

Lewisham and Greenwich NHS Trust

Queen Elizabeth Hospital

Quality Report

Queen Elizabeth Hospital

Stadium Road

Woolwich

London

SE18 4QH

020 8836 6000

www.lewishamandgreenwich.nhs.uk

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

Ratings

Overall rating for this hospital

Requires improvement



Accident and emergency

Inadequate



Medical care

Requires improvement



Surgery

Requires improvement



Intensive/critical care

Requires improvement



Maternity and family planning

Good



Services for children & young people

Requires improvement



End of life care

Requires improvement



Outpatients

Requires improvement



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	3
The five questions we ask about hospitals and what we found	4
What we found about each of the main services in the hospital	8
What people who use the hospital say	16
Areas for improvement	16
Good practice	17

Detailed findings from this inspection

Our inspection team	18
Background to Queen Elizabeth Hospital	18
Why we carried out this inspection	19
How we carried out this inspection	19
Findings by main service	20
Action we have told the provider to take	84

Summary of findings

Overall summary

During the inspection, the team looked at many areas. The detail of their findings is within the main body of the report. However in summary we found that:

On both sites, elements of the acute medical pathway (which is based on a different model on each site) are not providing optimal flow of patients through the hospital. This includes difficulties in accessing critical elements of some patient pathways provided externally to the Trust.

On the Queen Elizabeth site the A&E environment is not considered by the inspecting team to be fit for purpose.

On the Queen Elizabeth site, following admission via A&E, delays in access to investigation were witnessed, and also delays in accessing specialist internal opinion and by external transfer to specialist units.

The approach taken by the executive team to the formation of a single inclusive organisation, is appreciated by staff on both sites. Despite acknowledgement and appreciation of the executive

teams approach to the formation of a single, inclusive organisation on the Queen Elizabeth site, staff at the focus groups on that site remained concerned in view of their recent experiences.

The review team felt that the Executive Team should plan to re-evaluate their management capacity to address the issues described at regular intervals to ensure that this remains adequate.

We did however also see areas of good practice. These included

The single governance structure, including increased clinical involvement and the appointment of senior clinicians from the Queen Elizabeth (Greenwich) site to 4 Divisional Director roles, is also appreciated by staff on both sites.

The staff on both sites are committed to high quality care and this is a focus of their work.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

We saw that whilst hand hygiene facilities were available in most clinical areas; use of these was poor, especially by doctors. This presents an infection risk to people using the services.

Checks to clinical equipment should be carried out regularly to ensure that when they are required they will be working. These checks are recorded. In some areas the checks were carried out regularly, but in other areas this was more sporadic and often missed.

Space in some areas, e.g. A&E at Queen Elizabeth site, was limited, and the volume of work had risen significantly. Ambulance staff were frequently delayed or unable to hand over patients to the A&E team.

We saw an overreliance on temporary hospital notes that would not contain all the latest records.

We saw that there was not a consistent policy for managing patients at the end of their life.

The hospital reported incidents and shared the learning from these. A good reporting culture will lead to learning and improvement in care

Inadequate



Are services effective?

Due to the recent merger of this hospital and the dissolution of the South London Healthcare Trust, there are insufficient recent data on which to base a rating for effective for the Queen Elizabeth Hospital. As such this domain is not rated.

We were aware of a patient with Acute Upper GI Bleed who had presented to the A&E department. There was not an effective pathway for managing this patient. We were told by the Chief Executive that work is underway to ensure an effective pathway is developed for these patients. The trust participates in many clinical audits and the results are shared within teams. This demonstrates that clinicians are keen to examine clinical practice and improve outcomes where possible. We saw staffing levels in some areas below those that would be required for effective care. The trust discussed a recruitment plan; but this was not yet fully in place. The trust has employed a 'pharmacy runner' whose role is to collect medicines from pharmacy for patients to speed up their discharge. We saw this was working well. We observed good multi-disciplinary team working in many areas. A team that works well together and values each other's roles is likely to be more effective. Staff used

Not sufficient evidence to rate



Summary of findings

appropriate tools and systems (e.g. Paediatric Early Warning System). Staff had an appropriate level of training for the roles they carried out. In outpatients, the number of times a patient needs to attend to see a consultant for follow-up after their treatment is being reduced. This is in line with national best practice and reduces the impact of travelling to hospital regularly. We saw a shortage of beds for admission to the hospital. This created a block in the system particularly for patients from A&E. This meant that their admission was often delayed.

Are services caring?

The Friends and Family Test is a measure of whether people using the service would recommend that service to their friends and family should they require clinical care. The A&E service scores well in the friends and family test. Some wards also scored well; but others were less likely to be recommended. The maternity unit scored below the England average in this area. Many patients we spoke to praised the caring nature of staff in all the hospital sites. They were appreciative of the care provided. Staff largely made an effort to keep people informed on progress of their care. Patients told us the staff spoke to them with respect and dignity. However, this was not universally true. Two patients we spoke to had their operations cancelled, but had waited all day with nothing to eat. Other patients told us that staff seemed too busy to talk to them. We visited the mortuary and spoke to the staff. They described the process of caring for the deceased person and ensuring their families had a positive experience after death. We saw the effort they made and were impressed by their attention to detail.

Requires improvement



Are services responsive to people's needs?

The waiting times in the A&E services regularly fall below the national standard of 94% of patients being admitted or discharged within 4 hours. The ability of this service is constrained by its facilities and the pathway from A&E to an admission on a ward. Additionally, bed occupancy in the trust is regularly over 85%, which is a figure regarded as a marker of effective bed usage. Over 85% occupancy indicates that there is insufficient capacity in the hospitals bed numbers to respond to changes in demand. The bed occupancy for maternity should be much less (owing to the uncertain nature of a period of labour). In maternity, bed occupancy should be around 60%. The trusts bed occupancy in maternity is closer to 80%. Delays and excessive waiting times in clinics were a challenge for many patients. Some people told us they took a whole day off work to attend an outpatient appointment. Delays of 90 minutes were common. One patients on the day of our visit had waited two and a half hours for a routine ultrasound scan. Staff told us that clinics often ran late as appointments were often double and

Requires improvement



Summary of findings

triple booked. We were told that letters from the Speech and Language Therapist now clearly set out the length of wait for an appointment. This allows patients expectation to be clearly managed at an early stage. There was a buggy service on the QE site to help patients move around the hospital when they had limited mobility. This was staffed by volunteers and very much appreciated by those we spoke to. We heard examples of excellent practice responding to patient's needs. One person at on the Queen Elizabeth site described a service where they had taught volunteers to feed patients on a dementia ward. These patients often need extended time to encourage them to eat. This approach also developed a social interaction with these patients that also met their needs. We heard of the potential to extend this widely across the trust; and we would encourage the trust to consider this. The executive team were able to give clear examples (e.g. maternity bathroom cleanliness) where they had listen to and acted upon patient feedback. The Chairman and non-executives were able to talk in great detail about individual service elements. The trust has an OWL (outcomes with learning) group that allows learning from incidents to be shared and reflected back. We heard that the executive team were very proactive in managing complaints and compliments. We heard that the team would take letters from patients and go directly to the ward or department to discuss them. The Chief Executive reads and signs every complaint response. This allows the executive team to maintain a strong view of key issues and risks.

We noticed as we walked from the car park to the main hospital entrance that patients had to walk through a porch area in front of the main doors. This area was marked clearly as a 'no smoking' area. However, we saw patients, contractors and hospital staff smoking in the area. We also observed a patient being transported on a hospital bed to a passenger transport ambulance through people smoking in the area. The main entrance doors were automatically opened on arrival, however, the right-hand door on the first set of doors was locked and the left-hand door was locked on the second set of doors. Staff told us that this was to reduce the wind coming into the main reception area. However, it was confusing to visitors as there was nothing on the door to state that it was closed and it caused some congestion between visitors and patients entering and leaving the area.

Are services well-led?

The board set early priorities for the new merged trust and were clearly seen to be working towards them. We heard from some staff groups about the positive environment supportive culture. Staff felt the organisation engages with them in many areas. Staff at the trust felt positive about the merger and welcomed the opportunity to

Requires improvement



Summary of findings

develop. Staff on the QE site initially had misgivings about the merger of the two organisations based on previous experience. However, they told us of the positive attempts to bring the organisation together. We were regularly told of a challenge for the trust of Lewisham attracting the higher 'inner London weighting allowance' while staff working on the QE site attract the lower 'outer London' allowance. Whilst this is a challenging issue, we perceived it to be a significant barrier to integration and cross site working. Team leaders and managers gave us examples of recruitment challenges to vacancies on the QE site, despite having potential candidates. The issue given by candidates was the pay discrepancy between sites. Through our focus groups we heard from staff in the non-clinical workforce who felt undervalued. These staff play a vital role in maintaining core services; engaging with them is critical for the success of the trust. We saw good mentorship support to staff in training. We also observed good support to Health Care Assistants in their development. The trusts commitment to staff development and training was seen as a high priority by many people. The Trust told us of a single governance structure across both sites; however the perception of some staff was that governance arrangements at the trust are managed separately on both sites. This is likely to cause confusion and increase risk if staff are expected to work across site.

Summary of findings

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

Accident and emergency

Inadequate



Our inspection team spent one-and-a-half days during an announced inspection in the department at QEH. During this time we spoke with nine patients and five relatives about their experiences in the hospital. We also spoke with eight doctors and nurses of various levels of seniority, the porters, four members of the London Ambulance Service and one person who was working for the company contracted to provide cleaning services for the trust.

We returned, unannounced, the following week. This was a Saturday evening and we spent four hours in the department. We spoke with four other doctors, the nurse in charge and other nursing staff, the porters and security staff. We spent time with the triage nurse and spoke to several more patients.

We analysed data that were available to us, we used the findings of national surveys and used information from other agencies (eg ambulance handover delays).

We had serious concerns regarding the safety of A&E services. We saw issues with cleanliness, with use and disposal of clinical materials (e.g. needles) and with unsafe storage and disposal of clinical waste. We saw lack of vital equipment (i.e. resuscitation trolleys) low staffing and lack of security.

