

# Barts Health NHS Trust

## Quality Report

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

## Ratings

### Overall rating for this trust

Inadequate



Are services at this trust safe?

Inadequate



Are services at this trust effective?

Inadequate



Are services at this trust caring?

Requires improvement



Are services at this trust responsive?

Inadequate



Are services at this trust well-led?

Inadequate



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Barts Health is the largest NHS trust in the country, formed by the merger of Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust on 1 April 2012. Barts Health NHS trust serves East London and a population of around 2.5 million. The trust has 1,946 beds, across 8 locations. The trust employs over 15,000 staff and had an annual turnover (total income) of £1.25 billion in 2013/14. The trust deficit for 2013/14 was £38 million and the forecast deficit for 2014/15 was £93 million.

Barts Health offers the full range of local hospital and community health services (Tower Hamlets) with one of the largest maternity services in England and end of life care provided in people's homes. The trust's hospitals are home to world-renowned specialist centres, including centres for cancer, cardiac and trauma and emergency care and has one of Britain's biggest children's hospitals.

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

We inspected Whipps Cross University Hospital in November 2014 as a direct response to concerns identified by our intelligent monitoring system and through other information shared with us. Following this inspection, and the significant concerns we identified on inspection, we then inspected both the Royal London and Newham University Hospital in January 2015.

Overall, this trust was rated inadequate. We identified significant concerns in safety, effectiveness, responsiveness and with the leadership of the trust. We found that caring at this trust requires improvement.

### Our key findings were as follows:

- The trust lacked strategy and vision, systems and processes were poor and required strengthening, the trust lacked confidence in its own data and could not confirm its position in achieving the majority of national standards.
- The majority of staff were caring, compassionate and kind.
- The majority of data that was available was trust wide, and wasn't available at a local level, which meant that individual services could not be held to account and scrutinised appropriately, and risks could not be identified and addressed.
- The Clinical Academic Group structure which provided leadership across all sites was ineffective.
- Safety was not a sufficient priority. Staff did not always recognise concerns and incidents. Some staff were discouraged from raising their concerns and there was a culture of blame.
- When concerns, incidents and patient complaints were raised, or things went wrong, the approach to reviewing, investigating and learning was slow and in some cases absent. There was little evidence of trust wide learning and limited actions to improve patients' safety across the trust.
- Safeguarding processes and practise were not always adhered to and we could not be confident that children and adults were appropriately safeguarded and that security needs were consistently met.
- Staffing was a challenge across all three sites inspected and recommended standards were not always complied with. The trust was considerably reliant on temporary staff however process to support high usage of a flexible workforce were not robust.
- The trust had low compliance with mandatory training. In January 2015 the trust reported that 46% of staff had received the mandatory training booklet. The trust had introduced the booklet as the way in which they would deliver there mandatory training programme.
- The use of national clinical guidelines was not evident throughout the majority of services within the trust, and we had significant concerns in relation to End of Life care.
- The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied, and their use inconsistent across the trust.
- Patient outcomes were at or better than the national average across most medical and surgical specialties at the Royal London Hospital and were similar to or below the performance of other hospitals at the other sites we inspected.

# Summary of findings

- Audits carried out to check compliance with the World Health Organisation surgical safety check list were remarkably low. Less than 1% of patients (who had undergone surgery) were audited and there had been eight Never Events for wrong site surgery in the last 14 months. We had raised concerns about compliance with the check list in November 2013.
- The trust did not have a maternity dashboard to be able to understand the quality of the service being delivered, despite the trust being responsible for 15,715 (2013-14) births per year.
- We met a very committed workforce who felt undervalued by trust leadership, but valued by their patients and colleagues. Junior doctors were incredibly positive when talking about the support and learning opportunities at the trust, and the leadership demonstrated by consultants.
- There was limited evidence to demonstrate that information about the local population's needs was used to inform the planning and delivery of services. The services provided did not reflect the needs of the population served and did not ensure flexibility, choice and continuity of care.
- The emergency departments were not all meeting the national 4 hour waiting time target. The trust 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.
- Some patients had their surgery cancelled on multiple occasions due to a lack of beds. Patients well enough to leave hospital experienced significant delays in being discharged for a variety of reasons.
- Complaints were not always managed in a timely or appropriate manner. The central complaints team did not have sufficient oversight and management of individual complaints. The management of complaints was decentralised to promote local accountability, but this had led to inconsistent complaint response times and an inconsistent approach to complaints handling.
- There was lack of engagement with the workforce with low morale across the trust. 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. Only 32% recommend it as a place to work, which is third lowest in the country. There had been minimal improvements in the NHS Staff Survey 2014.

- The trust continued to breach regulations that it was non-compliant with in November 2013 when we last inspected.

## **We saw several areas of outstanding practice including:**

- A surgeon had become the first in the UK to broadcast online a live surgical procedure using a pair of Google Glass eyewear. The procedure was watched by 13000 surgical students around the world from 115 countries and they also had the opportunity to ask the surgeon questions.
- 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 at Whipps Cross University Hospital.
- 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
- Senior staff were trialling the Multidisciplinary Action Training in Crises and Human Factors initiative (MATCH). This was a framework within which Never Events and Serious Incidents could be discussed in an environment characterised by mutual respect and in which lessons learnt could be quickly introduced without damaging personal relationships. It was reported that initial results had been very promising. However, staff reported that whilst there had previously been plans to introduce this across the Trust, the financial pressures meant this was on hold.
- The Royal London Hospital is a pioneer in trauma care. 25% of the patients attending the trauma service as an emergency had penetrative wounds, which is significantly higher than any other UK trauma centre. The survival rate at the hospital was approximately twice the national average and the service had regular national and international visitors wanting to learn from the service. The service had worked with the Armed Forces whilst on combat operations and had taken specific learning from this and applied it to the service.

