one location across all sites. There was one phone number and one email address. Nurses and healthcare assistants told us this was not effective and staff presence was required to help support the local resolution of issues. The trust told us the office would be staffed three times a week and that they were working with volunteers to further improve the service.

Outpatients and diagnostic imaging

- The hospital recorded double the number of complaints received between July and September 2014 when compared with the same quarter the previous year (717 compared with 343). The trust told us the increase was mostly accredited to the outpatient departments and reflected the operational and service issues experienced in the reporting period, such as difficulties with booking appointments and problems with the telecom system. In addition, the Patient Advice and Liaison Service (PALS) told us the service was better advertised and they thought it was more accessible than in the past. Most PALS contacts had been responded to or resolved or responded to within 48 hours. had been resolved or responded to within the 48-hour timescale set by the trust (87%). However, the performance of the hospital then slightly declined with 82% of all complaints being responded to in September. This was due to staffing because there was a vacant post in PALS and one member of staff had been on long-term leave. We observed that the PALS office was open and staffed at the time of inspection. However, members of the patients' panel told us it was open during the week before the inspection for the first time in over a year.

Are outpatient and diagnostic imaging services well-led?

Inadequate

Outpatients and diagnostic imaging services were poorly led. We observed a lack of both leadership and long-term vision that had led to staff feeling demotivated. Staff felt disempowered and unable to use initiative to improve the hospital's performance. The senior management of the hospital were slow to address long-standing issues of bullying and harassment experienced by members of staff. There were no effective systems for monitoring the quality of services and risks associated with their delivery.

Vision and strategy for this service

- The trust's vision and values were not always understood or fully supported by the staff. Some nurses and healthcare assistants told us there was limited opportunity to express their concerns related to developments within the trust and how these affected their day-to-day work.
- Staff were able to identify the challenges they saw to their own service. They told us these were mostly linked to limited capacity to accommodate an increased number of patients in a few of the clinics and lack of control over organising outpatient clinics. Most felt they had no control in improving the trust's performance in relation to referral to treatment targets. They were unaware of the key performance indicators set for their clinics and how they performed in relation to them.

Governance, risk management and quality measurement

- The trust did not have systems that allowed performance and quality monitoring and they were not always able to provide us with required information promptly. Nurses and healthcare assistants working in the outpatient department told us that audits and quality improvement projects were not always discussed with the staff. There was a limited opportunity for learning to take place.
- There were monthly outpatient services board meetings chaired by the general manager and attended by the service manager, health records manager, central appointments manager and a matron of all outpatient services provided by the trust. They were also attended by a senior nurse and a service manager responsible for the outpatient department at the hospital. We noted that the team had discussed issues related to staffing levels, mandatory training, availability of health records and data collection. When actions needed to be taken, these were clearly allocated and followed up at the next meeting.
- Staff monitored action plans to ensure that recommendations from the previous CQC inspection had been implemented. However, we found that the trust had made limited progress in achieving compliance with regulations and make improvements required as highlighted during our inspection in 2013. For example, we had asked the trust to ensure that the hospital's risk register was managed more effectively. Nurses and healthcare assistants were not aware of what the risk registers and risk management plans contained. There were no local risk registers that would list risks related to individual specialties, clinics or modalities within the imaging service group. In addition, we had asked the hospital to address issues around waiting times (for the first appointment), but this had

not been done. We had also highlighted that patients had difficulties contacting outpatient departments, but we observed that no improvements had been made to improve service accessibility.

- The service did not routinely monitor quality and how it performed against targets. There was no effective operating system that would allow the monitoring of departments' performance. The medical director told us that the trust had invested in software that would allow the monitoring of key performance indicators tailored to individual departments. At the time of this inspection, the trust had started rolling out this programme.

Leadership of service

- The general manager who coordinated outpatient services across all the trust's sites told us they had spent about two days each week at the hospital. We noted that improvement plans, such as the one prepared in response to our previous inspection, had not been fully implemented. Leaders of the department lacked long-term vision and ability to foresee the impact of the changes introduced to the service, such as transport services or the electronic medical records system.
- Although the local leaders, responsible for day-to-day management of outpatient clinics, had many years' experience and the qualifications necessary for their job, we did not think they had full knowledge of the issues facing the outpatient departments. We also observed that they had limited control to implement changes and monitor quality of the service. Senior nurses working within radiology had sufficient knowledge and skills to run their departments and staff spoke positively of them.

Culture within the service

- Nurses, healthcare assistants and doctors we spoke with were focused on providing a good experience for patients who visited their department. They were patient focused and aimed to provide a better service for their patients. We observed that local teams worked efficiently and staff were supportive to one another.
- Some staff working in radiology told us they felt the culture within the department needed to improve. Staff were unable to openly challenge each other and they felt the management of the service was not supportive. Others told us some of their colleagues had left the department because they did not feel they were valued by their managers and the trust. A member of staff told us they were leaving the hospital because of an outstanding dispute with their manager that was not being resolved satisfactorily. Staff told us, when faced with conflict or communication difficulties, senior managers would try to support with conflict resolution. However, staff did not think enough was being done and that the conflict resolution strategies used did not work well. We were informed of a case where a senior manager had refused to address an issue raised by a member of staff because the incident concerned had taken place more than three months before the issue was raised. We also noted another example of a manager being impolite in their response to staff asking to book annual leave. Nurses working in the outpatient department told us that they had complained over a year ago about another member of staff, and had written a formal letter to senior management. They felt the trust took no action either to resolve the issue or address the grievance.
- At the time of this inspection, we were approached by other staff who felt that they were intimidated by their managers and felt that they had exhausted all avenues available to them in order to resolve the issue. We brought these examples to senior managers during our inspection. The director of human resources reassured us that they had invested in training and various programmes to address these issues. They also told us that pulse surveys, used to describe the health or well-being of the organization's culture, were undertaken regularly to monitor the improvements and change in staff attitudes.

Public and staff engagement

- Patients' views on service improvements were being sought through the patient representative mentor scheme. This was piloted at the hospital, where 16 patients were working together with senior sisters and charge nurses on shared goals and developments.
- Nurses, healthcare assistants and staff working in the diagnostic imaging department told us that they did not feel part of the trust or that they could influence decisions taken that affected their day-to-day work. One member of staff told us, "What London [the Royal London Hospital] does, we need to follow"; another said it is always the "Bart's way we need to do things" when expressing frustration about lack of involvement in changes being implemented at the hospital.

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

- The hospital worked in partnership with clinical commissioning groups towards developing new clinical care pathways (for example, the 'straight to test' colorectal pathway that avoided patients needing to attend an outpatient appointment before they could have a diagnostic test).
- The hospital was working towards improving rheumatology patient's pathways with an aim to move to one-stop clinic delivered within two weeks of referral. There were also plans to introduce 'see and treat' clinics for gynaecology with an aim to shorten the time to treatment and moving patients from day-case to an outpatient setting.

Outstanding practice and areas for improvement

Outstanding practice

- Pain relief for children following an operation had been audited to introduce different strengths of local anaesthetic in order to reduce the pain experienced post operation. This had been shared with other NHS organisations through a National Paediatric Conference.
- The Pain Team for adults was well regarded by patients and staff.
- The Great Expectations maternity programme had led to a reported better experience for women. There had been a reduction in complaints regarding staff behaviour and attitude and an increase in women's satisfaction of the maternity service.

Areas for improvement

Action the hospital MUST take to improve

- Safety and effectiveness are a priority in all core services
- Services are well-led.
- Encourage a change of culture to be open and transparent. Morale was low. Some staff were reluctant to speak with the inspection team, when staff did some did not want the inspection team to record the discussions in fear of repercussions.
- There are appropriate levels and skills mix of staffing to meet the needs of all patients in all staff groups to ensure safe, effective, caring and responsive care is provided.
- Bank and agency staff are fully inducted to ensure they can access policies, be aware of practices and provide care and treatment in the areas they are required to work in.
- Adequate steps are taken to meet the fundamental needs of patients.
- Handovers between medical staff are structured and ensure relevant staff are aware of specific patient information or the wider running of the hospital.
- Learning from incidents is embedded. Staff are encouraged to find the time to report incidents and action plans are developed with the involvement of all key staff.
- Compliance with mandatory training is improved. Ensure it is evident that learning from training is embedded.
- Ensure medications are stored safely.
- There is a consistent use of opioids across wards.
- A formal review of record keeping is conducted.
- Procedures for documenting the involvement of patients, relatives and the multi-disciplinary team 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times.
- Patients nearing the end of their life are identified, and their needs are always assessed and met.
- The application of early warning systems to assist staff in the early recognition of a deteriorating patient is embedded across all services. The use of an early warning system was embedded within the surgery, while in A&E and medical care areas, its use was inconsistent. The National Early Warnings System had not yet been implemented in the hospital.
- Accurate records are available for the majority of patients attending outpatient appointments.
- Safeguarding procedures are improved and followed.
- All staff understand the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Theatre ventilation is adequately monitored.
- Equipment is ready for use and appropriately maintained.
- The environment is adequately maintained to protect patients.
- The use of national clinical guidelines is evident throughout the majority of services. An
- End of life pathway to replace the existing Liverpool Care Pathway is introduced.
- National guidance for the care and treatment of critically ill patients is always followed.
- Patient outcomes in national audits are similar to or above the performance of other hospitals.
- Ensure staff are always caring and compassionate and treat patients with dignity and respect at all times.

Outstanding practice and areas for improvement

- The average bed occupancy needs to be reduced.
- Patients should not be cared for in the theatres recovery area.
- Patients well enough to leave hospital should not experience significant delays in being discharged because of documentation needing to be completed.
- There should be a reduction in the number of operations cancelled due to a lack of available beds.
- The average length of stay (ALOS) needs to be reduced.
- The recovery plan for the 18 weeks from referral to treatment (RTT) pathway needs to be regularly assessed and monitored to ensure it will be delivered within timescales.
- Patients should be able to get in contact with the services they need in the hospital promptly.
- The number of internal transfers needs to reduce. Patients should be cared for on wards that are the correct specialty for their needs.
- Complaints are investigated in a timely manner and patients are involved and action taken
- The executive team needs to be visible.
- Some nursing staff roles need to be supernumerary on a shift to provide leadership and guidance, in line with the Francis recommendations.
- Recruitment to vacant managerial posts needs to be addressed.
- The application of clinical governance is consistent and well understood. All services have a formal, robust oversight.
- Risks are identified, recorded, escalated and mitigated. Risks registers are applied in all clinical areas.

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
	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Suitable arrangements were not in place to ensure that patients were safeguarded against the risk of abuse. In critical care the use of restraint was not was not robust.

Regulated activity	Regulation
	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Suitable arrangements were not in place to ensure obtaining and acting in accordance with the consent of the patient in relation to their care and treatment. 50% (10 out of 20) ‘do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms we reviewed had not been fully completed.

Regulated activity	Regulation
	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Accurate records in relation to the care and treatment of patients were not kept. There were inconsistencies in the use of recording assessments for inpatients. Some patients had separate assessments carried out on separate sheets of paper. However others had a nursing assessment booklet. Nurses reported being confused as to which form was to be completed. In outpatients it was reported 4-8% temporary notes were used for patients but staff said there were more.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment In November 2013 we found improvements were needed to ensure that equipment is appropriately maintained and available for use. At this inspection we observed that some improvements had been made in the maternity service however not in all areas. In addition theatre ventilation was not properly maintained.

This section is primarily information for the provider

Enforcement 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 or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Patients were not protected against the risks of receiving inappropriate or unsafe care or treatment.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Patients were not protected against the risks of inappropriate or unsafe care by the means of an effective operation of systems to regularly assess and monitor the quality of the service or identify assess and manage risks.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not enough staff to provide care and treatment for patients. There was a high use of bank and agency staff who were not always inducted and aware of the policies and procedures.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints In November 2013 we found Improvements were needed to ensure that patients know how to make a complaint and that complaints are dealt with appropriately. At this inspection we found improvements were still needed across the hospital.

The enforcement action we took:

We issued a warning notice

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EPPING FOREST DISTRICT COUNCIL
NOTES OF A MEETING OF HOUSING SCRUTINY PANEL
HELD ON TUESDAY, 24 MARCH 2015
IN COMMITTEE ROOM 1, CIVIC OFFICES, HIGH STREET, EPPING
AT 5.30 - 7.01 PM

Members Present:	S Murray (Chairman), Mrs G Shiell (Vice-Chairman), K Chana, Mrs R Gadsby, J Lea, C Roberts, B Rolfe, Mrs T Thomas, H Ulkun, Mrs J H Whitehouse and W Marshall (Tenants and Leaseholders Federation)
Other members present:	D Stallan
Apologies for Absence:	
Officers Present	P Pledger (Assistant Director (Housing Property)), R Wilson (Assistant Director (Housing Operations)) and M Jenkins (Democratic Services Assistant)

46. SUBSTITUTE MEMBERS (COUNCIL MINUTE 39 - 23.7.02)

There were no made substitutions made for this meeting.

47. DECLARATION OF INTERESTS

There were no declarations of interest made pursuant to the Member's Code of Conduct.

48. TERMS OF REFERENCE / WORK PROGRAMME

The Panel's Terms of Reference and Work Programme were noted.

49. NOTES OF THE LAST MEETING

RESOLVED:

That the notes of the last Panel meeting held on 9 February 2015 be agreed.

50. HOUSING REVENUE ACCOUNT (HRA) BUSINESS PLAN 2015-16

The Panel received a report from the Assistant Director (Housing Property) regarding the Housing Revenue Account (HRA) Business Plan 2015-16.

HRA Business Plans dealt with council's plans and performance for the delivery and quality of its housing services to tenants. The Council's Audit and Governance Committee required that all of the authority's Business Plans were completed and published by 31 March each year. Highlights of the plan included the following:

(a) Updated statistics for 2013/14;

(b) Updated comments of the Tenants and Leaseholders Federation in the latest Business Plan;

(c) New section on the Council's new Corporate Plan 2015-20 and the Council's Key Strategic Aims and Objectives;

(d) Review of the Council's Rent Cap for affordable rents; and

(e) New Key Action Plan.

The Chairman of the Tenants and Leaseholders Federation advised the Panel that their members endorsed the Business Plan. They did express concern about further budget cuts by Essex County Council.

The Chairman of the Panel requested that a District Council press release should be issued regarding the Business Plan Objectives which set out the new Corporate Plan 2015-20, a framework for policy and decision making over this five year period.

RECOMMENDED:

(1) That the Housing Revenue Account (HRA) Business Plan 2015/16, incorporating the HRA Financial Plan and the Repairs and Maintenance Business Plan 2015/16 be recommended to the Housing Portfolio Holder for adoption; and

(2) That a press release be issued regarding the Business Plan Objectives and the new Corporate Plan.

51. HOUSING REVENUE ACCOUNT BUSINESS PLAN KEY ACTION PLAN (2014/15) - 12 MONTH PROGRESS REPORT

The Panel received a report from the Assistant Director (Property Services) regarding the Housing Revenue Account Business Plan Key Action Plan (2014-15) – 12 Month Progress Report.

In April 2014, the Council's Housing Revenue Account (HRA) Business Plan for 2014/14 was produced, incorporating the Repairs and Maintenance Business Plan. This set out the Council's objectives, strategies and plans as landlord in relation to the management and maintenance of its own housing stock.

An important section of the HRA Business Plan was the Key Action Plan, which set out the proposed actions the authority would be taking over the following year. One of the Panel's Terms of Reference was to review progress during the year.

A 6 month progress report on the actions contained within the Key Action Plan 2014/15 was reported to the Panel in October 2014.

The Panel noted that the Tenants and Leaseholders Federation were due to view the Action Plan in the immediate future and not, as indicted on the agenda, on 19 March.

RECOMMENDED:

That the Housing Revenue Account Business Plan Key Action Plan (2014/15) 12 Month Progress Report be recommended to the Housing Portfolio Holder for approval.

52. HOUSING SERVICE STRATEGY ON ANTI SOCIAL BEHAVIOUR

The Panel received a report from the Assistant Director (Housing Operations) regarding the Housing Service Strategy on Anti-Social Behaviour.

The Housing Service Strategies were produced in accordance with an agreed standard framework, regularly updated. In total, 14 Housing Service Strategies had been produced covering:

(a) Equality and Diversity;

(b) Housing and Neighbourhood Management;

(c) Tenant Participation;

(d) Private Rented Sector;

(e) Empty Council Properties;

(f) Anti-Social Behaviour;

(g) House Sales and Leasehold Services;

(h) Rent Arrears;

(i) Rent Collection and Administration;

(j) Under-Occupation;

(k) Housing Information;

(l) Older People's Housing Services;

(m) Energy Efficiency; and

(n) Harassment

The strategies were produced to a common format that set out how individual housing services would be delivered. This strategy was considered by the Panel at its meeting in October 2013, they agreed that the strategy should be considered again when the Anti-Social Behaviour Crime and Policing Act 2014 came into force, hence the need for the report. There was a legal requirement for the Council to have a strategy and summary.

Members asked for a graffiti phone number hotline to be put in the Bulletin.

RECOMMENDED:

That the Housing Service Strategy on Anti-Social Behaviour be recommended to the Housing Portfolio Holder for approval.

53. KEY PERFORMANCE INDICATORS 2014/15 - QUARTER 3 PERFORMANCE

The Panel received a report from the Assistant Director (Housing Operations) regarding Key Performance Indicators 2014/15 – Quarter 3 Performance.

Pursuant to the Local Government Act 1999, the Council was required to make arrangements for securing continuous improvement in the way its functions and services were exercised. As part of this duty, a range of Key Performance Indicators (KPIs) were adopted each year. Performance was monitored on a quarterly basis and provided an opportunity for the Council to focus on how specific areas for improvement would be addressed.

A range of 36 Key Performance Indicators (KPIs) for 2014/15 were adopted in March 2014, from this municipal year, the existing scrutiny panels were now each responsible for the review of quarterly performance within their areas of responsibility.

Ten of the Key Performance Indicators fell within the Housing Scrutiny Panel areas of responsibility. The overall position at the end of the third quarter of the year for those indicators was as follows:

(a) 10 (100%) indicators achieved the cumulative third quarter target; and

(b) 10 (100%) were currently anticipated to achieve the cumulative year-end target.

The Panel extended its congratulations to the Communities Directorate on reaching all the targets.

RESOLVED:

That the Key Performance Indicators 2014/15 – Quarter 3 Performance be noted.

54. KEY PERFORMANCE INDICATORS 2015/16 - TARGETS

The Panel received a report from the Assistant Director (Housing Operations) regarding Key Performance Indicators 2015/16 – Targets.

As indicated in the previous minute item, legislation required the Council to make arrangements for continuously improving its functions and services. Key Performance Indicators (KPIs) were adopted each year to help facilitate this with monitoring on a quarterly basis.

It was advised that the review of KPIs which fell within the areas of responsibility for the Panel had resulted in the definition to one indicator COM001, being changed. The remaining KPIs were unchanged.

RESOLVED:

That the Key Performance Indicators 2015/16 – Targets be noted.

55. REPORTS TO BE MADE TO THE NEXT MEETING OF THE OVERVIEW AND SCRUTINY COMMITTEE

The Chairman advised that he would give a verbal update report to the next Overview and Scrutiny Committee on the Panel's work.

56. LAST MEETING OF THE HOUSING SCRUTINY PANEL

It was noted that this was the last ever meeting of the Housing Scrutiny Panel, from 2015/16 onwards, the Overview and Scrutiny Committee had agreed a new system of Select Committees which included the new Housing Select Committee, which would meet five times per year in June, September, November, January and March.

The Chairman expressed his thanks to the Panel Members, Housing Portfolio Holder and officers for all their support to the Panel and work over the years. The Housing Portfolio Holder echoed these sentiments and said how appreciative he was of the Panel's work and advice around Housing policy.

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EPPING FOREST DISTRICT COUNCIL
NOTES OF A MEETING OF CONSTITUTION AND MEMBERS SERVICES SCRUTINY PANEL
HELD ON TUESDAY, 3 MARCH 2015
IN COMMITTEE ROOM 1
AT 7.00 - 9.32 PM

Members Present:	Mrs M Sartin (Chairman), D Dorrell, J Lea, Mrs M McEwen, J Philip, Mrs C P Pond, C C Pond, D Stallan, Mrs J H Whitehouse and G Waller
Other members present:	
Apologies for Absence:	A Watts and S Weston
Officers Present	S G Hill (Assistant Director (Governance & Performance Management)), S Tautz (Democratic Services Manager) and M Jenkins (Democratic Services Assistant)

35. NOTES OF THE LAST MEETING

RESOLVED:

That the notes of the last Panel meeting held on 16 February 2015 be agreed.

36. SUBSTITUTE MEMBERS (COUNCIL MINUTE 39 - 23.7.02)

It was noted that Councillor C C Pond was substituting for Councillor S Weston.

37. DECLARATION OF INTERESTS

There were no declarations of interest made pursuant to the Code of Member's Conduct.

38. TERMS OF REFERENCE / WORK PROGRAMME

(a) Terms of Reference

The Panel's Terms of Reference were noted.

(b) Work Programme

The following regarding the Panel Work Programme was noted:

(i) Item 5 Articles of the Constitution

The Articles were currently being re-drafted.

(ii) Item 7 Constitution – Thresholds for Leases and Licences

A report would be submitted at a later meeting from the new manager of Estates.

39. AMENDMENTS TO THE COUNCIL'S COMPLAINTS SCHEME

The Panel received a report from the Assistant Director (Legal Services) regarding Amendments to the Council's Complaints Scheme.

The Council's complaints scheme had four stages, an investigation of a complaint at each stage was undertaken by the following:

(a) Step 1 – Manager of the Service area concerned;

(b) Step 2 – Director or Assistant Director;

(c) Step 3 – Complaints Officer on behalf of Director of Governance; and

(d) Step 4 – Member Complaints Panel

The Panel was informed that in 2006 the Local Government Ombudsman introduced the "12 week rule" which urged councils to complete every stage of a complaint within 12 weeks of their first receipt. Inability to do so meant the complainant had the right to bypass any remaining stages in the complaints procedure and instead take their complaint to the Ombudsman. However, the complaints procedure adopted by the District Council made it impossible to complete all four stages within 12 weeks. Investigations at Steps 1, 2 and 3 usually took around 3 – 4 weeks each to complete. A complainant remaining dissatisfied could request a further review, although it could take 7 – 8 weeks to organise a meeting of the Step 4 Member Complaints Panel.

Therefore complainants were advised that it was not possible to offer a Step 4 review within the 12 week time limit, therefore they had the right to bypass this and take their complaint to the Ombudsman. It was advised that since 2007 no complainants had requested a review of their complaint upon completion of the Step 3 part resulting in very few Panel meetings during this time.

Members noted that discontinuing Steps 1 – 3 would not resolve the problem because whichever two of the three stages were retained, would still require a total of around 8 weeks to complete, which would not leave enough time to organise a Complaints Panel review within the 12 week time limit. It was advised that no other local authority in Essex, or indeed the rest of the country, had as many stages for complaints or offered a final review by Members.

Members supported recommending the changes. It was advised that a report would be submitted the Overview and Scrutiny Committee and the Council.

RECOMMENDED:

That the Amendments to the Council's Complaints Scheme be recommended to the Overview and Scrutiny Committee.

40. CONSTITUTION REVIEW - COUNCIL PROCEDURAL RULES

The Panel received a report regarding the Constitution Review – Council Procedural Rules from the Assistant Director (Performance Management) Governance.

Following on from the last Panel meeting in February, Members made progress with the procedure rules commencing from Item 9 "Interests" paragraph 1.5 "Conflicts of Interest" to Item 12 "Questions by Members," 12.10 "Supplementary Question."

However the meeting was adjourned to the next scheduled meeting date of 17 March in order to complete the work on the procedure rules.

RESOLVED:

That the Panel meeting be adjourned to the next scheduled meeting date of 17 March to continue the work undertaken on the Council Procedure Rules.

41. REPORTS TO BE MADE TO THE NEXT MEETING OF THE OVERVIEW AND SCRUTINY COMMITTEE

It was advised that the report regarding Amendments to the Council's Complaints Scheme would be submitted to the forthcoming Overview and Scrutiny Committee.

42. COMMENTARY ON THE PANEL NOTES

Councillor J H Whitehouse raised a concern regarding the 16 February Panel notes tabled at this meeting which, she felt, should have included reference to the conclusions of the Panel in regard to Councillor B Surtees' submitted views on minority references at planning committees. However, officers advised that the notes had been agreed at the start of this meeting without comment at which point Councillor J H Whitehouse had not been in attendance, therefore a Panel resolution could not be altered afterwards.

43. FUTURE MEETINGS

The next Panel meeting would be held on 17 March at 7.00p.m.

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EPPING FOREST DISTRICT COUNCIL
NOTES OF A MEETING OF CONSTITUTION AND MEMBERS SERVICES SCRUTINY PANEL
HELD ON TUESDAY, 17 MARCH 2015
IN COMMITTEE ROOM 1
AT 7.00 - 9.35 PM

Members Present:	Mrs M Sartin (Chairman), A Watts (Vice-Chairman), J Lea, Mrs M McEwen, Mrs C P Pond, C C Pond, D Stallan, Mrs J H Whitehouse and G Waller
Other members present:	
Apologies for Absence:	J Philip and S Weston
Officers Present	S G Hill (Assistant Director (Governance & Performance Management)), S Tautz (Democratic Services Manager) and M Jenkins (Democratic Services Assistant)

44. MEETING RECONVENED

Following the adjournment of the meeting held on the 3 March 2015 at 9.32p.m., the meeting reconvened on the 17 March 2015 at 7.00p.m.

45. SUBSTITUTE MEMBERS (COUNCIL MINUTE 39 - 23.7.02)

It was noted that councillor C C Pond was substituting for Councillor S Weston.

46. DECLARATION OF INTERESTS

There were no declarations of interest made pursuant to the Member's Code of Conduct.

47. TERMS OF REFERENCE / WORK PROGRAMME

The Panel's Terms of Reference and Work Programme were noted.

48. CONSTITUTION REVIEW - COUNCIL PROCEDURAL RULES

The Panel received a report regarding the Constitution Review – Council Procedural Rules from the Assistant Director (Governance and Performance Management) and undertook their review following the adjourned meeting on 3 March at Item 13 Motions – On Notice.

The Panel progressed through to Item 26 Application to the Executive, Committees and Sub-Committees and completed the subsequent sections concerning Substitute Members, Political Group Representatives, Minority References, Reports and Petitions.

In addition the Panel requested a further report in respect of the rules regarding 17.4 and 17.5 concerning Recorded Votes. This concerned the recent amendments to the

law which stipulated that all votes were recorded in respect of agreeing Council budgets.

RECOMMENDED:

(1) That the Constitution Review – Council Procedural Rules be recommended to the Council; and

(2) That a report be submitted to the Panel regarding rules 17.4 and 17.5 that concern the making of recorded votes in respect of Council budgets.

49. REPORTS TO BE MADE TO THE NEXT MEETING OF THE OVERVIEW AND SCRUTINY COMMITTEE

There were no reports forthcoming from this meeting to the Overview and Scrutiny Committee.

50. FUTURE MEETINGS

This was the last meeting of the Panel in its current guise as a scrutiny panel. From May 2015 it would become the Constitution Working Group reporting directly to the Council. The Chairman thanked members of the Panel and officers for their work and support during the Panel's existence. Councillor D Stallan echoed these sentiments, particularly as he had served a year as Panel Chairman.

It was advised that the first scheduled meeting date of the Working Group was 30 June 2015, which it was felt, was too wide a gap in time for effective continuity in carrying on the work of amending the Constitution. It was agreed to arrange an earlier meeting date in late May or June 2015.

EPPING FOREST DISTRICT COUNCIL
NOTES OF A MEETING OF FINANCE AND PERFORMANCE MANAGEMENT SCRUTINY PANEL
HELD ON TUESDAY, 10 MARCH 2015
IN COMMITTEE ROOM 1, CIVIC OFFICES, HIGH STREET, EPPING
AT 7.00 - 8.39 PM

Members Present:	T Church (Chairman), A Mitchell MBE (Vice-Chairman), K Angold-Stephens, D Dorrell, J Knapman, G Mohindra, J M Whitehouse and Ms S Watson
Other members present:	A Lion, J Philip and Ms S Stavrou
Apologies for Absence:	Mrs E Webster (Vice Chairman of Council)
Officers Present	P Maddock (Assistant Director (Accountancy)), D Newton (Assistant Director (ICT and Facilities Management)), B Copson (Senior Performance Improvement Officer) and A Hendry (Democratic Services Officer)

37. SUBSTITUTE MEMBERS (COUNCIL MINUTE 39 - 23.7.02)

The Panel noted that there were no substitute members.

38. NOTES OF LAST MEETING

The minutes of the previous meeting held on 11 November 2014 were agreed.

39. DECLARATION OF INTERESTS

No declarations of interest were made.

40. KEY PERFORMANCE INDICATORS 2014-15 - QUARTER 3 PERFORMANCE

The Senior Performance Improvement Officer, Barbara Copson introduced the report on the quarter 3 performance of the year's Key Performance Indicators that were relevant to this Scrutiny Panel.

Eleven of the Key Performance Indicators fell within this Panel's areas of responsibility. The overall position with regard to the achievement of target performance at the end of the third quarter of the year for these eleven indicators was as follows:

(a) 6 (55%) indicators achieved the cumulative third quarter target, and
(b) 5 (45%) indicators did not achieve the cumulative third quarter target,
(c) 7 (64%) were currently anticipated to achieve the cumulative year-end target.

At their last meeting this Panel had asked for information on targets and trends for the indicators. Officers hoped to adapt the charts and add in the information that was being sought.

Councillor Knapman noted that GOV001 (*How satisfied with their experience were visitors to the Council's website*), was not that useful. In getting to the calendar page he had to go through numerous steps. It seemed long winded and hard to find. As for GOV 002 (*what % of the rent we were due to be paid for our commercial premises was not paid*), it would be useful to know what this was in monetary terms, then members could get a better feel of what they were talking about. He was still concerned about sickness as we never seemed to have got to grips with this. It maybe that the target was wrong. We were not as good as compared to the private sector.

The Assistant Director (Accountancy), Mr Maddock noted that we had had hit our sickness targets last year but, unfortunately, not this year. Long term absences had come down slightly, but not the short term ones. Staff have been advised on the best way to avoid cross infection and on best hygiene practices; but it was likely that we would not hit our target this year.

Councillor Philip noted that this Panel used to review sickness figures regularly, but then they came down three years in a row. It had been the focus for some years by this Panel. As for the website, the website board will be looking at this at their meetings and, you should be able to access the calendar with just one click.

