

## **Barts Health special measures following the CQC inspection report for Whipps Cross University Hospital**

---

Following the Care Quality Commission (CQC) report published on the quality of services at Whipps Cross University Hospital after an inspection in November 2014, the Trust Development Authority (TDA) announced that Barts Health NHS Trust will be placed into special measures.

The Trust Development Authority (TDA) have taken this action as a result of the concerns in the report, the Trust's performance against the NHS Constitution standards and the financial challenges it faces.

### **CQC Report**

The Whipps Cross report identified a number of failings and the hospital site has been rated as 'inadequate', the lowest of four CQC categories. The Trust has been served with four warning notices under the Health and Social Care Act relating to:

- care and welfare of people who use services;
- assessing and monitoring the quality of service providers;
- complaints; and
- staffing.

### **The key findings were as follows:**

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

### **Safe:**

- There were not enough nursing and medical staff to ensure safe care was provided.
- Handovers between medical staff were unstructured and did not ensure relevant staff were aware of specific patient information or the wider running of the hospital.
- There was limited learning from incidents. Staff did not have the time to report incidents, were not encouraged to report incidents and were not aware of any improvements as a result of learning from these incidents. Some senior staff were unaware of serious incidents and action plans that involved them leading the required change.

- There were low levels of compliance with mandatory training. It was not always evident that learning from the training was embedded.
- Medicines management required improvement in some areas including, but not limited to the storage and administration of medicines. There was an inconsistent use of opioids across wards.
- Patients nearing the end of their life were not identified, and their needs therefore were not always assessed and met.
- The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied. The use of an early warning system was embedded within the surgery, while in A&E and medical care areas, its use was inconsistent. The National Early Warnings System had not yet been implemented in the hospital.
- Theatre ventilation was not adequately monitored.

#### **Effective:**

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

#### **Caring:**

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

#### **Responsive:**

- The average bed occupancy for from May to October 2014 was 91%. This impacted on the flow of patients throughout the hospital. Patients were cared for in recovery, or transferred out of critical care for non-clinical reasons.
- Patients well enough to leave hospital experienced significant delays in being discharged because of documentation needing to be completed. During inspection an estimated 30 patients were well enough to leave hospital but remained because their continuing health care assessments had not been completed. Staff that previously completed this paperwork were no longer in post because of the restructure.
- Operations were often cancelled due to a lack of available beds.
- The average length of stay (ALOS) was high, the trust recognised this issue was impacting on patient care and had taken some action to address it.
- The hospital was persistently failing to meet the national waiting time targets. Some patients were experiencing delays of more than 18 weeks from referral to treatment

(RTT). The trust had suspended reporting activity to the department of health and had started a recovery plan.

- Many patients experienced delays in their treatment as a result of lack of planning to introduce the electronic patient records system or when transport arrangements had changed. Patients complained that they were unable to get in touch with the hospital.
- Capacity issues within the hospital led to a high proportion of medical “outliers” (patients on wards that were not the correct specialty for their needs). The result of this was that patients were being moved from ward to ward on more than one occasion, this impacted on their treatment, delayed their stay in hospital and were on occasion transferred late at night.

#### **Well-led:**

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

#### **The hospital must ensure:**

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

- Equipment is ready for use and appropriately maintained.
- The environment is adequately maintained to protect patients.
- Medications are stored safely

### **Newham and Royal London Hospitals CQC Reports**

The Whipps Cross is the first report that the CQC has published following their inspection of Barts Health NHS Trust. We expect that reports on Newham General and the Royal London will be issued later this year following their site inspections in January 2015.

### **CCG response**

Waltham Forest, Newham and Tower Hamlets CCGs are in the process of working more closely in partnership with Barts Health, patients, local councils, Healthwatch and key stakeholders to fix the underlying causes of the issues identified in the report. They are currently developing a clinical strategy for east London that will transform the way care for patients is provided; preventing ill health, supporting people to live healthier lives and tackling inefficiencies, therefore investing in coordinated, high-quality sustainable services.

Whilst the CCGs will support managers and staff at Barts Health to make the improvements outlined by the CQC, they will also hold them to account if they do not see improvements and the change that is needed.

### **Health Scrutiny**

Tower Hamlets Health Scrutiny have requested for Barts Health to come and discuss the current issues, however due to the communication manager at Barts Health being away and the short notice in rearranging of the Health Scrutiny Panel meeting there hasn't been adequate time and notification to arrange this. However, this will be addressed through the Inner North East London Joint Health Overview Scrutiny Committee (INEL JHOSC) meeting in early May. We will also follow this up again with Barts Health after the Royal London CQC inspection report has been released.