# Summary of findings

- In particular, the trauma service in conjunction with military colleagues had developed the concept of the 'platinum ten minutes' based upon techniques used to help save the lives of soldiers in combat situations. Through the use of fluid, plasma, active surgical intervention and rapid assessment at the scene more patients were arriving at hospital alive.
- The Royal College of Physicians audit of stroke care rated the hospital as 97.5% for patient experience from diagnosis to rehabilitation - the highest result in London.
- The Gateway Surgical Centre's design, layout, forward planning, engaged staff and integrated care with members of the multidisciplinary team.

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

## **Importantly the trust must:**

We identified that there are 65 "must do" actions across the three locations inspected, details are in the location reports.

Due to our level of concern across the trust we wrote to the NHS Trust Development Agency (TDA) to suggest they urgently consider special measures for the trust in March. The trust was placed in special measures on 16 March 2015.

**Professor Sir Mike Richards**

**Chief Inspector of Hospitals**

# Summary of findings

## Background to Barts Health NHS Trust

Barts Health is the largest NHS trust in the country, having been formed by the merger of Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust on 1 April 2012. Barts Health NHS trust serves the area of East London the population is around 2.5 million. The trust has 1,946 beds, spread across 8 locations. The trust employs over 15,000 staff with an annual turn over (total income) of £1.25 billion 2013/14. The trust deficit for 2013/14 was £38 million and the forecast deficit for 2014/15 was £93 million.

Barts Health offers the full range of local hospital and community health services from one of the biggest maternity services in the country, to end of life care at home. The trust's hospitals are home to world-renowned specialist centres, including cancer, cardiac and trauma and emergency care, as well as one of Britain's biggest children's hospitals.

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

The trust covers four local authority areas: Tower Hamlets, the City of London, Waltham Forest and Newham. Tower Hamlets is one of the most deprived inner city areas in the country, coming seventh in a list of 326 local authorities. Fifty six per cent of the population of Tower Hamlets come from minority ethnic groups, with 30% coming from the Bangladeshi community. Life

expectancy in the borough varies, with those who are most deprived having a life expectancy of 12.3 years lower for men and 4.9 years lower for women than in the least deprived areas.

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

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

We inspected the trust in November 2013 using the new methodology. We returned to inspect the Whipps Cross University Hospital location in November 2014 as we had increased concerns, our concerns were corroborated by concerns from the public, 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.

## Our inspection team

Our inspection team was led by:

**Chair at Whipps Cross University Hospital:** Professor Edward Baker, Deputy Chief Inspector of Hospitals Care Quality Commission

**Chair at Newham University Hospital and The Royal London Hospital:** Diane Wake, Chief Executive Barnsley NHS Foundation Trust

# Summary of findings

**Head of Hospital Inspections:** Siobhan Jordan, Care Quality Commission

**Inspection Manager:** Whipps Cross University Hospital and The Royal London Hospital: Hayley Marle CQC

**Inspection Manager:** Newham University Hospital: Roger James, CQC

CQC inspectors and managers were joined on the inspection team by a variety of specialists including a

student nurse and junior doctor, consultants in all specialties inspected, emergency medicine, obstetrics, intensive care medicine and paediatrics, experts by experience, an associate medical director, a consultant nurse for older people, a head of consultant midwife, clinical nurse end of life care specialists, a physiotherapist, a radiologist and radiographer, a pharmacist and estates and facilities advisers and a CQC non-executive director.

## 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 announced inspection of Whipps Cross University Hospital visit took place between 11-14 November 2014.

The announced inspection of Newham University Hospital and The Royal London Hospital visit took place between 20-23 January 2015.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. A number of these organisations openly shared concerns about the quality of care being provided by the trust.

These included the clinical commissioning group (CCG); the Trust Development Agency (TDA); NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal

College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event in Walthamstow for Whipps Cross University hospital on 10 November 2014 and in Newham on 13 January and in Whitechapel on the 14 January 2015, where people shared their views and experiences of Bart's Health.

During our inspection we held focus groups with a range of hospital staff, including administrative and clerical staff, nurses, midwives, doctors, physiotherapists and occupational therapists.

We talked with patients and staff from all three sites and all areas of the trust, including the wards, theatres, outpatients, maternity and the trust's emergency department.

We observed how patients were being cared for, talked with carers and family members and reviewed patients' personal care or treatment records.

We would like to thank all staff, patients, carers and stakeholders for sharing their views and experiences of the quality of care and treatment provided by Bart's Health.

# Summary of findings

## What people who use the trust's services say

### Friends and family Test (FFT)

Friends and Family Test (FFT) average score 64% compared to England average 72% (period April 2013 to July 2014) and response rate 26% compared to England average 31%.

### Patient-Led assessment of the Care Environment (PLACE) 2014

Patient led assessment of the care environment (PLACE) Cleanliness 100% compared to England average 98% (2014) Food 86% compared to Eng. Average of 90%. Privacy, dignity and wellbeing 91% compared to Eng. Average of 87% Facilities trust 97% compared to 92% England average. (2014 data)

### Accident and Emergency Survey 2014

Accident and Emergency Survey 2014 – trust scored worse than expected for 6 questions, and similar to expected for 26

### NHS Choices

NHS Choices –features as an IM risk on the December 2014 report. (the number of negative comments is high relative to positive comments)

### Listening Events

We held three listening events before the inspections. Approximately 50 people attended and shared their views and experiences of the using services at the trust. Overall people were unsatisfied with the care and treatment they received. In particular accessing and communication about outpatient appointments was a service of concern.

## Facts and data about this trust

### Activity

- Inpatient admissions 270,258 (2013-14)
- Outpatient attendances 1,460,721 (2013-14)
- A&E attendances 429,583 (2013-14)
- Births 15,715 (2013-14)

### Bed occupancy

- General and acute: 94.4% (Quarter 1, 14/15). This was above both the England average of 87.5%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Adult critical care was at 94% bed occupancy – higher than England average of 85.7%

### Safe:

- 'Never events' in past year 4 (April 2014 to January 2015).
- Serious incidents (STEIS) 1,253 (April 2014 to January 2015) – the majority of these were pressure ulcers.