Councillor Lion added that this Panel used to review sick absence figures at each meeting, it improved and we decided to look at it on a six monthly basis. The commercial rent arrears seemed significant and we should look at these in more detail. Mr Maddock said that at the quarter 4 period they could produce more detailed information on this.

Councillor Watson wanted to know what areas of the website people were trying to access; this may be quite specific and what area someone was accessing may predetermine how happy they would be. As for commercial rent, she would like to see what the implications were for the end of the year. This needed to be quantified and we needed more details for us to use. On NNDR collection (RES 004 – *what % of the district's annual business rates were collected?*), she was confused why we were below the target and wondered if we would miss the target anyway, when we have missed the last 3 quarters.

Councillor Mohindra asked if the Panel could be supplied with the latest position on commercial premises and the position on the date due. Mr Maddock replied that these debts were regularly reviewed; as they were commercial they were more easily collectable. If needed, he could provide the latest position.

Councillor Mohindra commented on RES002 (*what % of the invoices we receive were paid within 30 days*); he noted that we had signed up to a charter on this but had not seen any commentary. Mr Maddock said that they had looked at the numbers for ways to speed up processing. It was too late for this year, but he was confident for the coming year. Also, internal invoices were still paper based, but e-invoicing was coming in to speed up this part of the system.

Councillor Church would like information on how many invoices were disputed and not just the ones that were agreed. Mr Maddock replied that if an invoice was disputed then that invoice would be put on hold and the clock would stop until it was sorted out.

Councillor Watson asked if finance knew when an invoice had arrived. She was told that 95% of invoices went straight into finance and the clock started when it was registered by finance.

Councillor Philip noted that a lot of the information on the website was covered by reports to the Website Development Board.

Councillor Angold-Stephens asked if we would meet the targets for the NNDR indicator (RES004) by the end of the year. Mr Maddock said that a lot of income would come in at the end of the year, so that they were confident that they would achieve it.

Councillor Watson wanted to know if a section took on an extra member of staff, would it cost more to achieve the target taking into consideration the added cost of that staff member. Could this sort of information be supplied? Councillor Angold-Stephens said that we did get this information last year about the fraud team, which more than covered the expenditure. Mr Maddock said that he could put in a comment along those lines.

Councillor Knapman commented on his concern about levels of attendance by staff on Fridays, was this a future problem in the making? Could this be looked into? Councillor Philip said that it would not be a problem unless it was in a customer facing job. Mr Maddock said that as a manager he saw the leave cards for his staff and organised his office around this. Councillor Lion agreed, it was down to the manager to manage his section. Councillor Stavrou said that she had not had a problem over the years with not being able to contact members of staff when needed.

RESOLVED:

That the performance of the Key Performance Indicators, for quarter 3, in relation to this Panel's area of responsibility was noted.

41. KEY PERFORMANCE INDICATORS 2015-16 - REVIEW AND TARGETS

The Senior Performance Improvement Officer, Barbara Copson introduced the report on the review of the Key Performance Indicators (KPIs) proposed for 2015/16. Although some revisions to existing KPIs were proposed, it was not intended that significant changes be made to the overall indicator set for the next year. Service Directors had identified provisional targets for each indicator with their relevant portfolio holders based on third quarter performance (and the estimated outturn position) for the current year.

The KPIs relevant to this Panel had a number of changes recommended. It was proposed that the following indicators were deleted:

i) *GOV001 How satisfied with their experience were visitors to the Council's website?* - this indicator has not generated a statistically viable sample to be worthwhile;
ii) *RES007 How many fraud investigations were completed?* - Housing Benefit investigation will cease to be the responsibility of the Council from October 2015;
iii) *RES008 In what percentage of potential benefit fraud cases investigated by the Benefit Investigation Team, was fraud proven?* - Housing Benefit investigation will cease to be the responsibility of the Council from October 2015.

Three new indicators were to be introduced to replace GOV001 Website Satisfaction:

I. Are customer needs being met by the Corporate Website being available?
II. Are customer needs being met by the Corporate Website not having broken links?
III. Are customer needs being met by the main Corporate Website having effective navigation?

The Panel noted that improvement plans would be developed for each KPI, identifying actions to achieve target performance, which would be considered and agreed by Management Board. As part of this process, the Board will also review the provisional targets for each KPI with reference to outturn data for 2014/15 when this becomes available. Any revisions to targets on the basis of the outturn position will be reported to this Scrutiny Panel in June 2015.

Councillor Jon Whitehouse commenting on the proposed website indicators noted that not everything that we wanted to know was measurable. Did we do any user testing on how people use the website? The Assistant Director ICT and Facilities Management, Mr Newton replied that they were considering doing this. The Website Development Board did receive a lot of statistics on the website. But the board was made up of Council employees who are familiar with the website. They were thinking of asking affiliated organisations, such as the Tenant Participation Board to get some impartial feedback. They also hoped to use other groups that we were in contact with. However, they would not like to pay an organisation to do this.

Councillor Knapman commented that there had been a lot of improvement over time on our website and this should be noted.

Councillor Mohindra asked if the council only looked at Housing Benefit fraud. He was told that it did. He then asked if we could look at Council Tax fraud or corporate fraud. Councillor Philip said that they would need to look at this to see what they would need to measure. As for the new three website indicators, these were what the big companies looked at.

Councillor Watson was unsure about the comments to RES003 ‘what % of the district’s annual Council Tax was collected?’ Mr Maddock said that he was unsure and that he would talk to the relevant Assistant Director about it.

RESOLVED:

That the proposed Key Performance Indicators and targets for 2015/16 that fall within this Panel area of responsibility be agreed and referred to the Finance and Performance Cabinet Committee.

42. ICT UPDATE

The Assistant Director ICT and Facilities Management, Mr Newton introduced the report updating the Panel on the ongoing works and projects of the ICT strategy. Overall the projects are on track and progressing well.

The Panel noted that:

- ICT now incorporates the GIS and the Gazetteer team. The opportunity was taken to merge the helpdesk, switchboard and desktop support to create a more proactive desk service team;

- The new telephone system was now fully live. Auto attendants (menu assisted calls) have been created to help direct calls, workgroups have been created to ensure quicker answering and less abandoned calls and calling line identification (CLI) is now displayed on all outgoing calls;
- New core and edge switches have now been installed resulting in network availability for January 2015 averaging 99.97%. It was essential to keep this up to date for reliability;
- The 'GOOD' and 'Mod.Gov' applications has now been installed on various devices to enable members and officers to access files and emails whilst not in the office. Feedback on ease of use and reliability had been excellent. If members wanted this system IT would need to set them up with an EFDC email address. Also 50 branch routers have been distributed to enhance home working;
- The whole council was now covered by wireless connectivity, which was working well. By the end of the month this would also include satellite offices;
- Host servers have been replaced by 'Fujitsu' and are now in place and undergoing testing;
- ICT now have out of hours call-out arrangements to enable them to resolve any problems before core working time begins. This has proved very successful to date with a number of potentially serious issues resolved outside of normal working hours; and
- We have now developed our own online booking system for leisure services and this will eventually link in with the Finance system.

Councillor Watson asked if the disposal of the old equipment was secure. She was assured that it was, very.

Councillor Watson then asked if officers could somehow market our in-house developed booking system to other authorities. Mr Newton said that they had looked into this; it appeared that other authorities wanted many variations to our basic system and made it confusing. He was, however, talking to the Essex on line partnership about this.

Councillor Mohindra asked how secure we were against a cyber attack. Mr Newton replied that we had a good security officer and system in place. So, much so that Essex County Council had a virus before Christmas and our system was good enough to block it.

Councillor Lion said that as our core switches were 99.97% effective, could this become a KPI. He was told that it was something officers could easily monitor.

Councillor Lion noted that now Mod.Gov was available on a tablet which could also provide the Council Bulletin and agendas, he encouraged members to use it as they were looking to save paper and printing costs. Mr Newton added that, at a future meeting, he could show the Panel the statistics on website use and could also demonstrate how Mod.Gov worked. The Panel thought this was good idea.

RESOLVED:

The Panel noted the progress on the ICT projects for 2014/15.

43. PERFORMANCE MONITORING - TELEPHONE CALL HANDLING

The Assistant Director ICT and Facilities Management, Mr Newton introduced the report on call handling. Following on from the September 2014 meeting of this Panel it was agreed that examples of monitoring reports be brought to a future meeting for discussion on possible ways of monitoring telephone call handling.

Our new telephone system was now live and could produce various monitoring information. Following the introduction of a number of auto attendants (menu assisted calls), a large number of calls now bypass the switchboard and go straight to directorate contact centres and workgroups. Reporting on the switchboard was still a requirement, but was it also necessary to report on the calls that have been relayed by the auto attendants.

Other authorities that have telephone systems like us tend to favour reporting on:

a. The percentage of abandoned calls; and
b. The number of calls sent directly to the voicemail system.

ICT tended to favour these indicators that specifically relate to the service callers were receiving. During January, 35,388 calls were received – 9.8% of these were classified as abandoned with 4.22% of calls going directly to voicemail. This may be something that the Panel would want to monitor, but not necessarily as a KPI.

Councillor Mohindra noted that before there was some concern about teams not adopting this system. Was this changing? Mr Newton said that it was changing. He noted that if a contact centre received an abandoned call they would call back. Other areas would need looking at. Councillor Mohindra asked if this Panel could have a list of the top three teams. Mr Newton replied that this sort of thing normally went to Management Board; he could ask if they could pass it on to this Panel.

Councillor Watson asked if a set number of rings could be logged before a number was classed as abandoned. This was to rule out the accidental call etc. she suggested a minimum of 4 rings. Mr Newton said he would find out if the system could do this.

Councillor Whitehouse noted that the length of waiting would drive abandoned calls. Did people know where they were in the queue? Mr Newton said that our system could not do that at present, but they were working with the suppliers on this. It could tell how many were in the queue and the average number of people calling etc. the contact centre could see what was happening in real time on their screens.

Councillor Knapman said that in doing this there was need to compare like with like. For example some parts of planning shuts down after midday as planners went off on site visits etc. this could not be compared to other sections. Councillor Lion noted that we could now divert calls to someone who was not in the office. Councillor Knapman understood that some officers had to use voicemail, but would like to see these callers have their calls returned.

RESOLVED:

1. That the Panel agreed to the new reporting definitions on call handling, that of:

i) The percentage of abandoned calls; and
ii) The number of calls sent directly to the voicemail system.

But this would be subject to a minimum of 4 rings for abandoned calls.

2. The Panel would like to see these figures on a quarterly basis.

44. QUARTERLY FINANCIAL MONITORING

The Assistant Director Accountancy, Mr Maddock introduced the financial monitoring report on income and expenditure for quarter 3.

The Panel noted that:

- The salaries schedule showed an underspend of £164,000 (or 1.1%). This time last year the variance was 1.2%. With the implementation of the new pay award the underspend would reduce going forward;
- The Governance Directorate was showing and underspend of £77,000, relating mainly to the Estates Division;
- The Resources Directorate showed an underspend of £75,000 relating to a number of areas, but mainly Revenues;
- Development Control income at month 9 was going particularly well. Fees and charges were £82,000 higher than the budget to date and pre-application charges were £16,000 higher;
- Building Control income was £18,000 higher than the budgeted figure at the end of the third quarter;
- Local Land Charges income was in line with revised expectations at the end of December and had continued the upward trend of recent months;
- Hackney Carriage income was up by £2,000 and other licensing in line with the budget;
- The income from MOT's were in line with the revised position. Cabinet had determined in October that the service would be re-located to a new depot at Oakwood Hill but would scale back its operations with the service breaking even;
- Things had improved on the parking income receipts as the teething problems experienced with the new cash collector were being overcome. Income was now slightly above the revised budget;
- The Housing Repairs Fund showed an underspend of £79,000. The full year's budget was likely to be fully spent;
- This was the second year for the new Business Rates Retention Scheme, whereby a proportion of rates collected were retained by the Council. There were two aspects to this monitoring, firstly changes in the rating list and secondly the collection of cash;
- Cash collection was important as the Council was required to make payments to the Government and other authorities based on their share of the rating list. These payments are fixed and have to be made even if no money was collected. Therefore, effective collection was important as this can generate a cash flow advantage to the Council. At the end of December the total collected was £27,551,925 and payments out were £24,304,499; meaning the Council was holding £3,247,426 of cash and so the Council's overall cash position was benefitting from the effective collection of non-domestic rates.

In all, it would be a surprise if the Council showed an underspend this year.

Councillor Mohindra queried the comments on industrial estates, wanting to know if £300k was more than expected as the commentary indicated the income was higher. Mr Maddock said that he would investigate and get back to him.

Councillor Whitehouse asked if income on off street parking was getting better. He was told that yes it was catching up, the income increase was due to the increase in pay and display charges.

Councillor Watson wondered if the increase in the income from Building Control and Development Control was due to the lack of a local plan and was the timetable for this slipping further. Councillor Philip said he did not believe that people were not putting in planning applications due to a lack of a local plan. The majority of the applications were for household changes. We still had the existing Local Plan in place, so it was not right to say that we did not have one. He noted that updates on this would be coming out soon, but they did not wish to rush this as they needed a good evidence base. But, he agreed that these figures needed to be kept under observation. Councillor Watson noted that the budget for forward planning had been revised downwards and re-profiled. Mr Maddock said that a substantial part had been moved into 2016/17. Councillor Watson asked if this could be brought back to the next meeting.

RESOLVED:

That the Panel noted the revenue and capital monitoring report for the third quarter of 2014/15.

45. TERMS OF REFERENCE / WORK PROGRAMME

The Panel noted their Terms of Reference and work Programme.

Councillor Whitehouse asked what had happened to item 15 of the work programme, the ‘use and cost of consultants’. Mr Maddock said that this would have to be moved into the work programme of the new Resources Select Committee in the new year.

46. REPORTS TO BE MADE TO THE NEXT MEETING OF THE OVERVIEW AND SCRUTINY COMMITTEE

To report back to the Overview and Scrutiny Committee with a general update on the reports considered at this meeting with a special emphasis on the ICT Update report.

EPPING FOREST DISTRICT COUNCIL
NOTES OF A MEETING OF SAFER, CLEANER, GREENER SCRUTINY PANEL
HELD ON TUESDAY, 28 APRIL 2015
IN COMMITTEE ROOM 1, CIVIC OFFICES, HIGH STREET, EPPING
AT 7.30 - 8.45 PM

Members Present:	J Lea (Chairman), , R Jennings, L Mead, A Mitchell MBE, S Neville, Mrs M Sartin and B Surtees
Other members present:	G Waller
Apologies for Absence:	Mrs H Brady and Mrs E Webster
Officers Present	K Durrani (Assistant Director (Technical Services)), S Stranders (Drainage Manager), L Savill (Resident Engineer) and A Hendry (Democratic Services Officer)

48. SUBSTITUTE MEMBERS (COUNCIL MINUTE 39 - 23.7.02)

The Panel noted there were no substitute members

49. NOTES OF THE LAST MEETING

The notes of the 24 February 2015 meeting were agreed as a correct record.

50. DECLARATIONS OF INTEREST

No declarations of interest were made.

51. PRESENTATION FROM THAMES WATER

The Chairman welcomed four officers from Thames Water (TW) to the meeting. They were there to give a presentation on their work in this area, the problems they faced and to outline some solutions.

The officers introduced themselves to the Panel. They were Mumin Islam, the Local, Regional Government Liaison; Mark Dickinson, their Development Planning Manager; Nigel Fuller, their Fields Operations Specialist and Anne Christie, Customer & Continuous Improvement Manager.

Before the meeting, our officers had sent them examples of problem works in our district and a list of questions from our Councillors. They started by apologising for the time taken for some of the work they had undertaken and for their lack of communication in aspects for the cases provided.

They showed a map showing the boundary of region that they covered mostly around Oxford and North London coming up to Waltham Abbey into Epping Forest District (a copy of their presentation is attached). We noted that they had a duty to provide public sewerage and to clean and maintain sewers. They also had a duty to provide and extend sewerage systems, but did not have the duty to provide capacity to deal with flood or ground water. They also did not deal with rivers or canals. There were

three types of sewer: foul water sewers, surface water sewers and combined sewers (these were mainly in London).

The causes of flooding could be many and complex. It was difficult to identify where the water initially came from. In general, it was noted that the local council and land owners were responsible for surface and ground water flooding; highway flooding was the responsibility of the local council and/or the Highway Agency; river flooding was the responsibility of the riparian owners and the Environment Agency; Thames Water was responsible for surface water sewers and foul water sewers.

On the cases raised by EFDC – they had repaired the problems that caused the flooding at Bower Vale, Epping. At Monkswood Avenue, Waltham Abbey they would be initiating repairs within the next few weeks. They had now stopped the flooding at Orchard Gardens and Mead Court and the drains had been cleared out. Sewardstone Road (junction with Farm Hill Road) could not be traced by their records; the Waltham Abbey Football Club was a private asset; and Horseshoe Hill was not on their records.

They apologised for their poor communication and for delays in responding to incidents. Thames Water was increasing the number of customer representatives in both their clean and waste teams to improve contact. They were also continuously reviewing their communications branch improving how they target communication to areas that needed it most.

They have a "Pollution Tile" project which was investigating issues in their highest risk pollution and flooding locations, their history and any remedial work needed. They would also review up to 200kms of blockage hotspots within the next few months.

They had a 'Hold/Closed the loop process', looking at how long it took to do work and to push their contractors to complete their work more quickly.

They were also looking into setting up a team to work with the Council to help in communications. They already hold quarterly North London liaison meetings with the Environmental Agency to discuss any relevant events in their area.

In 2015 they have planned maintenance sewer programme of 260km and currently in Epping Forest District have on-going planned maintenance for over 4,000 meters of network in 20 streets. They were also investigating hotspots for discharge of fats, oils and grease and were working closely with Environmental Health Officers and had a "Bin it don't block it" education campaign. They were also proactively working with Local Authority's surface water drainage officers.

To report surface flooding, they have a 24 hour Freephone line on 0800 316 9800 or you could go on their website at www.thameswater.co.uk or email customer.feedback@thameswater.co.uk

They prioritise their calls and have 2 hours for emergencies and 4 hours for operational blockages. If follow on works were needed, dependant on Highways Agency agreement and notice/permit had been granted it would be a 5 to 10 day notice.

As for planning matters – they were statutory consultees in the development of Local Plans but were not statutory consultees on individual planning applications or third party applications. Their team of 5 covered 96 local authorities where they were

responsible for making comments on applications. If individual applications were referred to them they would respond to them, but when they only receive weekly lists they could not guarantee a response. If EFDC really wanted a response they should specifically consult them on individual applications.

It should be noted that even if they knew a development would cause a flood, they cannot prevent it from joining their network without the help of Local Authorities Planners putting appropriate conditions on.

The types of documents that they could comment on were:

- Strategic Plans;
- Local Development Plans;
- Site Allocations;
- Development Strategies;
- Supplementary Planning Documents; and
- Neighbourhood Plans.

They may wish to seek to influence type, scale and location of developments and may seek to safeguard future sites or influence their designations.

They also appraise and comment on new developments in terms of:

- Sewer flood risk;
- Odour impact;
- Water pressure; and
- Asset protection.

They had commented on about 60,000 applications last year. It should be noted that under the Water Act they have a statutory duty to “provide, improve and extend” their network to serve customers and could not refuse connection outright.

They review Local Plans and third party applications to understand their impact. They would also have to develop individual schemes for individual developments. With advanced notice of properly appraised schemes they could deliver some infrastructure through their Business Plan. However, they would need to consider the cost benefits and environmental impact of potential network upgrades. Also network upgrades aren’t always straight forward; for example, they would need to consider the environmental impacts, did the design consider cumulative impacts and what consents were needed to build the upgrade, e.g. planning, access highways etc.

They could also ask the planning sections to impose Grampian conditions (A "Grampian condition" was a planning condition attached to a decision notice that prevents the start of a development until off-site works have been completed on land not controlled by the applicant).

The meeting was then opened up for questions from the members present.

Councillor Surtees asked about road works incidents at Ongar, the road works had begun but appears to be spread out over a long period of time. Also some of the works appear not to have been done well. He was told that their contractors tended to set up, do the work and move out as soon as possible. If it was a clean water repair they would have to leave it for some time to test the repair it over the long term, if it was a waste water repair it would be done quite quickly. If the exact location could be provided they would chase it up. Councillor Surtees added that the

temporary traffic lights had gone wrong but there was no obvious number displayed that they could call to report it. He was told that there should be a permit board with contact numbers displayed; all Thames Water sites had one.

Councillor Sartin thanked the officers for their interesting presentation and noted that we were a large rural district with very old areas and infrastructure. How was this dealt with? We also have proposed new developments that fall into the Rye Meads catchment, the area around Harlow; how far in advance did they plan these things? She was told that they did a lot work with the planning sections. The developers would tell people what they wished to hear. They would plot on their maps to plot the impacts this would have. They identified issues within their catchment area and formed a 'view' on how these areas would be best served. They would have an idea on what would need to be done and would firm that up nearer the completion. As for rural areas, we have inherited a lot of good Victorian engineering. We would build up a picture of an area and the problems it had and take this into consideration for new planning applications.

Councillor Neville asked if they could have road-works followed by road-works in the same place? He was told that they were looking into a more integrated approach; more of a one stop way of working, unless of course it was an emergency.

Councillor Lea asked if there were any plans to extend the network capacity for both surface and foul water systems in our district. She was told that there were certain conditions where the network would not cope. They worked to a 1 in 20 event, such as the exceptionally wet weather in the previous winter, where their systems could not cope. Other than that they did plan for local developments as long as they knew about it and where funds permitted.

Councillor Lea asked if there were any plans to extend TWs pumping stations. She was told that all their pumping stations were covered by telemetry and monitored continuously, any problems registered would be investigated and the system re-set. In extreme conditions pumping stations could be overwhelmed by the sheer volume of water, although they could be still working but could not cope with that volume. If the worst happened tankers could be brought in and they could deploy portable pumps.

Councillor Lea then asked if cess-pits were anything to do with TW, she was told that they were not but were asked about outlying villages and putting them on the main sewer system.

Councillor Lea went on to say that after some works have been completed, the filled in works sinks down within days, was this just inadequate making good. The officer from Thames Water said that there were two sides to the company, clean and waste water systems. He could not answer for the clean water, but for waste water it did not pay their contractor to have to come back. There may sometimes be problems with clean water reinstatement.

Councillor Sartin asked that as they were not a statutory consultee, had they put any pressure on the government about becoming one. She was told that they had recently asked for statutory consultee status for developments but were told no by the government. This also did not sit well with their problem that they could not refuse connection to their network.

Councillor Lea noted that we as a Council had good relation with Thames Water. Could our officer's enter into a formal liaison with you? She was told that they would be happy to set up a local liaisons group with EFDC and other local authorities.

Ms Stranders noted that they would only see planning applications that were specifically referred to them, how would Epping do this? TW Officers said that they would let her know. They were producing a 'Town Guide' on this and they would send her a copy. All they asked was for actual planning applications and large scale developments not lists.

Ms Stranders noted that she had referred to examples of poor communication and have noted their response. Blockages had improved but this was not a very co-ordinated way of working. TW officers replied that they had appointed a new contractor recently and that they were still bedding down. There had been problems in the past and they were looking to make this better such as proposing this new liaison group.

Mr Savill noted that there had been problems with telecommunications; all they needed was to get in touch with a network engineer to help us solve our problems more quickly. He was told that he had to go through their contact centre by law, but these new liaison groups would help this. They agreed that their engineers needed to be made available to EFDC officers, but would still need to quote a call reference number to give to the engineer (given by the call centre). Mr Savill noted that once they got a network engineer, things got sorted very quickly.

Councillor Surtees asked if their 'Town Guide' would be available on-line. He was told that it would not be, but they could supply him with a copy.

Councillor Lea asked if works at development sites were inspected by Thames Water. They replied that they did, but not all, as the sheer volume of work would overwhelm them, this also related to their lack of staff. They also asked building control officers to check drainage at new builds.

Councillor Lea then asked if there was anywhere in our district that was over capacity. She was told that they could not think of any area in Epping Forest that was under strain.

The Chairman thanked the Thames Water representatives for attending the meeting; it was a very interesting presentation and a very helpful question and answer session.

52. TERMS OF REFERENCE AND WORK PROGRAMME

The Panel's Terms of Reference and Work Programme were noted. They also noted that a possible Crime and Disorder meeting would be scheduled in June for the new Select Committee.

As this was the last ever meeting of this Panel (in its current form) the Chairman thanked her fellow Panel members and officers for their hard work during the past year. In turn the members of the Panel thanked the Chairman for her work over the year.

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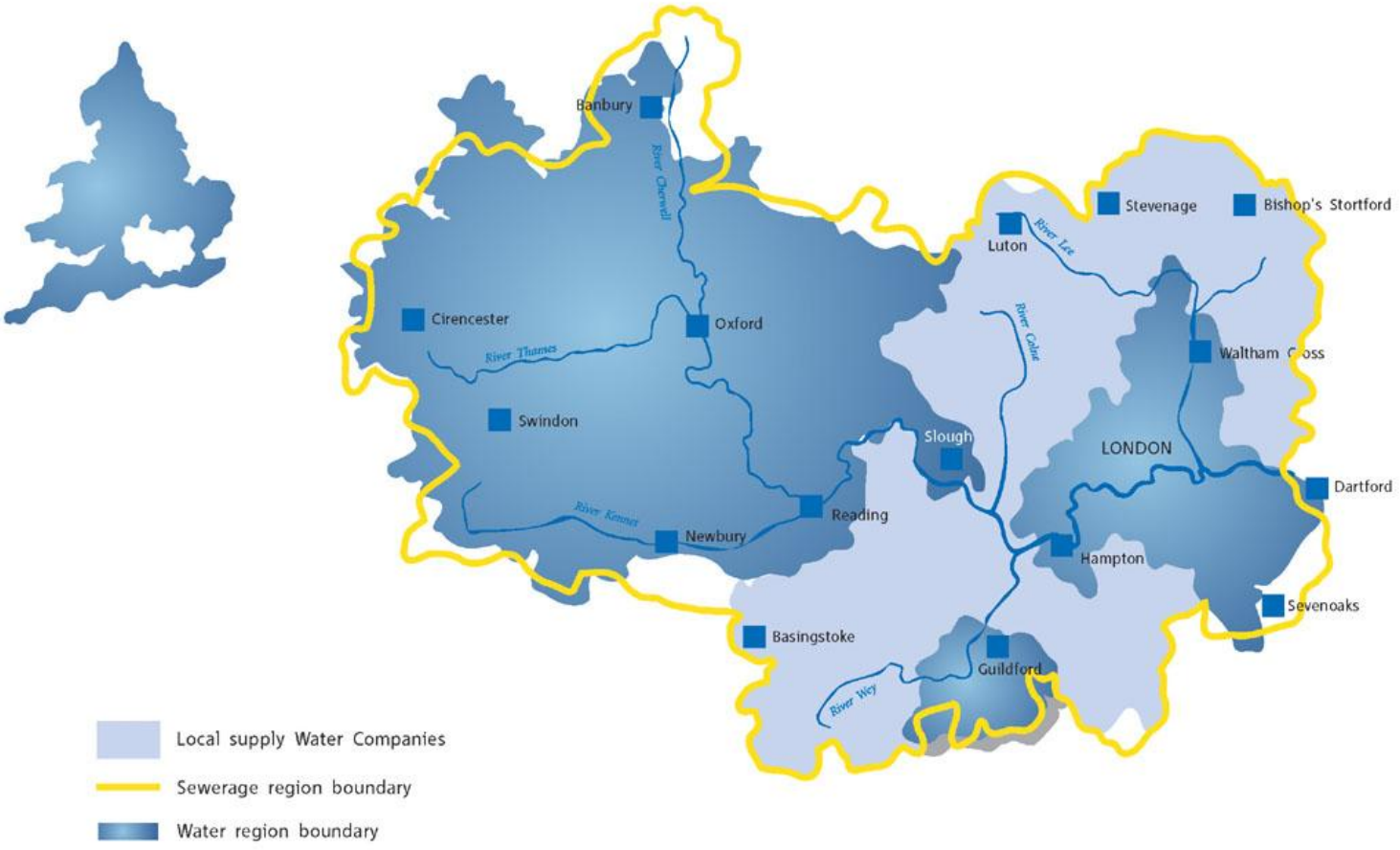
Thames Water

Epping Forest District Council Safer, Cleaner, Greener Panel

Tuesday 28th April 2015

Mark Dickinson – Development Planning Manager
Nigel Fuller – Fields Operations Specialist
Anne Christie – Customer & Continuous Improvement Manager
Mumin Islam – Local / Regional Government Liaison

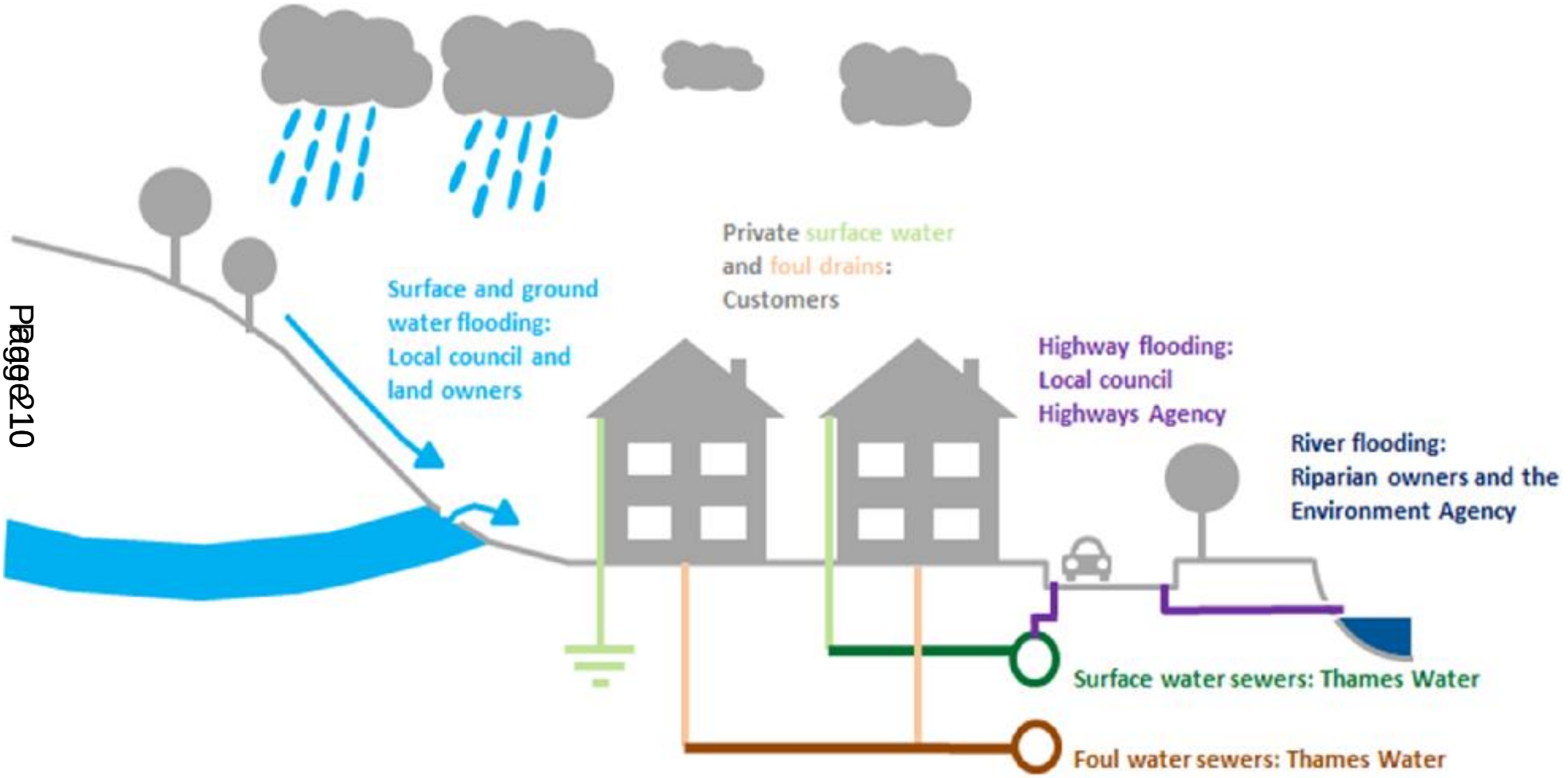
Thames Water – Our Region



Thames Water Responsibilities

- Appointed under the Water Industry Act 1991 to be responsible for sewerage
  - Duty to provide public sewerage and to clean and maintain sewers
  - Duty to provide and extend sewerage systems
  - However, do not have duty to provide capacity to deal with flood water
- There are three types of sewer:
  - Foul water sewers
  - Surface water sewers
  - Combined sewers

Root causes of flooding can be complex



Stakeholder responsibilities for drainage

Flooding cases raised by Epping Forest DC:

- Bower Vale, Epping, Essex
- Monkswood Ave, Waltham abbey, Essex.
- Orchard Gardens EN9 / Mead Court, external flooding

Other areas of concerns raised:

- Sewardstone Road J/W farm Hill Road – EN9
- Waltham Abbey Football Club – EN9
- Horseshoe Hill – EN9

Continuous Improvement

- Communication
  - Increasing the number of customer representatives in both clean and waste teams to improve community contact.
  - Continuously reviewing the communications branch of event team improving how we target communication to areas which need it most.
- “Pollution Tile” project
  - Proactively investigating issues in our highest risk pollution and flooding locations on waste network. This includes two of the areas concerned in Waltham Abbey, EN9.
- “Hold/closed the loop” process
- Reviewing End to end customer journey
- Quarterly North London liaison meetings with the EA to discuss any events in the area

Maintaining our sewer system

- Gravity sewers are designed as self-cleansing and should be maintenance free.
- However, we are aware of problem hot-spots and address these with site-specific maintenance where appropriate.
- In 2015 we have a planned maintenance sewer programme of 260km and currently in the Epping Forest district we have on-going planned maintenance for over 4,000 metres of network in 20 streets.
- Investigating hotspots for discharge of Fats, Oils and Grease working closely with Environmental Health Officers.
- “Bin It Don’t Block It” campaign - our proactive customer education program
- Proactive working with Local Authority's critical surface water drainage areas.