During our visits we noted that the staff were kind, caring and respectful towards people. However, we saw that, at times, patient safety and wellbeing was compromised. At times, there were long delays in people receiving treatment, admission or discharge. Staff acknowledged that there had been occasions when patient dignity and privacy could not be upheld and serious incidents had occurred.

We saw that information to help people who were not able to read or understand English was limited and complaints were not always responded to in a timely way.

We saw long waits for people and capacity issues that meant that a patients progress through the service may be delayed.

We saw that there were some issues regarding staff shortages, although we were told that these were improving. The majority of the staff we spoke with told us that they felt positive about the merger with Lewisham Hospital and they could see improvements were beginning to be made.

Summary of findings

We raised some concerns regarding infection control issues and also about the inconsistent way that information regarding serious incidents was disseminated to staff.

All of the patients we spoke with were very positive about their experiences within the department.

Medical care (including older people's care)

There was a mixed response from patients regarding their care and treatment at QEH. Some comments praised the staff, including that their privacy and dignity was maintained and that things were explained to them in terms they could understand. However some patients had very negative experiences, with staff being dismissive and not taking into account the patient's needs.

Data we received before our inspection suggested that there were concerns with how safe the hospital was. There was limited learning and improvements taking place at QEH. There were times where basic safety requirements such as observations, assessments and reviews were not being followed. Staffing levels were a concern across both doctors and nursing. Planning was conducted at varying degrees across QEH with different levels of detail.

QEH could improve the effectiveness of its care and treatment. Patients did not always feel they received care when they required it with varying amounts of standard clinical support and sometimes a lack of joined up specialist input.

Care and treatment at QEH was not always responsive. There was normally a lack of bed capacity at the hospital despite escalation wards being utilised. Patients were regularly at hospital for longer than they required as different patient pathways were not evolved to improve the time that patients moved onto a specialist ward. Well planned discharge arrangements were in place in most cases but there were times when the system failed. Patients who were vulnerable who had additional non-physical needs did not always receive the specialist support they required.

Medical care was not always well-led. Although staff felt well supported, their workload meant they had low morale. Performance was monitored but there was sometimes a lack of comparison cross wards or trust. Training was highly regarded and protected.

Requires improvement



Surgery

People we spoke with during our inspection were mostly positive about the care and treatment they had received. They were complimentary about the staff in the service and felt informed and involved. One person told us, "I would recommend the ward to my friends and family". Another person said, "The nurses are very busy but always smile and take time to cheer me up". Some people,

Requires improvement



Summary of findings

however, raised issues about communication with staff and involvement in their care and we were told of, or observed, instances where patients' needs were not being met. In particular, on one ward, there were not enough staff to provide the levels of support needed.

Over a period of time the services provided by the QEH day care unit had changed to the extent that it no longer functioned solely as a day case service. The unit now also provided an inpatient service for patients waiting for surgery and some medical patients who were accommodated in the unit because of lack of beds available on the main wards. As a consequence, the unit experienced difficulty in balancing the competing priorities of the patients it served. There were problems regarding capacity and the suitability of the facilities to meet competing demands, which impacted on service quality.

There were arrangements in place to ensure that patients were kept safe and people we spoke with told us they felt safe in the hospital. However, there was evidence in national and trust data and also in practice found during our inspection which indicated these arrangements were not sufficiently robust. There had been a Never Event (an incident so serious it should never happen) in surgery at QEH during the two months the hospital had been part of the newly formed trust. An action plan was in place in response to this and steps were being taken to embed learning across the trust to ensure such an incident did not happen again.

Nationally recognised guidelines and pathways were followed. There was evidence of multidisciplinary working, but on the QEH surgery wards, nursing staff reported difficulties in contacting orthopaedic doctors and consultants regarding patient care and treatment. A number of other issues reduced the effectiveness of the service. Relative risk re-admissions to surgery had been variable in general surgery. There were longstanding vacancies and staff shortages in some areas and high usage of bank (overtime) and agency staffing.

People we spoke with felt that staff were kind and caring and promoted their dignity and respect. We observed this on the wards and theatre areas we visited, but in a number of instances there were shortfalls in meeting the needs of patients.

The trust was meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing general surgery and trauma and orthopaedic surgery. The bed occupancy rates for the hospital were higher than target ranges and this impacted on the flow of patients between surgery and the surgical wards. There were

Summary of findings

some delays in the discharge of patients. The surgery risk register reported poor complaint management performance and the potential risk for poor patient experience and loss of opportunity to help staff learn. There was a recovery plan to address this.

Some staff were positive about the QEH merger with UHL and the leadership aims for the newly formed trust but felt there was still work to be done to achieve the 'one trust' vision. Other staff felt that communication and cooperation between QEH and UHL was not as effective as it could be. There were new clinical governance arrangements in place and managers were aware of the risks in their area and what action was being taken to reduce them. However, it would take time for the new arrangements to become embedded and for all staff to fully engage with them.

Intensive/critical care

We saw poor examples of hand hygiene and failure to follow the trusts 'bare below the elbows' policy. We also saw shortages in both medical and nurse staffing levels.

Patients' needs were being met by the service, care was delivered by experienced and skilled staff in a caring manner. Patients' care and treatment was delivered in line with national guidelines and evidence-based practices. Many families we spoke with were complimentary about the care their relative received. However, there was a lack of relatives' facilities in the critical care unit.

Staff participated in a range of audit and monitored patient outcomes to improve the quality of care provided. There was evidence that staff had learnt from incidents and made changes which had improved the quality of care patients received.

There were not always enough trained and experienced staff to deliver care, due to nursing agency shifts frequently not being filled.

Requires improvement



Maternity and family planning

We felt that more action should be taken with regard to concerns highlighted on the risk register. The team had concerns on the accuracy or way these data were collected which would impact on their use.

There was a lack of forward planning with regard to staffing levels.

We talked to a number of patients, to midwives and preceptors (instructors), to matrons, ward coordinators and senior manager, clinicians at all grades and ancillary staff.

We found a number of positive features of the maternity service at QEH. Midwives and clinicians were positive about working at the hospital, and many stated that there had been an improvement in

Good



Summary of findings

management support, visibility, policy and practice since the merger with Lewisham. Some staff stated that they had returned to work at the hospital post-qualification because they had enjoyed it previously and had been well supported.

There were a number of specialist midwives available, including those specialising in infant feeding, HIV and bereavement. The hospital had a popular e-midwife service – Edie – an experienced midwife able to answer all pregnancy-related questions online via social media, and also a well-used ‘call the midwife’ facility which gave direct access to a midwife.

Staff on labour ward were well organised into teams, with each team led by a registrar. We saw positive multidisciplinary working, and effective postnatal follow-ups.

Services for children & young people

We were concerned at the incident reporting process. Learning from incidents is an important part of making services safer. Staff told us that only a few people were authorised to report incidents. This may lead to a reduction in reporting and learning, or mis-reporting. All staff should be able to report incidents.

Care plans were poor, with pre-printed generic versions that were not individually tailored to each child's needs.

There was a shortage of staff and those staff on duty told us that the shifts left them exhausted; this challenged their ability to deliver the care they felt they should. We found that staff shortages were impacting on the quality of care provided. This, coupled with some equipment shortages, lack of learning from incidents, and lack of action following audits, meant that the service was not performing as well as could be expected.

We found caring was mixed in this service. We spoke to a number of parents, children, clinicians, nursing and ancillary staff. We received positive feedback from parents and children with regard to the care they received, and the interaction between them, nurses and doctors. Staff were proud of the care they gave but this was tempered by the pressures they felt from low staffing levels, increased workload and low morale.

Facilities were child friendly. There was evidence of good multidisciplinary working across specialties, but little evidence of joint working across the two hospital sites. There were examples of innovative practice – we were told that the oncology unit has one of the country's first paediatric oncology dietitians.

Requires improvement



Summary of findings

End of life care

At the time of our inspection previous end of life care best practice guidance was under review. The trust had a policy, but we saw that the staff on the wards were uncertain and using guidance from a number of different national guideline bodies. There were no clear guidelines on when and how to involve the specialist palliative care team (SPCT) for people who reaching the end of their life. However, the Trust had plans to introduce a clear framework for all staff to use on the principles of care for the dying patient. A joint steering group between University Hospital Lewisham and Queen Elizabeth Hospital had been set up. It was planned to present the principles to the board in March or April 2014. The agreed principles would be fully supported with staff training.

It was hard for us to ascertain whether every appropriate patient who was receiving end of life care (EoLC) pathway was treated by the specialist palliative team at the hospital. We also could not find out how many of those people were patients receiving oncology services or patients receiving care for other long term conditions such as COPD, heart failure or dementia.

We found that the SPCT were caring and supportive. Most of the patients and relatives we spoke with told us they felt supported and involved. They were aware of the people under their care and we saw records which showed they reviewed a patient's care, amended their medication accordingly and instructed the ward staff in any changes such as recording pain scores at observation checks. We found that recording in people's care plans for observations such as pain scoring, modified early warning score (MEWS), anticipatory medication and do not attempt to resuscitate (DNACPR) was mixed. Some staff recorded information very well, while others omitted to record the outcome. This meant we could not be sure that every patient had been involved in conversations about what to do in the event that their breathing or heart stopped. It also meant we could not be sure that all patients were receiving adequate reviews of their medication.

Most of the staff on the ward treated patients and their relatives with compassion and thought. The SPCT felt that ward staff did not always engage in palliative care and EoLC training and would like to see a greater understanding of how to support people at this time of their life.

The staff at the bereavement office and mortuary went out of their way to ensure that the deceased were treated with respect and dignity, and families and friends were treated compassionately.

Requires improvement



Summary of findings

There were audits and assessments to monitor how well the palliative EoLC team performed and identify any concerns or issues. However, the multidisciplinary meetings did not involve the bereavement office so they were unable to discuss any issues, such as wrapping bodies too tightly, or share in any learning.

Outpatients

During our visit we found a number of areas that gave us concern. We saw lack of notes available for consultations and overreliance on temporary notes. We also saw poor security of patients notes. We observed poor infection control and security of clinical sharps, syringes and chemicals.

All the patients we spoke with talked highly of the staff working within the outpatients department at QEH. Patients felt staff were “wonderful” and “caring” and said they had the opportunity to ask questions to help them understand their care and treatment.