- National reporting and learning system (NRLS) April 2014 - January 2015;

### Acute Death 19

### Severe Harm 36

### Moderate Harm 246

### Low Harm 2,345

### No Harm 11,741

### Total 14,396

- Infection control (March 2013 – September 2014)
- 122 cases of Clostridium Difficile
- 19 case of MRSA

### Effective:

- Hospital Standardised Mortality Ratio (HSMR): No evidence of risk (Intelligent Monitoring)
- Summary Hospital-level Mortality Indicator (SHMI): No evidence of risk (Intelligent Monitoring)



# Summary of findings

- Risk: Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures

## **Caring:**

- CQC inpatient survey (11 areas): Within expected range for 10 areas.
- FFT inpatient: Below the England average
- FFT A&E : Below the England average
- Cancer patient experience survey (68 questions) average for 6 questions; and in lowest scoring 20% of trusts for 28 questions.

## **Responsive:**

- A&E 4 hour standard – Worse than the England average during the course of the year (2013/14).
- Emergency admissions waiting 4 – 12 hours in A&E from decision to admit to admission: Worse than England average

- A&E left without being seen: Worse than the England average
- Cancelled operations since September 2013 the trust has been worse than the England average
- 18 week RTT- The trust not reporting since August 2014

## **Well led:**

- NHS Staff survey (28 questions)

Average for 17 questions; worse than expected (in bottom 20% of Trusts) for 12 questions;

- Sickness rate is better than the England average
- GMC National Training Scheme Survey (2014) The Trust was better than expected for three areas and within expectation for the other nine areas of the National Training Scheme Survey


## **CQC inspection history**

- 18 inspections had taken place at the trust since its registration in April 2010.



# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p><b>Safe</b></p> <p>Overall we rated the safety of services in the trust as inadequate. For specific information, please refer to the report for Whipps Cross University Hospital, Newham University Hospital and the Royal London Hospital.</p> <p><b>Incidents</b></p> <p>The trust had recently addressed a substantial back log of serious incidents as the Clinical Commissioning Groups had raised this as a significant concern. We were told of stronger commitment to the management of serious incidents while on inspection. However evidence of learning was limited, actions were not always timely and evident and staff spoken with were not always aware of incidents within their service, within their Clinical Academic Group (CAG) or within the hospital. Learning across the organisation was not apparent.</p> <p>The trust had 9 Never Events between November 2013 and January 2015. 8 of the 9 Never Events were for wrong site surgery.</p> <p>The trust had 42 new Serious Incidents (SI's) reported from April 2014 to January 2015.</p> <p>There were arrangements for reporting and investigating incidents and most staff were familiar with the reporting system. However, incident reporting was haphazard and learning from incidents was either not occurring or not appropriate. Feedback to staff on reported incidents to allow learning so that services could improve did not routinely occur, lessons learnt were not always known or widely shared.</p> <p>Some staff told us that they did not have the time to report incidents and were not encouraged to report incidents and were not aware of any improvements as a result of learning from incidents.</p> <p>We reviewed a number of Serious Incidents and there was limited assurance that the duty of candour had been upheld. One incident we reviewed occurred in December 2013 the report was completed in November 2014 and the intention to liaise with the family had not taken place in March 2015.</p> <p><b>Staffing</b></p> <p>Staffing levels in some areas were significantly below the recommended standards and did not provide consistently safe care. Staffing levels varied across all three sites inspected and all</p>	<p><b>Inadequate</b></p> 

# Summary of findings

specialities. The majority of staff told us staffing was a significant problem and recognised the impact of inadequate staffing levels on maintaining patient safety. Whilst some areas were displaying safety thermometer information, they were not displaying planned and actual nurse and nursing assistant/healthcare assistants staffing numbers and who was in charge for each shift in the clinical area that was accessible to patients, their families and carers, in line with NHS England guidance.

There was a high use of temporary staff however the data being presented to the trust board did not clearly illustrate this. The board received trust wide data that did not identify specific issues at hospital and service levels. Some examples included, children's services at Whipps Cross University, Obstetric services at Newham University Hospital and the stroke ward and older peoples services at The Royal London Hospital.

The processes that should be in place to ensure temporary staff are supported were not sufficient across the trust despite the high use of temporary staff.

The board papers in January 2015 advised the board that the trust were on track to meet the objective of 95% permanent staff by March 2015 the current rate being presented was 91% in January 2015, stated as being one of the highest in London. This was not the findings on inspection or the view expressed by staff at all levels across the trust.

## **Infection Prevention and Control**

The trust was exceeding its maximum trajectory for 2014/15 clostridium difficile and reported 79 cases (post 72 hours) in February 2015 against a full year trajectory of less than 71 cases.

The trust also reported 10 patients with MRSA bacteraemia (48 hours post admission) from April 2014 to January 2015, against a last year outturn of 11 cases of MRSA bacteraemia, there is zero tolerance as this is recognised as a hospital acquired infection.

The trust was worse than the England average for MSSA bacteraemia for the majority of the time period reported.

## **Environment**

There was a stark variation in environment. The Whipps Cross site is ageing and dilapidated requiring much investment. This is recognised by the trust, and work is due to commence. We identified non compliance with theatre ventilation on the Whipps Cross site as it was not adequately monitored or maintained. We advised the trust straight away and required them to take immediate action.

# Summary of findings

Care at Newham University Hospital is provided from a purpose built PFI completed in 2004. It is a well maintained environment. The Royal London Hospital is in a new state of the art purpose built hospital, also a PFI which opened in May 2012.