Getting in Touch

Reporting surface flooding:

- Call our 24-hour freephone on 0800 316 9800
- Website www.thameswater.co.uk
- Email customer.feedback@thameswater.co.uk

Response times

- We would prioritise and advise customers accordingly
- 2 hours – Emergency scenarios (e.g. Pollution incident)
- 4 hours – Operational blockages
- If follow on works are raised dependant on Highways Agency agreement and notice/permit has been granted it would be a 5 or 10 day notice (depending on the type of job)

Thames Water and Planning

- We are statutory consultees in development of Local Plans.
- We are not statutory consultees on individual planning applications.
- Where we do have sight of a specific application for development we will assess the capacity of the network to accommodate increased flows, including sewerage network, pumping stations and sewage treatment works.
- Request Grampian-style planning conditions if system is likely to be adversely impacted by increased flows.

Development Plans

- Assess growth and plan for strategic infrastructure improvements

- Types of documents we comment upon:
  - **Strategic Plans e.g. London Plan**
  - **Local Development Plans**
  - **Site Allocations**
  - **Development Strategies**
  - **Supplementary Planning Documents**
  - **Neighbourhood plans**

- Help local authorities influence the type, scale and location of development
- Work with LPAs on evidence base documents, e.g. IDPs, WCSs, SFRAs
- Seek to influence type, scale and location of development
- Propose positive infrastructure and amenity policies
- May seek to safeguard our future sites or influence their designations

Planning Applications

- Appraise and comment upon new developments in terms of:
  - **sewer flood risk,**
  - **odour impact (encroachment)**
  - **water pressure**
  - **asset protection**

- Sites uploaded to Geographical mapping system for appraisal
- Comment on 58688 planning applications last year
- Support councils via council meetings, attendance at planning committees, planning examinations, suggested bespoke conditions.

Why is Development Planning so important for us?

- Under the Water Act we have a statutory duty to “provide, improve and extend” our network to serve customers
- We cannot refuse connection outright.
- Influencing development plans/planning applications is a very important tool to ensure that development is aligned with future infrastructure capacity requirements.
- We are not Statutory Consultees for planning applications therefore we need to be proactive in responding to applications
- Influence Local Authorities with respect to ease of infrastructure provision e.g. water resources & water quality
- Capture of development sites for long term planning & asset protection purposes

Infrastructure Planning

- We review local plans and third party applications to understand the impacts
- The way planning works means we have to develop individual schemes for individual developments
- Drainage networks are complex and extensive, where opportunities exists to deliver more strategic solutions we will do this
- It is generally easier to plan for housing numbers at STW because regardless of the exact location of the development within the catchment you know where the flow will end up.

Ensuring appropriate infrastructure is in place ahead of occupation

- We can deliver some schemes through our Business Plan with advance notice via the Plan led system and in which potential schemes have been properly appraised
- We also need to consider whether the cost benefit and environmental impact of potential network upgrades.
- Delivering network infrastructure upgrades isn't always straight forward. For example:
    - Can the environmental impacts of the network upgrade be mitigated?
    - Does the design consider cumulative impacts and / or betterment?
    - What consents are needed to build the upgrade? E.g. planning, access, highways…etc.

Drainage Grampian conditions

Why are they needed?

- Planning legal advice agrees on the following:
- Foul drainage matters are a material planning consideration
- Foul drainage matters can be dealt with by way of appropriate worded planning condition
- Grampian conditions can be used by the local planning authority if the necessary planning condition tests are met

STW in Epping Forest

Local Authority Area	S.T.W. Catchments	STW Catchment Area (ha)	
Epping Forest	Abbess Roding	110	2%
Epping Forest	Beckton	1910	29%
Epping Forest	Deephams	1590	24%
Epping Forest	Epping (Fiddlers Hamlet)	420	6%
Epping Forest	Matching Tye (closed)	30	1%
Epping Forest	Moreton	70	1%
Epping Forest	North Weald	210	3%
Epping Forest	Riverside	430	7%
Epping Forest	Rye Meads (Within TW)	860	13%
Epping Forest	Stanford Rivers	380	6%
Epping Forest	Theydon Bois	250	4%
Epping Forest	Thornwood	100	2%
Epping Forest	Willingale	160	2%

L/A's that drain to Rye Meads STW

Local Authority Area	S.T.W. Catchments	STW Catchment Area (ha)	
Broxbourne	Rye Meads (Within TW)	860	43%
East Herts	Rye Meads (Within TW)	3040	60%
Epping Forest	Rye Meads (Within TW)	860	13%
Harlow	Rye Meads (Within TW)	2520	100%
North Herts	Rye Meads (Within TW)	450	29%
Stevenage	Rye Meads (Within TW)	2360	100%
Welwyn Hatfield	Rye Meads (Within TW)	2740	46%

Questions?

EPPING FOREST DISTRICT COUNCIL
NOTES OF A MEETING OF PLANNING SERVICES SCRUTINY PANEL
HELD ON TUESDAY, 14 APRIL 2015
IN COMMITTEE ROOM 1, CIVIC OFFICES, HIGH STREET, EPPING
AT 7.00 - 8.10 PM

Members Present:	G Chambers (Chairman), Ms Y Knight (Vice-Chairman), D Dorrell, H Kauffman, J Knapman, Mrs M McEwen, B Sandler, Mrs G Shiell, B Surtees and D Wixley
Other members present:	R Bassett (Planning Policy Portfolio Holder)
Apologies for Absence:	A Watts
Officers Present	D Macnab (Deputy Chief Executive and Director of Neighbourhoods), N Richardson (Assistant Director (Development Management)), Bean (Planning Policy Manager), P Millward (Business Manager) and M Jenkins (Democratic Services Assistant)

47. APOLOGIES FOR ABSENCE

In addition to the apologies indicated above, the Panel had also received apologies from Councillor J Philip Governance and Development Management Portfolio Holder.

48. SUBSTITUTE MEMBERS

There were no substitutions made for the meeting.

49. DECLARATIONS OF INTEREST

There were no declarations of interest made pursuant to the Council's Code of Conduct.

50. NOTES FROM THE LAST MEETING

RESOLVED:

That the notes of the last Panel meeting held on 26 February 2015 be agreed.

51. TERMS OF REFERENCE

The Panel's Terms of Reference were noted.

52. WORK PROGRAMME

It was noted that the Panel Work Programme for this municipal year was completed.

53. ELECTRONIC INFORMATION SYSTEMS DEVELOPMENT MANAGEMENT

The Panel received a report from the Business Manager regarding the Development Management of Electronic Information and Systems.

The re-structure of the Planning Support Team, agreed in October 2014, had led to a Senior Technical Officer Electronic Information and a Technical Officer Applications Systems being appointed. The key focus was to implement business process improvements in the use of the primary planning database Northgate M3 and information@work which managed plans, maps, photographs and documents.

Web mapping on the District Council website linked to planning and building control information was scheduled for 2015/16. Work was continuing on scanning of large site, conservation and contaminated land files with progress having already been made in scanning large site files.

Significant progress had also been made in the electronic conversion of historical microfiche planning records. It was estimated that by December 2015, 93,000 jackets comprising nearly 5 million historical planning images, would be converted to electronic format.

A key element in making progress towards mobile and flexible working was the roll out of tablets for Development Control, Trees and Building Control.

RESOLVED:

That the report regarding Electronic Information Systems Development Management be noted.

54. LOCAL PLAN

The Panel received an update on the Local Plan from the Planning Policy Manager.

The Local Development Scheme agreed in July 2014 had proposed that the next stage of consultation on the draft plan/preferred option was to run between May and July 2015. However, it was advised that it was not possible to meet the timetable for a number of reasons, one of which was that receipt of the consultant's report updating the Strategic Housing Market Assessment (SHMA) had been delayed due to new household projections published by the Government. The following was noted:

(a) Options for Growth – A series of three Member workshops were held in the autumn of 2014 to engage Members in the process of identifying options for testing.

(b) Strategic Housing Market Assessment (SHMA) – As indicated earlier, the receipt of the final report from consultants undertaking work on updating the SHMA had been delayed. New household projections had been published by the Government, therefore the consultants needed to update the SHMA calculations using these figures. A draft final report was expected very soon.

(c) Strategic Flood Risk Assessment (SFRA) – Work updating the Stage 1 SFRA was nearly complete, a Member's workshop would be arranged with the consultants once the Stage 2 work had been undertaken.

(d) Transport Matters – The District Council continued to work with neighbouring authorities on strategic transport modelling to gauge the current position in respect of the transport network in and around Harlow. Supporting the emerging Local Plan, was Essex County Council, who were currently preparing a transport

accessibility study. This would provide a further tool to assess possible site allocations.

(e) Plan Viability – Advice of viability of Local Plan policies was being undertaken by consultants. Their report would also inform policy choices on the Community Infrastructure Levy (CIL/S106). It had been agreed that the timetable should be revised to enable the general direction from Member workshops on Green Belt Review Phase 1 to inform the consideration of viability. A Member workshop would likely be scheduled for May 2015 reporting on the market position, consider options and include an informal view on the possibility of charging CIL.

(f) Economic and Employment Evidence – Consultants had provided interim findings on economic and employment evidence for supporting both the Local Plan and the District Council's overall Economic Development Strategy. This work was being used together with the SHMA with officers ensuring that the assessments of future need for housing and jobs were co-ordinated.

(g) Green Belt Review – Phase 1 of the Review undertook a comprehensive high level review of all Green Belt land across the district to identify its contribution to the Green Belt as stipulated in the National Planning Policy Framework. It would also explore areas of Green Belt land which no longer contributed towards the national purposes or, contributed the least. The Phase 1 report was approaching completion and it was advised that an extra meeting of the Local Council's Liaison Committee had been scheduled for 15 June 2015 for the purposes of sharing the report with parish and town councils.

(h) Duty to Co-Operate – Officers continued to meet regularly with the relevant neighbouring authorities and other bodies to consider cross boundary issues.

(i) Neighbourhood Plans – Moreton, Bobbingworth and the Lavers produced a revised draft plan which was being formally consulted on shortly before being put forward for independent examination. North Weald Bassett's application for their parish to be designated a neighbourhood area was currently under consideration, and consultation had just ended on an application from Loughton Town Council which would be considered soon.

New regulations came into force during February 2015 meant that future designations would need to be made within 8 weeks. The District Council would be writing shortly to all parish and town councils outlining the level of support, guidance and funding available to those progressing neighbourhood plans.

In addition, the following was noted:

(j) The Planning Policy Manager updated the Panel on Enfield Borough Council's North East Enfield Area Action Plan and in particular references in relation to a scheme concerning the North Gateway Access Road. District Council officers were objecting, they were submitting a full statement to the examining inspector. The examination would take place on 28 April 2015 with District Council planning officers being present, along with representatives from Waltham Abbey and Loughton Town Council.

(ii) The Planning Policy Portfolio Holder told the Panel that he had attended a meeting at City Hall (London), to meet representatives from the East and South East of England to establish better communication. At the meeting it was advised that London was planning on building 49,000 new homes within its own area with

no overspill into cross border spaces. City Hall would like to set up “round table” meetings in various places to discuss cross regional border Duty to Cooperate issues. Two meetings involving East of England authorities had now been arranged for later this year.

RESOLVED:

That the update on the Local Plan be noted.

55. ANY OTHER BUSINESS

The Assistant Director of Development Management advised the Panel of new planning legislation which had just come into effect. The changes affected permitted development rights with less permission required for building, from the Area Planning Sub-Committees. A note would be put in the Bulletin for Members.

The Planning Portfolio Holder commented on a recent judicial review involving the District Council, where approval had been given to a glasshouse development in Nazeing. A statutory consultee - the LVRPA - had objected to the application and later requested a judicial review. The review was dismissed and the judge refused an application to appeal the decision. This could have far reaching implications for the LVRPA and the scope of their powers under the 1966 in relation to planning applications.

56. DATES OF FUTURE MEETINGS

This was the last meeting of the Panel, its work would be transferred to two new committees, the Governance Select Committee and the Neighbourhoods and Community Services Select Committee.

The Chairman thanked Members and officers for their support over the last year.

Corporate Plan: 2015-2020

KEY ACTION PLAN 2015-2016

Action	Lead Directorate	Responsibility for Achievement	Target Date	Progress Report *(as at end of Quarter X)*
Aim (i) To ensure that the Council has appropriate resources, on an ongoing basis, to fund its statutory duties and appropriate discretionary services whilst continuing to keep Council Tax low.				
(a) To ensure that the Council's Medium Term Financial Strategy plans to meet the Council's financial and service requirements for any forward five year period, whilst minimising any reliance on Government funding.				
1) Deliver the savings identified for 2015/16 in the business cases approved by Members.	Management Board	Chief Executive	March 2016	
2) Progress preparations for delivering the savings identified for 2016/17 within the Medium Term Financial Strategy.	Management Board	Chief Executive	March 2016	
3) Develop additional business cases, through a structured approach, to address the need for net savings in subsequent years.	Management Board	Chief Executive	Sept 2015	
4) Commence the budget cycle early again next year with an updated MTFS to take account of any changes following the general election.	Resources	Director of Resources	July 2015	
(b) To continue to review and develop the Council's own assets and landholdings for appropriate uses, in order to maximise revenue streams and capital receipts, and to deliver the following key projects: ■ The Epping Forest Shopping Park, Loughton ■ St John's Redevelopment Scheme, Epping ■ Council Housebuilding Programme ■ North Weald Airfield				
1) Complete Phase 1 of the Council Housebuilding Programme to provide 23 new affordable rented homes in Waltham Abbey.	Communities	Asst. Director (Housing Property & Development)	Dec 2015	
2) Complete the major refurbishment scheme at Marden Close, Chigwell Row to convert 20 difficult-to-let bedsits and a communal hall into 12 self-contained flats.	Communities	Asst. Director (Housing Property & Development)	Sept 2015	

Note: some target dates may be subject to change after consideration by Members and prior to publication

3) Secure planning permission and commence Phase 2 of the Council Housebuilding Programme to provide up to 52 new affordable rented homes at Burton Road, Loughton.	Communities	Asst. Director (Housing Property & Development)	Aug 2015	
4) Negotiate and complete the St John's redevelopment Scheme at Epping, and identify a suitable location within the District to which the Housing Repairs Service can be relocated from the Epping Depot.	Neighbourhoods	Assistant Director (Policy, Planning & ED)	Sept 2015	
5) Work in partnership with Moat Housing to commence the development of the Council garage site at Vere Road, Loughton to provide up to15 affordable rented homes, together with up to 14 additional parking spaces to facilitate the development of the adjacent site of the former Sir Winston Churchill PH.	Communities	Director of Communities	March 2016	
6) Seek to vacate the Council's Hemnall Street Offices, Epping in order to redevelop/let the premises, by relocating Community Services staff to office accommodation to be purchased close to Epping Forest District Museum, Waltham Abbey, and at the Civic Offices through the freeing-up of Council accommodation as a result of flexible working arrangements.	Communities / Management Board	Chief Executive / Asst. Director (Community Services and Safety)	March 2016	
7) Review all licence arrangements at North Weald Airfield.	Neighbourhoods	Assistant Director (Neighbourhoods)	April 2015	
8) Progress the Epping Forest Shopping Park scheme in association with Member decisions.	Neighbourhoods	Assistant Director (Policy, Planning & ED)	Sept 2016	
(c) To explore appropriate opportunities to make savings and increase income through the shared delivery of services with other organisations, where such arrangements would provide improved and/or more cost effective outcomes.				
1) Work with 5 neighbouring councils, through a consortium arrangement, to renew the contract and service arrangements for the Shared Housing Register Management Service, in order to continue to share the Service's costs and improve service delivery.	Communities	Assistant Director (Housing Operations)	Jan 2016	

2) Approach neighbouring authorities to carry out checking and vetting of Building Control plans through partnership working.	Governance	Assistant Director (Development Management)	Jan 2016	
3) Review the shared opportunities with the Public Law Partnership: • to pool knowledge when implementing legislative change, • work towards standardising documentation used in the member Council used in the provision of services across the partnership, and take advantage of reductions in the costs of on-line library services and training which are negotiated by the partnership.	Governance	Assistant Director (Legal Services)	March 2016	
4) Explore the possibility of sharing an integrated HR/Payroll IT system with other authorities.	Resources	Assistant Director (HR)	Sept 2015	
5) Explore providing payroll services to other authorities.	Resources	Assistant Director (HR)	March 2016	
6) Explore providing an audio typing service to other authorities.	Resources	Assistant Director (HR)	March 2016	
7) Identify additional Council services that may benefit from a shared provision with other organisations (either provided by the Council or others), to reduce costs, create income and/or improve service delivery.	Management Board	Chief Executive	March 2016	

Aim (ii) To ensure that the Council has a sound and approved Local Plan and commences its subsequent delivery				
(a) To produce a sound Local Plan, following consultation with local residents and working with neighbouring councils, that meets the needs of our communities whilst minimising the impact on the District's Green Belt.				
1) Update the Council's Housing Strategy, following production of the Preferred Options for the Local Plan.	Communities	Director of Communities	Dec 2015	

2) Complete the gathering of information to form the evidence on which key decisions will be taken as part of the Local Plan.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	April 2015	
3) Agree on objectively assessed Housing and Employment Need for the Local Plan Period.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	April 2015	
4) Agree a Draft Local Plan and undertake the appropriate sustainability appraisal.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	June 2015	
5) Undertake the Preferred Options Consultations.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	June-Sept 2015	
6) Submit the Final Local Plan to the Planning Inspectorate for Examination.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	Nov 2015	
4) To increase opportunities for sustainable economic development within the District, in order to increase local employment opportunities for residents.				
1) Consider the practicalities of revising procurement arrangements to encourage/require contractors to employ local residents for Council contracts.	Resources	Director of Resources	Dec 2015	
2) Incorporate the findings of the Economic Development Study into the Local Plan Evidence base with a view to determining future Employment Need.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	April 2015	
3) After consultation on Preferred Options to allocate Employment land within the Council's Local Plan.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	Nov 2015	
4) Develop and implement a new Economic Development Plan for the District, building on the work that has been undertaken with regard to individual Town Centres.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	May 2015	
5) Continue to support the work of Local Business Partnerships to support the local economy and generate additional local employment opportunities.	Neighbourhoods	Assistant Director (Policy Planning & Economic Development)	Ongoing	

6) Continue with the Council's apprenticeship scheme for the district's young people, providing sustainable employment opportunities.	Resources	Assistant Director (HR)	Sept 2015	
(c) To deliver the Council's new Leisure and Cultural Strategy, in order to maximise participation and value for money in the provision of leisure and cultural services to local residents and visitors.				
1) Complete the extension and major refurbishment of the Epping Forest District Museum, Waltham Abbey and open to the public.	Communities	Assistant Director (Community Services and Safety)	Dec 2015	
2) Work in partnership with Waltham Abbey Town Council to investigate the feasibility of developing a new leisure/community hub at Hillhouse, Waltham Abbey.	Neighbourhoods / Communities	Director of Neighbourhoods / Director of Communities	March 2016	
3) Appoint external specialist support to the competitive dialogue process for the new Leisure Management Contract, to ensure that the Council achieves best consideration.	Neighbourhoods	Assistant Director Neighbourhoods)	April 2015	
4) In accordance with the recommendations of the Leisure and Culture Strategy to jointly pursue the provision of a new Secondary School on the Ongar Campus site, with a view to entering a Dual-Use Agreement for the Leisure Centre.	Neighbourhoods	Assistant Director (Neighbourhoods)	May 2015	
5) As part of the competitive dialogue procurement process for the new Leisure Management Contract, take forward the provision of a replacement swimming pool in Waltham Abbey.	Neighbourhoods	Director of Neighbourhoods	April 2015 onwards	

Aim (iii) To ensure that the Council adopts a modern approach to the delivery of its services and that they are efficient, effective and fit for purpose.				
(a) To have efficient arrangements in place to enable customers to easily contact the Council, in a variety of convenient ways, and in most cases have their service needs met effectively on first contact.				
1) Increase the opening hours of the Council Office at the Limes Centre, Chigwell, to improve access for local residents to a range of Council services.	Communities	Assistant Director (Community Services and Safety)	June 2015	

2) Introduce web-based and smartphone applications to enable Council tenants to report repairs on-line.	Communities	Asst. Director (Housing Property & Development)	May 2015	
3) Establish a multi–disciplinary officer group to undertake a review and report on proposals for improving customer contact with the Council.	Management Board	Assistant Director (Governance and Performance Improvement)	March 2016	
(b) To utilise modern technology to enable Council officers and members to work more effectively, in order to provide enhanced services to customers and make Council services and information easier to access.				
1) Introduce more flexible methods for customers to pay for Council services.	Resources	Assistant Director (Revenues)	Dec 2015	
2) Introduce an on-line facility for customers to easily view and research objects held by the Epping Forest District Museum.	Communities	Museum Heritage and Culture Manager	March 2016	
3) Scan old Development Control & Building Control files and microfiche and increase the number of planning records available on the Council's website.	Governance	Assistant Director (Development Management)	July 2016	
4) Investigate and, if possible, implement the returns of Local Land Charges Searches by email.	Governance	Assistant Director (Legal Services)	April 2016	
5) Update the Contracts Register so that the contract documentation can be accessed and viewed by using an icon on the register. This will apply to new contracts at first.	Governance	Assistant Director (Legal Services)	April 2016	
6) Identify, during audits, any manual documentation or process that can be improved by conversion to electronic form.	Governance	Chief Internal Auditor	March 2016	
7) Continue the implementation of the Council's ICT Strategy, with the completion of the following key projects: (a) Printer reduction, removal and redeployment, and implementation of print management software; and (b) Mobile and flexible working.	Resources	Assistant Director (ICT & Facilities Management)	March 2016	

8) Complete a review of accommodation and make recommendations on utilisation of space and flexible methods of working.	Management Board	Chief Executive	Sept 2015	
(c) To ensure that the Council understands the effects of an ageing population within the District and works with other agencies to make appropriate plans and arrangements to respond to these effects.				
1) Undertake a study to identify and better understand the demographics of an ageing population in the District and the effects on the Council and local residents.	Communities	Assistant Director (Community Services and Safety)	March 2016	
2) Review the provision and delivery of community and cultural services to older people, to ensure that appropriate resources are targeted at the increasing numbers of older people, in order to help improve their general health and wellbeing.	Communities	Assistant Director (Community Services and Safety)	Oct 2016	
3) Undertake a review of the Council's sheltered and designated accommodation for older people, with a view to rationalising the amount and location of such accommodation and identifying improvements required to the retained accommodation to ensure it remains fit for purpose.	Communities	Assistant Director (Housing Operations) / Assistant Director (Housing Property & Development)	March 2016	

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Report to Overview and Scrutiny Committee

Date of meeting: 9 June 2015

Portfolio: Leader (Councillor C. Whitbread)

Subject: Corporate Plan Key Objectives 2014/15 – Outturn (Quarter 4) performance

Responsible Officer: B Copson (01992 564042)

Democratic Services Officer: A. Hendry (01992 564246)

Recommendations/Decisions Required:

That the Committee reviews the end of year position in relation to the achievement of the Council's key objectives for 2014/15

Executive Summary:

The Corporate Plan is the Council's key strategic planning document, setting out its priorities over the four-year period from 2011/12 to 2014/15, with strategic themes reflecting those of the Community Strategy for the district. Updates to the Corporate Plan are published annually, to reflect the key objectives for each year of the plan period and progress against the achievement of objectives for previous years.

The annual identification of key objectives provides an opportunity for the Council to focus attention on how areas for improvement will be addressed, opportunities exploited and better outcomes delivered during the year. The key objectives are intended to provide a clear statement of the Council's overall intentions for each year, and are supported by a range of actions and deliverables designed to achieve specific outcomes.

A range of key objectives for 2014/15 was adopted by the Cabinet in April 2014. Progress in relation to individual actions and deliverables is reviewed by the Cabinet and the Overview and Scrutiny Committee on a quarterly and outturn basis.

Reasons for Proposed Decision:

It is important that relevant performance management processes are in place to review progress against the key objectives, to ensure their continued achievability and relevance, and to identify proposals for appropriate corrective action in areas of slippage or under-performance. This report presents year-end progress against the key objectives for 2014/15.

Other Options for Action:

No other options are appropriate in this respect. Failure to monitor and review performance against the key objectives and to consider corrective action where necessary, could have negative implications for the Council's reputation and judgements made about its progress, and might mean that opportunities for improvement were lost. The Council has previously agreed arrangements for the review of progress against the key objectives.

Report:

1. The Corporate Plan for 2011/12 to 2014/15 translates the vision for the district set out by the Community Strategy, into the Council's strategic direction, priorities and the most important outcomes that it wants to achieve. The Corporate Plan helps to prioritise resources to provide quality services and value for money.

2. The key objectives adopted for each year of the Corporate Plan represent the Council's high-level initiatives and over-arching goals for the year. The objectives are not intended to reflect everything that the Council does, but instead focus on national priorities set by the Government and local challenges arising from the social, economic and environmental context of the district.

3. The key objectives for 2014/15 were adopted by the Cabinet at its meeting on 7 April 2014. The achievement of the objectives is supported by a range of individual deliverables and actions, with target dates spread throughout the year (and beyond in some instances). Some of the deliverables can only be achieved incrementally or are dependent upon the completion of other actions, and are intended to be fluid to reflect changes in priorities and other influencing factors.

4. Progress against the key objectives was an area of focus in former corporate inspection processes, in order to assess the Council's success in improving the services that it delivers, and to identify and reflect plans to secure improvement. Whilst such external assessment processes have generally ceased, it remains important to review progress against the key objectives, and to take appropriate corrective action where necessary in areas of slippage or under-performance. Progress towards the achievement of individual deliverables and actions is therefore reviewed on a quarterly basis, in order to ensure the timely identification and implementation of appropriate corrective action.

5. A schedule detailing year-end progress against the fifty-four individual deliverables and actions designed to support the achievement of each of the key objectives, is attached as Appendix 1 to this report. In reporting progress, the following 'status' indicators have been applied to the outturn position for each individual deliverable or action:

> **Achieved (Green)** - specific deliverables or actions were completed or achieved in accordance with in-year targets; and
> **Behind Schedule (Red)** - specific deliverables or actions were not completed or achieved in accordance with in-year targets.

6. At the end of the year:

> (a) 35 (65%) of the individual deliverables or actions supporting the key objectives had been achieved;
> (b) 19 (35%) of the deliverables or actions were not completed by year-end albeit significant progress has been made. Details of the progress made are set out in the comments against the individual deliverables or actions in the attached schedule.

7. The Overview and Scrutiny Committee is requested to review year-end progress against the key objectives for 2014/15. This report will also be considered by the Cabinet at its meeting on 11 June 2015.

Resource Implications:

Resource requirements for actions to achieve specific key objectives for 2014/15 will have been identified by the responsible service director/chief officer and reflected in the budget for the year.

Legal and Governance Implications:

There are no legal or governance implications arising from the recommendations of this report. Relevant implications arising from actions to achieve specific key objectives for 2014/15 will have been identified by the responsible service director/chief officer.

Safer, Cleaner, Greener Implications:

There are no implications arising from the recommendations of this report in respect of the Council's commitment to the Climate Local Agreement, the corporate Safer, Cleaner, Greener initiative, or any crime and disorder issues within the district. Relevant implications arising from actions to achieve specific key objectives for 2014/15 will have been identified by the responsible service director/chief officer.