Although the staff’s interactions with patients were seen as very good, we observed that staff did not always speak to people in an appropriate manner or were aware of people who may need extra assistance.

Patients told us that staff made them feel safe and they thought the department was clean and tidy. However, we found there were some processes and staff attitudes within the department that meant patients’ safety and privacy were not always protected.

There were no systems in place to assess what a patient’s experience of using the outpatients department was, as opposed to the individual clinic they attended. Each division at the hospital responded to complaints and comments relating to the clinic they had attended. These were discussed at inter-divisional meetings, however, nursing and administrative staff told us there was little cross-learning between each of the outpatient clinics. Therefore, it was difficult for us to ascertain what the out patient’s department did well or what the main concerns for patients were. However, all staff and patients agreed that the main area for concern was the waiting time for the phlebotomy and anti-coagulation clinics.

Staff told us that the demand for clinics outstripped the number they could schedule. The department responded to the increase in demand by putting on additional clinics to ensure patient waiting times from referral to appointment did not breach the waiting time targets. The department had a high number of patients who did not attend their appointments and this meant staff double booked time slots to ensure the clinic was used to its full capacity. However, this could cause long waiting times for patients as clinics overran.

Requires improvement



Summary of findings

QEH staff were very positive about the merger with UHL in October 2013. We could see there had been some joint meetings across the two sites. However, it was too early to see how the shared working practices and learning could benefit patient care and welfare at each location.

Summary of findings

What people who use the hospital say

We spoke to many people during our visit to the trust who were using the services. Both as a patient and as a carer or relative of those using the service.

We also held two public listening events on 25 February; one in Lewisham and one in Greenwich. Approximately 40 people joined us to share their views and experiences of the trust.

We also held a focus group before the inspection (on 5 February) where we invited representatives of community groups whose work relates to people who use the hospitals services. Additionally, we surveyed a number of local people about their experiences.

People told us of challenges in discharge planning, specifically that element of interface between trust and community. They also told us of long waits in pharmacy. Reports of over 4 hours to get an outpatient prescription dispensed appear common. They also shared concerns of interpreter use and of letters available only in English. Additionally people said that whilst food was available for people with strict dietary requirements (e.g. Halal), the choice was very limited (often the same menu each day) and so did not reflect their individual needs. Some people discussed a concern of lack of understanding of people with disabilities, learning needs and mental health needs.

Those we spoke to however were very keen to point out that individual staff were mainly very caring.

The Care Quality Commission undertook a detailed survey of the people from the Lewisham and Greenwich area who had recently used the services of Lewisham and Greenwich Trust. The survey was undertaken by RAISE who have significant experience with Health and Social Care along with community and voluntary services.

They received 44 responses from people who had used that services the trust. Their survey focused on the key domains that the CQC inspection team also look at.

Against the 5 domains that CQC look at:

- 81% said they felt services were safe
- 88% said they felt services were effective
- 88% said they felt services were caring
- 75% said they felt services were responsive to their needs
- 74% said they felt services were well led.

78% of people knew how to make a complaint to the trust.

When asked to rate the services they had experienced, the people responding to the survey said:

- Outstanding 27%
- Good 52%
- Satisfactory 16%
- Requires Improvement 5%

Areas for improvement

Action the hospital MUST take to improve

- The hospital must improve its hand hygiene practices, especially by medical staff.
- The hospital must ensure that all medical equipment is checked regularly.
- The hospital must ensure that appropriate levels of staff with the required competencies are available in all clinical areas.
- The hospital must review the use of the 'grey chairs' in the A&E service.
- Whilst the majority of staff are caring and patient focused, a small number are letting their colleagues down. The hospital must ensure that the high standards set by the majority are carried throughout the whole team.
- The hospital must reduce the use of temporary notes in outpatients.
- The hospital must improve its flow of patients through the hospital
- The hospital must ensure that there are appropriate clinical pathways for all patients.

Summary of findings

Action the hospital SHOULD take to improve

- The hospital should review its clinical capacity for inpatients (both general and maternity)
- The hospital should ensure that OP clinic appointments run to time and avoid undue delays.
- The hospital should improve the timeliness of its discharge processes for end of life care patients.
- The hospital should improve discharge planning for its patients

Good practice

During our visit we observed a number of areas of good practice:

- there was good incident reporting in the hospital.
- there is a strong participation in audit in many areas.
- generally, we saw very caring staff, many of whom were recognised and praised by their patients.
- the pharmacy support worker (runner) is seen as a good response to supporting access to medication before discharge.
- we noted that there is a programme of training volunteers to assist with feeding dementia patients. We saw this as a good example of innovative practice.
- the pregnancy-plus pathway for obese patients is seen as a good initiative.
- there is a good engagement amongst many of the staff to the merger.
- there is good MDT working amongst and across teams.

Queen Elizabeth Hospital

Detailed Findings

Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Services for children & young people; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Dr Nigel Acheson Regional Medical Director, NHS England

Team Leader: Tim Cooper, Head of Hospital Inspections Care Quality Commission.

The team had 37 members including CQC inspectors, Experts by Experience, lay representatives and medical and nursing clinical specialists.

Background to Queen Elizabeth Hospital

Lewisham and Greenwich NHS Trust was formed in October 2013 by the merger of Lewisham Healthcare Trust and the Queen Elizabeth Hospital Greenwich (following the dissolution of the South London Healthcare Trust by the Trust Special Administrator).

The trust serves a population of over 500,000 covering (in the main) the boroughs of Lewisham, Bexley and Greenwich.

The trust serves an area of high deprivation (approximately 30th out of 326 local authorities where one is the most deprived). Life expectancy is worse than the national average for both localities.

The hospital has just under 500 beds on this site. Overall the trust has close to 1,000 beds.

The trust has main services on both its Lewisham and Greenwich sites; additionally it has some surgery and some outpatient clinics at the Queen Mary Hospital in Sidcup. This activity at the Queen Mary site is through a non-standard arrangement where the patient and the clinician from Lewisham and Greenwich Trust receive care in a tripartite arrangement with Lewisham and Greenwich Trust, Dartford and Gravesham Trust and Oxleas Trust. The trust has a plan to repatriate its activity from Queen Mary back to the Queen Elizabeth site. We visited all three site during our visit. Within this report we have included the Queen Mary activity as part of the Queen Elizabeth report, identifying where appropriate the site to which our comments refer.

We held meetings with the residents of the Lewisham and Greenwich NHS trust area in the weeks before our visit through facilitated focus groups. On the evening of our visit we held two public listening events, one in Lewisham and one in Greenwich, where those who use the services of the trust were invited to share their experiences of care with our inspection team. Approximately 40 people came to tell us their story. This was used by our team to inform and support their inspection visit.

Important note on use of data in this report

It is important to note that since the new organisation was created in October 2013, there is very little current data available that describes the new organisation. There are

Detailed Findings

data available for the previous organisations both for the University Hospital Lewisham and for the South London Healthcare Trust. Whilst these data give an indication of previous healthcare within these buildings; they must be used with caution when drawing conclusions on the new trust as they do not describe the current management and clinical arrangements that now exist.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We looked at a range of data and information, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. We recognised that the previous organisations (University Hospital Lewisham and South London Healthcare Trust) were higher risk; and so following disaggregation of SLHT and merger with UHL, using this model, Lewisham and Greenwich NHS trust was considered to be a high risk service.

How we carried out this inspection

In planning for this visit we identified information from local and national data sources. Some of these are widely in the public domain. We developed 115 pages of detailed data analysis which informed the thinking of the inspection team. The trust had the opportunity to review this data for factual accuracy, and corrections were made to the data pack from their input.

We sought information in advance of the visit from national and professional bodies (for example the Royal Colleges and central NHS organisations). We also sought views locally from commissioners and local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our thinking. We therefore held a well-publicised listening event on 25 February 2014. This was held before the inspection began and helped inform

the thinking of the inspection team. Over 40 local residents and service users attended the listening event, and each had the opportunity to tell their story, either in small groups or privately with a member of the inspection team.

We received information and supporting data from staff and stakeholders both before and during the visit.

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






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

The inspection team inspected the following core services:

- Accident and emergency
- Medical & Frail Elderly
- Surgical & Theatres
- Critical care
- Maternity & Family Planning
- Children's care
- End of life care
- Outpatients

Before visiting, we reviewed information we held about the hospital (although we recognised it was a new trust) and asked other organisations to share what they knew about the hospital. We carried out an announced visit to the trust on 26 to 28 February 2014. During our visit we talked with patients and staff from all areas of the hospital, including the wards and the outpatient department. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event for the trust where patients and members of the public were given an opportunity to share their views and experiences of all the trust locations. Further unannounced visits were carried within the following two weeks.

Accident and emergency

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

Information about the service

The Accident and Emergency (A&E) department at Queen Elizabeth Hospital (QEH) provides a 24-hour service, seven days a week, with the purpose of treating emergency patients. It was incorporated into Lewisham and Greenwich NHS Trust on 1 October 2013 following the dissolution of the South London Healthcare NHS Trust.

QEH is a large A&E department and, between October 2013 November 2013, 16,000 people attended. Of these attendances, 26 – 28 % were children under the age of 16.

We noted that the workload had increased substantially since the closure of the A&E service at Queen Mary's Hospital in 2010. We were told that this increase was around 50%.

The department has an urgent care centre area where people who walk into the department, and have minor injuries and illnesses, are assessed and treated by doctors and emergency nurse practitioners. This is staffed and managed by the Hurley Clinic partnership, not by the trust.

The department has a major injuries (Majors) area and resuscitation area. Those people who arrive by ambulance, via another entrance, are directed to the most appropriate department.

There is also a rapid assessment and treatment area and clinical decision unit (CDU). This is a consultant-led, nine-bed unit. People can be assessed, provided with pain relief and sent for diagnostic tests from the unit.

We analysed data and findings of other organisations (eg ambulance delays) to support our findings.

Summary of findings

Our inspection team spent one-and-a-half days during an announced inspection in the department at QEH. During this time we spoke with nine patients and five relatives about their experiences in the hospital. We also spoke with eight doctors and nurses of various levels of seniority, the porters, four members of the London Ambulance Service and one person who was working for the company contracted to provide cleaning services for the trust.