## **Equipment**

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.

The trust had been given special dispensation from the Department of Health not to submit data which detailed patient pathways and compliance with the 2 week, 32 day, 62 day and 52 week national pathway targets.

The trust could not assure us that the work which was taking place was having the required impact and when the issue would be resolved. Staff at the trust did not know when they would be able to recommence monitoring in line with the national requirements. The trust had not reported since August 2014 and the group set up to have oversight had its inaugural meeting in January 2015.

## **Medicines**

Medicines management required improvement in some areas across the trust. There were concerns related to both storage and administration of medicines. There was no consistency in the use of opioids, no policy and no guidance with some wards using morphine and others diamorphine. The trust recognised significant concerns in the management of control drugs and the board were aware of these concerns.

The trust had committed to undertaking a number of actions following non-compliance of medicines management on the previous inspection at Newham University hospital however these actions were only partly in place.

## **Records**

Record keeping was a significant issue across all three sites and an area of concern that we had previously identified in 2013 when we last inspected.

Improvements were needed to ensure accurate records were maintained and that there were suitable prompts for staff to follow to ensure all patient needs had been met and recorded. Nursing documentation was a known issue to the Chief Nurse however we were not provided with details of how this was being addressed.

The trust was using the modified early warning score (MEWS) to monitor patients at risk of deterioration. The national early warning score (NEWS) was launched in July 2012 however it had not been implemented at Bart's Health at the time of our inspection. Evidence

# Summary of findings

suggested that the NEWS chart was to be piloted in January 2015. Given the number of SI's that related to poor management of the deteriorating patient we did not see evidence that the investigations had identified and prompted the use of the nationally recognised tool. Trust paper work and board papers suggested post inspection that roll out of the NEWS would be in spring 2015 with no date being confirmed.

The trust recognised that three patients died following a fall while in hospital in December 2013, April 2014 and in January 2015 the board papers state that the falls documentation is still under review to standardise the paper work and the risk assessment tool used across all sites. The trust also suggest devising a leaflet in February 2015 to reduce the risk of falls while in hospital. The trust was not using best practise and structured paper work to support the reduction in patient harm.

## **Safeguarding**

The majority of staff told us that they understood safeguarding procedures in order to protect vulnerable adults and children and knew how to report concerns.

We noted that whilst safeguarding arrangements were in place and followed in most circumstances, we identified some instances where this was not the case.

We observed and we reference examples within the location reports where safeguarding practises and process are not consistent and robust to ensure that children and adults are safeguarded at all times.

We noted incidents where children known to be at risk are put at further risk due to individual and organisational failings.

Compliance for post graduate doctors for both safeguarding adults and children was not at the required level.

## **Mandatory training**

There were low levels of compliance with mandatory training across all staff groups.

The trust had implemented a booklet to be provided to staff to meet the statutory and mandatory training requirements. As of January 2015 the trust was reporting 6,796 out of 15,000 staff had received the booklet this representing only 46% of the trust staff.

It was not always evident that learning from the training was embedded.

# Summary of findings

Ward staff had not received any training in care of the dying patient for at least three years. We were told by the palliative care team they intended to roll out end of life training once the care planning documentation to replace the Liverpool Care Pathway had been implemented. The trust were currently behind with both.

## Are services at this trust effective?

Overall we rated the effective aspects of services in the trust as inadequate. For specific information, please refer to the report for Whipps Cross University Hospital, Newham University Hospital and The Royal London Hospital.

## Evidence Based Care and Treatment

The trust was not always compliant with NICE guidance and other national guidance this was not identified as a risk for the trust despite audits being carried out identifying this as a significant concern.

The use of national clinical guidelines was not evident in the majority of services, two examples were the delivery of end of life care and care provided to children. National guidance for the care and treatment of critically ill patients was not always followed.

Some trust guidance and policies were out of date. The trust had not replaced and ensured compliance with a pathway of care for patients at the end of their life since the Liverpool care Pathway (LCP) was withdrawn in 2013.

The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied and its use inconsistent across the trust. The National Early Warnings System (NEWS) had not yet been implemented in the hospital despite being launched in 2012 the trust were using the modified early warning Score (MEWS).

## Patient outcomes

Patient outcomes were at or better than the national average across most medical and surgical specialties at The Royal London Hospital and were similar to or below the performance of other hospitals on the other sites inspected.

The trust participated in national audit and the outcomes varied. There were excellent outcomes for Stroke at Newham University hospital and trauma outcomes at The Royal London Hospital. However, we did not see evidence or any action plans on how they were addressing the outcome findings for the majority of audits which they had undertaken.

Inadequate



# Summary of findings

25% of the patients attending the trauma service at the Royal London Hospital as an emergency had penetrative wounds, which is significantly higher than any other UK trauma centre. Despite this, the survival rate at the hospital was approximately twice the national average.

Audits carried out to check compliance with the World Health Organisation (WHO) surgical safety check list were remarkably low - less than 1% of patients notes who had undergone surgery were audited and there had been eight Never Events for wrong site surgery in the last 14 months. We had raised concerns about compliance with the check list in November 2013.

The hospital scored 1 out of 5 in the National Care of the Dying Audit in Hospitals (NCDAH) in the organisational indicator for access to specialist support for care in the last hours or days of life, at all three sites inspected.

Morbidity and mortality meetings were taking place across the trust, however it was recognised by the Medical Director (MD) that they varied in quality and failure to resuscitate was a recurring theme. The MD could not confirm that all deaths were reviewed within 15 days and that actions from Serious Incidents were implemented within the agreed time frame. It was the CAGs' responsibility to ensure this. We noted significant delay in SI reporting, actions being taken and shared learning to ensure positive outcomes for patients.

The trust participated in submitting data to the patient safety thermometer a point prevalence audit that took place once a month. The audit collected data on harms observed, falls VTE, pressure ulcers and hospital acquired urinary tract infections. However, other than this there was no proactive monitoring of quality and metrics to ensure that quality was being maintained as well as improvements being aspired to.