Consultation Undertaken:

Progress against actions to achieve specific key objectives for 2014/15 as set out in this report, has been submitted by each responsible service director/chief officer direct to the 'Ten' performance management system. Current progress in respect of each of the key objectives for 2014/15 has been reviewed by Management Board (13 May 2015) and will be reviewed by the Cabinet (11 June 2015).

Background Papers:

Year end progress submissions for the key objectives for 2014/15 and relevant supporting documentation is held by responsible service directors/chief officers.

Impact Assessments:

Risk Management

There are no risk management issues arising from the recommendations of this report. Relevant issues arising from actions to achieve specific key objectives for 2014/15 will have been identified by the responsible service director/chief officer.

Equality:

There are no equality issues arising from the recommendations of this report. Relevant issues arising from actions to achieve specific key objectives for 2014/15 will have been identified by the responsible service director/chief officer.

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1. Proactively promote the policies and reputation of the Council internally and externally

Action	Lead Directorates	Target Date		Status	Progress
(a) - Communicate information about the waste contract	Neighbourhoods	(not specified)		Achieved	(Q1 2014/15) - The Council appointed its new Contractor, Biffa, in May 2014 who is in their mobilisation phase with handover planned first week in November. The new Contractor and the Council will be developing a communication plan to inform the public of the planned 4 day collection arrangements due to start in April 2015. (Q2 2014/15) - The Council's new Waste Management Contractor has been working closely with the Council during the mobilisation period up to the start of the contract on the 3rd November to ensure that a smooth transition is achieved. These arrangements have included joint work on communications to provide accessible and timely information about the revised 4- day collection arrangements due to start in April 2015. (Q3 2014/15) - the target date for commencement of the new revised four day collection arrangements has been set for early May 2015. A communications plan has been developed to ensure adequate notice is given to residents, the majority of whom will have if not a day change, but a change of collection time. (Q4 2014/15) the revised 4 day waste and recycling collection arrangements are due to commence on the 12 May 2015. In liaison with the contractor a communications plan has been developed which will see all households mailed directly about the revised arrangements and the launch of an on-line tool on the Council's Website.
(b) - Communicate information about the Local Plan	Neighbourhoods	(not specified)		Behind Schedule	(Q1 2014/15) - The Local Development Scheme published in July 2013 is due to be updated and published in July 2014. (Q2 2014/15) - The updated Local Development Scheme was agreed by Cabinet at their meeting in July 2014 and has been published on the Council's Website. (Q3 2014/2015) - The timescales outlined in the Local Development Scheme have slipped as a result of further work to update the Strategic Housing Market Assessment being undertaken with the Council's partner authorities.

					(Q4 2014/2015) - The timetable for the Local Plan, the Local Development Scheme is due to be considered by the Cabinet on the 11th June 2015. Thereafter, it will be published on the Council's website and other supporting information will be provided. It is planned to update all Town and Parish Councils at a special Local Council's Liaison Committee on the 15 June where information will also be provided with respect to the conclusions of Phase I of the Green Belt Review.
(c) - Communicate information regarding welfare reforms	Resources	(not specified)		Achieved	(Q1 & Q2 2014/15) - There have been no significant announcements to publicise in the first half of 2014/15. (Q3 & Q4 2014/15) No significant announcements in Q3 or Q4 and it is unlikely that there will be any now until after the general election.

2. Engage with communities and put them at the centre of the Council's policy development and service design

Action	Lead Directorates	Target Date	Status	Progress
(a) - Development programme for areas with identified health inequalities	Communities	31-Mar-15	Achieved	(Q1 - Q4 2014/15) Comprehensive community engagement programmes have been developed and delivered in key SOAs throughout 2014/15: Limes Farm – Activity has included; a weekly Community Café initiative, table top sales, children's craft sessions, boccia, bingo and vibrant football and boxing programmes for young people. A number of community days were staged in The Limes Centre, a community newsletter has been produced and support is on-going to re-establish a representative community association for the estate. Waltham Abbey - Following the launch of the 3G pitch a balanced programme of bookings has been established throughout the week on the pitch. This includes the Epping Forest College and Tottenham Hotspur Foundation Football Development programme for 16 -18 year olds, local clubs and a free Friday night Football Inclusion programme every week for 11-16 year olds. Average attendance at these sessions is 40-50 young people per week. An environmental tree planting project was delivered in partnership with Hill House Primary School and an extremely well attended community craft event was facilitated at the Town Hall. Support is on-going for the Ninefields Residents Panel and Older Peoples` Group. Play-schemes have been delivered at Leverton

					School, along with Play in the Park sessions at Town Mead and Ninefields estate. Oakwood Hill – Community events have been staged and support has been given to OHERA in order to successfully increase membership by 25%. Engagement projects have included; support for the Older Peoples` Group and the introduction of a variety of new activities for members, table top sales, craft sessions and coffee mornings. A Good Neighbour Pilot Project was successfully rolled out on the estate. Play in the Park and Street Play sessions were delivered. Shelley, Ongar – Support is on-going for the Shelley Residents Association and the Ongar Orchard Project, work undertaken with children from Shelley Primary School via the Active Assemblies project and Motiv8 event. Play in the Park was delivered and a Good Neighbour Pilot Project was successfully rolled out on the estate.
(b) - (i) Undertaking a consultation exercise on gypsy & traveller site licences	Communities	31-Jul-14		Achieved	(Q1 2014/15) The Housing Portfolio Holder agreed draft site licence conditions in June 2014 (based on the previously-agreed conditions for permanent residential sites) for consultation. The consultation exercise is in progress and a report will be considered by the Cabinet in September 2014 on the proposed final version of the Conditions, following which new site licences will be issued. (Q2 2014/15) The Cabinet agreed the proposed new site licence conditions at its meeting in September 2014, and the Private Sector Housing Team are currently in the process of issuing the licences (Q3 2014/15) All new licences, with the new licence conditions, have been issued (Q4 2014/15) As Q3
(b) - (ii) Introduction of gypsy & traveller site licences and licence conditions	Communities	31-Mar-15		Achieved	(Q1 - Q4 2014/15) See 2(b)(i) above.
(c) - (i) Undertaking a consultation exercise on proposed car park tariffs	Neighbourhoods	31-Oct-14		Achieved	(Q1 2014/15) Intention to undertake survey in early summer. (Q2 2014/15) 2 (c) (i) Survey completed and results used to inform the new Parking Strategy.

					(Q3 2014/15) 2 (c) (ii) The Car Parking Strategy containing a range of revised tariff proposals was agreed by Cabinet in February 2015 and subsequently adopted by Full Council. (Q4 2014/15) As Q3.
(c) - (ii) Adoption of off-street car parking strategy and parking tariffs by 31 March 2015	Neighbourhoods	31-Mar-15		Achieved	(Q1 2014/15) Consultation work on tariff review commenced. (Q2 2014/15) As above the survey has concluded. The generation of income from off-street car parking will be a key consideration as part of the 2015/16 budget proposals. It is time-tabled to consider the off-street parking policy and any revised tariff arrangements in December 2015. (Q3 2014/15) 2 (c) (ii) The Car Parking Strategy with proposed tariff charges are due to be formally considered by the Cabinet in February 2015. A business case to guarantee £100K of additional revenue from off street parking has been incorporated as part of the budget process. Further investment is to be made in new payment machines and CCTV to be sought as part of the Strategy. (Q4 2014/2015) The Car Parking Strategy containing a range of revised tariff proposals was agreed by Cabinet in February 2015 and subsequently adopted by Full Council.

3. Deliver a robust and resilient Local Plan that facilitates appropriate growth, whilst protecting the special character of the district.

Action	Lead Directorates	Target Date		Status	Progress
(a) (i) - Publication of Local Plan Preferred Options Consultation	Neighbourhoods	31-Oct-14		Behind Schedule	(Q1 2014/15) The proposed new Local Development Scheme subject to agreement in July 2014 predicts that the revised date for the preferred options consultation will take place from mid-May 2015. (Q2 2014/15) The Local Development Scheme agreed by Cabinet in July 2014, still indicates that the preferred options consultation will take place from mid-May 2015. (Q3 2014/15) Due to the delay in compiling the evidence base, it is unlikely that the preferred options consultation will be undertaken until the Summer of 2015. (Q4 2014/2015) Revised Local Development Scheme due to be considered by Cabinet on the 11 June 2015. Preferred Options timescale dependent on this item being considered.
(a) (ii) - Publication of Local Plan	Neighbourhoods	31-Mar-15		Behind Schedule	(Q1 2014/15) Following the preferred options consultation, the new draft Local Plan should be published in the autumn of 2015. (Q2 2014/2015) Incorporating the findings of the preferred options consultation, the new draft Local Plan should be published in the Autumn of 2015. (Q3 2014/15) The Local Development Scheme published in July 2014 has slipped due to the need for further work on the evidence base. Unlikely that the preferred options consultation will be undertaken until the Summer 2015. (Q4 2014/2015) Revised Local Development Scheme due to be considered by Cabinet on the 11 June 2015. Preferred Options timescale dependent on this item being considered.

4. Promote cultural change to breakdown silo working, and implement new, flexible ways of working.

Action	Lead Directorates	Target Date		Status	Progress
(a) - Develop overarching Organisational Development Plan	Resources Governance Chief Executive Neighbourhoods Communities	31-Dec-14		Behind Schedule	(Q1 2014/15) Completion of Organisational Development Plan dependent on achievement of related actions. Completion scheduled for end of third quarter. (Q2 2014/15) Management Board away day considered different types of organisational structure to help inform the organisational development structure. The session scheduled to progress this to the next stage was substituted by a joint session with the cabinet to set strategic priorities. (Q3 2014/15) A draft of the Corporate Plan incorporating the Council's strategic priorities has been reviewed by Cabinet and is scheduled for wider consultation during the 4th Quarter. The next stage of the Organisational Development Plan will be considered at an away day scheduled for late March / early April. (Q4 2014/15) A workshop was held on 24 April 2015 and the Organisational Development Plan was discussed. Outcomes to be developed.
(b) - (i) Agreement of Phase 2 organisational structure	Chief Executive Resources Neighbourhoods Governance Communities	30-Sep-14		Achieved	(Q1 2014/15) Phase II reviews in progress and being conducted by each Assistant Director, although unlikely to have all been agreed by the end of September 2014. Restructure of ICT and Forward Planning completed, but outcome of the Debt Working Party awaited to inform resource requirements for review of Legal Services. (Q2 2014/15) Economic Development and Asset Management Phase 2 agreed at Council. Legal, Governance and Performance Management and Development Management ready for Management Board consideration; and Internal Audit/Corporate Fraud – out for consultation with affected service areas. Phase II reviews still progressing with savings generated in some areas. Debt working party draft report ready. (Q3 2014/15) Governance restructures complete and agreed at appropriate levels. During Q3 Cabinet approved the restructure of the Benefits Service. (Q4 2014/15) Phase 2 restructure is complete.

(b) - (ii) Implementation of Phase 2 organisational structure	Governance Communities Resources Neighbourhoods Chief Executive	31-Mar-15		Achieved	(Q1 & Q2 2014/15) See 4(b)(i) above. (Q3 2014/15) Appointments made / awaiting Job Evaluation or on hold pending transfer between Directorates. The restructure of the Benefits Service approved late in Q3 will be implemented in Q4. (Q4 2014/15) Phase 2 restructure is complete.
(c) - (i) Development of action plan to embed values & behaviours	Neighbourhoods Resources Chief Executive Governance Communities	31-Mar-14		Achieved	(Q1 2014/15) Draft designs for poster campaigns considered by Leadership Team. Roll-out anticipated in September 2014. (Q2 2014/15) Poster campaign now expected for November. (Q3 2014/15) Subject matter for the posters has been considered by Leadership Team and the final designs reviewed by Management Board. Values and Behaviours have been incorporated into the PDR process for all staff and two training sessions held with Managers to explain the new format of PDRs. Posters illustrating good examples of each the values have been discussed at an all staff briefing and will be displayed in Council buildings. (Q4 2014/15) Final poster design signed off and being printed. New PDR process incorporates values and behaviours discussion for all staff.
(c) - (ii) Assessment of performance against values & behaviours	Resources	31-Dec-14		Achieved	(Q1 2014/15) Human Resources are completing the analysis of the initial trial and this will be used to inform the rollout later in the year. (Q2 2014/15) The analysis of the initial trial was presented to Management Board on 20 August and a session is planned with Leadership team for 5 November to take forward the rollout later in the year. (Q3 2014/15) Values and behaviours have been incorporated into the PDR process for all staff and two training sessions have been held with managers to explain the revised format of PDR documentation. (Q4 2014/15) New PDR process incorporates values and behaviours discussion for all staff.

(d) - (i) Adoption of customer centric approach to service delivery	Neighbourhoods Governance Communities Chief Executive Resources	30-Sep-14		Achieved	(Q1 & Q2 2014/15) Potential service areas for pilot study considered by Leadership Team. Possible external partners for the development of a service review methodology to be investigated. (Q3 2014/15) Improvements made to the customer experience from the work identified by the Corporate Debt Working Party include better communication, early contact and revising the procedure for instigating legal proceedings. The methodology used by this group has been shared with Leadership Team and further process reviews are planned for the customer experience around lifetime events such as bereavement, redundancy, unemployment. This approach will be rolled out to other processes in due course. (Q4 2014/15) A working methodology has been established and will be used by other services as processes are reviewed.
(d) - (ii) Generation of increased revenue by traded services	Communities Neighbourhoods Chief Executive Resources Governance	31-Mar-15		Achieved	(Q1 & Q2 2014/15) Parking review underway and report anticipated in October 2014. Presentation by East of England Local Government Association on commercialisation of local authority services to be made to Leadership Team in September 2014. Proposals for the commercialisation of the Council's MOT and vehicle servicing facilities via a controlled company able to generate profit, being investigated. Trade waste service to be provided as part of new Waste Management Contract. (Q3 2014/15) The review of the Council's MOT and vehicle servicing facilities concluded that developing a commercial operation of sufficient scale to return a profit would be difficult. Alternative proposals to reduce the number of service bays on relocation of Fleet Operations to Oakwood Hill were approved. This should reduce the costs of servicing the in-house fleet to a sustainable break even point. Proposals to revise parking tariffs which will yield an additional income are being considered by Cabinet for recommendation to Council in the 2015/16 budget. Fees and charges for other services have been reviewed to ensure the Council is at least recovering costs. (Q4 2014/15) New parking tariffs approved by Council as part of the budget for 2015/16. We continue to perform strongly in Development Management and Building Control areas.

(e) - Review of outsourced Out Of Hours Call Handling Service	Communities	31-Mar-15		Achieved	(Q1 2014/15) The new call handling service operated by Mears was successfully introduced in April 2014. Some teething problems have been identified which are being resolved and a formal review of the new arrangements will be undertaken later in the year. (Q2 2014/15) As Q1 above. (Q3 2014/15) As Q1 above. (Q4 2014/15) As Q1 above.
(f) - (i) Investigation of options for flexible working	Chief Executive Governance Resources Communities Neighbourhoods	30-Sep-14		Achieved	(Q1 & Q2 2014/15) ICT capability has been identified to enable flexible working opportunities and a bid for capital funding is to be made as part of budget process for 2015/16. The trialling of a number of options has taken place and appropriate service areas to pilot flexible working approaches are to be identified. (Q3 2014/15) Trials of iPhones and iPads have been conducted by the Planning, Facilities Management and Housing teams. Branch routers are being used by approximately 40 staff allowing them quick, reliable and secure remote access to Council servers to work remotely. This technology will eventually replace the cumbersome VPN technology. Facilities Management staff on call have improved their efficiency by being able to log into Council servers out of hours. Development work is proceeding to enable remote access to the M3 system which will transform the way the Neighbourhoods team are able to deal with customer calls relative to waste management. The next step is to use the learning from all of the trials and look at the potential for further roll out to other services. This will be co-ordinated with a review of work spaces across the Council in action (n) below. (Q4 2014/15) The wider concept of this is scheduled for discussion at Leadership Team in April 2015.

(f) - (ii) Adoption of flexible working strategies	Resources Neighbourhoods Chief Executive Governance Communities	31-Mar-15		Behind Schedule	(Q1, Q2 & Q3 2014/15) See 4(f)(i) above. (Q4 2014/15) Visit to Colchester Borough Council attended by Portfolio Holder for Technology & Support Services, Chief Executive and Director of Resources. Project brief drafted to engage space planning consultants. Service Director responsible for implementing flexible working in Colchester will attend EFDC Leadership Team meeting in April 2015. See comments in 4 (f) (ii) above. Initial pilot trials conducted. Full roll out will be undertaken in 2015/16 using reserves specifically set aside to improve efficiency.
(g) - Implementation of National Land & Property Gazetteer	Resources	31-Jul-14		Achieved	(Q1 2014/15) - All major issues have been resolved but work is continuing to eliminate some duplicate references. (Q2 & Q3 2014/15) - All major issues have been dealt with and there are only a few duplicate references still to be resolved. (Q4 2014/15) This objective has been achieved.
(h) - (i) Review of Allocation Scheme and Tenancy Policy	Communities	30-Dec-14		Achieved	(Q1 2014/15) Officers have identified a number of proposed changes to both the Housing Allocations Scheme and Tenancy Policy, following the introduction of the new Schemes in September 2013. Following informal discussion with Cabinet Members, the Housing Portfolio Holder will make a Portfolio Holder Decision on proposed changes in principle, which will be considered in detail by the Housing Scrutiny Panel in October 2014. (Q2 2014/5) The Housing Portfolio Holder made a formal Portfolio Holder Decision in October 2014 on proposed changes that he would like the Housing Scrutiny Panel to consider. Officers have produced a report based on these principles, along with a number of more minor issues, for consideration at the Housing Scrutiny Panel meeting on 21st October 2014. (Q3 2014/15) At its meeting in October 2014, the Housing Scrutiny Panel considered a number of recommended changes to the Allocations Scheme and Tenancy Policy from the Housing Portfolio Holder and officers, and made a number of recommendations to the Cabinet on proposed changes, which will be considered at the Cabinet its meeting in March 2015, after the required statutory consultation exercise on the proposed changes has been undertaken.

					(Q4 2014/15) The recommendations of the Housing Scrutiny Panel were considered and agreed at the meeting of the Cabinet on 9th March 2015. The target date for implementation is 1st July 2015.
(h) - (ii) Implementation of any changes required to Tenancy Policy	Communities	31-Mar-15		Achieved	(Q1 2014/15) Not yet required. (Q2 2014/15) As Q1 above. (Q3 2014/15) As Q1 above. (Q4 2014/15) Following adoption of the revised Tenancy Policy by the Cabinet in March 2015, officers are currently preparing for the implementation of the new Policy. The target date is 1st July 2015.
(i) - Implementation of Child and Adult Safeguarding Policy	Communities	31-Mar-15		Achieved	(Q1 2014/15) Following the appointment to the new posts of Safeguarding Officer and Safeguarding Administration Assistant, good progress is being made with delivering the identified actions within the action plan, produced following the safeguarding audit in 2013, in accordance with the Council's Child and Adult Safeguarding Policy. A full training programme commenced in April 2014 which has been provided to 80 staff and 25 Members. Work has commenced on a full review of the Council's Safeguarding Policy. (Q2 2014/15) Work on the review of the Council's Safeguarding Policy, and the implementation of the training programme, continues. (Q3 2014/15) The Safeguarding Audit has nearly been completed, and the numerous actions undertaken since the last Audit have now placed the Council in a much better position with regard to its approach in this very important area. The deadline for completing and submitting the Audit is the end of January 2015. A new Safeguarding Policy and associated procedures have been produced. The new Policy will be submitted to Cabinet in March 2015 for adoption. (Q4 2014/15) The new Safeguarding Policy (which covers both children and adults with care and support needs) was adopted by the Cabinet on 9th March 2015.

(j) - Determination of the Council's Housing Strategy for 2013-2016	Communities	31-Dec-14		Behind Schedule	(Q1 2014/15) The Housing Portfolio Holder has previously agreed that the new Housing Strategy should be deferred until the production of the Preferred Options for the Local Plan (see 3(a)(i)), due to the inter-relationship between the two documents and the significant influence that the Local Plan will have on the Housing Strategy. Due to the extension of the timescale for production of the Preferred Options for the Local Plan being extended, the production of the new Housing Strategy has been similarly delayed. (Q2 2014/15) As Q1. (Q3 2014/15) As Q1. (Q4 2014/15) As Q1.
(k) - Development of Council's Economic Development Strategy	Neighbourhoods	30-Sep-14		Behind Schedule	(Q1 2014/15) Progress in formulating a draft Economic Development Strategy has continued alongside work on economic development activities. The Waltham Abbey Town Centre Economic Development Plan has been presented to the Asset Management & Economic Development Cabinet Committee and further geographic and thematic plans are being formulated. However the target timescale for the development of the Council's Economic Development is unrealistic in light of current staffing resources available. (Q2 2014/15) New staffing structure agreed at Council on 30/9/14. Work on new JDs/person specs underway for job evaluation and advertisement via HR (Q3 2014/15) One Economic Development Officer appointed - further recruitment on hold pending transfer between Directorates. (Q4 2014/15) Work on the new strategy delayed pending receipt of Economic Development evidence being prepared as part of the Local Plan.
(l) - Development of Council's Waste Strategy	Neighbourhoods	31-Mar-15		Behind Schedule	(Q1 2014/15) - The Council's new Waste Strategy will be influenced by the work that is currently underway with respect to the review of the Inter Authority Agreement at a County level. This may lead to some slippage.

					(Q2 2014/15) The work around the review of the Inter Authority Agreement at a County level is ongoing and will not conclude until early in the new year. it is hoped to report a more definite timescale at Q3. (Q3 2014/15) Work on the Inter Authority Agreement at County level is still to conclude. Further work on a pan Essex basis has been commissioned by ECC to explore synergies across the County. It is hoped to provide a more definite timescale at Q4. (Q4 2014/15) Work being undertaken on the Inter-Authority Agreement at County level, which is outside the Council's control, is still to be completed and outcomes yet to be agreed between the partners. The outcome of this action is dependent upon external factors outside the Council's control.
(m) - Development of Council's Leisure, Culture and Community Strategy	Communities Neighbourhoods	31-Jul-14		Achieved	(Q1 2014/15) Draft Strategy due to be considered by Portfolio Holder Advisory Group in September 2014, with final adoption by Cabinet in November 2014. (Q2 2014/15) The new Leisure and Cultural Strategy for the District, to include the proposed procurement process for the next Leisure Management Contract was considered by the Cabinet on the 3 November, and will be considered by Council on 16 December. (Q3 2014/15) The Council formally adopted the new Leisure and Cultural Strategy in December 2014. The Strategy is now being used to shape the procurement of the new Leisure Management Contract. (Q4 2014/15) Initial feasibility studies of what facilities could be provided through a new Leisure/Community Hub at Hillhouse, Waltham Abbey are under consideration, including discussions with Waltham Abbey Town Council, who are supportive of the initial thinking. As at Q3, the new Leisure and Cultural Strategy has been formally adopted. Consultants to support the procurement of the new Leisure Management Contract have been appointed and will utilise the objectives within the strategy to steer the process.

(n) - Development of Council's Operational Property Strategy	Chief Executive Resources	30-Sep-14		Behind Schedule	(Q1 2014/15) Recent improvements in the Council's wireless capability will facilitate the development of the Operational Property Strategy. A review of potential partners to carry out a workspace review is to be undertaken. (Q2 2014/15) Recent improvements in the Council's wireless capability will facilitate the development of the Operational Property Strategy. A review of potential partners to carry out a workspace review is to be undertaken. (Q3 2014/15) Visits to Essex County Council's flexible working hub and Maldon District Council's contact centres have taken place and a visit to Colchester Borough Council is being scheduled to meet the Director responsible for implementing their flexible working space. Progress has been slower than hoped but it was important to complete Phase II of the organisational review before proceeding further. Good progress has been made in trialling technology to enable remote working in the mean time. (Q4 2014/15) Visit to Colchester took place and the Service Director responsible will attend EFDC's April Leadership Team to share their experiences. Draft terms of reference for engaging space planning experts agreed by Management Board and Portfolio Holder for Technology & Support Services. Full roll out will be in 2015/16.

5. Deliver key priorities within budget.

Action	Lead Directorates	Target Date		Status	Progress
(a) (i) - Achievement of target for all KPIs	Chief Executive Governance Communities Resources Neighbourhoods	31-Mar-15		Behind Schedule	(Q1 2014/15) At the end of the first quarter of the year, 61% of the key performance indicators for 2014/15 had achieved target performance. (Q2 2014/15) At the end of the second quarter of the year, 69% of the key performance indicators for 2014/15 had achieved target performance. (Q3 2014/15) At the end of the second quarter of the year, 72% of the key performance indicators for 2014/15 had achieved target performance.

					(Q4 2014/15) At the end of the 4th Quarter of the year, 72% of the key performance indicators for 2014/15 have achieved target performance.
(a) (ii) - Achievement of specified deliverables for key objectives	Neighbourhoods Resources Communities Chief Executive Governance	31-Mar-15		Behind Schedule	(Q1 2014/15) At the end of the first quarter of the year, 68% of the individual deliverables or actions supporting the key objectives for 2014/15 had either already been achieved or were anticipated to be completed in accordance with in-year targets. (Q2 2014/15) At the end of the second quarter of the year, 80% of the individual deliverables or actions supporting the key objectives for 2014/15 had either already been achieved or were anticipated to be completed in accordance with in-year targets. (Q3 2014/15) At the end of the third quarter of the year, 87% of the individual deliverables or actions supporting the key objectives for 2014/15 had either already been achieved or were anticipated to be completed in accordance with in-year targets. (Q4 2014/15) At the end of the 4th Quarter of the year 65% of the individual deliverables or actions supporting the key objectives for 2014/15 have been achieved.
(b) - Consumption of resources within budget	Resources	31-Mar-15		Achieved	(Q1 2014/15) It is very early in the year to make predictions about the outturn. At this time there are no reasons to believe that overall expenditure will not be contained within the budget. (Q2 2014/15) The financial monitoring reports for the end of Q2 are still being prepared. However, early indications suggest that overall expenditure will be contained within the budget. (Q3 2014/15) The revised estimates for 2014/15 show an improvement of £250,000 on the original estimate of the General Fund position. A budget is being proposed for 2015/16 that is in line with the guidance set by Members. (Q4 2014/15) The final accounts for 2014/15 are still being completed but early indications are that spending has been contained within the budget.

(c) - Setting low District Council Tax & maintaining services	Resources	31-Mar-15		Achieved	(Q1 2014/15) The current Medium-Term Financial Strategy assumes that Members will continue with their policy of freezing the Council Tax. (Q2 2014/15) The Medium-Term Financial Strategy has been updated and Members have confirmed they will continue with their policy of freezing the Council Tax. (Q3 2014/15) The draft budget going to Cabinet and Council in February continues the policy of freezing the Council Tax and should not impact significantly on the delivery of any front line services. (Q4 2014/15) The budget approved for 2015/16 continues the policy of freezing the Council Tax and does not impact significantly on the delivery of any front line services.
(d) - (i) Review of sample processes	Governance Resources Neighbourhoods Communities Chief Executive	30-Sep-14		Achieved	(Q1 2014/15) Appropriate sample processes for review to be identified in the second quarter of the year. (Q2 2014/15) Several processes have been reviewed as part of the work of the Corporate Debt Working party. The reviews have been cross-cutting but have dealt with processes primarily in Communities, Governance and Resources. Now rescheduled after the Phase II restructuring is substantially complete. (Q3 2014/15) The final Phase II organisation review has now been completed. Process improvement recommendations made by the cross directorate Corporate Debt Working Party have been presented to the Council's Leadership Team and are being implemented. They include earlier intervention with arrears, service areas raising the charge and alternative collection arrangements for debts below £500 to avoid relatively expensive legal proceedings where possible. (Q4 2014/15) The approach adopted by this working party will be used for other processes with planned reviews of the customer experience during lifetime events such as bereavement, redundancy, unemployment etc. This will fit into the Council's customer centric approach to service delivery in action 4(d)(i) above.

(d) - (ii) Realignment of key performance indicator set	Neighbourhoods Communities Chief Executive Governance Resources	30-Sep-14		Achieved	(Q1 2014/15) Realignment of indicator set to be considered in the second quarter of the year. (Q2 2014/15) Indicator set to be reconsidered in light of the cabinet's review of strategic priorities. (Q3 2014/15) The Corporate Plan has progressed well and subject to comments received through the consultation process the Cabinet's strategic priorities will be finalised in Q4. This will enable adjustment of the key indicator set to monitor the new strategic priorities set out in the Corporate Plan. (Q4 2014/15) The key indicator set reflects strategic priorities set out in the Corporate Plan.

6. Prepare for changes arising from the transfer of public health responsibilities.

Action	Lead Directorates	Target Date	Status	Progress
(a) - Provision of services to meet health and wellbeing needs	Neighbourhoods	31-Jul-14	Behind Schedule	(Q1 2014/15) Draft Health and Wellbeing Strategy prepared and due to be finally considered by West Essex Health and Wellbeing Committee in October 2014, with adoption by the respective partner authorities in November 2014. (Q2 2014/15) The draft Strategy is still in development pending the finalisation of the Clinical Commissioning Group's new five year plan, and will not be ready for adoption until February 2015. (Q3 2014/05) - The draft Strategy has yet to be agreed and is not likely to be adopted until April 2015. (Q4 2014/2015) - Strategy still to be finalised pending the adoption of the Clinical Commissioning Group's priorities. Timescale now likely to be June 2015.

7. Maximise potential of the Council's key development sites

Action	Lead Directorates	Target Date		Status	Progress
(a) - (i) Completion of a development agreement with the owner of the T11 site	Neighbourhoods	31-Mar-15		Behind schedule	(Q1 2014/15) Negotiations between the Council and Polofind Ltd, and respective specialist legal and tax advisers in respect of the Langston Road (Epping Forest Shopping Park) site, has led to a proposal for the optimum way of owning and managing the new shopping park. This will be reported to the Cabinet in October 2014. Marketing of the site to secure anchor tenants of quality is underway. Confidential oral updates of such commercially sensitive information will be given when available. (Q2 2014/15) The documentation continues to be negotiated between the parties whilst considering further options emerging as a result of those negotiations. The report in private session has therefore been rescheduled to the November Cabinet. (Q3 2014/15) December Cabinet considered the legal structure and approach in private session and agreed updates to each Cabinet meeting. (Q4 2014/2015) Joint Venture Agreement largely agreed and in a position to be entered into. However, this is pending the response from the Council's development partner to an offer from the Council to purchase their interest.
(a) - (ii) Facilitation of a detailed planning application for the T11 site	Neighbourhoods	(not specified)		Achieved	(Q1 2014/15) See 7(a)(i) above. (Q2 2014/15) The progress of a planning application is dependent upon the decisions of the November Cabinet (Q3 2014/15) December Cabinet considered the legal structure and approach in private session and agreed updates to each Cabinet meeting. (Q4 2014/2015) Reserved matters on the application are due to be considered by District Development Management Committee on the 10 June 2015.