We returned, unannounced, the following week. This was a Saturday evening and we spent four hours in the department. We spoke with four other doctors, the nurse in charge and other nursing staff, the porters and security staff. We spent time with the triage nurse and spoke to several more patients.

We analysed data that were available to us, we used the findings of national surveys and used information from other agencies (eg ambulance handover delays).

We had serious concerns regarding the safety of A&E services. We saw issues with cleanliness, with use and disposal of clinical materials (e.g. needles) and with unsafe storage and disposal of clinical waste. this was raised with the trust management and dealt with on site. We saw lack of vital equipment (i.e. resuscitation trolleys) low staffing and lack of security.

During our visits we noted that the staff were kind, caring and respectful towards people. However, we saw that, at times, patient safety and wellbeing was compromised. At times, there were long delays in

Accident and emergency

people receiving treatment, admission or discharge. Staff acknowledged that there had been occasions when patient dignity and privacy could not be upheld and serious incidents had occurred.

We saw that information to help people who were not able to read or understand English was limited and complaints were not always responded to in a timely way.

We saw long waits for people and capacity issues that meant that a patient's progress through the service may be delayed.

We saw that there were some issues regarding staff shortages, although we were told that these were improving. The majority of the staff we spoke with told us that they felt positive about the merger with Lewisham Hospital and they could see improvements were beginning to be made.

We raised some concerns regarding infection control issues and also about the inconsistent way that information regarding serious incidents was disseminated to staff.

All of the patients we spoke with were very positive about their experiences within the department.

Are accident and emergency services safe?

Inadequate 

Safety in the past

There were 10 serious incidents reported from QEH for the period of October and November 2013. Considering that University Hospital Lewisham reported five serious incidents between December 2012 and November 2013 this figure is comparatively high. All of these incidents were around ambulance handover delays.

Learning and improvement

The minutes from Trust Board meetings reflected the discussions which had taken place about incidents that had occurred. The minutes relating to the part of the meeting open to the public were available on the trust website.

The matron of the department told us that reporting mechanisms had improved since the merger and they thought that staff felt they were listened to and supported more than they used to be. All of the staff was able to report any incidents of concerns they might have. We were told that information was shared via email or a newsletter. A senior doctor told us that there were weekly governance meetings at which concerns were discussed.

However, some of the staff thought that information was not always shared well. A nurse we spoke with said, "it's so busy here no one wants to stay behind afterwards to chat about things, we just want to go home". A more junior doctor told us, "we just get an email if something has happened. The senior consultant is good about that but I don't get an opportunity to discuss it".

Systems, processes and practices

Since the closure of the accident department at QMH in 2012, we were told that attendances had risen from around 300 to over 450 people per day. This included both adults and children. The department was finding it difficult to cope with this increased volume of patients. Space within the department was limited and there was a lack of available beds for patients requiring admission. The matron told us that ambulance personnel were frequently unable to hand over their patients in a timely manner and they remained on ambulance trolleys in the

Accident and emergency

corridors which meant that they could not be assessed properly. At times staff had treated patients in the back of the ambulance. We looked at information in the communication book and there were frequent entries regarding delays in treatment due to the large volume of patients attending the department.

All the staff we spoke with confirmed that, when the rapid assessment and treatment area was working it was much better; they were able to meet their waiting time targets and people did not wait unnecessarily. The area operates from 10am until 7pm Monday to Friday and from 1pm until 10pm at the weekend. This is the winter opening hours of this area. There were also nine cubicles, with beds, for use as a clinical decision unit (CDU). However, these beds often had to be used as additional space in order to observe patients waiting to be moved to a ward. At times this included overnight stays.

We saw that patients who were waiting to be assessed by doctors from other specialties such as medicine or surgery also waited in the department. At times this prevented people being brought in by ambulance from being transferred into the care of the department.

The department had attempted to be efficient with the use of their limited space to try and see treat and discharge patients more effectively. There was an area for patients who had less serious ailments or injuries which was staffed by doctors and nurses. There was also a seated area known as 'the grey chairs'. People who were assessed as being well enough were receiving treatment there. A nurse was allocated to the area. However, at both of our inspections we saw that patients, who would have benefited from being able to lay on a trolley or bed, were having their treatment sitting in a chair, in full view of other people. On the first day we inspected the department, we observed people who were in pain, vomiting, or receiving intravenous fluids sitting in this area. We had some concerns about infection control practices within the department. We observed that a paramedic who was on a training day in the department was not adhering to the 'bare below the elbows' guidelines. They were wearing a fleece with long sleeves throughout the day.

We noted that all of the patient cubicles had protective gloves available for staff, however, on our first inspection we saw that some hand gel dispensers were empty.

Staff toilets were sited in changing areas. At our first inspection visit we saw that they were not very clean; paper on the floors and the female toilet did not have a bin for used hand towels. By the afternoon, the male toilet was out of use because it was blocked. We were told that the toilet for people with disabilities was also blocked.

In the area where clinical waste was stored, yellow bins were overflowing. Porters who would need to move them could not have done so without handling the waste bags. However, they told us they were not able to access gloves that would protect them from injuries caused by inappropriately discarded sharps. There was also an extremely smelly and dirty wet towel on the floor. Staff were not able to provide evidence to show when the last infection control audit had taken place.

We brought our concerns to the attention of trust representatives who addressed them during the time of our inspection. Following our visit they provided us with evidence of their infection control audits.

Omissions in the records on the resuscitation trolleys did not provide evidence to show that they had been checked on a regular basis. We saw an undated memo confirming that checks were to be completed from 26/27 February. The bank nurse we spoke with was not sure what procedure had been in place prior to this.

The paediatric area had a high dependency area. However, should a child require resuscitation they would have to be taken through the main waiting area or the back corridor.

At our announced inspection we saw that equipment, including blood bottles and butterfly cannulas (winged infusion tubes), had been left in the corridor of the paediatric area. There were also plaster trolleys with scissors in open drawers.

We observed a nurse in the paediatric area place a bottle of medication on the waste bin, draw up an amount into a syringe and put it back on the bin.

There was no resuscitation trolley in the Majors area or the rapid assessment and treatment area. We were told that the results of a business case to address this were pending.

The matron told us that staffing levels and sickness rates had improved. However, the information we received

Accident and emergency

from the trust highlighted that there were still vacancies for 28.72 full-time equivalent nurses. However, the duty rotas showed that there was still a reliance on agency nurses. The children's department was fully staffed with appropriately trained staff.

We were told that there were also vacancies for four consultants and six junior doctors. The trust told us that a staffing review is currently underway.

Monitoring safety and responding to risk

Security measures within the department were very poor. We noted that one of the complaints the trust had received was regarding an elderly person with cognitive impairment who had managed to leave the department unnoticed. The trust's intention was to fit keypad access to the ambulance doors to prevent a reoccurrence. However, we were able to wander freely throughout the department without needing a keypad code or a swipe card. At our unannounced inspection, we spoke with a security guard. They told us that there were six of them on duty for the hospital, however, none of them had had training about restraining mental health patients. They told us, "we just do our best".

We also noted that security from the waiting area into the treatment area in the paediatric department was not ideal. The main door was wedged open, giving open access to patients waiting to be seen in the cubicle area. The door to the back corridor was also open. We were concerned that this might have compromised the safety of children in the department.

Staff told us that they had all received training regarding the protection of both children and vulnerable adults and they were able to tell us who the safeguarding lead for the trust was.

The department's matron told us that those people who were judged as being susceptible to the formation of pressure sores, due to their frailty or comorbidity (having more than one disease), were moved on to pressure-relieving mattresses as soon as possible to try and minimise the risk. We saw that beds were brought down to the department for them.

During our evening visit we spent some time with the triage nurse. We observed safe practice in a prompt and timely way, within 15 minutes. However, staff admitted that often this 15-minute guideline could not be met.

Anticipation and planning

There were escalation procedures in place to alert senior staff when the department became exceptionally busy. We were told that, as soon as the first ambulance breached the target waiting time, an alert was raised. However, a comment we received was, "we tell the service manager and the information is noted, nothing really happens though because nothing can". Staff all cited the limited bed capacity throughout the hospital as making the discharge of patients from the department very difficult.

There was a major incident plan in place and staff we spoke to were familiar with the procedures to follow. We were told that the plan had recently been revised.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate 

When we visited the department, on each occasion we raised concerns about the flow of patients through the department. A high number of patients and insufficient bed capacity led to delays in treatment and admission.

Evidence-based guidance

The audit results we have relate to QEH prior to the merger with Lewisham NHS Trust. However, the doctors we spoke with told us that they had developed good ambulatory pathways for deep vein thrombosis (DVT) and cellulitis (skin infection). There was also a 'fast track' for people with a fractured neck of femur.

The consultants we spoke with told us that they followed National Institute for Health and Care Excellence (NICE) guidelines for the care pathways in the department. They had undertaken various audits to monitor and improve care for patients and had developed good ambulatory care pathways for deep vein thrombosis (DVT) and cellulitis (skin infection) patients which prevented unnecessary admission into hospital.

Monitoring and improvement of outcomes

The consultants we spoke with were aware of results of the audits that had been undertaken. They told us that measures were being undertaken to improve their results

Accident and emergency

and local audits were producing good results. Both doctors and nurses told us that they didn't think that patients waited for very long before getting pain relief, as long as the rapid assessment and treatment area was operating. Nurses working in the resuscitation area said analgesia was given promptly as the patient was assessed. We saw that it was prescribed as part of the initial process within the area.

Sufficient capacity

We looked at staffing rotas to see if enough staff were available in the department to meet the needs of the people who attended. The College of Emergency Medicine acknowledges that there is currently a general shortfall of emergency medicine consultants. Their recommendations are that all emergency departments should have a minimum of 10 full-time equivalent consultants in place. For larger departments, their recommendations are that there should be up to sixteen consultants. This would allow a greater level of cover. However, they say that for this to be achieved, there would need to be a programme of consultant expansion.

Are accident and emergency services caring?

Good 

Staff within the department demonstrated professionalism, compassion and respect for patients. People were treated with kindness and they were kept informed about what was happening and involved in discussions regarding their care.