The trust did not have a maternity dashboard which detailed the quality of service being delivered across their maternity services despite the trust being responsible for 15,715 (2013-14) births per year.

## **Multidisciplinary Team Meeting**

There was evidence of multidisciplinary working across all sites. The CAG structure facilitated multidisciplinary working across sites but it relied on effective communication and strong working relationships.

The trust was working towards seven day working and job planning with medical staff to support seven day working had started.

# Summary of findings

Access to fundamental diagnostic and screening tests varied across sites, and the trust did not have a consistent model across all three sites inspected to manage critically ill patients out of hours, which is after 5pm and at weekends.

## **Consent and Mental Capacity Act and Deprivation of Liberty Safeguards**

Most staff lacked an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and how it applied to their roles. The actions that had been reported to be taken to raise staff awareness of the Mental capacity Act (2005) and deprivation of liberty safeguards had not been effective.

## **Nutrition and hydration**

The management of patients nutritional and hydration needs varied. In the management In the National Care of the Dying Audit patients' nutrition and hydration requirements being met was worse than the England average.

## **Are services at this trust caring?**

Overall we rated the caring aspects of services in the trust as require improvement. For specific information, please refer to the report for Whipps Cross University Hospital, Newham University Hospital and The Royal London Hospital.

## **Compassionate Care**

At the listening events, most people told us they were dissatisfied with the care provided by the trust. However, during our inspection most patients and relatives were satisfied with the care and support they received and felt that staff listened to them and were compassionate. We were told of many examples where staff had been caring and compassionate.

However improvements were required to ensure staff treated patients with dignity and respect at all times. We observed staff holding discussions about patients conditions and care plans in communal areas on wards and in some outpatient areas.

The Friends and Family Test (FFT) response rate for December 2014 for the Trust was 28%, the national average response rate was 31%. Of the 1,318 patients who completed a Friends and Family Test card, 95% would recommend the Trust with 2% of patients not recommending services to their friends and family. The remaining 3% were neither likely nor unlikely to recommend.

## **Understanding and involvement of patients and those close to them**

Patients were not always offered cultural and religious support they wished to receive. Psychological support was not routinely available to patients.

**Requires improvement**





# Summary of findings

Chaplaincy and bereavement services demonstrated a caring and compassionate approach to working with people, and how they wanted to be more involved and involved earlier with patients and their families.

patients told us they understood the care and treatment they were offered or had received. However 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 trust performed in the bottom 20% of 50 out of 64 questions. In our last inspection (November 2013) and during this inspection we found limited improvements to ensure patients understood and were involved in their care and treatment.

We observed information leaflets were available and posters were displayed.

## Emotional support

Patients were not always offered cultural and religious support they wished to receive. Psychological support was not routinely available to patients.

Chaplaincy and bereavement services demonstrated a caring and compassionate approach to working with people, and how they wanted to be more involved and involved earlier with patients and their families.

## Are services at this trust responsive?

Overall we rated the responsive aspects of services in the trust as inadequate. For specific information, please refer to the report for Whipps Cross University Hospital, Newham University Hospital and the Royal London Hospital.

## Service planning and delivery to meet the needs of local people

There was limited evidence to demonstrate that information about the local population's needs was used to inform the planning and delivery of services.

Senior staff were unaware of their local population make up. There were over 200 different languages spoken in the local population and the 'top 5' were not consistently known and services were not planned for. Information in languages other than English were available upon request.

The services provided did not reflect the needs of the population served and did not ensure flexibility, choice and continuity of care.

Inadequate



# Summary of findings

There was a stark difference in the facilities and premises and the environment in some areas of the trust was not appropriate for the services that were being delivered.

## Meeting individual needs

There was information available to patients in written form; however, this information was only provided in English, and not in the language of the predominant population served by the hospitals.

Translation services were available when required. The trust could not provide any audit information on the usage and effectiveness of translation services despite the population being served from at least 20% to 80% ethnic minority groups.

Patients nearing the end of their life were not always identified, and their needs therefore were not always assessed and met.

The trust had provided dementia training for 3,130 of its 15,000 staff (21 %) between April 2014 - March 2015. This meant the trust had not achieved the recommendations of the National Dementia Strategy published in 2009.

## Access and flow

The emergency departments were not meeting the national 4 hour waiting time target. This target was introduced by the Department of Health for NHS acute hospitals in England, and sets a target that at least 95% of patients attending emergency departments must be seen, treated, admitted or discharged in under four hours. Some patients waited considerable periods in the A&E department, at the Whipps Cross Hospital site. Newham University Hospital consistently performed better.

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.

Bed occupancy was very high, the average between April and December 2014 was 95%. This meant patients were not always cared for in the appropriate environment and the high occupancy impacted on the flow of patients through the hospitals.

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

In November 2013 we identified that patients were inappropriately cared for in recovery for significant periods of time. On this inspection we found this was still a common occurrence. Patients in critical care were transferred for non clinical reasons were higher than the national average.

Many patients experienced delays in their treatment as a result of the poor implementation of the new IT system.

Patients were delayed in accessing treatment that could only be provided at a given site if there was no capacity to receive them on that site.

The average length of stay was higher than the national average. The executive team told us they had implemented the "Barts Health Way" - an initiative to reduce the average length of stay. However staff on the wards did not resonate that this was the purpose of the Barts Health Way.

Some patients had their surgery cancelled on multiple occasions due to a lack of beds, We observed patients with cancer having their surgery cancelled while on inspection in November 2014 and we were given assurance that this would not happen without escalation to senior staff within the clinical academic group (CAG) however in February 2015 the board papers refer to another patient with cancer having their surgery cancelled on two occasions and no assurance on when their surgery would take place.