(a) - (iii) Commencement of development at the T11 site	Neighbourhoods	31-Mar-15		Achieved	(Q1 2014/15) See 7(a)(i) above. (Q2 2014/15) The timetable for vacant possession and development of the site will be agreed between the parties via the Cabinet process (Q3 2014/15) The timetable for vacant possession is still to be agreed, being dependent upon the Oakwood Hill Depot location being ready and the services being ready to transfer. (Q4 2014/2015) The award of tender for construction of the new Oakwood Hill Depot is due to be considered by Cabinet in June 2015. Vacant possession of Langston Road is required by 31 March 2016, if construction is to commence in time for the new shopping park to be open by Christmas 2016.
(b) - Preparation of development brief for North Weald Airfield	Neighbourhoods	31-Mar-15		Achieved	(Q1 2014/15) The North Weald Bassett master-planning exercise is due for completion and consideration by Members, for incorporation into the Local Plan evidence base, in October 2014. (Q2 2014/15) The North Weald Bassett Master-plan was formally accepted into the Local Plan evidence base in October 2014. (Q3 2014/15) Marketing exercise to be undertaken by the Council's consultants to seek potential operational partners to increase revenue and interesting aviation activity planned for early in 2015. (Q4 2014/15) Marketing exercise for Development Partner underway with good level of interest. Initial Expressions of Interest to be considered in July 2015.
(c) - Development of plans for the disposal of all or part of the St. Johns Road site	Neighbourhoods	(not specified)		Achieved	(Q1 2014/15) Heads of Terms for mixed use development have been agreed by the Council, not objected to by Epping Town Council and are being considered by Essex County Council. Relocation of the Housing Depot is a pre-requisite to the development. Potential sites are subject to the outcome of Member decisions on related sites.

					(Q2 2014/15) The relocation of the Housing depot is being actively considered following Members' agreement to downsize and relocate the Fleet Operation service to Oakwood Hill. (Q3 2014/15) Negotiations with Essex County Council to purchase the school site and with Frontier Estates to deliver the mixed use development have progressed, with solicitors instructed. (Q4 2014/15) Legal documentation progressing to completion. Frontier Estates have indicated that they still wish to proceed with the scheme as per their original submission. Epping Town Council have appointed professional advisers and are still supportive of the scheme. Work has commenced on options to relocate the Council's Housing Repairs Services.
(d) - Disposal of the Nursery Service from the Pyrles Lane site	Neighbourhoods	31-Mar-15		Behind Schedule	(Q1 2014/15) Work has continued with a view to the submission of a planning application in October 2014. (Q2 2014/15) Liaison with Highways at Essex CC and our own internal housing services continue to address the density and access issues raised by the sub committee. The aim is to resubmit the application having resolved those issues. This is likely to be November/December now – but is not on the critical path for the Langston Rd project. (Q3 2014/15) Negotiations to achieve amendments to an amended planning application for Pyrles Lane continue with a view to resubmission. (Q4 2014/15) As per position at Q3.
(e) - (i) Detailed planning application for depot provision	Neighbourhoods	30-Jun-14		Achieved	(Q1 2014/15) The planning application has been referred to the District Development Control Committee and an outcome is awaited (NB. Application agreed at 13 August 2014 meeting). A Member decision in relation to the Fleet Operations relocation/future requirements will be taken into consideration in the design and development of the site. (Q2 2014/15) Planning consent was granted at the DDCC and the Members decided on 6/10/14 to relocate Fleet Operations to Oakwood Hill albeit on a

					smaller scale. This will inform the design and build contract. (Q3 2014/15) December Cabinet agreed to proceed with a design and build contract for Oakwood Hill Depot and made appropriate financial provision. (Q4 2014/15) Detailed Planning Consent Agreed.
(e) - (ii) Detailed design & development of the Oakwood Hill	Neighbourhoods	30-Oct-14		Achieved	(Q1 2014/15) See 7(e)(i) above. (Q2 2014/15) See 7(e)(i) above. (Q3 2014/15) December Cabinet agreed to proceed with a design and build contract for Oakwood Hill Depot and made appropriate financial provision. (Q4 2014/15) Scheme out to tender. Tender acceptance to be considered by Cabinet on the 11 June 2015.
(e) - (iii) Commencement of Oakwood Hill development	Neighbourhoods	31-Mar-15		Behind Schedule	(Q1 2014/15) See 7(e)(i) above. (Q2 2014/15) To relocate services from Langston Road it will be necessary to progress the construction and we remain on target for this. (Q3 2014/15) Work on the letting of the design and build contract is progressing, and will proceed in accordance with all planning conditions. (Q4 2014/15) Tender acceptance report due to be considered by Cabinet in June. Work scheduled to commence in July 2015.
(f) - (i) Start on site Phase 1 housebuilding programme	Communities	31-Aug-14		Achieved	(Q1 2014/15) Tenders have been sought from five contractors from the East Thames Contractors Framework or from contractors registered on Constructionline in May 2014. These have been evaluated by the Council's Development Agent and the Council House-building Cabinet Committee will appoint the contractor in August 2014. Since it is a Design and Build Contract, the appointed Contractor will require a 3-month lead-in for design and mobilisation. Start on site will be around November 2014

					(Q2 2014/15) Cabinet has appointed the contractor to undertake Phase 1, which is still due to start on site in November 2014 (Q3 2014/15) The contractor started on site in November 2014. (Q4 2014/15) The Council Housebuilding Cabinet Committee has agreed names for all of the new developments and continues to monitor progress with the progress of works.
(f) - (ii) Obtain investment partner status for HCA funding	Communities	31-Dec-14		Behind Schedule	(Q1 2014/15) The Council learnt in July 2014 that its bid for Affordable Housing Grant was approved by the Homes & Communities Agency (HCA) and the next stage is to achieve Development Partner Status. Once details on how to achieve Investment Partner Status are available, East Thames will prepare and submit an application on behalf of the Council. (Q2 2014/15) The Council is still waiting for the HCA to publish its updated guidance on applying for Investment Partner status. The Director of Communities is due to meet with the HCA's Relationship Manager on 27th October, when he will raise this issue again (Q3 2014/15) The HCA has only just (Jan 2015) issued its guidance on applying for Investment Partner status. The Council's Development Agent, East Thames, has been asked to draft the document, for approval by the Director of Communities. (Q4 2014/15) The application has been submitted to the HCA and approval is expected by the end of June 2015. Whilst not achieved at year end, a revised target date of 2015/16 has been identified for this action.

(f) - (iii) Start on site at Phase 2 housebuilding programme	Communities	31-Mar-15		Behind Schedule	(Q1 2014/15) Following detailed consideration of three feasibility studies and consultation with ward members, the Council Housebuilding Cabinet Committee agreed to seek the development of 56 affordable rented homes at the Burton Road, Loughton as Phase 2 of the house-building Programme. Following consultation by Pellings, the architects appointed by the Council's Development Agent, some changes to proposed layouts have been made resulting in a reduction from 56 to 52 new homes. The planning application for Phase 2 is due to be submitted by the end of August 2014 allowing for Phase 2 to commence on site in May 2015. (Q2 2014/15) The planning application will be submitted by the end of October 2014. (Q3 2014/15) The detailed planning application, for 52 affordable rented homes, was submitted at the end of October 2014 and the planning application was determined by the Area Plans South Sub-Committee in Jan 2015. Planning permission was refused. Officers are currently discussing options with the Housing Portfolio Holder, which will be submitted to the Council Housebuilding Cabinet Committee at its meeting on 5th March 2015. The planning refusal has delayed the project and will result in additional fees. (Q4 2014/15) The Housebuilding Cabinet Committee has agreed that a revised planning application should be submitted for Phase 2, for 52 properties, but with a revised design. The Council's Development Agent is currently producing the revised application and drawings. The delay in commencing Phase 2 has resulted in concerns about the Council's ability to spend all of its Right to Buy one-for-one receipts within the required 3 years of receipt. The Cabinet Committee has requested a report to its next meeting on how this can be overcome.
(g) - Conversion of difficult-to-let bedsits into self-contained flats	Communities	31-Mar-15		Behind Schedule	(Q1 2014/15) In July 2014 the Housing Portfolio Holder agreed the appointment of PA Finley Ltd to undertake the design and build contract for the conversion of 20 bedsits at Marden Close and the ground floor of Faversham Hall into 12 self-contained 1-bed flats. The contract is currently being drawn up and a date of possession is estimated to be around the beginning of September 2014 after the detailed design has been completed by the Contractor. Completion is estimated to be 12-months later around September 2015.

					(Q2 2014/15) Works commenced on site in September 2014 as planned. (Q3 2014/15) Works continue to be progressed on target. (Q4 2014/15) As Q3. Whilst not achieved at year end, a revised target date of 2015/16 has been identified for this action.
(h) - Extension and refurbishment of Epping Forest District Museum	Communities	31-Mar-15		Achieved	(Q1 2014/15) Following a long period of time to agree the terms of the lease for the first floor over the library with Essex County Council, the lease was signed in April 2014. This enabled the opening up works to commence and in turn allow the architects and engineers to commence with the detailed design in consultation with the Listed Building Officer at ECC. In the meantime, the Pre-qualification Questionnaire has been issued to a long list of contractors with a view to agreeing a short list for inclusion on a tender list. Tenders are due to be issued and returned by October 2014 with works due to start on site around December 2014 and completing around June 2015. This will be followed by a short period of around 12-weeks for fitting out the Museum before reopening in September 2015. (Q2 2014/15) The PQQ process has been completed and the short-list of contractors agreed. Tenders are due to be issued by the end of October 2014 and to be reported to the Cabinet in December 2014. (Q3 2014/15) In December 2014, Cabinet awarded the Works Contract to the contractor that submitted the lowest price and highest quality score. The Council's Legal Team are in the process of drawing up the Works Contract. (Q4 2014/15) A Letter of Intent (to enter into a contract) has been issued to the contractor, Coniston Ltd, to enable the contractor to mobilise for the commencement of works. The Works Contract is close to being signed and works are expected to commence W/C 20th April 2015, with works due to complete in October 2015. This will then be followed by the fit-out stage, with the museum expected to open to the public in February 2016.

(i) - Undertake Environmental Estate Improvement Scheme at Oakwood Hill	Communities	31-Mar-15		Behind Schedule	(Q1 2014/15) The Cabinet has allocated £200,000 towards the Environmental Improvement Scheme, which has been match-funded by £200,000 from Essex County Council for footpath and highway works. An Oakwood Hill Environmental Task Force has been formed, chaired by the Housing Portfolio Holder and comprising local residents, which first met in July 2014 and suggested improvements for further consideration including footpath improvements, the creation of a public space, off-street parking, landscaping, CCTV, and cleaned/replaced fascias and soffits. The Council's total budget allocation of £200k for the improvements is spread equally between 2014/15 and 2015/16. (Q2 2014/15) The Task Force has now met on two occasions, which have proved very useful, and discussed potential works to be included within the Improvement Scheme. (Q3 2014/15) Good progress continues to be made. Essex CC have agreed to repair/renew all of the adopted footpaths on the Estate, and the Task Force has agreed that the renewal/repair of EFDC's footpaths should be funded from the Project Budget. The Task Force has formulated a menu of potential improvements that are currently being costed. Works are due to commence in May/June 2015. (Q4 2014/15) As Q3. Whilst not achieved at year end, a revised target date of 2015/16 has been identified for this action.

8. Prepare and plan for the effects of welfare reform in and effective and co-ordinated way.

Action	Lead Directorates	Target Date		Status	Progress
(a) - Implementation of updated scheme of local support for Council Tax	Resources	31-Dec-14		Achieved	(Q1 2014/15) The Cabinet has agreed the key items to be included in the consultation and the consultation will commence in August 2014.

					(Q2 2014/15) The annual consultation has now concluded and the responses are being evaluated. A proposal for the 2015/16 scheme will be going to Cabinet in December. (Q3 & Q4 2014/15) A scheme has been approved by Council for 2015/16 which is largely unchanged from the 2014/15 scheme.
(b) - Retention of adequate resources to ensure the threat of fraud is effectively managed	Resources	31-Dec-14		Achieved	(Q1 2014/15) The Chief Internal Auditor and the Assistant Director of Resources (Benefits) are working on reports for future consideration by the Cabinet, which will set out the amended structures and resources required for both a Corporate Fraud Unit and the Benefits Service. (Q2 2014/15) The Chief Internal Auditor and the Assistant Director of Resources (Benefits) are working on reports for future consideration by the Cabinet, which will set out the amended structures and resources required for both a Corporate Fraud Unit and the Benefits Service. (Q3 & Q4 2014/15) Cabinet has approved the new structures for both a Corporate Fraud Unit and the Benefits Service.
(c) - Retention of adequate resources to ensure the benefit function is effectively operated	Resources	31-Dec-14		Achieved	(Q1 2014/15) It remains unclear when Universal Credit will be implemented in the district and the role that this Council will have. At this point staff retention has not become a significant issue. (Q2 2014/15) It remains unclear when Universal Credit will be implemented in the district and the role that this Council will have. At this point staff retention has not become a significant issue. (Q3 2014/15) An amended structure has been agreed for the Benefits Service although this may need to be considered again when it is known what will happen with Universal Credit. (Q4 2014/15) Effectiveness evidenced by achievement of KPI targets for processing both new claims and changes of circumstance.

Task and Finish Panels – Nominations

Grant Aid Task and Finish Panel

Nominations 2015/16
Chairman: Caroline Pond **Vice Chairman:** J Knapman
Members: **Conservative Group:** J Knapman, T Boyce, A Mitchell, G Shiell **LRA:** C P Pond **Liberal Democrats:** B Surtees **Other Nominations:** S Murray ***(The above were the Panel members from last year)***

Youth Engagement Task and Finish Panel

Nominations 2015/16
Chairman: S Murray **Vice Chairman:** G Mohindra
Members: **Conservative Group:** G Mohindra **LRA:** C Roberts **Liberal Democrats:** B Surtees; *Also was K Adams now vacant* **UKIP:** R Butler **Other:** S Murray ***(The above were the Panel members from last year – one vacancy has occurred and is to be filled for this year)***

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Report to Overview and Scrutiny Committee

Date of meeting: 9 June 2015

Subject: Overview and Scrutiny Annual Report for 2014/15

Officer contact for further information:
Stephen Tautz, Ext.4180

Committee Secretary: A Hendry (ext 4246)

Recommendations/Decision Required:

That the attached Annual Overview and Scrutiny Report for 2014-15 reporting the work undertaken during the past municipal year be agreed and submitted to the Full Council at its meeting on 28 July 2015.

Introduction:

1. Further to the Overview and Scrutiny Committee meeting held on 27 April 2015, the attached annual report has been amended incorporating the comments made by the committee at that meeting. The meeting is now asked to agree the report so it can be referred to the full Council meeting on 28 July 2015.

2. This report is produced in accordance with Overview and Scrutiny procedure Rule 20 of the Constitution that requires an annual report to be submitted to the Council each year.

3. This is the tenth report under the new scrutiny regime instituted by the Council in April 2005, incorporating (for the last time) the five Scrutiny Panels and the Task and Finish Panels created this year.

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Overview and Scrutiny Annual Report for 2014-2015

Epping Forest District Council
www.eppingforestdc.gov.uk

CONTENTS

OVERVIEW AND SCRUTINY ANNUAL REPORT: MUNICIPAL YEAR 2014/2015

Introduction and Welcome from the Chairman

Welcome to the tenth report of the Overview and Scrutiny Structure of Epping Forest District Council. After an 11 month long review into the organisation, principles and structure of the Overview and Scrutiny functions we have altered the way we conduct our business. That, as well as the reorganisation of the directorate structure of the authority will mean that we will be looking at fundamental changes to the Scrutiny structure in the new municipal year.

At present, the Overview and Scrutiny Committee and Scrutiny Panels are charged with reviewing Cabinet decisions, the Corporate Strategy, the Council's financial performance and also scrutinising the performance of the public bodies active in the District by inviting reports and presentations from them. The bare bones of scrutiny will not change in the new year, only the way it will be carried out.

At the beginning of the 2014/15 municipal year the Overview and Scrutiny Committee agreed to the setting up of five Scrutiny Panels for the year and two Task and Finish Panels were commissioned.

During the year we received numerous presentations from outside bodies including the Epping Forest College, Essex Children Services, the EF Youth Council, the Counties Mental Health Services for young people and the North Essex Parking Partnership.

My special thanks go to the Chairmen and members of the various Scrutiny Panels and especially the members and officers of the Task and Finish Panel that reviewed our Scrutiny Panel arrangements.

And of course, I would like to thank all the officers that have worked so hard to keep the Panel members informed and supplied with the background information that they needed to carry out their investigations.

Cllr Richard Morgan
Chairman, Overview and Scrutiny Committee

What is Scrutiny?

- Ø Scrutiny in local government is the mechanism by which public accountability is exercised.
- Ø The purpose of scrutiny in practice is to examine, question and evaluate in order to achieve improvement.
- Ø The value of scrutiny is in the use of research and questioning techniques to make recommendations based on evidence.
- Ø Scrutiny enables issues of public concerns to be examined.
- Ø At the heart of all the work is consideration of what impact the Cabinet's plans will have on the local community.
- Ø However, the overview and scrutiny function is not meant to be confrontational or seen as deliberately set up to form an opposition to the Cabinet. Rather the two aspects should be regarded as 'different sides of the same coin'. The two should complement each other and work in tandem to contribute to the development of the authority.

Alongside its role to challenge, the scrutiny function has also continued to engage positively with the Cabinet and there continues to be cross party co-operation between members on all panels.

Scrutiny has continued to provide valuable contributions to the Council and the Cabinet remained receptive to ideas put forward by Scrutiny throughout the year.

The rules of the Overview and Scrutiny Committee also allow members of the public to have the opportunity to address the Committee on any agenda item.

The Overview and Scrutiny Committee

The Committee coordinated with the Cabinet and pre scrutinised their forward plan on a meeting by meeting basis. This acted as a troubleshooting exercise, unearthing problems before they arose.

The Committee also engaged with external bodies in order to scrutinise parts of their work that encroached on the District and its people. They also received stand alone reports from officers and reports from the Scrutiny Panels on the work they carried out during the year.

Scrutiny Panels

A lead Officer was appointed to each Panel to facilitate its process. The Overview and Scrutiny Committee agreed the terms of reference for each of the Panels on the basis of a rolling programme. The Scrutiny Panels have a 'rolling programme' to consider ongoing and cyclical issues. Five Scrutiny Panels were established, dealing with:

i. Housing
ii. Constitution and Member Services
iii. Finance and Performance Management
iv. Safer Cleaner Greener
v. Planning Services

Scrutiny Panels reported regularly to the Overview and Scrutiny Committee on progress with the work they were carrying out.

Task and Finish Panels

The Task and Finish reviews are restricted to dealing with activities which are issue based, time limited, non-cyclical and with clearly defined objectives on which they would report, once completed, to the Overview and Scrutiny Committee. Three Task and Finish Panels were established during the year, they were the Scrutiny Panel Review Task and Finish Panel, the Grant Aid Review Task and Finish Panel and the Youth Engagement Review Task and Finish Panel.

OVERVIEW AND SCRUTINY COMMITTEE

The Overview and Scrutiny Committee consisted of the following members:

Councillor R Morgan (Chairman)
Councillor K Angold-Stephens (Vice Chairman)
Councillors G Chambers, K Chana, A Church, D Dorrell, L Girling, P Keska, J Lea, A Mitchell, S Murray, B Rolfe M Sartin, G Shiell, B Surtees A Watts and D Wixley

The Lead Officer was Derek Macnab, Deputy Chief Executive.

Terms of Reference

The Overview and Scrutiny Committee's main functions are to monitor and scrutinise the work of the executive and its forward plan, external bodies linked to the District Council and the Council's financial performance. It is tasked with the consideration of call-ins, policy development, performance monitoring and reviewing corporate strategies.

The Committee's workload over the past year can be broken down as follows:

(a) Scrutinising and monitoring Cabinet work

The Committee has a proactive role in this area through carrying out pre-scrutiny work. This involved considering the Cabinet Forward Plan for the coming months on a meeting by meeting basis.

(b) Call-ins

The Committee received no call-ins this year.

(c) Scrutiny Panels work programme monitoring

The Committee received regular updates from the Chairmen of the various Scrutiny Panels reporting on the progress made on their current work programme. This allowed the Committee to monitor their performance and when necessary adjust their work plans to take into account new proposals and urgent items.

(d) Items considered by the committee this year

Over the year the Overview and Scrutiny Committee received various presentations and considered a range of diverse topics.

Presentations:

(i) Strategic Direction of Epping Forest College - The Committee at their meeting in July 2014 received a presentation from Penny Morgan, the recently appointed Principal of Epping Forest College; she had been appointed in December

2013. She was there to speak on the strategic direction of the college, its vision for the future and its relationship with the Community.

The college had made great strides over the last five years, taking in over 3,500 students each year and had hundreds of visitors that came in to use the college for various events etc. Over 85% of the students live within 10 miles of the college. The college was also a major employer for local people, over 59% of staff live within 10 miles of the college, thus contributing to the local economy.

They provided a wide range of training, skills and educational provision, such as Business, Childcare, Construction, Media and Music, IT, Maths and English and Sport, ensuring that they were giving students the best opportunity to become work ready and gain employment. They also work with local employers and help to provide apprenticeships in local businesses, an achievement they were very proud off.

They were always striving to improve on the range of courses and opportunities offered to their clients whilst additional demands were placed on them by the government.

The meeting was then opened out to questions from the members of the committee.

(ii) Presentation from Children Services - At their meeting in November 2014 the Committee welcomed Chris Martin, the Integrated Commissioning Director (West) from Essex County Council. He was there as part of a follow up to last years successful presentation on Children Services, given by Jenny Boyd.

Mr Martin noted that it was important to support children and their families from birth right through to the early years of their life (2 to 5 years), to give them the best possible opportunity to succeed. They wanted to be challenging and have all the people working across the early years system to have a single vision of what needed to be changed, this would require big shifts in culture and practice.

They would be working towards building capacity and capability of parents to support themselves and to support one another; with professional workers starting from peoples strengths and finding ways to build on them to prevent problems occurring. This would involve thinking differently about the workforce, letting them do what needed to be done and to make use of their diverse experience. If they get this right they would achieve better outcomes for children while at the same time saving money.

It was noted that they had less money to spend than before and so would need to be more effective with what they did have. More needed to be done and improvement continued as resources diminished.

They were undertaking an ambitious, strategic, broad reaching review of early years in collaboration with Clinical Commissioning Groups (CCGs) to

identify innovation across the system, especially with families, removal of duplication of resources and roles, developing a common understanding and model of child development and skilling up the workforce to deliver new approaches.

They would also engage in ethnographic research with Essex parents and families, taking an in-depth look at the lives of eight families living across Essex combined with observational fieldwork at over 30 services. This type of research reveals behaviours and patterns that other methods would not pick up. Insights gained so far was that they needed to focus on building the resilience of families and reducing their isolation.

The meeting was then opened to questions from the members present.

(iii) Presentation from the Epping Forest Youth Council - At their meeting in January 2015, the Committee received a presentation from six members of the Youth Council; they were joined by thirteen other Youth Council members.

They were there to give an overview of what the Epping Forest Youth Council had been up to over the past year. This was their first year in office of the two they were elected for.

By far their highest profile event last year was the Youth Conference held in the Council offices on 14 October 2014. 90 pupils from years 7, 8, 9 and 10 representing ten secondary schools from the District attended. They were consulted about issues affecting the lives of local young people; gathering their views on possible solutions and gather ideas on how to improve the local community. They were also keen to promote local democracy.

Three main concerns were highlighted. They were alcohol misuse, bullying and stress. Other issues raised were around skills and jobs and the need for more volunteering opportunities, the misuse of drugs particularly ‘legal highs’.

The Youth Council had launched a campaign called '#URNotAlone' during national Bullying Awareness week in November; highlighting services and support groups for victims of bullying and their parents and also gave presentations to all year 9 pupils in the district. The project was deemed a great success by pupils, parents and teaching staff and the Youth Council were really proud of this piece of work.

The Committee noted that:

- Social Media was also an important part of their job as it promoted their work and raised the profile of young people in the district.
- They had been asked to contribute to 10 consultations this year and were pleased to have representations on the Epping Forest Youth Strategy Group.
- The Council's Youth Volunteer Programme was now being taken up by all secondary schools in the district.
- They had secured external funding of £1200 from the Jack Petchey Foundation, £900 from 'Think Big O2' for their project work and a further £750 from the Jack Petchey Small Grants awards.

They had hoped that they had shown that the 21 Youth Councillors had developed strong links with schools and youth groups and had connected with many thousands of their peers on behalf of the council.

(iv) Mental Health Services in the District – In March 2015 the Committee welcomed Chris Martin (Integrated Commissioning Director (West)) and Christina Pace (Commissioning Lead, Essex County Council) to the meeting. They were representing the Child and Adolescent Mental Health Services (CAMHS) and were there to give a presentation on the joint re-commissioning of emotional well being and mental health services for Children and Young People in Southend, Essex and Thurrock.

They noted that now with national government plans to put in more funding, their new service model would be based on needs assessment and feedback from consultation with service users and partners. This highlighted the need for more integration and clearer access routes to services, especially for vulnerable people and for the consistency of the quality of service.

They were jointly commissioning one integrated service for the whole county for targeted and specialist mental health services. There would be a single point of access for all referrals to the service, including self referrals. The services would be community based and available in each area. They would focus on identifying and treating young people who need CAMHS services as early and effectively as possible.

There would be 24/7 access to the crisis services and a community based intervention service. There would also be consistent advice and training for all their partners.

It was noted that a new national taskforce had recently made recommendations on improving mental health for children and families and nationally, an additional £1.25 billion investment over a five year period was set out in the budget. CAMHS were uncertain how any future government would respond, but this was an opportunity to build on their new service model.

The meeting was then opened out to questions from the Committee.

(v) **North Essex Parking Partnership –** members of NEPP came to the April 2015 meeting of the Committee. The NEPP officers gave a presentation outlining the background to their organisation, their functions, policies and processes. After an interesting presentation, members questioned the NEPP officers on various aspects of parking in the District.

(See case study for full details)

Other Topics Considered:

(i) This year for the first time the Committee considered the Cabinet's Forward Plan and Key Objectives for the coming year on a regular meeting by meeting basis. At their first meeting of the year in July 2014 the Committee look at the coming year's work programmed in for the Cabinet.

It was noted that the Cabinet took an interest in the work of the Overview and Scrutiny Committee and appreciated the important role scrutiny played in providing checks and balances to the Executive.

The Cabinet's Key Objectives for 2014/15 were presented under a number of broad themes and these constitute the priorities of the Cabinet over the next municipal year. It was noted that a number of items were an extension of last year's programme.

The Local Plan was probably the most significant document that the Council would produce for many years. It would determine the future character of the District and help deliver benefits to the residents in terms of homes and employment. All key decisions in relation to the Local Plan would be taken by the Cabinet, but they wished to be as consultative in their approach as possible. It was noted that the Scrutiny Panel on Planning was responsible for scrutinising the Local Plan and this was an area where it was hoped that the Cabinet and Scrutiny could work together.

It was highlighted that the Council was keen to embark on a Council House Building Programme and the Housing Portfolio Holder had established a Cabinet Committee to advise him. With tenders being received for the first phase this was an exciting initiative for the Council.

The Council had also embarked on the development of a new Leisure and Cultural Strategy, which would not only clarify the role that the Council would play in future provision, but also determine the best way to procure the new Leisure Management Contract.

(ii) In July 2014 the Committee received a report setting out the year end outturn of the Corporate Plan Key Objectives for 2013/14. A range of key objectives for 2013/14 was adopted by the Cabinet in March 2013; progress in relation to individual actions and deliverables are reviewed on a quarterly basis.

At the end of the year, 23 (42.6%) of the individual deliverables or actions supporting the key objectives had either been completed or achieved. Some 20 (37.0%) deliverables or actions were not completed by year-end. A further 11 (20.3%) deliverables or actions were on-hold at year end, as a result of external circumstances.

(iii) In September 2014 the Panel received a report from the Returning Officer regarding the Local Elections held on 22 May 2014.

The following elections were held in May 2014:

(a) Election of 7 Members of the European Parliament for the Eastern Region of the UK;

(b) 19 District Council Wards; and

(c) 1 Parish Council by-election for Buckhurst Hill West.

Voter turnout at the various elections ranged between 44% in the Buckhurst Hill East Ward and 28% in Waltham Abbey Paternoster Ward. Turnout for the European Parliamentary Election, within the district, was 35.58% compared with a turnout of 35.90% across the region.

It was noted that there were few issues with the election, generally all practices were completed successfully.

(iv) Also in September the Panel received a report from the Returning Officer regarding the Review of Polling Districts, Polling Places and Polling Stations.

The Electoral Registration and Administration Act 2013 made it compulsory for this authority to carry out a review of Parliamentary polling districts and polling places within 16 months, starting from 1 October 2013, with further reviews starting on 1 October of every fifth subsequent year.

A polling district was a geographical area created by the sub division of a UK Parliamentary Constituency for the purposes of an election. A polling place was the building or area in which polling stations would be selected by the Returning Officer. A polling station was the room or area within the polling place where voting took place.

(iv) The Committee received a report regarding the London Infrastructure Delivery Plan consultation from the Deputy Chief Executive and Director of Neighbourhoods.

The London Infrastructure Delivery Plan (IDP) had been published by the Mayor of London for consultation making the case for better infrastructure provision in London.

It was noted that the London Infrastructure Delivery Plan did not set out how policies would be delivered, implemented and monitored. Instead, it made a business case for London to control its own finances through fiscal devolution. The Committee supported the prioritization of transport schemes, such as four tracking the West Anglia Lines along the whole of the Upper Lee Valley and the Central Line because of:

(a) Predicted job growth in Central London;

(b) The Central Line's importance in delivering commuters to this area; and

(c) Its particular importance to the lower end of the London-Stansted-Cambridge corridor.

Members were particularly concerned about providing car parking facilities around train stations as there was currently a congestion problem there.

(v) In November 2014 the Committee received a report on the Communities and Local Government Consultation on 'Planning and Travellers', seeking views on proposed changes to planning policy and guidance for the travelling community. The stated intentions of the proposed changes were to (i) ensure that the planning system applies fairly and equally to both the settled and traveller communities; (ii) further strengthen protection of "sensitive areas" and Green Belt; and (iii) address the negative impact of unauthorised occupation. The consultation also stated that the Government remained committed to increasing the level of authorised traveller site provision in appropriate locations to address historic undersupply as well as to meet current and future needs.