Compassion, dignity and empathy

On the NHS Friends and Family Test, the A&E department had a poor aggregated score (between October 2013 –December 2013) of 41 and response rate of 6.8%, which highlights that patients aren't very happy with the care they have received and that they could also be doing more to encourage patients to respond. However, a poster outside the triage area showed that, out of 2,750 people surveyed, 88% of them had been happy and would recommend the department to their friends. There was no date on it.

All of the people we spoke with during our inspection provided us with positive feedback. They told us that staff

had been "very friendly", and "very kind". One person commented "it's a brilliant service, everything is excellent". Another person who had been in the department before told us, "it's improving; we're very happy. People told us that staff had asked if they would like a drink and two people confirmed that they had been offered a meal. During our evening visit we saw that one person had been made comfortable in bed. They told us, "I had a moan, I was really uncomfortable so they brought this in. It's lovely I'm really cosy now".

Those people who had taken children into the paediatric area all spoke positively about the experience. We saw that it was a well-designed well-managed and well-equipped department and ensured that children were seen by appropriately skilled staff. During our evening inspection it was extremely busy in the paediatric department. However people waiting said that staff were "efficient" and "being as quick as they can".

Involvement in care

All of the people we spoke with confirmed that staff had kept them informed about what was going on. Those people waiting for results of blood tests and x-rays understood why they were waiting. They said that, where there had been choices to be made about how they were treated, they felt included in the decision-making process. One person told us, "Staff are good, I'm waiting for some blood tests to come back; my only hold-up was at x-ray, it was very busy and the doctor came down to check that I was alright, as I was so long".

Trust and respect

We observed that people were treated with respect and dignity. Individual cubicles had curtains around them and staff pulled these closed when they spoke to people. We heard staff introduce themselves and address people politely.

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

Inadequate 

The department was below target in meeting waiting times, particularly for elderly people or those requiring admission.

Accident and emergency

We did judge that the relative's room required improvements. We were told of a plan to refurbish this. People wishing to see deceased patients would have had to walk through the department and may not have been able to see them in private.

The department frequently experienced capacity issues. Serious incidents had occurred within the department because of the poor flow-through of patients. The process for learning from serious incidents did not always seem to be robust.

Information and signage within the department was not sufficient for people who were unable to understand English.

People's complaints were not always responded to in a timely manner.

Meeting people's needs

Trusts in England are tasked by the government to see, admit or discharge 95% of their patients within a four-hour target time. Waiting times at QEH in the months October–November 2013 showed that only 83–85% were being seen within four hours. In Admitted patients were consistently waiting more than four hours. Only 60–65% of admitted patients were seen within four hours, which means that QEH has lower bed capacity than University Hospital Lewisham (UHL) – where around 75% are admitted within four hours.

In addition, CQC 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) rated the trust as a 'risk' for A&E waiting times from October–December 2013 via the CQC Tier 1 risk indicator, which agrees with this analysis. An analysis of attendances against waiting times suggest that waiting times weren't because of the A&E department itself, but rather an issue of capacity in the rest of the hospital.

An analysis of patients 'post decision-to-admit' confirms that 20% of patients at the trust overall, were waiting four to 12 hours for a bed. Also, many ambulance handovers were delayed by more than 30 minutes at the trust, sometimes 40 in one day – this agreed with the high numbers of ambulance delays that QEH has reported as

serious incidents. This was because there weren't enough available beds for patients in the A&E departments (possibly due to the fact that patients were waiting in beds to be admitted to other wards).

The senior nurse in the department on the day of the inspection told us that, since the dissolution of South London Healthcare Trust and the closure of Accident and Emergency services at Queen Marys Hospital, attendances had increased significantly. This had led to increased patient waiting times and had put extra pressure on staff.

Too many patients were waiting more than four hours to be seen, too many ambulance handovers were being delayed and a lot of patients were waiting over four hours for admission, which means problems with pathways and bed capacity. This was supported by staff we spoke with. All of the staff told us about the lack of beds available for people once they had been assessed as needing admission. They said that they also experienced problems with numbers of patients waiting in the department who had been referred by their GP.

Staff we spoke with explained that the patient flow through the department was often difficult. Attendances were very high and patients who had been sent in by their own GPs for an assessment by a surgeon or physician were also sent through the department. One of the senior doctors explained that, if these patients were thought to definitely need admission, they were able to start the process and send them to the ward. However, bed capacity within the hospital was often limited. When we looked in the communication book, there were several references to the lack of empty beds throughout the hospital. This meant that patients were often not able to be moved out of the department.

Nurses in the triage area were able to refer some patients directly to a particular specialty, such as the early pregnancy unit under an agreed protocol. There was access to an alcohol liaison nurse specialist. For those people presenting with mental health problems there was a psychiatrist and psychiatric liaison nurse on call. The psychiatric unit in the hospital was managed by another care provider. There was a section 136 unit, allowing mental health patients to be detained for their own safety, on the site so that people could be assessed, however, most of the time the psychiatrist

Accident and emergency

came over to the department. When we undertook our unannounced visit in the evening, we noted that several patients had needed a referral and were told that the psychiatrist had been in the department all evening.

There was a dedicated 'relative's room'. However, it was very stark and uninviting. The only seating was hard plastic chairs. There was no viewing room linked to it. This meant that distressed families had to walk through the main department to see a deceased person and they might not have been able to see them in a private area.

A family told us they had to sit and wait in A&E in the triage area because there were no cubicles available, even though their child needed to be admitted. Parents did speak highly, however, of the paediatric staff in A&E.

Distressed relatives were also seated there as the designated relative's room was occupied. We judged this arrangement was compromising people's dignity and privacy and there was also a potential risk from seating unwell people in this area.

The room designated to see patients with gynaecological concerns had a door and we saw that doctors and nurses knocked prior to entering. However, it was pointed out to us that it was not possible to fit a couch in this room so its usage was limited.

On both occasions when we visited the department we noted that many of the patients were from ethnic minority backgrounds. However, there was very little in the way of information for those people for whom English was not their first language. In the main waiting area there was no information to tell people that they should approach the receptionist at the desk before sitting down. All signage was in English. We noted there were no vending machines or facilities for people who were waiting to get a drink. Seating was not very comfortable and, on the first day we visited, we saw that there was a broken seat with a sticker on saying that it had been condemned some time previously.

Vulnerable patients and capacity

There was one room in the department specifically for patients with mental health concerns.

There appeared not to be any particular mechanisms for addressing the needs of people with cognitive impairment. During our first inspection, we observed an elderly person, who appeared to have dementia, wandering round the department and into rooms.

The paediatric department had a play area to keep children amused. We asked staff about how they would support people with particular needs. For those people with physical disabilities the department had a hoist to help transfer them from the ward. Toilet facilities had adaptations to help those with limited mobility. Nurses we spoke with admitted that caring for people with dementia was sometimes challenging if the person was not accompanied by a relative or another staff member. They said that, where people came from a residential setting, the standard of the patient information was variable.

Access to services

People who walk into the department were registered by a receptionist prior to being prioritised or triaged by a trained nurse. Many of these nurses had additional qualifications as a nurse practitioner. After an initial assessment, patients would be directed to the urgent care centre, or asked to wait until they were called into the most appropriate area for a full assessment and treatment. The nurse was able to request an x-ray if it was thought to be necessary.

Leaving Hospital

When people were assessed as being able to return home with support, in particular the elderly, staff told us that they liaised with community care managers, occupational therapists and physiotherapists. However, this was made difficult by the fact that the catchment area covered three different local authorities, each with its own clinical commissioning group. We were told that this was sometimes compounded by the fact that a patient may have an address in one local authority and a GP in another.

Learning from experiences, concerns and complaints

We asked staff in the department about the complaints process. They told us that they were able to resolve many complaints within the department by talking to people and explaining what had happened. Where people wished to make a formal complaint they were given the

Accident and emergency

details of the Patient Advice and Liaison Service. We saw that leaflets promoting the service were available at the reception desk, although they were not very evident. There were no posters explaining the process.

A&E received 35 complaints during the period 1 October 2013 to 30 January 2014. The majority related to clinical treatment, although some related to staff attitude and communication. Less than 50% of the complaints received were responded to within 25 working days and eight were still in progress. The trust was also able to provide us with details about the outcome of the complaints and, where the complaint had been closed, the measures that were taken in order to minimise any reoccurrence.

Are accident and emergency services well-led?

Requires improvement 

Although staff acknowledged the issues within the department, all of them were optimistic about the future. They said they felt supported by senior staff and were listened to. They told us that opportunities for training had improved and they had been provided with extra equipment. We have no data from our Intelligent Monitoring system relating to this area. All of our available data relates to the time prior to the merger.

Vision, strategy and risk

The trust published their vision for the future on their website. It explains that they intend to unite services and staff in Lewisham and Greenwich to build on what they do well. They state that this will ensure that they meet the needs of demographically challenging, diverse and rapidly growing local populations.

We were able to see examples of the trust being involved in forward planning such as work around 'winter pressure'. This had resulted in extra money being made available to cope with the need for increased resources through the winter.

Quality performance and problems

All reported serious incidents were investigated, although the methods for learning about incidents did not always

seem to be robust. Some staff told us that they were informed about incidents that had occurred, while others said they had not. All of the staff we spoke with were positive about the good team work in the department. We heard that there was "good teamwork" and "senior support".

All of the staff we spoke with talked about capacity issues. They told us of patients waiting for up to 12 hours on trolleys and times where patient safety had been compromised because of this.

Leadership and culture

Both doctors and nurses in the department told us that they felt supported by the senior staff within the department. They were positive about the merger with Lewisham and said that they were beginning to get more equipment and that staffing levels had increased. They said they thought they were listened to more now and they felt more optimistic about the future.






Patient experiences, staff involvement and engagement

We saw that there were NHS Friends and Family Test questionnaires, to determine patient feedback on whether they would recommend hospital wards to others, in each area of the department and a box on the wall for completed surveys. Some of the nurses told us that they were encouraged to give them out to patients. We were told that the Patient Advice and Liaison Service team had increased and there was now a team dedicated to looking at the patient experience. Matron told us that the department was now beginning to receive 'thank you' and compliments letters which were shared with staff.

