

Barts Health NHS Trust

Quality report

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

Overall summary

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

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

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

The Royal London hosts one of the country's busiest trauma centres with state-of-the-art facilities and a dedicated paediatric accident and emergency (A&E) department. It is also the base of the London Air

Ambulance service. Both Whipps Cross and Newham also have A&E departments. St Bartholomew's Hospital has a minor injuries unit.

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

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

Summary of findings

Overall summary (continued)

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

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

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

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

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

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

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

Are services effective?

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

Are services caring?

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

Are services responsive to people's needs?

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

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

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

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

Summary of findings

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

Are services well-led?

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

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

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

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

Summary of findings

What people who use the trust say

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

Comments posted on the Patient Opinion and NHS Choices websites highlighted that care by doctors and communication by all staff could be improved, although

these also featured in positive comments. This was also apparent in our inspection visits where patient opinions of care was polarised, with some telling us of care that went beyond the call of duty and others telling us about very poor care.

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

Areas for improvement

Areas where the trust MUST improve:

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

Other areas where the trust could improve:

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

Summary of findings

Good practice

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

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

Are services safe?

Summary of findings

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

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

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

Our findings

Safety/incident reporting/never events/managing risk

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

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

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

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

Staffing

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

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

Are services safe?

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

Cleanliness and infection prevention and control

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

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

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

Medicines management

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

Environment

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

Safeguarding vulnerable adults and protecting children

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

Medical equipment

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

Are services effective?

(for example, treatment is effective)

Summary of findings

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

Our findings

Mortality rates

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

NHS Safety Thermometer

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

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

National guidelines

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

Clinical audits

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

Collaborative working

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

Are services caring?

Summary of findings

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

Our findings

Patient views and feedback

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

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

Privacy and dignity

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

Food and drink

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

End of life care

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

Are services responsive to people's needs?

(for example, to feedback)

Summary of findings

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

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

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

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

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

Discharge

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

Information

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

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

Our findings

Responding to patients' needs

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

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

Complaints and feedback

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

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

Are services well-led?

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

Summary of findings

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

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

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

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

also risks, particularly in the way the trust implemented the new structure. Some staff reported difficulties in working across the three main hospitals. They said that it was sometimes difficult to know who was in charge in specific areas. At times, they found that the governance structure prevented issues being addressed. The trust had recognised this and strengthened site level leadership at operational and clinical levels. This had been implemented just before our inspection so its impact could not be assessed. It is, in our view, a positive move.

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

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

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

Our findings

Leadership and clinical governance structures

Barts Health NHS Trust came into being on 1 April 2012. It was created by a merger of Barts and the London NHS Trust, Whipps Cross University Hospital and Newham University Hospital. In October 2012, the trust introduced a clinical leadership structure (the Clinical Academic Group (CAG)) covering specific specialties, such as emergency medicine or surgery, across all Barts Health sites. There are distinct advantages to this structure: it creates the opportunity to share best practice, make improvements, streamline services and innovate. However, there are

Organisational culture

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

Are services well-led?

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

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

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

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

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

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