The consultation contained 13 questions with draft answers contained in the appendix to the report.

It was also noted that all the pitches/caravans were in the Green Belt and that our District was 92% Green Belt.

The extent of Green Belt in different Council areas varies very widely – e.g. East Herts was about 33% Green Belt while Uttlesford was significantly less – i.e. both these neighbouring districts have potentially significantly greater options for identifying suitable locations. This proposal by the Government – a "one size fits all" approach seems too blunt and inflexible given the wide variation in Green Belt coverage of affected districts. It was particularly unfair to those districts which have a very high

percentage of Green Belt, and where there was already a long-established and sizeable traveller community.

Officers could think of no immediate and practical solutions to the problems, other than to suggest a re-think at national level. The planning system as it currently operates was not making adequate provision for the needs of the travelling community. The problem was particularly acute in Green Belt areas, where there does seem to be a perception of favourable treatment for travellers, but the proposals in the consultation would only exacerbate the overall problem of meeting total needs, and make it very much harder to identify suitable sites in the Green Belt.

The Committee noted and agreed the draft answers to the CLG Consultation on Planning and Travellers.

(vi) In February 2015 the Committee considered the draft Corporate Plan for 2015 to 2020. They noted that the current Corporate Plan would end on 31 March 2015 and this new Corporate Plan had been developed to take the authority forward over the next five years.

The Council's main areas of focus for the five year lifetime of the new Plan had been captured in a new set of corporate aims; in addition a new set of Key Objectives had been developed to support the aims. On consideration the Committee agreed the proposed new plan and recommended it to the Cabinet and Council.

(vii) Also in February 2015, the Committee considered the final report of the Task and Finish Panel looking at the current Scrutiny Panels of the Council (see a fuller report under the Task and Finish Chapter of this report).

With the revision of the Council management structure in December 2013, reducing the service directorates down to four, the Panel considered the creation of a four panel structure to align with the new directorates. This proposal arose in part, due to the existing arrangements, where not all service areas were subject to scrutiny by any particular Panel.

The Committee agreed with the Panel that a new Overview and Scrutiny framework, based on a structure of four 'select committees', be established with effect from the commencement of the 2015/16 municipal year.

(viii) The Committee also considered a consultation report from the Lee Valley Regional Park Authority (LVRPA) on its Park Development Framework. They noted that whilst it was not a planning authority, there was a duty to prepare plans for the management and development of the park.

The proposals in the consultation document were generally in line with the statutory duties of the Park Authority. Subject to the detail of individual projects, the Council were supportive of these proposals, as they were in line with the original purposes of the Park and relevant policies of the current Local Plan and Alterations and the National Planning Policy Framework.

However, there were two matters within the proposals which were of concern. Firstly, a significant number of new buildings were being suggested to support implementation of the proposals, and a lot of these were in the Green Belt. The consultation document

generally acknowledges the need to take account of Green Belt location for most of these suggestions, but the proposals could still amount to a significant amount of development with implications for the openness of the Green Belt.

Secondly, there was the casual reference to the use of Compulsory Purchase Powers for large areas of glasshouses etc. The document also indicated that it was likely that the Authority would resist major redevelopment or expansion of new large-scale glasshouse uses.

Members noted that recently the Council had formed the Lea Valley Food Task Force. The intention was to develop a standard policy approach in new Local Plans, supportive of the glasshouse industry, across local authority boundaries as an example of positive co-operation.

The Committee agreed that the overall approach of the proposals in the context of the statutory functions of the Park Authority, ie in relation to sport and recreation, leisure, education and landscape, heritage and nature conservation be supported.

But they expressed concerns about the possible extent of new building being proposed in the Green Belt and to object to proposals, as currently worded, concerning the use of compulsory purchase powers in relation to a number of glasshouse sites and other long-standing commercial uses within the Park.

(ix) In March 2015 the Committee considered the review of the operation of the Planning Committees and their Terms of Reference. This had originated from a PICK form that initially went to the Planning Services Scrutiny Panel and then on to the Constitution Scrutiny Panel, when they looked at the following matters:

(a) The operation of the speaking arrangements and deadlines for submission of material to planning sub-committees; and
(b) The terms of reference of the Planning Sub-committees and the District Development Control Committee.

The changes would also bring clarity to the role of the Chairman in controlling the business at the meeting, particularly for speakers. It was considered by the Panels that these rules should be implemented in advance of the completion of the Constitution Review to allow a period of operational experience to be undertaken with a check in 2016 to make sure that they were still appropriate.

On consideration the Committee endorsed the proposed changes and made this recommendation to the next full council meeting.

(e) Case Study: North Essex Parking Partnership

At their April meeting the Committee received a presentation from officers from the North Essex Parking Partnership (NEPP).

The NEPP officers outlined the background to their organisation and the Committee noted that:

- Essex County Council had decriminalised parking functions between 2002-2004, which led to them being policy makers for 12 agencies in districts and boroughs running parking enforcement;
- A growing deficit reaching £900,000 across the county led, in 2009, to the County Council ordering district and boroughs to cancel all agencies;
- The agencies were replaced by two organisations, the North and South Essex Parking Partnerships. The North was responsible for Epping Forest, Harlow, Uttlesford, Braintree, Colchester and Tendering; and the South was responsible for Brentwood, Basildon, Chelmsford, Maldon, Rochford and Castle Point.

The strategic priorities for this new organisation (NEPP) was:

- Improving safety for drivers and pedestrians;
- Improving business opportunities through better parking policies;
- Discouraging commuters from parking in permit only areas;
- Increasing enforcement to improve availability for Blue Badge holders; and
- Greater environmental efficiency.

The NEPP Business Plan was to improve on efficiency and be financially sustainable. The NEPP had inherited a deficit of £574,301; currently they had a small surplus of £80,000.

Their business plan was to bring all parking matters into one place, improve on the backlog built up on signage and maintenance of signs and lines; maintain income from the PCNs as far as possible, within policy. They were a council shared service and did not act under a client / contractor service. They wanted to make efficiencies in whole operation to eliminate their deficit and make savings from reduced management, overheads and accommodation.

The meeting was then opened up to questions from the members present.

During this the Committee was advised of the Essex Act, peculiar to this county, which allowed for enforcement. In cases where land was owned by an authority, it was advised that legislation should be checked first. Highways owned land required an S50 application for entering the highway to carry out mowing. Each licence needed to be applied for separately, by the authority carrying out the mowing work, and each area needed proof that it was kept in the condition to which the law related. Enforcement could then be carried out by notice. A trial had been carried out in Braintree with successful results. It was felt that in the medium to longer term better enforcement could be achieved with this legal mechanism.

The NEPP officers confirmed that they did have a comprehensive database on road lining. They advised that there was limited funding to cover maintenance of all lines

across NEPP (£150,000 for the whole area) and so maintenance was done by priority. NEPP informed the Committee that lines were made of plastic which bonded with the road surface and as such it could only be laid during the summer months.

They noted that safety and congestion schemes would first fall to ECC as did new developments, the rest fell to NEPP with schemes being progressed by Essex County Council as Area Reviews. It was advised that there was no funding for NEPP, new schemes were scored and given a priority.

NEPP officers had brought with them copies of a “Who’s Who” of their staff and contact details. Members asked for this staff guide to be circulated via the Bulletin.

They also advised that enforcement times varied. However, if there was an area which required more enforcement then Members could notify the Area Enforcement Manager. If there was a clear system of lines and signs in place then action could be taken, however if lines were very worn then enforcement action may not have a chance of success. The minimum standard for signage and lines was covered in the national rules. All enforcement had to be of a sufficient standard to withstand an appeal. The rules for signage were presently being reviewed for implementation this year, the intention being to reduce signage wherever possible. Councils were being encouraged to use “zone” systems to reduce the amount of signage in place.

SCRUTINY PANELS

1. HOUSING SCRUTINY PANEL

The Housing Scrutiny Panel consisted of the following members:

Councillor S Murray (Chairman)
Councillor G Shiel (Vice Chairman)
Councillors K Chana, R Gadsby, S Jones, J Lea, C Roberts, B Rolfe, T Thomas, H Ulkun and J H Whitehouse

The Lead Officer was Alan Hall, Director of Communities. The Panel also appreciated the Housing Portfolio Holder, Councillor D Stallan, attending the meetings to help them with their deliberations.

Wyn Marshall represented the Tenants and Leaseholder Federation, attending the meetings as a non-voting co-opted member to provide the views of residents and stakeholders.

Terms of Reference

The Housing Scrutiny Panel was tasked to undertake reviews of a number of the Council's public and private sector housing policies and to make recommendations arising from such reviews to the Housing Portfolio Holder, Overview and Scrutiny Committee or Cabinet as appropriate. They also undertake specific projects related to public and private sector housing issues, as directed by the Overview and Scrutiny Committee.

The Panel scrutinised a number of important issues over the last year, which included:

(i) Communities Directorate's Housing Service Strategy on the Private Rented Sector – In July 2014 the Panel received a report regarding the Communities Directorate's Housing Service Strategy on the Private Rented Sector. There were 17 Housing Service Strategies produced to date and they set out how individual housing services would be delivered. They had assisted in achieving the Customer Service Excellence Award and the ISO 9001:2008 Quality Accreditation.

(ii) DCLG Guidance on Rents for Tenants on High Incomes - The Panel received a report regarding the DCLG Guidance on rents for Social Tenants with High Incomes. In June 2013, the Department for Communities and Local Government (DCLG) issued a consultation paper entitled "High Income Social Tenants Pay to Stay."

Under "Pay to Stay," the Government set out their intention that local authorities should be permitted to charge high income tenants a higher level of rent to stay in their homes. The DCLG's proposal at that time was based on higher rents set at 80% of market rents.

In May 2014, the DCLG issued its Guidance on rents for Social Housing, which would come into effect from April 2015.

In regard to social tenants with high incomes, the Government did not expect local authorities to adhere to its Social Rent Policy for properties let to households with an income of £60,000 per year. Instead authorities could choose to charge them up to full market rent. It was noted that this proposal was at variance with the original proposal at 80% of market rents made under the "Pay to Stay" consultation in 2013.

However, difficulties were identified with administering any separate rent policy for the Council's high income social tenants.

Government estimates suggested that between 11,000 and 21,000 social tenants, representing around 1% of all social tenancy households in England met the threshold. When applied to the number of properties in the Council's housing stock, around 64 high earning Council tenants would be required to pay market rents. It was found that rents would increase on average by around £83.00 for each of the 64 tenants affected, bringing in total additional income of around £276,000 per annum.

The Panel concluded that the District Council be recommended to take no further action on this issue at present; and that a further report be submitted to the Panel setting out the options regarding a separate Rent Policy for high income tenants when legislative compulsion on tenants to declare incomes is established along with sanctions for tenants found to have failed to declare.

(iii) Housing Under-Occupation Officer Post – 1 Year Review – At the Cabinet meeting in April 2012, the recommendations from this Panel, to appoint some additional new posts, were agreed. One post was that of a new Housing Under-Occupation Officer. The Cabinet requested that the Panel review the effectiveness of any new posts agreed after a period of 1 year.

It was known that many Council properties were under-occupied, which did not make the best use of the Council's housing stock but often resulted in older and vulnerable tenants incurring greater household running costs.

The new Housing Under-Occupation Officer was appointed in May 2013. Prior to the review of the Housing Allocations Scheme, letters were sent to around 1,300 homeseekers on the Housing Register. As a result, there were around 40 enquiries, all of which were followed up. This led to 5 of the Council's existing tenants moving to smaller accommodation. During the year, a further 1,300 letters were sent to all existing tenants over 60 years of age who were under-occupying Council accommodation, promoting sheltered accommodation and offering other opportunities. This led to 30 enquiries, all followed up with 6 appointments.

The Panel recommended that the role of the Housing Under-Occupation Officer post be expanded and that the post be re-designated as Re-Housing Support Officer to reflect its future role

(iv) Tenant Profile report 2014 - In August 2013, the District Council's Housing Information Team began a postal survey or "census" of Council tenants. At the time there were approximately 6,400 properties on the Housing Revenue Account. The two principal aims for conducting the survey were to:

(a) Check that the data held on the Housing system was correct; and

(b) Build a better profile of tenants for service planning purposes.

A total of 6,390 households received questionnaires and 3,649 were subsequently returned by the closing date in January 2014. The questionnaires then went onto ask:

(a) Their preferred form of communication;

(b) Their main language;

(c) Whether they had internet access;

(d) If they had any disabilities;

(e) Whether they wanted assistance with communications;

(f) Their contact details for next of kin and keyholders; and

(g) If they had access to a current account with a bank or building society.

The data gathered through the survey gave Housing staff access to more accurate information of tenants. Special needs identified were being flagged on the computer system so officers were aware of them. In addition, the Council had appointed a firm of external consultants, ARP Research, to produce a tenant profile report. ARP was provided with data collected from the survey returns and from this they produced a written report, executive summary, district mapping and ward profiles.

(v) Presentation by Essex County Council's Floating Support provider – Family Mosaic – The Panel welcomed Karla McLeish, Acting Floating Support Manager and Angela Randle of Family Mosaic, who gave a presentation regarding their organisation's work.

Family Mosaic possessed around 24,000 good quality homes available for rent serving more than 45,000 people, providing care and support services. They were one of the largest housing providers in London, Essex and the South East. Karla McLeish managed a team in Waltham Abbey which covered Epping Forest and Uttlesford.

(vi) Key performance Indicators 2014/15 - The Panel received quarterly reports for their Key Performance Indicators 2014/15 from the Director of Communities.

The Scrutiny Panels were now each responsible for the review of quarterly performance against specific KPIs within their areas of responsibility.

(vii) Government Consultation Paper "Right to Move" - The Panel received a report regarding a Department for Communities and Local Government (DCLG) Consultation Paper entitled "Right to Move".

The Consultation Paper explained that the Government expected local authorities to ensure that their Housing Allocations Schemes, residency requirements enabling social tenants to move across local authority boundaries for work related reasons so as not to impede labour mobility. The proposed regulations would remove the residency requirement for local authorities or housing association tenants who sought to transfer from another local authority district in England in order to be closer to their work or take up job offers, apprenticeships or work related training opportunities in order to avoid financial hardship.

The Government further proposed to ensure that authorities set aside a proportion of lets for tenants who needed to move for this purpose with a minimum expectation of 1% of lettings.

The Council responded to the consultation paper setting out the following:

(i) The Council would welcome the Government's proposal to "spell out" in more detail the circumstances in which they would expect local authorities to apply the addition to the "hardship" reasonable preference category for those needing to move for work or work related training.

(ii) The Council asked that it was clarified whether such preference would only apply to those in financial hardship and how such hardship were measured, particularly as there were no legal powers available to require applicants to declare their income.

(iii) The Council had concerns about setting aside a proportion of lets for this purpose and the difficulties with publishing information on the demand and lettings on any right to move quota.

(iv) There were a number of difficulties with giving priority to existing tenants for a "community contribution" in order to assist them to move within their own local authority area.

(viii) Review of the Housing Allocations Scheme - The Government required local authorities to have a Housing Allocations Scheme for determining priorities and the procedure for selecting a person for accommodation. Government guidance allowed for authorities to decide how accommodation should be allocated based upon local priorities, provided schemes were both legal and rational.

The Panel was advised that the amended Housing Allocations Scheme would be considered by an external legal advisor prior to statutory consultation being undertaken and final Cabinet approval

(See Case Study for full details)

(ix) Review of the Tenancy Policy - Under the Localism Act 2011 registered housing providers were granted additional powers allowing for local decisions on the management of social housing. This included enabling providers of social housing with the option to use flexible tenancies for a minimum period of 5 years. Flexible tenants generally enjoyed the same rights as secure tenants, including the Right to Buy, subject to the current qualifying criteria. On expiry of the fixed term, the tenant was assessed against an agreed Assessment Criteria to determine whether a further tenancy should be granted. If another tenancy was not offered, there was a requirement to provide the tenant with advice and assistance.

(x) Home Option Choice Based Lettings Scheme – Progress Report - The Choice Based Lettings Scheme introduced in November 2007 was administered externally by Locata Housing Services (LHS). Under the scheme, all vacant social rented properties were advertised to applicants on the website and a two weekly Property List giving details of location, type, rent, service charge, council tax band and landlord of the available accommodation. Applicants applying for a property by

expressing an interest in up to a maximum of three properties for which they had an assessed need.

Between 1 September 2013 and 31 August 2014, 345 properties had been allocated to homeseekers on the Housing Register. A further 49 properties were allocated direct to homeless applicants and an additional 11 to applicants leaving supported housing.

Some of the 345 properties allocated from the Housing Register had been advertised on more than one occasion, as they were difficult to let, this had resulted in 427 advertisements being placed on the website and in the Property Lists. With 24,307 expressions of interest being made, this was an average of around 70 expressions of interest from homeseekers each time a property was advertised. Most properties attracted in excess of 200 expressions of interest. Almost 97% of homeseekers expressed an interest in properties over the Internet.

Around 71% of all applicants registered on the Housing Register had participated in the scheme during the last year.

As a result of the introduction of the Local Eligibility Criteria under the current Housing Allocations Scheme, the numbers of homeseekers on the Housing Register had substantially reduced. As at 31 August 2014 there were 1,563 homeseekers on the Housing Register compared to 6,219 in June 2011.

(xi) Annual Review of Protected Characteristics – Housing Applicants and Lettings - In previous years, the Panel had undertaken an annual review of the ethnicity of applicants on the Housing Register and compared this with the ethnicity of those allocated accommodation, considering any disparities and whether there should be any resultant changes to the Housing Allocations Scheme. No such disparities had yet been identified.

Following the introduction of the Equality Act 2010 and the Public Sector Equality Duty in 2011, public bodies had to consider all individuals when carrying out their day to day work. There were nine “Protected Characteristics” which had considerations as follows:

- Age
- Disability
- Gender reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation

Generally, it was found that the statistics confirmed that the Protected Characteristics of homeseekers housed in Council accommodation were similar to those on the Housing Register. Therefore, it was recommended that no amendments be made to the Council’s Housing Allocations Scheme.

(xii) Landlord Accreditation Scheme – At their February 2015 meeting the Panel received a presentation regarding the Landlord Accreditation Scheme from the Private Housing Manager.

The Essex Landlord Accreditation Scheme (ELAS) was intended to raise standards in private sector rented accommodation. The scheme encouraged private landlords to come forward, make themselves known and enhance their professionalism.

ELAS was a consortium of 8 Essex District Councils, including Epping Forest District Council, administered through Blue Watch a wholly owned trading company of the Chief Fire Officer's Association (CFOA) Blue Watch Ltd for 5 years. Membership was £95.00 per annum and once a landlord was registered their properties could be advertised free on the ELAS website, they could receive discounted property insurance, they would have access to free impartial advice and information and for landlords that have licenceable houses in multiple occupation (HMO), some councils including Epping would reduce the HMO licence fee.

Despite the scheme being launched in September 2014 it had made slow progress with only two landlords having joined across Essex. It was hoped that with further publicity and exposure there would be an increase in membership.

(xiii) Housing Improvements and Service Enhancements Fund 2015/16 - It was noted that for the past three years, the Cabinet had asked the Housing Scrutiny Panel to consider and recommend a proposed list of housing improvements and service enhancements to the Cabinet utilising the additional funding received by the HRA which the Panel had last examined in March 2014.

There were 7 new housing improvements and service enhancements being undertaken in 2014/15, in addition to the completion of a further 7 projects extending/carried forward into 2014/15. Generally good progress had been made with the delivery of most of the projects during the year to date.

(xiv) Housing Services Strategy - The Housing Service Strategies were produced in accordance with an agreed standard framework, regularly updated. In total, 14 Housing Service Strategies had been produced covering:

(a) Equality and Diversity;
(b) Housing and Neighbourhood Management;
(c) Tenant Participation;
(d) Private Rented Sector;
(e) Empty Council Properties;
(f) Anti-Social Behaviour;
(g) House Sales and Leasehold Services;
(h) Rent Arrears;
(i) Rent Collection and Administration;
(j) Under-Occupation;
(k) Housing Information;
(l) Older People's Housing Services;
(m) Energy Efficiency; and
(n) Harassment

The strategies were produced to a common format that set out how individual housing services would be delivered.

Case Study: Housing Allocations Scheme

At its meeting on 21 October 2014, the Housing Scrutiny Panel reviewed the Council's Housing Allocations Scheme.

It is a Government requirement that local authorities have a Housing Allocations Scheme for determining priorities and a procedure for selecting a person for accommodation. Their guidance allowed for authorities to decide how accommodation should be allocated based on local priorities, provided their schemes were legal and rational.

The Council's Cabinet had asked the Housing Scrutiny Panel to undertake a 12 month review of the Housing Allocations Scheme. The Panel received the Department for Communities and Local Government (DCLG) Guidance providing social housing for local people (October 2013) and allocation of accommodation (June 2012) which the Panel had regard in respect of its deliberations on the proposed changes to the scheme.

The Housing Portfolio Holder had initial views on the 12 month review following informal discussions with the Cabinet. These were as follows:

(1) That the Residency Criteria should be increased with new applicants who had lived in the district for less then five continuous years immediately prior to their date of registration, not qualifying for inclusion on the Housing Register.

(2) That all existing home seekers on the Housing Register who had lived within the district for less than 4 ½ continuous years immediately prior to the date the new Housing Allocations Scheme was introduced, should be removed from the Register.

(3) That all existing home seekers who were removed from the Register because they did not meet the Local Eligibility Criteria, should be allowed to re-register if, or when, they did meet the criteria but that their registration date be their date of registration.

The Housing Portfolio Holder advised that despite the local housebuilding programme, there was still a shortage of social housing. He felt that local residents with the longest connection to the district ought to be prioritised.

It was felt that the wording within the Government's Code of Guidance was open to interpretation, particularly in regard to exceptions relating to applicants with a "strong association" to the area. However the Panel felt that an exception should be made for existing social housing tenants who were seeking to move from another local authority in order to access work. A paragraph should be added to include those who had secured either permanent employment comprising of a minimum of 24 hours each week, or an apprenticeship or full time work related training and currently lived either in excess of 50 miles from their current or intended place of work.

The Panel recommended that those who had moved out of the district into settled accommodation for less than 3 years but had lived in the district for at least 5 years immediately before moving out should be treated as home seekers who had lived in the district for more than 5 years. Members also recommended that a lesser residential requirement of 3 years should be applied to those leaving care.

It was recommended that where an applicant's gross annual household income including residential property equity, savings, shares or other assets exceeded £76,000, they should not qualify to join the Council's Housing Register.

The Chairman of the Panel was concerned that the long term effects of these proposals would change the social mix of the social housing sector, however the Panel supported the proposals.

Any tenant of the Council is offered an incentive payment to encourage downsizing their accommodation, where both properties were owned by the Council. The maximum payment is currently £2,000. During 2013/14, 41 tenants of the Council downsized to another property owned by the Council with less bedrooms. This resulted in 54 bedrooms being released; the total amount paid in downsizing payments was £47,500.

The Housing Portfolio Holder felt that the downsizing incentive payments should be increased. Accordingly, the Panel supported the incentive payments for each bedroom released being doubled to £1,000 with the amount paid for removal costs remaining the same and a standard decoration allowance payment of £500.00 being paid using "Homebase" vouchers subject to a maximum payment of £4,000.

The Panel was of the view that the increased incentive payments should only apply to tenants who were not subject to the removal of the spare room subsidy. It was noted that the increased incentives could result in an estimated increase in budget provision of around £68,000 making a required total annual budget of £115,500.

The Panel endorsed the view that the current policy on homeseekers refusing two offers of suitable accommodation within any three months period having their application being deferred for 6 months should be strengthened to two refusals within any period having their housing application deferred for 12 months. However, although those downsizing Council accommodation would be penalised in the same way, the penalty would apply following three refusals. The Panel supported a number of more minor changes suggested by officers

The Panel was advised that the amended Housing Allocations Scheme would be considered by an external legal advisor prior to a statutory consultation being undertaken and final Cabinet approval.

2. CONSTITUTION AND MEMBER SERVICES SCRUTINY PANEL

The Constitution and Member Services Panel consisted of the following members:

Councillor M Sartin (Chairman)
Councillor A Watts (Vice Chairman)
Councillors D Dorrell, J Lea, M McEwen, J Philip, Caroline Pond, D Stallan, G Waller, J H Whitehouse and S Weston

The Lead Officer was Simon Hill, Assistant Director, Governance and Performance Management.

Terms of Reference

To undertake reviews of constitutional, civic, electoral and governance matters and services for members on behalf of the Overview and Scrutiny Committee and to report to the Overview and Scrutiny Committee, the Council or the Cabinet with recommendations on matters allocated to the Panel as appropriate.

The Panel scrutinised a number of issues over the last year, which included:

(i) Local Elections – 22 May 2014 – At their July 2014 meeting, the Panel received a report from the Returning Officer regarding the Elections held on 22 May 2014. They were:

(d) Election of 7 Members of the European Parliament for the Eastern Region of the UK;

(e) 19 District Council Wards; and

(f) 1 Parish Council by-election for Buckhurst Hill West.

Voter turnout at the various lections ranged between 44% in the Buckhurst Hill East Ward and 28% in Waltham Abbey Paternoster Ward. Turnout for the European Parliamentary Election, within the district, was 35.58%, compared with a turnout of 35.90% across the region.

It was noted that there were few issues with the election, generally all practices were completed successfully.

The issue of postal votes went smoothly. Initially problems were experienced with software and scanners used for checking personal identifiers, but this was resolved remotely. 196 postal votes were rejected for various reasons, over 60 of which did not contain a ballot paper or postal voting statement. It was advised that new legislation

required the Electoral Registration Officer to inform electors, after a poll, that their postal vote identifiers had been rejected.

(ii) Review of Polling District, Polling Places and Polling Stations - The Electoral Registration and Administration Act 2013 made it compulsory for this authority to carry out a review of Parliamentary polling districts and polling places within 16 months, starting from 1 October 2013, with further reviews starting on 1 October of every fifth subsequent year. It was necessary for the Council to consider polling districts and places in the Epping Forest Parliamentary constituency and those parts of the Brentwood and Ongar and Harlow situated within the district.

A polling district was a geographical area created by the sub division of a UK Parliamentary Constituency for the purposes of an election. A polling place was the building or area in which polling stations would be selected by the Returning Officer. A polling station was the room or area within the polling place where voting took place.

Notice of a review together with details of the existing polling districts, polling places and polling stations were given on 24 March 2014. The consultation period ran from 24 March to 30 May 2014.

Following the consultation, the Panel advocated that a report be submitted to the Council making several minor recommendations on the future of the district's polling places and stations.

(iii) Constitution Review - The Panel noted that the Council adopted a new constitution, based on a government model, in 2000. However in order to reflect changing circumstances, the constitution had grown to over 650 pages with no overriding review having been undertaken since its adoption.

The agreed Business Plan for the Governance Directorate included the aim of completing a review of the Constitution by March 2016. Although this Panel had undertaken a number of reviews of sections of the Constitution, the proposed review sought to ensure consistency of wording and rules across the piece and rationalise procedures to avoid duplication or repetition.

(See Case Study for full details)

(iv) Joint Consultative Committee – Review of Terms of Reference - Following a Management Board report in December 2012, it was acknowledged that the Terms of Reference for the Joint Consultative Committee (JCC) had not been reviewed for a period of considerable time. Therefore Management Board agreed that a review of the JCC should take place.

The JCC was the Council's forum whereby discussions took place with the recognised trade unions in line with the representations at a regional level. However the Performance Improvement Unit (PIU) had identified that non-union members were not represented at the JCC. Whilst technically correct, as trade unions were not required to represent non-union staff, it was noted that:

(a) The trade union representatives who attended the Committee had to be employees of the Council;

(b) There were 9 trade union representatives from a range of service areas who between them were likely to hold a range of views similar to employees who were not trade union representatives; and

(c) All representatives, whether staff or member, were permitted to share their views with the Committee and did so.

It was advised that work was progressing outside the review of the JCC Terms of Reference regarding internal staff communications and as part of the review they would draft and develop an Employee Engagement Strategy.

The Panel were happy to recommend the amended and updated terms of reference for the JCC.

(v) Planning Committees and their Terms of Reference - At their February 2015 meeting the Panel considered a review of the operation of Planning Committees and their Terms of Reference. This originated from the Overview and Scrutiny Committee, at its meeting on 16 September 2014, when it referred a PICK form request to the Planning Scrutiny Panel who then referred their deliberation on to this Panel.

The Panel supported the Planning Scrutiny Panel's recommendation on the criteria for referring applications to the DDCC subject to the inclusion of "large scale development schemes" to the items that would go directly to the DDCC.

The Panel supported changing the name of the District Development Control Committee to District Development Management Committee to reflect new directorate section titles and the adoption of the revised draft Article on the operation of and arrangements for Planning Committees.

(vi) Amendments to the Council's Complaints Scheme - The Council's complaints scheme had four stages, an investigation of a complaint at each stage was undertaken by the following:

(a) Step 1 – Manager of the Service area concerned;

(b) Step 2 – Director or Assistant Director;

(c) Step 3 – Complaints Officer on behalf of Director of Governance; and

(d) Step 4 – Member Complaints Panel

The Panel was informed that in 2006 the Local Government Ombudsman introduced the "12 week rule" which urged councils to complete every stage of a complaint within 12 weeks of their first receipt. Inability to do so meant the complainant had the right to bypass any remaining stages in the complaints procedure and instead take their complaint to the Ombudsman. However, the complaints procedure adopted by the District Council made it impossible to complete all four stages within 12 weeks. Investigations at Steps 1, 2 and 3 usually took around 3 – 4 weeks each to complete. A

complainant remaining dissatisfied could request a further review, although it could take 7 – 8 weeks to organise a meeting of the Step 4 Member Complaints Panel.

Therefore complainants were advised that it was not possible to offer a Step 4 review within the 12 week time limit, therefore they had the right to bypass this and take their complaint to the Ombudsman.

Members noted that discontinuing Steps 1 – 3 would not resolve the problem because whichever two of the three stages were retained, would still require a total of around 8 weeks to complete, which would not leave enough time to organise a Complaints Panel review within the 12 week time limit. It was advised that no other local authority in Essex, or indeed the rest of the country, had as many stages for complaints or offered a final review by Members.

Members supported the recommended changes.

Case Study: Review of the Council's Constitution

The most substantial task undertaken by the Constitution and Member Services Scrutiny Panel has been to start the process of reviewing the Council's Constitution.

The Council's Constitution dates back to the Local Government Act 2000 which required every council to have a Constitution containing the authority's standing orders, code of conduct and such other rules and information that were considered appropriate.