Learning improvement and sustainability

Staff told us that joint working with Lewisham hospital was increasing. There had been management meetings to discuss the capacity problems and they were able to escalate their concerns now on a daily basis. The matron told us that, although there were still some issues with staffing levels among nurses. Nurse training had been improved. The department now had a practice development nurse who worked with her counterpart at Lewisham hospital. Training for nurses had increased, with mandatory training being undertaken in one-week blocks.

Medical care (including older people's care)

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

Information about the service

We visited medical care (including older people's care) at Queen Elizabeth Hospital over two days. In total we visited ten wards, including Wards 1 and 2 (Acute Medical Unit - AMU), Wards 12, 20, 15a, and 15b (older people's wards), Ward 3 (Stroke Unit) Ward 4 (Cardiology and Coronary Care Unit - CCU), Ward 14a (Respiratory Ward), and Ward 14b (Endocrinology Ward). We also visited the discharge lounge and the pharmacy.

We spoke with a total of 16 patients, nine visitors, reviewed 15 patients' nursing and/or medical records and spoke with 43 staff from a wide range of disciplines.

Summary of findings

There was a mixed response from patients regarding their care and treatment at QEH. Some comments praised the staff, including that their privacy and dignity was maintained and that things were explained to them in terms they could understand. However some patients had very negative experiences, with staff being dismissive and not taking into account the patient's needs.

Data we received before our inspection suggested that there were concerns with how safe the hospital was. There was limited learning and improvements taking place at QEH. There were times where basic safety requirements such as observations, assessments and reviews were not being followed. Staffing levels were a concern across both doctors and nursing. Planning was conducted at varying degrees across QEH with different levels of detail.

QEH could improve the effectiveness of its care and treatment. Patients did not always feel they received care when they required it with varying amounts of standard clinical support and sometimes a lack of joined up specialist input.

Care and treatment at QEH was not always responsive. There was normally a lack of bed capacity at the hospital despite escalation wards being utilised. Patients were regularly at hospital for longer than they required as different patient pathways were not evolved to improve the time that patients moved onto a specialist ward. Well planned discharge arrangements

Medical care (including older people's care)

were in place in most cases but there were times when the system failed. Patients who were vulnerable who had additional non-physical needs did not always receive the specialist support they required.

Medical care was not always well-led. Although staff felt well supported, their workload meant they had low morale. Performance was monitored but there was sometimes a lack of comparison cross wards or trust. Training was highly regarded and protected.

Are medical care services safe?

Requires improvement 

Learning and improvement

The trust had systems in place to report and monitor incidents, including near misses, incidents that resulted in harm, Never Events and allegations of abuse. We found the trust had appropriately reported incidents when they had occurred.

Staff used the trust's online reporting system to report incidents, and we found evidence that the trust collated this information and fed back to senior staff any trends or ongoing concerns so that improvements could be made. Various meetings were held to review incidents and other patient feedback (such as complaints) involving a range of senior staff, including ward manager meetings and department meetings. The ward meeting records we saw showed that only incidents that had occurred on medical wards within the QEH were reported to floor-level staff at ward meetings. This meant that there was not shared learning from incidents across the trust.

Systems, processes and practices

We checked a sample of patients' nursing and medical records. Some of them showed appropriate assessments and checks had been completed such as VTE, falls risk, MRSA, do not attempt resuscitation (DNACPR) records and modified early warning scoring (to determine a patient's level of illness) with reviews and relevant prescriptions or equipment (such as no-slip socks) were supplied. However, some records showed these assessments had either not been completed or not been reviewed as required.

Wards were required to report clinical indicators on a daily basis which audited various aspects of the ward, such as if the resuscitation trolleys had been checked, whether any bays were mixed-sex, if falls and the five-step malnutrition universal screening tool assessments had been conducted, whether patients had acquired or were admitted with pressure sores, how many patients required support to eat, and if any patient had an nasogastric tube in situ. However, we found these assessments were not always fully completed.

Some of the medical records we checked, although clearly written, had loose sheets in them. We were told that these

Medical care (including older people's care)

were temporary records used on a patient's admission until the ward could obtain their permanent records. We were told this could sometimes take 24 hours, but we saw some loose/temporary records that had not been put in the permanent records within three days.

As part of this inspection we looked at the medicine administration records for 12 people on three wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed that people were getting their medicines when they needed them, there were no gaps on the administration records and reasons for not giving people their medicines were recorded. If people were allergic to any medicines this was recorded on their medication administration record chart. This meant people were receiving their medicines as prescribed.

We saw medication was stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. Controlled drugs were stored and managed appropriately.

Monitoring safety and responding to risk

We saw that patients who required isolation or who may be an infection risk were placed in a side room with appropriate signage to show why. Patients who were assessed as needing additional equipment, such as low-rise beds, bed rails and air mattresses, received them, although, on one ward staff told us that there was a shortage of bed rails.

Most wards we checked showed both staff, and patient-to-staff ratios gave concern for staffing levels. Wards were sometimes able to follow staffing level guidance by having a ratio of 1:2 registered nurses to patients who were considered high risk and 1:6 for patients on medical wards during the day. However, on both our inspection days, and in last two months, a number of wards had ratios of 1:10. This was due to existing staffing vacancies and either bank (overtime) or agency staff not being available to fill shifts. In addition, most staff said, and staffing rotas showed, that the number of vacancies and reliance on using bank and agency staff (who were not always available) meant wards were sometimes short staffed. At the weekend, there were two consultants on call during the day and one overnight, one specialist for the AMU and one general medicine consultant. One registrar, one senior house officer, were on-call.

There was an ongoing investigation into the pathway management of one patient with an upper gastrointestinal bleed. It was clear that there was no appropriate pathway for either managing these patients at the hospital, or transferring them elsewhere for care. Staff told us a new gastrointestinal bleed service would be set up in the future.

On each of the wards we visited, we checked the suitability and safety of equipment and the environment. Resuscitation trolleys on each of the wards had been checked on a daily basis and personal protective equipment was available outside each bay and side room. All the areas of the medical wards we checked were clean and tidy and patients confirmed this was the case. However, in some wards, hand hygiene facilities were not always ideally accessible. In two wards, there was no hand hygiene gel directly inside or outside the ward area. We were advised (and observed) that staff had personal hand gel with them at all times due to the dispensers being emptied by patients. Although all the patient bays and rooms had hand-washing facilities, one did not have a bin underneath which meant staff had difficulty in disposing of the hand towels after drying their hands.

Many patients told us they felt there was a lack of staff as call bells were not being answered promptly at times. However, on the day of our visit, we observed call bells being answered quickly.

Anticipation and planning

Patient boards were in place in all the wards we checked. However, they varied in quality. The AMU had a clear board showing patient names, their clinician (including their medical specialty), their condition, with colour coding to show whether they were near discharge or transfer to another ward. The AMU had a meeting every morning to review each patient, and determine which consultant or doctor treating patients in the wards was required to attend, in some areas social services input was evident. However, other boards were not as comprehensive. None of the other wards we saw had the AMU colour-coding system. The notes on other boards were not as clear to show whether a patient was near discharge or transfer. Only some ward boards showed whether a patient had an additional risk such as dementia, requiring support for food or at risk of falls.

Handover in AMU and Ward 3 took place both verbally and was recorded centrally in writing with updates on the patient's diagnosis, estimated discharge date and any

Medical care (including older people's care)

changes or issues, such as new infections or tests planned. However, some other wards only had verbal handovers with notes in each individual patient's notes which meant there was a risk staff would not be fully aware of patient changes since their last shift.

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

Not sufficient evidence to rate 

Due to the recent dissolution of South London Healthcare Trust there were not enough current data to reliably rate this service.

Evidence-based guidance

The trust's policy for the nutrition of patients did not meet NICE guidance as there was no access to a nutrition nurse and no audit of central line sepsis (due to use of central venous catheters). We checked the naso-gastric tube and falls protocols and these conformed to national guidance. We spoke with staff about national guidance relating to bed rails, nutrition, and they were able to tell us the protocols they needed to follow. However, when we asked staff for the bed rails assessment procedure, they were unable to find it for us.

Ward rounds were conducted in AMU twice daily during the week to ensure all patients were seen within 12 hours, which follows both national guidance and trust policy. An AMU consultant was available at the weekend and we were told that any patient admitted over the weekend was reviewed by one of the on-call team in a timely manner. However, ward rounds on other wards were conducted less frequently, with some only twice a week, despite a recommendation that these should be increased. Ward rounds at the weekend were nurse-led so any changes to a patient's condition which could either delay or bring forward their discharge date and time had to be fed back to an available doctor to review the patient's discharge plan.

The trust had a set of hospital forms which listed medication the pharmacy stocked, with guidance on prescribing. This was used to promote rational, cost-effective prescribing and any amendments to the

forms had to be approved by the drug and therapeutics committee. We saw that this information set, along with the trust antimicrobial prescribing guidelines, was easily accessible to all staff via the trust's intranet.

Monitoring and improvement of outcomes

We saw the trust had responded to the 2010 National Patient Safety Agency rapid response alert, 'Reducing harm from omitted and delayed doses', by doing yearly audits to check how doses were omitted or delayed and what proportion of these were on the critical list (drugs that should be administered as soon as possible and, at the latest, within a maximum of two hours from prescription).

Sufficient capacity

Most of the patients we spoke with, and the medical notes we saw, confirmed that patients were treated by staff who specialised in their condition. This included patients treated in the AMU, as consultants would take on those needing specialist treatment even if there was no capacity on their specialist ward, and would treat them in the AMU until they were either ready for discharge or capacity became available in their ward.

Multidisciplinary working and support

Multidisciplinary working was conducted across all the wards at varying levels. The AMU had cross-specialty working, including social workers attending on a daily basis. However, we were told they did not receive as much input from elderly care or urology specialists but did have access to on-call endocrinology and liver teams. It was reported that there was a lack of multidisciplinary input into specialist wards, particularly from consultants, although some specialist wards did have weekly multidisciplinary meetings.

Some patients reported that there was a lack of access to certain specialists and lack of communication between different specialist clinicians. One patient told us that they had been admitted with a blood condition but only seen a haematologist twice in nearly a week and that their doctor did not seem to be aware of the haematologist's opinions.

Medical care (including older people's care)

Are medical care services caring?