Patients well enough to leave hospital experienced significant delays in being discharged for a variety of reasons and some because of documentation needing to be completed. During our inspection in November 2014 an estimated 90 patients across the trust 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.

## **Learning from complaints and concerns**

Complaints were not always managed in a timely or appropriate manner. There was no central team for managing complaints - complaints were managed locally within the CAG structure. Time frames were not being met and CAG leads had been spoken with.

The trust received 231 formal complaints in January 2015 of which 157 (68%) were acknowledged within three working days. Also only 38% of complaints were responded to within the negotiated time frame in January. Year to date the trust on average responded to 20% of complaints within the agreed time frame.

# Summary of findings

The trust also had between 15 to 25 complaints re-opened each month. The trust had 29 active or open Parliamentary and Health Service Ombudsman (PHSO) cases.

In January 2015 the trust reported a high number of compliments for the trust at 44 compared to 33 the previous month.

Many patients experienced delays in their treatment as a result of the poor implementation of the new IT system. There were also many complaints regarding transport and outpatient appointments. A constant complaint from patients and their relatives about Whipps Cross hospital was how difficult it was to make contact with the hospital. One example was a patient who telephoned 79 times without success and had to go to the hospital to make an enquiry.

## Are services at this trust well-led?

Overall we rated the leadership of the trust as inadequate. For specific information, please refer to the report for Whipps Cross University Hospital, Newham University Hospital and The Royal London Hospital.

### Vision & strategy

The board had brought together three trusts across eight sites in 2012 and was now the largest healthcare provider in Europe with a budget of £1.3 billion. We were not provided with the strategy that detailed the merger objectives and the short, medium and long term plan for the future of the organisation.

The board members interviewed did not share an agreed strategy or vision for the organisation as a whole other than an aim to be financial viable which was proving a challenge at the time of inspection. Individual board members had different visions.

There was no nursing and quality strategy. There was no estates strategy despite the variation in accommodation from which health care services were being provided. There was no IT strategy again an area where we identified areas of concern that were directly impacting on patient care and outcomes.

The medical director took a paper detailing the strategic plan for end of life care to the trust board in January 2015. This paper referred to the removal of the LCP which took place nationally in July 2013. It was confirmed at the board meeting that the strategic plan had not been through a structured engagement process and had not included engagement with patients, this supported findings on inspection that end of life care was inadequate.

There was no strategy for children's services however staff spoke of how children's services were to be centralised at the Royal London Hospital. We could not confirm if this was a firm decision approved

Inadequate



# Summary of findings

by the board with a confirmed date or not. The CEO had recognised that children services on the Whipps Cross site was one of the trust's greatest risks, however the plans shared on inspection would mean more children being treated on the Whipps Cross site and Newham University Hospital would reduce their provision.

## **Governance, risk management and quality measurements**

There was a Clinical Academic Group (CAG) structure in place across all sites. At our last inspection in November 2013 we found the CAG structure was not embedded with the exception of the Emergency Care and Acute Medicine CAG and site-specific management was in development. At this inspection we found the CAG structure was still not embedded and site-specific management had not been developed. A clear process for board to ward governance and engagement was not evident.

The systems and processes of assurance was variable with some services lacking any formal, effective oversight. Risk registers were poorly applied in some clinical areas which led to some risks not being identified, recorded and managed or escalated.

Performance dashboards and information was in some cases not available and some were unreliable. Senior staff did not always have the information they needed to have oversight of the services they led. The trust has one of the largest maternity services in the country and is responsible for the birth of 15,715 babies each year and did not have a maternity dashboard that covered all aspects of care. The three metrics related to performance that were presented to the board for maternity services were percentage of women who had caesarean sections, number of neonatal deaths and the number of maternal deaths.

An example of poor governance with no ownership was a patient who had their surgery cancelled on five occasions and neither the Surgical and Cancer CAG leads nor the Hospital Director and Hospital Matron were aware. Children's services sat across three CAG's and we heard of a range of developments within children's services however this was compromised with no one known as the lead.

The board had identified children's services as an area of significant risk however there was no clear plan or proposal on how this would be addressed and who owned the issues.

Risks were apparent across the trust and staff commitment to reporting and escalating concerns varied considerably. Some staff told us they had actively been told not to report incidents other staff told us they did not report because there was no action taken.

# Summary of findings

Staffing levels on the maternity unit at Newham University Hospital were significantly compromised. Obstetric cover was 74 hours against an expected of 168 hours. Midwife to mother ratio was 1:33 against birth rate plus recommendation of 1:26. 56% of births at this unit were identified as falling into the higher risk category, this risk was not being managed.

In November 2013 we judged the trust to not be meeting 15 CQC standards. In the last 12 months the trust board papers did not demonstrate that the trust had achieved or had plans to achieve compliance with the regulatory standards to protect patients from harm.

The trust submitted data to the patient safety thermometer, a point prevalence audit that took place once a month. The audit collects data on harms observed, falls, venous thrombotic embolism (VTE), pressure ulcers and hospital acquired urinary tract infections. However, other than this there did not appear to be monitoring of quality and metrics to ensure that quality was being maintained as well as improvements being aspired to.

The trust participated in national audit and the outcomes varied. They had excellent outcomes in stroke at Newham University Hospital and Trauma outcomes at The Royal London Hospital. However, we did not see evidence and action plans in place to address the outcomes of the national and local audits in the majority of cases. Audits carried out to check compliance with the World Health Organisation (WHO) surgical safety check list were weak - less than 1% of patients notes who had undergone surgery were audited. There had been eight wrong site surgery Never Events. We had raised concerns about compliance with the check list in November 2013.

## Leadership

The trust board were not aware of significant issues on specific sites, due to the lack of site-specific management and information. The trust board had delegated responsibility of delivery to the CAGs to ensure patients received safe, effective, efficient care in an appropriate environment. At the time of inspection the board was receiving trust wide data which did not detail the level of issues and concerns we identified on specific sites and when we spoke with both executives and non-executive directors the detail was not evident when looking at trust wide data.