Over time the Constitution had grown to over 650 pages which whilst reflecting changing circumstances, had made easy access to the rules governing Council business at times difficult. No overriding review has been undertaken since its adoption.

The Business Plan for the new Governance Directorate included the ambitious task of completing a review of the Constitution by March 2016. It sought to ensure consistency of wording, rules and a rationalisation of procedures to avoid duplication and repetition.

The Constitution and Member Services Scrutiny Panel commenced work on the review with consideration of a scoping report at its September 2014 Panel meeting. The Panel was aiming to examine the following specific areas during this year:

(a) Articles of the Constitution;

(b) Delegations and contract standing orders;

(c) Minority references;

(d) Council Procedure Rules; and

(e) Use of the Chairman's Casting Vote

Given this huge task the Members of the Panel have prioritised their working method as follows:

(i) Reviewing sections from the Constitution at each meeting with short commentaries by officers with suggested changes;

(ii) Undertaking consultation with other parties; and

(iii) Extending invitations to Committee/Panel Chairmen when a Constitutional review issue relevant to their area arose.

The Panel planned to complete the work by March 2016 with the aim of the Council agreeing the new Constitution document by the end of that municipal year. The review was currently making good progress.

3. FINANCE AND PERFORMANCE MANAGEMENT SCRUTINY PANEL

The Finance and Performance Management Scrutiny Panel consisted of the following Members:

Councillor A Church (Chairman)
Councillor A Mitchell (Vice Chairman)
Councillors K Angold-Stephens, D Dorrell, J Knapman, H Mann, G Mohindra; H Ulkun, Jon Whitehouse, S Watson and E Webster

The Lead Officer was Peter Maddock, Assistant Director (Accountancy).

Terms of Reference

Performance Management

1. To review Key Performance Indicator (KPI) outturn results for the previous year, at the commencement of each municipal year;

2. To identify on an annual basis, subject to the concurrence of the Finance and Performance Management Cabinet Committee:

   (a) a basket of KPIs important to the improvement of the Council's services and the achievement of its key objectives; and

   (b) the performance targets and monitoring frequency of the KPIs for each year.

3. To review performance against the adopted KPIs on a quarterly basis throughout each year, and to make recommendations for corrective action in relation to areas of slippage or under performance;

Public Consultation and Engagement

4. To develop arrangements as required, for the Council to directly engage local communities in shaping the future direction of its services, to ensure that they are responsive to local need;

5. To annually review details of the consultation and engagement exercises undertaken by the Council over the previous year;

Finance

6. To consider the draft portfolio budgets for each year, and to evaluate and rank proposals for enhancing or reducing services where necessary, whilst ensuring consistency between policy objectives and financial demands;

7. To review key areas of income and expenditure for each portfolio on a quarterly basis throughout the year;

Information and Communications Technology

8. To monitor and review progress on the implementation of all major ICT systems;

Value for Money

9. To consider a regular analysis of the Council's comparative value for money 'performance', and to recommend as required to the Finance and Performance Management Cabinet Committee, in respect of areas where further detailed investigation may be required; and

Equality

10. To annually review the achievement of the Council's equality objectives for 2012/13 to 2015/16, and progress in relation to other equality issues and initiatives.

The Panel scrutinised a number of important issues over the last year, which included:

(i) Key Performance Indicators 2013/14 – The outturn report on the key performance indicators adopted by the Council for 2013/14 went to Panel's July's meeting. The meeting noted that a range of thirty five Key Performance Indicators had been adopted by the Finance and Performance Management Cabinet Committee in March 2013.

The position in regard to the KPIs for the end of the year was as follows:

a) 28 (80%) indicators achieved the cumulative target; and
b) 7 (20%) indicators did not achieve the cumulative target, although 2 of these indicators performed within the agreed tolerance for that indicator.

Members were reminded that as part of the Overview and Scrutiny Review undertaken in 2013/14, changes had been made to the existing arrangements for the quarterly review of KPI performance.

From the first quarter of the year, four of the existing Scrutiny Panels (Finance and Performance Management, Housing, Planning, and Safer Cleaner and Greener) will each be responsible for the review of quarterly performance against relevant KPIs, rather than all indicators being considered by the Finance and Performance Management Scrutiny Panel.

(ii) Sickness Absence 2013/14 (final figures) – At their July, 2014 the Panel received a sickness absence report for quarters 3 and 4 for 2013/14. The Panel noted that the Council's target for sickness absence under KPI10 for 2013/14 was an average of 7.25 days per employee. The final overall outturn figure of 7.01 days was below the target of 7.25 days for the year.

(iii) Consultation and Engagement – The Panel received the annual report on the public consultations carried out during 2013/14.

Every year a list of consultation planned and carried out by the Council was published on the website and brought to the attention of this Panel.

The Consultation Register was a list of the most recent exercises, which have been carried out on behalf of the Council or by the Council in the last financial year.

It was noted that some new policies and initiatives had been consulted on such as the Introduction to Annual Site Licence Fees for Permanent Residential Park Homes; and the HealthWorks Survey (Healthworks was a health improvement and well-being project for young people aged 11 to 19, and encourages them to adopt healthier lifestyles, providing a range of activities, workshops and courses).

The Panel noted that the Council had undertaken 6 statutory surveys and had planned a further 2 so far this year. It had also carried out 4 discretionary surveys.

Costs were being kept low by using resources in-house and using online technology. Three statutory surveys made up the bulk of the costs involved in public engagement which totalled £111,000; the 'Local Plan Preferred Options' consultation planned for December, involved the highest costs mentioned in the report of £90k.

Judgement on whether or not to include a consultation on the register should be relative to the impact and local sensitivity of the subject. For example if the changes being proposed are likely to be either:

- contentious,
- an expensive project,
- a possible cause for complaint,
- effect a lot of people,
- controversial;

- or a possible nuisance to residents

then they would be included on the register, however small they were.

More emphasis had been given to data protection in consultation**.** Further monitoring would be carried out to ensure this happened.

Online consultation was steadily becoming more advanced and the Council was starting to use WebHost, which was Cloud technology and gave more control and faster recovery of data and analysis.

Further use of Social Media for consultation purposes was being researched to see if the feedback or publicity aspects were a useful source of public engagement and or feedback.

(iv) Provisional Capital Outturn for 2013/14 – This report set out the Council's capital programme for 2013/14, in terms of expenditure and financing, and compared the provisional outturn figures with the revised estimates. The revised estimates, which were based on the Capital Programme, represented those adopted by the Council in February 2014.

The Council's total investment on capital schemes in 2013/14 was £13,006,000, compared to a revised estimate of £15,610,000. The largest underspends were experienced on General Fund projects, virtually all of which were underspent.

(v) Provisional Revenue Outturn for 2013/14 - This provided an overall summary of the revenue outturn for the financial year. The Panel noted that the net expenditure of the Continuing Services Budget (CSB) for 2013/14 totalled £14.219 million, which was £149,000 (1.0%) below the original estimate and £265,000 (1.9%) below the revised. When compared to a gross expenditure budget of approximately £75 million, the variances can be restated as 0.2% and 0.35% respectively.

There were also improvements in the funding position as this showed an increase of £286,000, however this was not the full story as movements between the Collection Fund (where Council Tax and Business Rates are accounted for) and the General Fund are governed by specific regulations.

The Panel noted that when HRA Self Financing was introduced it became clear that more money would be available for service improvements and enhancements. Each year an amount was allocated for service enhancement based on the likely funding available. There was an underspend on the programme last year and therefore £112,000 was requested for carry forward into 2014/15.

(vi) Key Performance Indicators – Performance by Quarters – The Panel noted that from this year, each Scrutiny Panel would be receiving their own performance indicators to review on a quarterly basis. Through the year the Panel received a quarterly update on their own set of indicators.

Eleven of the Key Performance Indicators fell within the F&PM SP areas of responsibility.

By their last meeting the Panel had the third quarter results for the KPIs specific to their Panel for 2014/15 and noted that:

(a) 6 (55%) indicators achieved the cumulative third quarter target, and
(b) 5 (45%) indicators did not achieve the cumulative third quarter target.
(c) 7 (64%) were currently anticipated to achieve the cumulative year-end target.

(vii) Quarterly Financial Monitoring – the Panel also received quarterly updates on the financial state of the council.

They noted that the new Business Rates Retention scheme was in its second year whereby a proportion of rates collected were retained by the Council. By the end of June 2014 the figures were looking good with the Council retaining funding of £40,680; but this might not continue depending on the number of claims from small businesses that were received.

(viii) Performance Monitoring – Call Handling – The report on call handling performance that was produced in response to a request made by this Panel at their March meeting. They had wanted to know how long a member of the public would have to wait before they were answered by the switchboard. They noted that our new telephone system was now live and capable of producing very detailed management information. However it was noted that although a report on switchboard times was possible the majority of calls now bypass the switchboard and go to direct dial extensions. It would be more beneficial to monitor what happens following the switchboard transferring a call.

ICT staff had only just been trained in the use of this new monitoring system and on the subsequent production of reports. They were now looking to members to give a steer as to what they would like to have monitored. Officers could then produce regular reports monitoring as appropriate.

By their March 2015 meeting the Council's new telephone system was live and could produce various monitoring information. Following the introduction of a number of auto attendants (menu assisted calls), a large number of calls now bypass the switchboard and go straight to directorate contact centres and workgroups.

They noted that other authorities that had telephone systems like us tended to favour reporting on:

a. The percentage of abandoned calls (subject to a minimum of 4 rings); and
b. The number of calls sent directly to the voicemail system.

ICT tended to favour these indicators that specifically relate to the service callers were receiving. During January, 35,388 calls were received – 9.8% of these were classified as abandoned with 4.22% of calls going directly to voicemail. This may be something that the Panel would want to monitor. The Panel agreed that these would be appropriate points to monitor in the coming year.

(ix) Financial Issues Paper - This provided the initial framework for starting the 2015/16 budget. It had been to the Cabinet Finance Committee in July and was here for the Panel comments on the initial budgetary structure for 2015/16.

The report took the members through the General Fund Outturn for 2013-14, the updated Medium Term Financial Strategy and the Continuing Services Budget. It also went through central government funding, noting that significant changes had happened at the start of 2013/14 and we were only a year and a half into these changes. It was noted that as part of abolishing Council Tax Benefit and introducing Local Council Tax Support (LCTS), the DCLG had to determine whether parish Councils would be affected by the reduction in council tax base or left outside the calculations. However, despite the consultation response on the scheme being massively in favour of tax base adjustments only at district level, the DCLG decided that parish councils should also be affected. One of the problems with this decision was that DCLG did not have a legal power to make grant payments directly to parish councils. This meant the funding for these councils had to be included in the grants to districts and it was then for districts to determine how much of the grant was passed on. Members determined that parish councils should be fully protected from this change for 2013/14, a decision that was not shared by many authorities across the country.

It was noted that half of the Business rates retention was kept locally, 40% to EFDC, 9% to Essex County Council and 1% to the Essex Fire Authority; and 50% went to Central Government.

As the billing authority we were responsible for collecting the money and then paying it over. However, as our share (£12,755,334) exceeds the amount of our funding deemed to come from retained business rates (£2,909,311) the excess (£9,846,023) was also paid to Central Government as a "Tariff". The tariffs are used to provide "Top Ups" to those authorities whose non-domestic rate income was lower than their deemed funding from business rates. Overall this meant we were collecting nearly £32 million but retaining less than £3 million, or just over 9%.

(x) Equality Objectives 2012-2016 – At their November 2014 meeting the Panel noted the quarter 2 progress on the Equality Objective. In 2012 the Cabinet had agreed a range of equality objectives for the four years from 2012 to 2016, designed to help the Council meet the aims of the general duties of the Equality Act (2010) and bring about positive improvements to service design and delivery. The report reflected progress against these objectives as at the end of the second quarter of 2014/15. The achievements of these objectives were supported by an action plan spread across the four year time frame.

(xi) Sickness Absence for 2014/15 – The Panel noted the absence figures for quarters 1 and 2 for 2014/15. It included absence figures for each directorate and the number of employees who had met the trigger level. It was noted that the figures had taken a bit of a downturn this year; this seemed to be due to several long term absences.

(xii) Equality Information – Workforce Data - This report on Equality Information, generated under action E04.02 of the Council's Equality Objectives 2012-16 to "carry out analysis of workforce data to identify trends and patterns in areas as identified by Corporate Equalities Working Group".

The Panel noted that:

- Women were well represented in the Council's workforce (56.02%) and there was evidence that they were accessing training opportunities and achieving promotion;
- Disabled people were well represented in the Council workforce. The figure was 11.14% for the Council and 10.17% for the district. There was evidence that this group were accessing training opportunities and achieving promotion;
- The Council workforce was older on average than the local population, with 34.06% being in the 45-59 age range;
- 52.97% of Council staff did not wish to disclose their religion or belief. Statistics for the staff that did provide this information show that non-Christian groups are under-represented with 3.05% for the Council and 8.1% for the district; and that
- 51.07% of Council staff did not wish to disclose their sexual orientation. There was no comparative information from the 2011 Census.

(xiv) Fees and Charges 2015/16 - This report that went to the Panel's November 2014 meeting, provided details on the fees and charges that the council levies and what scope, if any, there was to increase any particular charge. This was an annual report produced as part of the annual budget process.

It was noted that:

- The medium term financial strategy had identified the need for savings around £1.5m over the four year period, with £500,000 falling in 2015/16. This may well rise to near £1m;
- Increasing existing fees and charges would help reach the savings target set, however, there were issues to consider such as whether fee increases will drive customers away and have the opposite of the desired effect and actually reduce income;
- The September Retail Prices Index (RPI) has recently been published at 2.3%. Previously this has been used as a guide when setting the level of increase however other factors such as cost of provision also need to be considered;
- Generally, it was recommended that the majority of fees and charges be increased by the Retail Prices Index (RPI) for September 2014 (2.3%) - rounded up or down as appropriate.

The Panel broadly agreed with the proposed level of the fees and charges for 2015/16, but would like the increase charges to the 'Careline' services to be revisited.

(xv) Commercial Property – Rent Paid – The Panel at its meeting in September 2014 considered KPI GOV002 (Commercial Property – Rent Paid) and noted that the percentage of rent arrears over 90 days was 4.73% against a target of 3% and an explanation was required as to why this figure was below target.

Members were invited to look at how this indicator was presented, it had distorted figures as it included former tenants and historic debts and did not relate to current

expected income for the financial year. Targets would need to be adjusted to reflect this, perhaps by breaking it down into two sets of figures.

The Panel, on consideration thought that there was a need for early intervention, a way to see and identify the warning signals.

(See Case Study for full details)

(xvi) ICT Updates – The Panel received update on the Council's Information and Computer Technology systems updating them on the ongoing works and projects of the ICT strategy. Overall the projects were on track and progressing well.
They noted that the Council now had:

- An Auto Attendant telephone system with menu assisted calls;
- There were now mobile applications to enable officers and members to work out of the office;
- The whole council was now covered by wireless connectivity;
- ICT now have out of hours call-out arrangements to enable them to resolve any problems before core working time begins; and
- The Council has now developed its own online booking system for leisure services and this will eventually link in with the Finance system.

(xvii) Financial Monitoring - The Panel undertook quarterly financial monitoring on income and expenditure for quarter three of the financial year. The last quarter would be reported in the new municipal year.

By the end of quarter three it was reported that it would be a surprise if the Council showed an underspend this year.

Case Study – Commercial Property – Rent Paid

At their meeting in September 2014 the Panel considered KPI GOV002 (Commercial Property – Rent Paid) and noted that the percentage of rent arrears over 90 days was 4.73% against a target of 3% and an explanation was required as to why this figure was below target.

The Chief Estates officer noted that:

- The Council had substantial property portfolios;
- This KPI excluded debts under 90 days to enable people to pay;
- There had been resources issues but it was hoped that two Asset Management & Economic Development Assistants, approved by Council in September 2014 would be able to help chase outstanding debts;
- Members were invited to look at how this indicator was presented as it had distorted figures as it included former tenants and historic debts and did not relate to current expected income for the financial year; and

- Targets would need to be adjusted to reflect this, perhaps by breaking it down into two sets of figures.

The Panel considered a list of arrears from current tenants and former tenants and lists of debts that the council's legal services were dealing with. Where it was felt that the situation would not improve, court orders had been obtained for possession of the properties so that the Council could re-let to new tenants. It was noted that some tenants were making regular payments to reduce their debt; or had been paying but had now stopped; there were a number of debts not worth pursuing as they may have gone into administration. If these were taken out, the arrears would go down to below 3%.

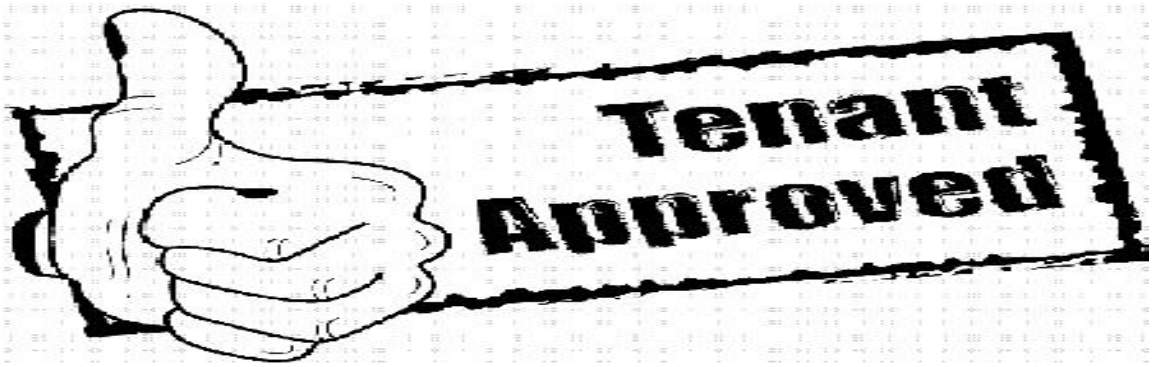
The Panel noted that these were only commercial property debts; and that although some went back to 2006, were still listed, but as they were still being paid of, if only a small amount on a regular basis, the Council was still collecting.

Asked if the Council asked for deposits and took due diligence in letting to new tenants, the Chief Estates Officer said that they did exert due diligence and also took a deposit and used it if they have to take re-possession.

The Panel went on to examine certain cases as detailed in the report in more depth to get a better knowledge of the cases outstanding.

The Panel concluded that there was a need for early intervention, a way to see the warning signals. Future problems were hard to identify as the signs were not always clear. Officers did not know the tenants business in detail and had to make judgement calls on this.

The Chairman summed up by saying that the general consensus was that prevention was better. Deposits could be use to pay arrears and if used they should be topped up by the tenants and if they could not, it would be a sign that they were in trouble. This could be used as an indicator. The Panel recommended that the risk management policy for this be reviewed. They would also like the KPI reviewed to consider if the figures should include historic debt which did not relate to the current expected income for the financial year. Targets would need to be adjusted to reflect this.



4. SAFER CLEANER GREENER SCRUTINY PANEL

The Safer, Cleaner, Greener Scrutiny Panel consisted of the following members:

Councillor J Lea (Chairman)
Councillor H Brady (Vice Chairman)
Councillors K Chana, R Gadsby, B Jennings, L Mead, A Mitchell, S Neville, M Sartin, B Surtees and E Webster

The Lead officer was Qasim Durrani, Assistant Director, Technical Services.

Terms of Reference

1. To approve and keep under review the "Safer, Cleaner, Greener" initiative development programme.

   (Note: this development programme will encompass the three main issues and will therefore include matters such as:

   (i) environmental enforcement activity
   (ii) safer communities activities
   (iii) waste management activities (in addition to WMPB information))

2. To keep under review the activity and decisions of the Waste Partnership Member Board and the Inter Authority Member Working Group.

3. To receive reports from the Waste Management Partnership Board in respect of the operation of and performance of the waste management contract

4. To monitor and keep under review the Council's progress towards the preparation and adoption of a sustainability policy and to receive progress reports on the Council's Climate Change Strategy from the Green Working Group.

5. To receive and review the reports of the Bobbingworth Nature Reserve (former Landfill site) Liaison Group.

6. To act as the Council's Crime and Disorder Scrutiny Committee and to keep under review the activities of the Epping Forest Safer Communities Partnership as a whole or any of the individual partners which make up the partnership and:
   - That one meeting a year be dedicated as Community Safety Committee meetings.

7. To monitor and review the new Local Highways Panel.

8. To receive the minutes of the North Essex Parking Partnership (NEPP) for the purposes of monitoring the work and progress of the partnership.

9. To monitor and review the minutes of the Police and Crime Panel.

10. To receive copies of the Leisure Board minutes.

The Panel scrutinised a number of important issues over the last year, which included:

(i) Road Traffic Accidents – At their first meeting of the year in July 2014 the Chairman welcomed Adam Pipe, the Casualty Reduction Manager from Essex Police and PS Simon Willshire. They were there to talk about the work Essex Police were doing with the road traffic collisions data for the Epping Forest area.

The Panel noted that the traffic sections were having a difficult time as they were not seen as a priority by central government and had to deal with cuts in their resource budgets. They were to get down to 80 from the current 160 officers for the County and to 10 motorcycle units, with only 2 officers responsible for commercial vehicles. They were also down to 9 special constables responsible for casualty reduction.

Mr Pipe's section was also responsible for the road side safety cameras and carried out camera offences investigations. The cameras were not just for fines and a lot of the people caught this way were told by the courts to take safety courses. They were creating all sorts of courses for low level offenders from cyclists, to motorcyclists and drivers, all based around educating them and modifying their behaviour.

Part of their job was to reduce the number of people killed or seriously injured (KSI) on Essex roads through enforcement, education and engagement. Partly this would be down to the maximum use of re-education for the low end offenders and ensuring, where possible, that top end offenders were brought to justice.

The meeting noted that a disproportionate 26% of KSIs were motorcyclists who made up only a small percentage of motorised road traffic. They were also noticing an increase in drunk drivers at present.

In the Epping Forest area, in 2014 so far there had been 35 KSIs. There had been 40 for 2013. As for cyclists, so far this year there have been substantially less KSIs than last year, which was encouraging. There had been quite a few pedestrian accidents so far this year especially in the Loughton area, a densely populated urban area.

They also identified those persons who used the road network to commit crime.

(ii) Anti Social Behaviour Case Review Model – Also at their July meeting the Panel noted that new legislation on Anti-Social Behaviour, the Crime and Policing Act 2014 (formally known as 'Community Triggers') received royal assent on 13 March 2014. The Act was designed to introduce simpler, more effective powers to tackle anti-social behaviour and provide better protection for victims and communities.

Within the Act are new responsibilities for the relevant bodies including the District Council, the Police, clinical commissioning groups, health providers and registered social housing providers.

To ensure agencies took a more joined up, problem solving

approach, Safer Essex had agreed to develop a consistent County-wide approach across all agencies who are involved in the use of the new legislation; providing victims of anti-social behaviour with a coherent and effective response regardless of where they lived in Essex.

It was important to note that the District Council would play a key pivotal role in this process by taking the lead over the other agencies, including Essex Police, in recording, collating and responding to all Anti-social Behaviour Review requests from the public.

(iii) Waste Contract Update – The meeting received a rundown on the latest of the new waste management contract awarded to BIFFA. The Cabinet had agreed on 19 May to award the contract to Biffa Municipal Limited. Following the publication of the decision on 21 May there was the Alcatel mandatory standstill period. This was to allow any unsuccessful bidder to challenge the decision made by the Council. It was noted that no challenges were made to the awarding of the contract and the contract had now been formally awarded to them. The unsuccessful bidders had a debrief session on 3rd July. This was attended by SITA, SERCO and Ubaser.

(iv) Recycling in Flats and Multiple Occupancy Dwellings – The Panel received a verbal report on the current state of recycling in flat blocks in the District. There were a total of 7,400 flats in the District and some of these were not able to have suitable containers put in to collect the recycling. 80% of flats that were suitable for having recycling containers have now got them and officers were exploring ways to put some containers in the other 20% of flats. They were also looking at ways to put in food recycling but there had been problems with contamination. Recycling bins were being redesigned along with new literature and leaflets to educate the residents in the flat blocks.

(v) Update on the Environment Agency River Roding Strategy – In October the Panel received an update on the Environment Agency's River Roding Strategy telling members that the Environment Agency (EA) would be adopting the recommendations of the River Roding Strategy. They would be writing to all properties and landowners within the boundary of the River Roding's flood plain, advising them of the strategy recommendations and how the implementation would impact on their property. This strategy would benefit 1000 properties in the catchment but unfortunately some properties would remain at high risk or in a few cases have an increased risk of flooding. They would be working with those property owners to offer advice and guidance to ensure they were aware of the risks and the steps they could take to minimise these.

Once the River Roding Strategy was fully implemented it was likely that there would be impacts on the district and resourcing implications for the Council.

(vi) Key Performance Indicators 2014/15 - The specific Key Performance Indicators (KPI) for each quarter of the year that was appropriate to this Panel were noted. This was the first year that these specific indicators had gone to the Panel since being agreed by last year's Overview and Scrutiny Review Task and Finish Panel.

Over the year the Panel considered the performance of the Key Performance Indicators for 2014/15 relevant to the council services that the panel monitors on a quarterly basis.

By the end of quarter three, the Panel noted that of the KPIs that fell within the Safer Cleaner Greener Scrutiny Panel area of responsibility their position was:

i) 7 (78%) of indicators achieved the cumulative third quarter target;
ii) 2 (22%) of indicators did not achieve the cumulative third quarter target;
iii) 8 (89%) were currently anticipated to achieve the cumulative year-end target.

(vii) CCTV – 3 Year Action Plan – At their January 2015 meeting the Council's CCTV Operations Officer updated the Panel on the CCTV three year action plans. The Panel noted that the use of CCTV had helped in the investigation of some unpleasant crimes, including a violent assault on a taxi driver in Epping. A lot of these investigations had led to arrests directly attributable to the use of CCTV.

Relevant CCTV footage was made available to the Police and other responsible authorities.

The Panel noted that:

- Loughton High Road now had high definition cameras installed along its length and this had proved useful so far;
- The museum in Waltham Abbey will have high definition cameras installed and the current system at North Weald Airfield would also be improved;
- Officers were looking to stream the live CCTV footage back to the Civic Offices so that they could be monitored in real time;
- There were now about 450 cameras across the district, with the police asking for about 253 downloads of incidents last year;

- The Council has recently completed a self assessment on its CCTV services and has found itself to be in good shape as an authority;
- The Council was now receiving more and more requests from insurance companies for CCTV footage and officers have now started charging for these images;
- For any operations using covert surveillance, magistrate's authorisation would have to be sought. The Council had also developed its own policy for this. A recent success for the use of covert surveillance was the catching of a long term fly tipper;
- Officers were updating the way people could request CCTV footage by using the council's website. This was now a clearer and quicker way to request footage by way of a web form and a generated unique reference number; and
- We would be helping Waltham Abbey Town Council with their CCTV systems during the coming year.

(viii) Enforcement Activities Update – The Panel received an update on the Council's enforcement activities. The figures remained fairly constant over the periods shown, fly tipping remained an ongoing problem and the council tended to publicise successful prosecutions to act as a deterrent. The report detailed some of the more successful prosecutions.

(ix) Air pollution – At their meeting in February 2015, the Panel received a report that was in reply to the querying of the amount of air pollution in our district and in particular the levels of particulate pollution in Epping Forest, attributable to 6% of all deaths.

They noted that officers carried out an assessment every 3 to 4 years based on PM_{10} particulates.

Research showed that particulate pollution reduced life expectancy by two years and could also be the cause of serious illnesses. The current Mayor of London had an objective to achieve an ultra low emissions zone in London. However, it was noted that our power to influence this issue was very limited because of the motorways and commuters going in and out of London.

It was also noted that there was a need for a safer set up for cyclists in our area, the rural roads were just too dangerous. It was highlighted that 'Sustrans' the transport charity were looking into this at present in the Epping area.

(x) Engineering and Drainage – the Panel received a presentation by the Council's Drainage Manager on the Council's role in alleviating the risk of flooding in the district and what the Engineering, Drainage and Water Team (EDWT) did.

The Panel noted that EDWT provided a discretionary 24/7 – 365 emergency flood response standby service to deal with out of hours flooding incidents involving Council owned assets or to assist members of the public, where appropriate. They would respond to all types of flooding incidents, working closely with the Environment Agency where necessary.

(See case study for full details)

(xi) Thames Water – at their very last meeting the Panel received a presentation from four officers from Thames Water. They were there to tell the Panel about their work in this area, the problems they faced and to outline some solutions. They started by apologising for the time taken for some of the work they had undertaken and for their lack of communication in aspects for the cases provided.

Thames Water was increasing the number of customer representatives in both their clean and waste teams to improve contact. They were also continuously reviewing their communications branch improving how they target communication to areas that needed it most.

The Panel noted that they had a duty to provide public sewerage and to clean and maintain sewers. They also had a duty to provide and extend sewerage systems, but do not have the duty to provide capacity to deal with flood or ground water. They also do not deal with rivers or canals. There were three types of sewer: foul water sewers, surface water sewers and combined sewers (these were mainly in London).

The causes of flooding could be many and complex and it was difficult to identify where the water initially came from. In general, it was noted that the local council and land owners were responsible for surface and ground water flooding; highway flooding was the responsibility of the local council and/or the Highway Agency; river flooding was the responsibility of the riparian owners and the Environment Agency; Thames Water was responsible for surface water sewers and foul water sewers.

They prioritise their calls and have 2 hours for emergencies and 4 hours for operational blockages. If follow on works were needed, dependant on Highways Agency agreement and notice/permit had been granted it would be a 5 to 10 day notice.

Case Study: Engineering and Drainage

In February 2015 the Council's Drainage Manager, gave a presentation on the Council's role in alleviating the risk of flooding in the district and what the Engineering, Drainage and Water Team (EDWT) did.

A note from the planners outlined the role of planning in flood risk prevention. It was noted that Local Plans should be supported by a Strategic Flood Risk Assessment and polices to manage flood risk from all sources. The National Planning Policy Framework (NPPF) set strict tests to protect people and property from flooding, which all local planning authorities were expected to follow. Where these tests were not met, national policy was clear that new development should not be allowed.

In terms of day-to-day development management, planners assessed applications using mapping data made available by the Environment Agency. In addition recent guidelines issued by government requires all local authorities to consult with their Lead Local Flooding Authority; in our case it was Essex County Council, on development of 10 dwellings or more, to assess flood risk from surface water, groundwater and ordinary watercourses and to promote sustainable drainage proposals.

The EDWT provided a discretionary 24/7 – 365 emergency flood response standby service to deal with out of hours flooding incidents involving Council owned assets or to assist members of the public, where appropriate. They would respond to all types of flooding incidents, working closely with the Environment Agency where necessary.