Requires improvement 

Compassion, dignity and empathy

On the NHS Friends and Family Test in December 2013, Wards 1, 3, 14, 15, 16 and 21 scored below the trust average, with a number of wards having a response rate of less than 10%.

Most complaints at the trust related to communication between staff and patients. There were aspects of care we heard and observed that were not empathetic. One observation we saw on Ward 16 was a doctor refusing to give information to a relative and told them that they would have to attend the ward to receive any information. Another patient told us that, although they were happy with most of their care on ward 14a, they felt one nurse on the ward was 'dismissive' and they did not feel they got personalised care on Ward 2 of the AMU. One patient in the AMU told us that they had been given their commode during breakfast and another said the attitude of one of the night nurses was poor as the nurse was unsympathetic with the pain they were in. Two patients on Ward 20 and another on Ward 15b complained to us about other patients in their bay screaming or in delirium but staff did not do anything about it and did not take these patients to side rooms.

However, there were some patients we spoke with who gave a positive experience of the dignity and empathy they received from all staff, including being introduced by name to their consultant. Whenever we observed a staff member discussing treatment with a patient, the curtains were pulled round and these fully covered the whole bed area. Although patients told us it could be cold when transferring to get an x-ray, they said they were given a blanket to keep them warm.

Involvement in care

Some patients and relatives told us they felt they had not been involved at all, or not enough, in their care. One family on Ward 14 told us they had not seen a doctor since their relative had left A&E over two days before and had not been informed about any of their care and treatment. Some patients were unaware of who their doctor was and how they were being treated, although some of these patients had dementia or confusion. One patient told us they were unaware of their discharge plan. However, most

of the patients we spoke with told us that they were involved in their care. They told us their condition and treatment were explained to them in a way they could understand. One set of relatives on Ward 14 told us that a doctor had come to see them when they requested. Another patient in the AMU told us that they were asked to swap beds and given the reason why by staff. Most wards had 'thank you' messages and compliments on a noticeboard.

Most of the patients we spoke with were happy with the food and the choice they were offered. One patient in AMU told us the food had 'improved' since they were last admitted to the hospital. However, some patients told us that the Caribbean food offered was very 'samey' and not varied. One patient in AMU told us that they sometimes did not get their choice because not enough of each choice was cooked, despite being asked earlier in the day what they wanted. Another said they did not get tea in the morning. One patient on Ward 14a told us that they had been promised occupational therapy and physiotherapy but had not yet received it despite being admitted over six weeks earlier.

We saw that patient information leaflets were available on every ward. These included how to contact the Patient Advice and Liaison Service, how to make a complaint, information of conditions specific to the specialty of the ward, hand hygiene, carers' support and norovirus (or winter vomiting bug). Some of these were also available in other languages. However, some of these leaflets still had the old trust name and so had not been updated since the new trust was formed in October 2013.

Some of the records we checked showed that the family had been involved in any do not attempt resuscitation (DNAR) decisions. However, there were also a number where this had either not been completed fully or there was no written evidence of the family involvement. This meant that there was a risk of patients receiving inappropriate care.

Trust and respect

Most of the patients we spoke with told us that they trusted the staff looking after them and that they were treated with respect. Each patient had a dedicated nurse and doctor whose names were displayed above their bed. However, as

Medical care (including older people's care)

most patients from A&E came through AMU, there was a risk that the staff dedicated to them would change as patients were likely to be transferred to a specialist ward if they were not discharged directly from the AMU.

Emotional support

Most patients we spoke with told us that they felt they were being treated safely. All the wards we checked had a day room or relatives' room so patients or their relatives could see staff in private.

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

Requires improvement 

Meeting people's needs

Average length of stay was higher than the national average across the hospital and we spoke with a number of patients and viewed records where patients had been admitted nearly two months prior. Most of the wards we checked were at 100% capacity or were due for patient admissions to bring them up to 100% capacity during the day we inspected. In the last year, except for one month, the hospital averaged over 90% capacity with a yearly average over 95%. National guidance suggests that quality of care could be affected if capacity is above 85%. Some wards were using day rooms for patient beds and the winter pressure wards were open when we inspected. We were told this was the case at all times other than three months during the summer. Due to the lack of bed spaces on specialist wards at QEH, patients were not moved from the AMU within the recommended 72 hours around 50% of the time and the number of patients in A&E waiting between –four and 12 hours between decision to admit and admitting to a bed was below the national average. Bed management reports from the last three weekends also showed at least six patients were at risk of waiting more than 12 hours to be admitted unless they converted their rapid assessment and treatment area to a clinical decision unit (CDU). This meant some patients were discharged from AMU without receiving the specialist ward support they needed. Modelling by the trust showed they were short of up to 70 beds at QEH, particular for frail elderly patients.

We viewed the bed management reports for three afternoons of the last three weekends. These showed that there was a constant use of escalation beds, including a number of beds at QMH which are run by another trust. This was despite low A&E attendances at the time of reporting, compared to what the hospital expected. There were also two occasions where they considered converting the rapid assessment and treatment area into a CDU. This was due to a lack of capacity in the medical wards because of a low amount of discharges and a possible breach of the 12-hour wait for a bed. Although we were told that they do consider using University Hospital Lewisham (UHL) for patients, none of the bed management reports showed they were being used for escalation, although UHL bed capacity was either rated amber or black at the time, suggesting shortage of capacity.

Access to services

Visiting hours were advertised on most wards we visited. Wheelchairs were available on all the wards we visited for people with poor mobility.

The trust was above the 92% standard for 18 weeks between referral and treatment in medical specialties. This means patients were being treated within expected timelines.

We saw evidence that all new patients admitted onto AMU were allocated a consultant at 11am each morning. However, other wards only had ward rounds twice a week.

Most care pathways meant patients who came through A&E were placed in the AMU before being transferred to a specialist ward or being discharged. We saw a number of patients who did not require acute care and so could have been transferred straight to a specialist ward. For example, one patient who had severe asthma, was in the AMU for nine days before being transferred to the respiratory ward. The hospital was recommended to prioritise AMU patients for transfer to specialist wards but staff told us that if the patient stay was unlikely to be lengthy, staff liked to keep patients in AMU as they were able to discharge them quicker than specialist wards. Staff informed us that they were developing pathways to bypass the AMU, such as when a patient has chest pain that is not severe and can be transferred straight to the cardiology ward. However, this pathway had not yet been fully implemented.

Pharmacists visited all wards each week day. We saw pharmacists completed the medicines management

Medical care (including older people's care)

section on the medicines administration record for every patient to confirm medication reconciliation had occurred. An audit in December 2013 showed that 72% of patients had their medicines reconciliation completed within 24 hours of admission to the hospital.

The AMU had a satellite pharmacy and a team of three pharmacists, two technicians and an assistant technical officer which meant medicines reconciliation and lists of drugs to take out were completed in a timely way. The officer based on AMU had a site-wide role to facilitate the provision of medication to take out for patients waiting to be discharged. We were told by the nurse in charge of the discharge lounge that they found this service very useful as they could page the assistant technical officer who would help sort out any delays around medications.

Vulnerable patients and capacity

Safeguarding information was displayed on most of the noticeboards in the wards we checked which included how to report and refer a suspicion of abuse to the relevant hospital safeguarding team.

Although there were wards dedicated to providing care to people with dementia, staff on the wards told us that they had received no dementia training (although one member of staff told us the training had been booked). We were told that there was a dedicated dementia nurse at QEH but they were currently on maternity leave.

Patients who required support with eating their food were highlighted by using red trays. Although we observed patients receiving the support they needed to eat, staff told us this was hard to do in a timely manner due to both staff and volunteer shortages.

Leaving hospital

Although there were discharge coordinators across the hospital, only three were available across all hospital sites. This meant a lot of discharges were nurse-led. The hospital mainly discharged to two local authorities which had different referral forms, both of which were lengthy. As the nurse staffing levels were low in many areas, with a heavy reliance on bank (overtime) and agency staff who may not be familiar with local discharge and referral arrangements, there was a risk that this resulted in patient discharge delays and an overall high average length of stay. Although the AMU discharged around 350 patients a month and was

due to either discharge or transfer patients within 24 to 72 hours on admission, this only occurred on around 50% of occasions, despite a recommended target of 65% for patients over two days' stay.

All wards on the QEH site had patient-own drug lockers so "one-stop dispensing" could be done. This meant patients had a reduced wait for their take-home medications and this was confirmed by the pharmacy scorecard which showed that, on average, 90% of urgent discharge prescriptions were completed in less than two hours.

All patient records we saw had a discharge plan with an estimated date for discharge. This was reviewed and updated on ward rounds to reflect the patient's condition. However, we saw on one patient's medical record that their discharge planning would be triggered by the next day's ward round as there was no doctor's round on Sunday; this would mean that discharge would be unnecessarily delayed.

Learning from experiences, concerns and complaints

Staff used the trust's online incident reporting system to report incidents, and we found evidence that the trust collated this information and fed back to senior staff any trends or ongoing concerns so that improvements could be made. Various meetings were held to review incidents and other patient feedback (such as complaints) involving a range of senior staff, including ward manager meetings and department meetings. However, only incidents that had occurred on medical wards within the QEH were reported to floor-level staff at ward meetings.

Are medical care services well-led?

Requires improvement 

Quality, performance and problems

There was a persistent problem of over reliance on temporary notes. We saw no action to deal with this challenge.

Governance arrangements

Clear governance arrangements were in place on all the wards showing who was responsible for investigating incidents.

Medical care (including older people's care)

Leadership and culture

Matrons led each specialty such as cardiology, AMU or elderly care. Each ward was managed by a ward manager.

Although most staff told us that they felt well-supported and that there was a good team ethic in each ward, they felt overworked and understaffed and so had a low morale. Junior doctors told us that there was an over-reliance on locum consultants, particularly at the weekend, and locums did not give them quality support.

There was a culture of training at the QEH. Most staff told us that training was embedded in the trust and that internal training was scheduled during protected time for staff so it was not part of a shift on the ward.