The CAG clinical directors had recently joined the executive board in January 2015 as non-voting members. The majority of staff did not know the executives leading the trust nor were they familiar with the leaders of the CAGs despite this structure being in place since October 2012.

# Summary of findings

It was apparent across all three sites inspected that the CAG structure did not provide local leadership. More recently the trust had introduced site-based hospital directors. This was a success at Newham University Hospital as the individual had been in post some time, but variable on the other sites. The hospital matron was again a new post and there were plans to have a site specific medical director. However when we explored this local triumvirate they did not have accountability and responsibility and had to refer to the CAGs. The relationships and responsibilities between site specific leaders and CAG leadership team were confused.

Board members did not describe a cohesive strategy for the organisation and how they monitored progress against delivery. They told us they had discussed the strategy but there was nothing written to confirm what the short, medium and long term strategy was. They went on to confirm that they could not monitor it as they had no process to do so. They told us there were limited metrics to assess the effectiveness of the CAGs and believed the information being received at the Quality Assurance Committee and at the trust board provided adequate assurance.

They also got assurance from their executive walk rounds. We were provided with some examples that the non-executive directors on their walk rounds had identified concerns that they had previously not been aware of. The reasons for the trust having a back-log of 100 open SIs and complaints for months and in some cases complaints never answered were unknown.

The Francis Inquiry 2013 recommended that nurse leaders such as ward managers should be in supervisory roles to ensure local leadership, support and guidance. This was not in place at the trust and there were no plans for implementation. The staffing restructure in 2013 removed many nursing posts who were providing local leadership, support and guidance.

To support staff in their leadership roles a Changing Lives programme had begun. At the time of our January 2015 inspection 200 out of the identified 1,500 leaders had participated in the programme. We observed a changing lives programme workshop. The workshop encouraged staff to consider their roles and how they could be empowered to make improvements. However the majority of staff had attempted to develop and improve the service with limited progress because of the financial restraints.

There were some examples of good local leadership, and most staff felt supported by their immediate line managers. However, not all senior managers supported local managers effectively.



# Summary of findings

## Culture

Staff spoke of a "take over" rather than a merger and the staff on the Whipps Cross Hospital site and Newham University Hospital site felt disadvantaged by the merger and provided examples of this. An example cited was the allocation of consultant clinical excellence awards. A hospital the size of Newham University Hospital would have expected to receive 20 to 30 awards each year however in 2014 only one senior clinician at the hospital received one award.

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 for fear of repercussions.

We felt an overwhelming sense of commitment from the front line staff at the trust, many of whom had worked at their hospitals for a number of years. Staff described their passion and commitment to the community they served and to their immediate colleagues. Staff did not however speak of vision, strategy and leadership and feeling valued by senior colleagues. Indeed staff gave examples of not being valued or recognised. We spoke with a number of temporary staff and also staff who were actively trying to leave the trust.

The majority of medical staff spoke with overwhelming commitment to the patients and colleagues regardless of the management structures in place. They went on to describe how in some cases the management structure or lack of it inhibited them. Consultants were held in high esteem by doctors in training and many described it an honour to work at the trust due to the complexity of the patients and the consultants support in ensuring learning.

Staffing was a key challenge across all services and the environment was not conducive to recruitment and retention and the sustainability of services. There were a number of vacant managerial posts and interim staff in post making it difficult for staff to be well-led.

On the last inspection, November 2013 we identified a culture of bullying and harassment, in response to this the trust commissioned an independent review by Duncan Lewis that found:

- Unreasonable management: mainly associated with negative behaviour from line managers and other managers.
- Incivility and disrespect: mainly associated with behaviours from work colleagues and from line managers, but can also include patients and the relatives of patients.
- Approximately 75-80% of the respondents indicated that most of the 26 ill-treatment behaviours were still occurring within the last three months.

# Summary of findings

The review was presented to the board in October 2014 and it was agreed a further 90 day conversation period with staff should commence with a report back to the board in January 2015. There was a lack of timely response to address the bullying and harassment culture. We have concerns about whether enough is being done promptly to encourage a change of culture to be open and transparent.

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. Only 32% recommend it as a place to work, which is third lowest in the country. There had been minimal improvements in the NHS Staff Survey 2014.

For the 2014 survey, 3,924 staff at Barts Health NHS Trust took part in this survey. This is a response rate of 30% which is in the lowest 20% of acute trusts in England, and compares with a response rate of 46% in this trust in the 2013 survey.

## **Engagement with patients and public**

Local commissioners had engaged the Patients Association, an organisation committed to listening to patients; speaking up for change. In response to an absence of the patients voice being heard.

The trust had a proactive apprenticeship initiative which encouraged members of the local community to work at their local hospital providing employment opportunities.

In congruence with most strategies the board papers stated that the Patient Experience Strategy had been deferred on several occasions and it was last recorded as planned for the April 2015 board meeting.

The Patient Advice and Liaison Service (PALs) had a 'hub' based at the Royal London hospital. Some patients were dissatisfied that there was not continuous PALs presence at other hospital sites however there was dedicated telephone numbers and email addresses and face to face contacts could be booked. The team handled approximately 200 telephone calls a day.

## **Engagement with Staff**

The trust participated in a programme of work called "project search" which supported individuals with learning disabilities to work within the trust and this resulted in a number of these individuals being appointed substantively.

In the 2014 NHS Staff survey, the engagement score for the trust was 3.61 which is in the worst 20% when compared with other acute trusts of a similar type. Nationally scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged.