It was noted that there were three Flood Alleviation Schemes (FAS) in the district that were the responsibility of the Council, and that:

- They were built in high risk areas, with properties at risk of flooding;
- The levels of water in the storage areas at two of the sites were monitored 24/7, 365 by telemetry and recently installed CCTV;
- In addition there was the Loughton Brook Scheme, which was statutorily classified as a Reservoir and was managed by the Environment Agency.

In addition to the FAS the EDWT monitor and maintain (with the Council's Term Contractor) the council's 50 storm grilles and approximately 2,500km of ordinary water courses.

It was also noted that:

- We were the only District in Essex with its own Byelaws on Land Drainage;
- As an authority we liaise with Thames Water, Essex County Council (Highways), Affinity Water, Environment Agency (& other organisations);
- Under the Environmental Protection Act 1990, the Council was statutorily obliged to inspect and assess potentially contaminated land sites within its boundary;
- Local Authorities must set out its approach as a written strategy;
- There were thought to be several thousand potentially contaminated land sites, due to historic contamination, with 91 landfill sites;
- Local Authorities also had a statutory duty under the Building Act 1984 and the Public Health Acts to ensure buildings had adequate drainage and that blockages, defects and pollution from sewage were properly dealt with;
- In October 2011 most private sector sewers transferred to Thames Water; the Council was still responsible for all rural drainage systems and for many situations where there were drainage problems in urban areas;
- EDWT provided investigation and enforcement services on private sewers that fell outside the jurisdiction of Thames Water;
- The poor performance of Thames Water meant that officers often had to get involved with problems that should have been dealt with by Thames Water;
- EDWT maintain the Council's own drainage records and also have access to the Thames sewer maps;
- EDWT have recently purchased a vehicle and have replaced their old CCTV equipment to assist with flooding and drainage work;
- The Council's Local Plan should take into account climate change over the longer term which would include flood risks;
- EFDC have their own Flood Risk Assessment Zones (FRAZ) set out in its Local Plan;
- The FRAZ have been identified and mapped by officers;
- These FRAZ were not the same as the Environment Agency Flood Zones;
- EDWT officers assessed planning applications and if the development falls within a FRAZ a flood risk condition would be recommended;
- The Council encourages all developers to follow the principals of Sustainable Drainage Systems (SuDS) in designing facilities for the handling of rainwater runoff;

- The Government had recently decided to remove the responsibility for delivering SuDS from the Local Lead Flood Authority (ECC) and strengthen the planning system – which has placed the responsibility back on us;
- The Flood and Water Management Act (April 2010) was intended to implement Sir Michael Pitt's recommendations following the widespread flooding of 2007. This flooding was largely caused by surface water runoff overloading drainage systems.

It was noted that there was disjointed help offered from the Highways Agency. Officers also noted that what problems they had encountered in carrying out their work had mainly been the inefficiency of the Highways Agency and Thames Water. There was only so much our officers could do without any co-operation.

In conclusion the Panel confirmed that they wanted Thames Water to come to a future meeting.

5. PLANNING SERVICES SCRUTINY PANEL

The Planning Services Scrutiny Panel consisted of the following members:

Councillor G Chambers (Chairman)
Councillor Y Knight (Vice Chairman)
Councillors D Dorrell, H Kaufman, M McEwen, B Sandler, G Shiell, B Surtees, S Watson, A Watts and D Wixley.

The Lead officer was Nigel Richardson, Assistant Director (Development Management)

Terms of Reference

1. To consider and review Measures taken to Improve Performance within the Directorate concerning:

   a) Performance standards and monitoring; and
   b) Other Reviews

2. To monitor and receive reports/updates on the delivery of the Local Plan;

3. To monitor and receive reports/updates on the Planning Electronic Information System. To provide information regarding the progress and availability of planning information held on i-Plan.

4. To establish whether there are any resource implications arising out of the topics under review and advise Cabinet for inclusion in the Budget Process each year;

5. To report to the Overview and Scrutiny Committee at appropriate intervals on the above. To report to the Overview and Scrutiny Committee, the Council and the Cabinet with recommendations on matters allocated to the Panel as appropriate;

6. Response to Planning Consultations;

7. Receiving feedback from Chair and Vice Chairmen of Development Control meetings; and

8. Business Plans Review Development Control – Governance and Forward Planning – Neighbourhoods.

The Panel scrutinised a number of important issues over the last year, which included:

(i) Update on Local Development Scheme – At their first meeting of the year the Panel received a report regarding an update on the Local Development Scheme.

The Localism Act 2011 made a requirement that local authorities must prepare and maintain a Local Development Scheme specifying the local development documents. The last scheme, formerly adopted by the Council in July 2013, set out the proposed

programme for the preparation of the Epping Forest Local Plan. Members noted that the Council had made good progress in developing the evidence base.

(ii) Section 106 Annual Report - Section 106 of the Town and Country Planning Act 1990 allowed a local planning authority to enter into a legally-binding agreement or planning obligation with a land owner/developer over a related issue.

Section 106 Agreements could act as a main instrument for placing restrictions on developers, requiring them to mitigate on-site and site specific impacts. Such agreements could be sought when planning conditions were inappropriate to ensure and enhance the quality of development and enable proposals that might otherwise have been refused to go ahead in a sustainable manner. Contributions may be secured by:

(a) Work in-kind provided or constructed by the developer;

(b) A financial payment (which may be decided using a formula); and

(c) Transfer of land for a facility.

Performance for the Year 2013/14
Benefits negotiated through the year would provide a total of £729,218 received into the public purse. Benefits actually realised through the year had provided a total of £725,711 received into the public purse, Highway improvements at the developer's expense and funding of a fixed 1 year term Conservation Technical Officer post.

The Future
The use of S106 Agreements attached to planning permissions granted after April 2015 were to be restricted, as they were being replaced by the Community Infrastructure Levy (CIL). The adoption of the CIL required an up to date development plan and adoption after consultation and examination, before such a levy could be adopted and payment received. Monies raised under CIL could only be spent on infrastructure which included roads and other transport facilities, flood defences, schools and other education facilities, medical facilities and sporting and recreational facilities. From 6 April 2015, it would not be possible to use S106 Agreement delivery of such infrastructure items, unless it was site specific and no more than 5 S106 obligations could be pooled together for that one delivery requirement.

As part of the Local Plan the Council must consider the infrastructure necessary to accompany development. In the Local Plan this assessment of infrastructure would form the Information Delivery Plan (IDP). Once all infrastructure needed was identified, all of the existing revenue streams would then be reviewed.

(iii) Local Plan Progress Reports – At various time during the year, the Panel received a progress reports regarding the Local Plan.
They noted that:

- The Strategic Housing Market Assessment (SHMA) was being updated with a draft report. The report would help identify the District's Objectively Assessed Housing Need and constitute an approach to future housing provision.
- Progress had been made on the master planning work for North Weald Bassett in consideration of the way the airfield would relate to the wider village.
- Consultants had been engaged for further work on economic and employment evidence for supporting the Local Plan and the Economic Development Strategy.

- The joint Essex-wide Gypsy and Traveller Accommodation Assessment had been completed with briefings by the consultants held in July 2014. The Planning Policy Portfolio Holder advised that there was a requirement for the district to source 112 extra Gypsy and Traveller pitches, although they would be around existing settlements.
- The Cabinet approved a draft methodology for a comprehensive Green Belt Review which outlined further work being undertaken based on the experience of other recent examinations.
- Officers had been meeting regularly with the appropriate authorities to consider cross boundary issues.

(See Case Study for full details)

(iv) The London Infrastructure Delivery Plan - The London Infrastructure Delivery Plan (IDP) had been published by the Mayor of London for consultation making the case for better infrastructure provision in London. The Mayor had published a number of key policy reports making the case as follows:

(a) The Independent London Finance Commission Report argued for the full devolution of property taxes to London government with an associated increase in borrowing levels enabling London government to increase investment in its own infrastructure;

(b) The Mayor's 2020 Vision document identified world class infrastructure provision which met the city's needs;

(c) The Further Alterations to the London Plan (FALP) document set out the scale of the housing challenge to 2036 with planning policies to address it, including identified housing capacity to 2025. There were a range of other proposals about infrastructure and the environment ensuring good quality sustainable development; and

(d) The London First Infrastructure Commission examined the challenges faced by the capital because of growing population, workforce, ageing infrastructure and demanding fiscal context. The commission looked at all solutions to planning, delivery and financing for the future, specifically calling for stronger city wide strategic infrastructure planning with greater coordination across sectors.

Members supported the Mayor's approach to London's growth by keeping it within current boundaries and not encroaching on the Green Belt, at least until the full London Plan Review undertaken in 2015.

(v) Progress Report on Electronic Information Systems for Development Management – In September the Panel received a progress report regarding Electronic Information Systems Development Management.

Development Management was dependent on the operation of its planning database for both Development and Building Control which was linked to Information@work, the software for all plans, maps, photographs and documents.

Significant benefits came from reducing the use of paper, therefore work continued on improving electronic access to planning information by Parish and Town Councils. It was advised that the District Council was no longer able to print plans and other documentation received electronically for circulation to Parish and Town Councils. Officers were aware that Internet and computer equipment were limited in some areas, therefore progress had been made on improving the situation with funding for electronic projectors to Parish Councils. Fourteen Parish and Town Councils had made applications for grant funding to support electronic equipment.

A project to convert microfiche records to electronic format was due to begin in November/December 2014. The aim was to convert 71,000 historic Development Control microfiche jackets (4 million images) to electronic format during the course of the next twelve months.

Significant progress had been made in the electronic conversion of historical microfiche planning records. It was estimated that by December 2015, 93,000 jackets comprising nearly 5 million historical planning images, would have been converted to an electronic format.

Members expressed frustration at the quality of the plans submitted to Development Control meetings. Officers advised that there was no legal requirement to control the types of plans displayed at meetings, adding that they were often hampered by the electronic technology available at meetings. In particular Area Plans South Sub-Committee had basic resources compared to the District Council's Chamber.

(vi) Key Performance Indicators 2014/15 – The Panel received quarterly reports regarding Key Performance Indicators for 2014/15 specific to their Panel's responsibilities.

Six of the KPIs fell within the Planning Scrutiny Panel areas of responsibility. The overall position with regard to the achievement of target performance at the end of the third quarter of the year for these six indicators was as follows:

(i) 3 (50%) indicators achieved the cumulative third quarter target;
(ii) 3 (50%) indicators did not achieve the cumulative third quarter target, although 1 (17%) of these KPIs performed within the agreed tolerance for the indicators; and
(iii) 5 (83%) were currently anticipated to achieve the cumulative year end target.

(vii) Community Infrastructure Levy – The Panel noted that planning obligations were legal contracts made under Section 106 of the 1990 Town and Country Planning Act linked to a planning application decision made by the local planning authority. The obligation related to the land within the planning application only. Planning obligations were used to:

(a) Prescribe the nature of development to comply with policy (for example, requiring a portion of housing to be affordable);
(b) Compensate for loss or damage created by a development; and
(c) Mitigating a development's impact.

A review in 2004 concluded that S106 could not deliver strategic infrastructure and in its place the Community Infrastructure Levy (CIL) was conceived to capture an element of land value for funding strategic investment. The CIL was introduced in 2010 with new

regulations. Planning obligations entered into from 6 April 2010 needed to meet three new tests:

- Necessary for making the development acceptable in planning terms;
- Directly related to the development;
- Fairly and reasonably related in scale and kind to the development.

The District Council was yet to decide whether to adopt a CIL which could not be introduced without an up to date adopted Local Plan. It was advised that Council consultants would inform Members on the potential for introducing CIL in the district. As of November 2014 only 12% of councils (less than 50) had a CIL in place.

(viii) Meeting of the Chairmen and Vice Chairmen of the Planning Sub Committee and the District Development Control Committee - The Panel received a copy of the notes from the meeting of Development Control Chairmen and Vice-Chairmen held on 2 December 2014.

The Panel were informed that:

(a) The District Development Control Committee (DDCC) would be re-titled District Development Management Committee;
(b) The Council would use the Department of Communities and Local Government (DCLG) definition advice in determining those planning applications applicable to be reported straight to DDCC;
(c) The procedure for referring a planning application from an Area Planning Sub-Committee to DDCC was being amended so that a minority reference could only take place after a committee vote had been taken; and
(d) A Portfolio Holder report was being prepared on the options for the possible re-location of the Area Plans South Sub-Committee from Loughton.

(ix) Building more Homes on Brownfield Land, Consultation Proposals - A Government consultation published on 28 January 2015 sought views on proposals for measures making it easier for building on brownfield land suitable for housing. They expected that permissions on brownfield land suitable for housing would in future be granted by Local Development Orders (LDO) and had set an objective that by 2020, LDOs should be in place in over 90% of brownfield land suitable for housing, with an intermediate target of 50% by 2017, and which did not already benefit from planning permission.

LDOs granted permission to specific types of development within a defined area and removed the need for developers to make a planning application. Members noted that a particularly controversial aspect of the consultation was the proposed sanction of placing councils under special measures for not making sufficient progress in setting LDOs in place. In these cases, applicants would have a choice of applying directly to the Secretary of State for planning permission. Whilst it was acknowledged that in a district such as Epping Forest, which was over 92% green belt, the Government's

proposals should not be a major issue, there were still a number of potentially harmful implications and an objection in principle to the proposals was recommended.

The Chairman requested that the full response submitted by the Panel be put before the next meeting, be placed in the Council Bulletin and also be copied to the local MPs.

Case Study: Delivery of the Local Plan

Contained within the Terms of Reference of the Planning Scrutiny Panel is a requirement for the Panel to monitor and receive reports on the delivery of the Local Plan.

At the July 2014 Panel meeting it was reported that under the Duty to Co-Operate, a Strategic Housing Market Area (SHMA) Group had been established with neighbouring authorities, widening its brief to include other cross boundary issues.
Members noted that Developer Briefings had been held in the Spring of 2014 allowing those who had put forward large sites on the edge of Harlow, to set out current thinking on their proposals.

The September 2014 Panel noted that progress had been made on the master planning work for North Weald Bassett in consideration of the way in which the airfield related to the wider village.

The Panel was advised that the Essex wide Gypsy and Traveller Accommodation Assessment had been completed with briefings by the consultants held in July 2014. The Planning Policy Portfolio Holder advised that a requirement had been made for the district to source 112 extra Gypsy and Traveller pitches.

The Council had been a signatory to a letter sent from local authorities in the South East to the Greater London Authority in response to the consultation on the draft Further Alterations to the London Plan, expressing concern that it potentially undershot the provision of future homes that London needed by a considerable margin. It had failed to adequately plan for the interim level of need identified of 49,000 dwellings per annum because only 42,000 were specifically allocated to London boroughs.

The December 2014 Panel was advised of the importance in ascertaining the relationship between the housing need evidence in the Strategic Housing Market Assessment (SHMA) and employment forecasts. The District Council's Local Plan consultant advised the Panel that a neighbouring district council's Local Plan had been examined by the inspector who had found that their housing numbers were not sufficient to meet their objectively assessed need. The District Council's work with neighbouring authorities had led to inclusion of an additional population scenario using the intercensual charge between the 2001 and 2011 census. This more accurately reflected the situation on the ground.

The Panel Chairman requested an extra-ordinary meeting scheduled for February 2015 for further discussions on the Local Plan and any consultations that might arrive. This meeting received confirmation that the Uttlesford Local Plan Examination had not been recommended for adoption by the inspector. There was concern that the housing numbers had derived from an outdated SHMA and Objectively Assessed Need for housing, plus the potential expansion of the village of Elsenham, particularly concerns about the capacity of the local road network in the absence of committed significant infrastructure improvements.

At the Panel's last meeting in April 2015, Members were advised that receipt of the final report from consultants on the updated Strategic Housing Market Assessment (SHMA) was slightly delayed. This was because new household projections had been published by the Government requiring an updated SHMA.

The Phase 1 of the Green Belt Review was nearing completion and its findings would be shared with parish and Town Councils at the Local Council's Liaison Committee scheduled for 15 June 2015 which would be a single item agenda meeting.

It was noted that planning officers from the District Council would be attending an Inspection of the Northern Gateway Access Road scheme, submitted by Enfield Borough Council on 28 April 2015, along with representatives from Loughton and Waltham Abbey Town Councils. A District Council final statement objecting to the scheme had already been submitted.

The Planning Policy Portfolio Holder informed the Panel that he had attended a meeting at City Hall to develop better communication with local authority representatives in the south east. He was advised that there were plans to build 49,000 homes in London with no expectation that any of these would be exported beyond its boundaries.

This was the final Panel meeting and Members were informed that their Work Programme was completed.

TASK AND FINISH PANELS

1. SCRUTINY PANEL REVIEW TASK AND FINISH PANEL

Origin:

At its meeting on 25 February 2014, the Overview and Scrutiny Committee agreed the establishment of a new Task and Finish Scrutiny Panel to review the structure of the Council's existing framework of Scrutiny Panels, and to make recommendations for how any new structure could best complement the new management structure of the Council.

Aims and Objectives:

(a) To report findings to the Overview and Scrutiny Committee and to submit a final report for consideration by the Committee and the Council by the end of March 2015;

(b) To gather evidence and information in relation to the review through the receipt of appropriate data, presentations and by participation in fact-finding visits to other authorities if necessary;

(c) To have due regard to relevant legislation and the Council's procedures;

(d) To consult political groups and independent Councillors during the review process.

Term of Reference:

To review the current structure of the overview and scrutiny panel framework, taking into consideration the report of the recent overview and scrutiny review and how any future panel framework would best fit the management structure of the Council;

(1) To specifically consider whether the Council should:

- retain the current five-panel structure; or
- move to a panel structure based around the new directorate responsibilities (i.e. have four panels instead of five); or
- move towards a commissioning model based upon a work programme;

(2) To consider options for any other panel structure deemed appropriate;

(3) To review the workload and terms of reference of each of the existing scrutiny panels for relevance and consider how their processes could be improved;

(4) To consider how any future scrutiny panel established to review relevant functions of the Governance Directorate would interrelate with the terms of reference of the Audit and Governance Committee and the Standards Committee; and

(5) To report to the Overview and Scrutiny Committee on options for a new scrutiny panel framework to be implemented from the 2015/16 municipal year.

The Panel

The Committee appointed the following members to serve on the Panel:

Councillors K Angold-Stephens (Chairman), M Sartin (Vice Chairman), R Gadsby, A Grigg, D Stallan and J H Whitehouse

The Lead officer was S Hill, Assistant Director Governance and Performance Management.

A review of the Council's Overview and Scrutiny arrangements was undertaken in 2013/14. The Council's service directorates had recently been restructured, resulting in a change from seven directorates to four. A proposal for a suggested new Overview and Scrutiny Panel structure aligned to the directorate framework was considered by the Overview and Scrutiny Committee on 25 February 2014.

This review only concerned the future structure of the Scrutiny Panel arrangements. Wider constitutional aspects (unless the Panel identify issues that affect the Constitution) and a review of the Overview and Scrutiny Committee itself, were excluded from the scope of the work of the Task and Finish Panel.

As part of the investigation process a Saturday workshop was held to get the view of members. Fourteen Members attended the scrutiny workshop facilitated by an independent Scrutiny Advisor, on 22 November 2014 with a mixture of Chairmen and Vice-Chairmen of the Scrutiny Panels, members of the Task and Finish Panel, members of the Overview and Scrutiny Committee and members of Cabinet. The workshop focused on three main sections:

- Strengths, Weaknesses & Aspirations for the current provision of Scrutiny;
- Applying insights gained from section one to the different types of Scrutiny; and
- Weighing evidence, making choices.

Attendees also discussed the following different methods of scrutiny that could be utilised in individual circumstances:

- challenge session – single issue, one session;
- single day scrutiny – a snap shot review;
- focus group meeting – focus is on consultations with users/stakeholders as opposed to scrutinising officers/members/providers;
- short-term single issue panel – typically two or three meetings to review a single issue;
- longer-term panel work – typically over four to six months, with detailed scrutiny;
- Overview and Scrutiny Committee meeting – an item with presentation and questions, discussion and with the option to make recommendations.

The utilisation of these approaches, as appropriate to individual scrutiny activities, was agreed by the Task and Finish Panel and formed part of its recommendations for a future panel framework.
The Panel recommended to the Overview and Scrutiny Committee a four committee structure, replacing the Panel Structure with a new Directorate orientated Select Committee structure. The four Select Committees being:

- Environment Select Committee;
- Governance Select Committee;
- Housing Select Committee; and
- Resources Select Committee.

They also recommended that no action be taken at the present time with regard to any possible combination of the Audit and Governance Committee and the Standards Committee but that, if necessary, a further Task and Finish Panel be established in future to consider such combination in light of new legislative audit requirements.

These recommendations were accepted by the parent Overview and Scrutiny Committee and would be put into action when practicable.

2. GRANT AID REVIEW TASK AND FINISH PANEL

Origin:

At its meeting on 16 September 2014, the Overview and Scrutiny Committee agreed the establishment of a new Task and Finish Panel to review the Council's Grant Aid Scheme for Sports, Arts, Leisure and Community Groups in terms of the overall policy/guidance and procedures for Major Grants and Service Level Agreements including those for the determination of applications, and those for the pre and post determination stages.

Aims and Objectives:

(a) To report findings to the Overview and Scrutiny Committee and to submit a final report for consideration by the Committee and the Council by April 2015;

(b) To gather evidence and information in relation to the review through the receipt of appropriate data, presentations and by participation in fact-finding visits to other authorities if necessary;

(c) To have due regard to relevant legislation and the Council's procedures;

(d) To consult political groups and independent Councillors during the review process.

Term of Reference:

To review the current structure of the Grant Aid Scheme, taking into consideration the terms of the overall policy/guidance and procedures those for the determination of applications, and those for the pre and post determination stages and how this framework would best fit the structure of the Council.

(1) To specifically consider:

- The eligibility criteria and assessment arrangements for funding taking into account the budget available and the thematic areas in the leisure and cultural strategy;

- The grant maxima;

- Appropriate arrangements for safeguarding;

- Review procedures.

(2) To consider any other matters that are deemed appropriate.

The Panel

The Committee appointed the following members to serve on the Panel:

Councillors Caroline Pond (Chairman), J Knapman (Vice Chairman), T Boyce, A Mitchell, S Murray, G Shiell and B Surtees.

The Panel did not finish its work by the end of the 2014/15 municipal year and would continue into the next year.

3. YOUTH ENGAGEMENT REVIEW TASK AND FINISH PANEL

Origin

The Overview and Scrutiny Committee meeting of 10 February 2015 set up a Task and Finish Panel to review potential options for the best use of the existing budgets for youth engagement for the future. Also, they agreed that it would be helpful to co-opt two youth councillors to sit on this panel and give their input. This Panel stemmed from a PICK form submitted by Councillor Kane the Portfolio Holder for Leisure and Community Services.

Aims and Objectives

(a) To report findings to the Overview and Scrutiny Committee and submit a final report for consideration by the Committee and the Council by November 2015;

(b) To include two representatives from the District Youth Council on the Task and Finish Panel;

(c) To determine the impact of the Council's current engagement with young people, through consultation with local statutory and voluntary sector partners, and,

(d) To determine the best use of the allocated funding for the future.

Draft Terms of Reference

1. To review the operation of the Youth Council and identify specific areas of work undertaken and the success and impact of these;

2. To review the level of engagement with peers in local schools and 'other young people' of all ages across the district, through the range of work undertaken by

the Youth Council and the importance of this engagement for local community groups;

3. To consider feedback from local schools and other partners in respect of the work of the Youth Council;

4. To identify the expenditure related to various elements of the Youth Council work programme and analyse the cost/benefit of this;

5. To consider other work undertaken by Community Services and Safety to engage with young people and identify the costs associated with this;

6. To consider the status of Essex Youth Services following recent service transformation and resulting implications for the district; and,

7. To prepare a set of recommendations for consideration by the Overview and Scrutiny Committee at its meeting in November 2015.

The Panel

The Committee appointed the following members to serve on the Panel:

Councillors S Murray (Chairman), G Mohindra (Vice Chairman), K Adams, R Butler, C Roberts and B Surtees

Two non-voting youth Councillors were also co-opted to help the Panel with their work. They were Youth Councillors J McIvor and M Tinker.

The Panel had its first meeting in April 2015 and will continue on into the new municipal year, hopefully finishing in November 2015.

Overview and Scrutiny Work Programme – May 2015

Overview and Scrutiny Committee			
Item	**Report Deadline / Priority**	**Progress / Comments**	**Programme of Future Meetings**
(1) OS Annual Report 2014/15	June 2015	Final report to go to the June 2015 meeting.	09 June 2015; 21 July; 20 October; 05 January 2016; 23 February; and 19 April.
(2) To receive an information item on 'Volunteering Through Time Banking'	July 2015	To receive an information item from the VAEF time banking co-ordinator.	
(3) To meet with Essex County Council in respect of Children Services and on annual basis, with the attendance of the Director of Children's Commissioning.	October 2015?	Recommendation taken from the Children Services Task and Finish Panel. Chris Martin last attended the November 2014 meeting.	
(4) Six monthly review - (a) Monitoring of OS recommendations (b) OS work programme	October 2015	Last completed in November 2014	

(5) To review the strategic direction of Epping Forest College, its vision for the future and its relationship with the Community	October 2015	The new Principal of Epping Forest College addressed the July 2014 meeting. *In September 2014, the Committee agreed that the Principal should be asked to address them on an annual basis*.	
(6) (a) To receive a presentation from Youth Council members; (6) (b) To receive a presentation from Essex County Fire and Rescue Service	Jaunary 2016	Members of the Youth Council to attend with an update on their programme of work. Presentation on service review proposals (see main agnda)	
(7) Key Objectives 2014/15	Outturn report to June 2015 meeting	Outturn report for 2014/15. (*Quarterly progress reports in respect of the annual Key Objectives are made to the Cabinet and the Overview and Scrutiny Committee)*	
(8) Corporate Plan Key Action Plan 2015/16	Progress reports to be considered on a quarterly basis.	Quarterly progress to be considered at meetings to be held in Oct. 2015 (Qtr. 1), Jan 2016 (Qtr. 2) and Feb 2016 (Qtr. 3).	
(9) Corporate Plan Key Action Plan 2016/17	July 2015	The Key Action Plan process has been brought forward to align with the budget setting process. To be considered by Cabinet in October.	

Select Committees

Housing Select Committee (Chairman –)

Item	Report Deadline / Priority	Progress/Comments	Programme of Future Meetings
(1) To review the specific quarterly KPI's for 2015/16	Sept. 15	Progress reports to meetings: Q1 in September '15; Q2 in November '15; and Q3 in March '16	16 June 2015 08 September; 10 November; 12 January 2016; and 08 March
(2) KPIs 2014/15	June 2015	Outturn report to meeting on 16 June	

Governance Select Committee (Chairman –)			
Item	**Report Deadline / Priority**	**Progress / Comments**	**Programme of Future Meetings**
(1) To review the specific quarterly KPI's for 2015/16	Quarterly	Progress reports to Meetings: Q1 in October '15; Q2 in December '15; Q3 in February '16.	07 July 2015; 06 October; 01 December; 02 February 2016; 05 April
(2) KPIs 2014/15	July 2015	Outturn report to July 2015 meeting	
(3) To consider and report on any recent meeting of the Chairman and Vice Chairman of the Area and District Committees Invitation Panel.	As appropriate		
(4) Equality Objectives 2012/16	July 2015	2014/15 Outturn report	
(5) Equality Objectives 2012/16	December 2015	Bi-annual progress report	

Neighbourhood & Community Services Select Committee (Chairman –)

Item	Report Deadline / Priority	Progress / Comments	Programme of Future Meetings
(1) Enforcement activity	Next due - January 2016	Annual report to Panel –last went to the January '15 meeting	23 June 2015 15 September; 17 November; 19 January 2016; 15 March
(2) CCTV action plan review	Next due - January 2016	Annual report to Panel – last went to January '15 meeting	
(3) CSP scrutiny review meetings	June 2015	Report last went to April 2014 meeting.	
(4) KPIs 2014/15	June 2015	Outturn report for 2014/15	
(5) To review the specific quarterly KPI's for 2015/16	Quarterly	Progress reports to meetings: Q1 in September 2015; Q2 in November 2015; Q3 in March 2016	

Resources Select Committee (Chairman –)			
Item	**Report Deadline / Priority**	**Progress / Comments**	**Programme of Future Meetings**
(1) To review the specific quarterly KPI's for 2015/16	Quarterly		14 July 2015; 13 October; 08 December; 09 February 2016 and 12 April
(2) Use/cost of Consultants	Report on value and benefit derived from the use of consultancy services across the Council services.		
(3) Key Performance Indicators – 2014/15 - Outturn	Outturn KPI performance (all indicators) considered at the first meeting of each municipal year.	Outturn KPI performance report for 2014/15 for July 2015 meeting.	
(4) KPI 2015/16 progress reports	Quarterly	Progress reports to meetings: Q1 to October '15; Q2 to December '15; Q3 to February '16	

Task and Finish Panels

Grant Aid Task and Finish Panel (Chairman – Cllr C P Pond)			
Item	**Report Deadline / Priority**	**Progress/Comments**	**Programme of Future Meetings**
First meeting to define Terms of Reference.	Final Report by Autumn 2015	To continue from last year. Final Report to go to the October O&S Committee meeting.	~~14 January 2015~~; ~~2 March;~~ ~~31 March;~~ ~~16 April~~

Youth Engagement Task and Finish Panel (Chairman – Cllr Murray) 2014/15			
Item	**Report Deadline/Priority**	**Progress/Comments**	**Programme of Meetings**
(1) Terms of reference, scoping report and work programme	Terms of reference and work programme to be considered at initial meeting and referred to the June, Overview and Scrutiny Committee for adoption	Held their first meeting on 20 April 2015 – Final report to go to the October O&S Cttee meeting.	~~20 April 2015~~ ~~18 May~~ 22 June

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Request by Member for Scrutiny Review
2015/16 Work Programme

Please complete the form below to request consideration of your issue by the Overview and Scrutiny Committee

Proposers Name:	**Date of Request**
Supporting Councillors (if any):	
Summary of Issue you wish to be scrutinised:	
NOTE: ENTRIES BELOW RELATE TO ISSUE CATEGORIES OF THE PICK PROCESS. PLEASE REFER TO THE EXPLANATORY NOTES TO THIS FORM FOR FURTHER INFORMATION	
Public Interest Justification:	

Impact on the social, economic and environmental well-being of the area:	
Council Performance in this area (if known: Red, Amber, Green):	
Keep in Context (are other reviews taking place in this area?)	
Office Use:	
Pick score:	**Considered By OSCC:**