# Summary of findings

In the 2014 NHS Staff survey, the trust have deteriorated in 7 areas compared to their results in 2013 such as having equality and diversity training and receiving health and safety training in last 12 months, experiencing harassment, bullying or abuse from staff as well as experiencing discrimination at work in the last 12 months, effective team working, feeling satisfied with the quality of work and patient care they are able to deliver and finally fairness and effectiveness of incident reporting procedures.

The areas in which the trust improved on from their 2013 results were limited to three areas these include percentage of appraisals in the last 12 months, witnessing potentially harmful errors, near misses, or incidents and staff recommendation of the trust as a place to work or receive treatment.

Staff told us that the executive team were not visible however several staff told us they received the chief executive's weekly email message.

The trust carried out staff surveys known as "pulse" surveys throughout the year and the director of human resources told us that 4,000 staff were sent the survey every month, however this did not provide the intelligence to support the required changes that would see this trust as improving overall when the annual staff survey was carried out.

Speak in Confidence had been launched for staff to securely and confidentially raise any concerns with the executive team. This feedback mechanism had been utilised on 75 occasions between March 2014 and January 2015 as this system was not widely known.

## **Improvement, innovation and sustainability**

We found the financial position of the trust impacted on the volume of innovation, improvement and sustainability initiatives for the services.

Innovation was prevalent in the trauma and emergency centre at the Royal London Hospital.

25% of the patients attending the trauma service as an emergency had penetrative wounds, which is significantly higher than any other UK trauma centre. Despite this, the survival rate at the hospital was approximately twice the national average and the service had regular national and international visitors wanting to learn from the service. The service had worked with the Armed Forces whilst on combat operations and had taken specific learning from this.

The Trauma service in conjunction with military colleagues had developed the concept of the 'platinum ten minutes' based upon

# Summary of findings

techniques used to help save the lives of soldiers in combat situations. Through the use of fluid, plasma, active surgical intervention and rapid assessment at the scene more patients were arriving at hospital alive.

Senior staff were trialling the Multidisciplinary Action Training in Crises and Human Factors initiative (MATCH). This was a framework within which Never Events and Serious Incidents could be discussed in an environment characterised by mutual respect and in which lessons learnt could be quickly introduced without damaging personal relationships. It was reported that initial results had been very promising. However, staff reported that whilst there had previously been plans to introduce this across the trust, the financial pressures the trust faced may put this on hold.

A surgeon had become the first in the UK to broadcast online a live surgical procedure using a pair of Google Glass eyewear. The procedure was watched by 13,000 surgical students around the world from 115 countries and they also had the opportunity to ask the surgeon questions.

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.

We were told the Older People's Improvement Programme had led to improvements in patient centred care, a reduction in falls and preventable pressure ulcers and increased staff engagement.

The Gateway Surgical Centre's environment - design, layout, equipment and integrated care with members of the multidisciplinary team was recognised as meeting patients needs and delivering excellent. The centre supported new pathways of care and achieved one of the best day care rates in the country.

The diabetes service at Newham University Hospital offered web-based follow up Skype meetings for all patients where physical examination was not required. The service provided an accessible and cost effective care for patients.

## **Duty of candour**

The Director of Human Resources advised us that the Medical Director and the Director of Corporate Affairs were responsible for the implementation of the Duty of Candour legislation and the Fit and Proper Person Requirements which came into effect on 27 November 2014. At the January 2015 board meeting the new legislations were discussed, however the appropriate steps to ensure compliance and on-going monitoring were not yet in place.

# Overview of ratings

## Our ratings for Whipps Cross University Hospital

	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	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Requires improvement	N/A	Requires improvement	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate

## Our ratings for The Royal London Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Good	Good	Inadequate	Requires improvement	Inadequate
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Inadequate	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

# Overview of ratings

End of life care	Requires improvement	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

## Our ratings for Newham University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
End of life care	Requires improvement	Inadequate	Good	Good	Inadequate	Inadequate
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

## Our ratings for Barts Health NHS Trust

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

# Overview of ratings

## Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging



# Outstanding practice and areas for improvement

## Outstanding practice

We saw several areas of outstanding practice including:

- A surgeon had become the first in the UK to broadcast online a live surgical procedure using a pair of Google Glass eyewear. The procedure was watched by 13,000 surgical students around the world from 115 countries and they also had the opportunity to ask the surgeon questions.
- 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
- Senior staff were trialling the Multidisciplinary Action Training in Crises and Human Factors initiative (MATCH) . This was a framework within which Never Events and Serious Incidents could be discussed in an environment characterised by mutual respect and in which lessons learnt could be quickly introduced without damaging personal relationships. It was reported that initial results had been very promising. However, staff reported that whilst there had previously been plans to introduce this across the Trust, the financial pressures meant this was on hold.
- The hospital is a pioneer in trauma care. 25% of the patients attending the trauma service as an emergency had penetrative wounds, which is significantly higher than any other UK trauma centre. Despite this, the survival rate at the hospital was approximately twice the national average and the service had regular national and international visitors wanting to learn from the service. The service had worked with the Armed Forces whilst on combat operations and had taken specific learning from this and applied it to the service.
- In particular, the Trauma service in conjunction with military colleagues had developed the concept of the 'platinum ten minutes' based upon techniques used to help save the lives of soldiers in combat situations. Through the use of fluid, plasma, active surgical intervention and rapid assessment at the scene more patients were arriving at hospital alive.
- The Royal College of Physicians audit of stroke care rated the hospital as 97.5% for patient experience from diagnosis to rehabilitation - the highest result in London.
- The Gateway Surgical Centre's design, layout, forward planning, engaged staff and integrated care with members of the multidisciplinary team.

## Areas for improvement

### Action the trust MUST take to improve

We identified that there are 65 "must do" actions across the three locations inspected, details are in the location reports.

Due to our level of concern across the trust we wrote to the Trust Development Agency (TDA) to suggest they urgently consider special measures for the trust in March. The trust was placed in special measures on 16 March 2015.