Patient experiences and staff involvement and engagement

We were told the executive team had an open meeting once a week where staff could receive feedback on how the trust was performing and any changes coming forward. This also allowed for staff to provide feedback to the executive team on any concerns they had. However, when we requested 'exit interview' information from the trust,






which should show one-to-one interviews with staff about the reasons they have left, we were provided with surveys that were sent to staff after they had left. This suggested there was a risk that the trust was not fully aware of the reasons staff were leaving, as a minority of staff will have completed a survey.

The last complaints report we could access was for November 2013. This showed that the directorate which covers medical wards received the most complaints and the second-highest amount of Patient Advice and Liaison Service concerns mainly related to communication and information or treatment. The report gave examples of the types of complaints received and the outcome of their investigation, with a summary of any learning, such as additional staff training needed.

Learning, improvement, innovation and sustainability

Staff told us that they received feedback on any complaint and incidents investigations concerning their ward and this was clear from the ward minutes.

Surgery

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

Information about the service

QEH has seven theatres providing both elective and emergency surgeries including; gynaecology; obstetrics; orthopaedic; colorectal; and urology. There is also a day care unit, endoscopy unit and a surgery discharge lounge. There are three surgical wards.

The trust also made use of surgery facilities at the Queen Mary's Hospital (QMH) at Sidcup to provide elective surgery services for adult patients from QEH. These facilities included seven theatres, an admission unit, a day care surgery ward and a short stay surgery ward. The facilities were shared with the Dartford and Gravesham NHS Trust and staffed by employees from both trusts. Plans were in progress to transfer the Lewisham and Greenwich NHS Trust staff and surgery services to the University Hospital Lewisham (UHL) site within the next year.

A key part of the trust's transformation programme was the creation of an elective surgery centre at the UHL site by 2016. Plans were in place and approval had recently been given for the first phase which included orthopaedic surgery. This would require the relocation of some surgery services currently provided at the QEH and QMH sites and there were plans to develop the QEH theatres primarily for emergency surgery. We were told that day care services would cease at QEH and be moved to UHL. The day care unit would be re-configured to enable expansion of the endoscopy unit and other potential uses, for example, the set up of a surgical assessment unit. Decisions on this, including the timescales and impact on staff, were part of the ongoing planning process.

Our inspection team spent one-and-a-half days during an announced inspection in the department at QEH. During this time we were able to speak with 12 patients and 15

staff, including senior and junior medical staff, senior and junior nurses, care assistants, therapy, phlebotomy and domestic staff. We visited the theatre areas, day care unit, recovery and discharge lounges, and the three surgical wards.

We spent one day at QMH the following week. We spoke with three patients and eight staff, including theatre managers, senior and junior nursing staff and theatre staff. We visited the theatre areas, the admission unit, day care surgery ward and the short stay surgery ward.

We returned to the QEH day care unit, unannounced, two weeks after the initial inspection. We spent five hours there. We were able to speak with the matron, sister, a senior nurse, care assistant and theatre operations manager. We spoke with two more patients and two relatives of another patient.

At all hospitals, we observed care and treatment and looked at records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed the performance of the service.

Surgery

Summary of findings

People we spoke with during our inspection were mostly positive about the care and treatment they had received. They were complimentary about the staff in the service and felt informed and involved. One person told us, “I would recommend the ward to my friends and family”. Another person said, “The nurses are very busy but always smile and take time to cheer me up”. Some people, however, raised issues about communication with staff and involvement in their care and we were told of, or observed, instances where patients’ needs were not being met. In particular, on one ward, there were not enough staff to provide the levels of support needed.

Over a period of time the services provided by the QEH day care unit had changed to the extent that it no longer functioned solely as a day case service. The unit now also provided an inpatient service for patients waiting for surgery and some medical patients who were accommodated in the unit because of lack of beds available on the main wards. As a consequence, the unit experienced difficulty in balancing the competing priorities of the patients it served. There were problems regarding capacity and the suitability of the facilities to meet competing demands, which impacted on service quality.

There were arrangements in place to ensure that patients were kept safe and people we spoke with told us they felt safe in the hospital. However, there was evidence in national and trust data and also in practice found during our inspection which indicated these arrangements were not sufficiently robust. There had been a Never Event (an incident so serious it should never happen) in surgery at QEH during the two months the hospital had been part of the newly formed trust. An action plan was in place in response to this and steps were being taken to embed learning across the trust to ensure such an incident did not happen again.

Nationally recognised guidelines and pathways were followed. There was evidence of multidisciplinary working, but on the QEH surgery wards, nursing staff reported difficulties in contacting orthopaedic doctors and consultants regarding patient care and treatment. A number of other issues reduced the effectiveness of the

service. Relative risk re-admissions to surgery had been variable in general surgery. There were longstanding vacancies and staff shortages in some areas and high usage of bank (overtime) and agency staffing.

People we spoke with felt that staff were kind and caring and promoted their dignity and respect. We observed this on the wards and theatre areas we visited, but in a number of instances there were shortfalls in meeting the needs of patients.

The trust was meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing general surgery and trauma and orthopaedic surgery. The bed occupancy rates for the hospital were higher than target ranges and this impacted on the flow of patients between surgery and the surgical wards. There were some delays in the discharge of patients. The surgery risk register reported poor complaint management performance and the potential risk for poor patient experience and loss of opportunity to help staff learn. There was a recovery plan to address this.

Some staff were positive about the QEH merger with UHL and the leadership aims for the newly formed trust but felt there was still work to be done to achieve the ‘one trust’ vision. Other staff felt that communication and cooperation between QEH and UHL was not as effective as it could be. There were new clinical governance arrangements in place and managers were aware of the risks in their area and what action was being taken to reduce them. However, it would take time for the new arrangements to become embedded and for all staff to fully engage with them.

Surgery

Are surgery services safe?

Requires improvement 

Learning and improvement

There were systems in place to ensure that incidents were reviewed in order to learn from mistakes and to improve safety standards. We saw from minutes of recent Trust Board and surgery governance committee meetings that serious incidents and Never Events had been discussed and lessons learned identified. The clinical governance lead for surgery, anaesthesia and critical care showed us the action plan for the Never Event at QEH which was being monitored by the surgical clinical governance committee.

The latest surgery risk register provided by the trust recorded in November 2013 that, following review, action plans developed from serious incident investigations prior to the appointment of a surgical clinical governance manager had not been adequately monitored, nor was there robust evidence of completion. Action to address this was due for completion by January 2014.

The implementation of the action plans for serious incidents was reviewed at monthly governance meetings, including the communication of lessons learned. Key outcomes from serious incidents were also reported to staff at all levels through team and unit meetings and through a quarterly staff newsletter, Reflect, which we saw on display in some of the surgery areas we visited.

Staff on wards and in the operating theatres told us of the computer-based system for reporting incidents. Information on each incident was graded by an investigator. Where the incidents were considered to be high risk, a root cause analysis was undertaken. We were told a new system had recently been introduced for safeguarding incidents and staff had received training in this. There were some issues to be resolved regarding the functionality of the system but this was being worked on.

Systems, processes and practices

Measures were in place to ensure patients were protected from the risk of infection. To promote safe practices, there were infection control nurses for each area. They were responsible for carrying out audits and disseminating key messages to staff. The trust's infection control rates for *Clostridium difficile* (C. difficile) and MRSA were within the

expected range when compared with other trusts. There had been a C. difficile infection on Wards 17 and 19 at QEH in December 2013 and infection control follow-up audits had been undertaken to ensure the required protocol had been followed. Both audits identified that the patient or relative had not been given any information leaflets about the infection in accordance with hospital guidance. On one QEH ward we visited, the filing of infection control audits was disorganised and it was not clear how the findings were shared with staff or if any action plans were implemented.

Health Protection Agency data for surgical site infections was only available for one quarter in 2012/13 and did not contain sufficient data on which to draw conclusions. Previous benchmarking data from Public Health England, within the former trust showed a relatively low incidence of orthopaedic surgical site infections. There was no hospital-specific data available for either QEH or QMH. However, one patient we spoke with had been re-admitted to the hospital due to an infection following hip replacement surgery. We noted that the details regarding the infection had not been recorded in the nursing or ward notes.

Each ward we visited had dedicated domestic staff who were responsible for ensuring the environment was clean and tidy. We spoke with a member of the domestic team on one QEH ward who told us they felt part of the ward team and had received effective induction onto the ward. Patients we spoke with were complimentary about the cleanliness of the hospital at both the QEH and QMH sites. We saw cleaning staff present on wards during our visit. We also observed ward areas to be clean and there was hand gel available for use and toilet facilities had liquid soap dispensers and paper towels.

We noted that there were systems in place for the cleaning and decontaminating of equipment, such as mattresses and commodes. In the theatre areas we visited, there were processes for the cleaning of surgical instruments. However, in the endoscopy unit, staff told us there was equipment which had not been not cleaned efficiently, leading to bottlenecks and delays to operations.

Patients with infections were accommodated in side rooms on wards we visited. Signage was in place to reflect this and we saw staff wearing appropriate personal protective equipment. The day care unit had three side rooms which were frequently used to accommodate patients with MRSA

Surgery

and occasionally C. difficile. However, the rooms were not designed for this purpose and, in particular, had no toilet facilities. Staff recognised that their use for isolation was not ideal and was a last resort when no side rooms were available elsewhere in the hospital.

We were told that the QEH discharge lounge was always fully staffed. Theatre managers told us that they made occasional use of bank (overtime) staff for complex surgery cases. Wards 18 and 19 had appropriate numbers of staff on the day of the inspection. However, senior ward staff told us there were often staffing shortfalls and it was difficult to get bank and agency cover. On Ward 18 we were told staff were frequently working 12-hour shifts to meet shortfalls. The sister frequently covered one of the patient bays when they were short of staff and this made it difficult to coordinate the management of staff across the ward.

On Ward 17 staff told us the staffing levels were not sufficient to always meet the needs of patients who had high acuity and dependency levels, including several patients with dementia who were at risk of falling and wandering. Our observations confirmed this. We observed lunch time on this ward and saw there were not enough staff to give people who needed it support in eating and still provide a good service to other patients. Some people had a long wait for their food and the food was not hot when it reached them. We were told that, due to staff shortages, nursing staff often had to cancel mandatory training and were beginning to complete the training in their own time. A practice development nurse had been appointed recently and this had improved training support but we were told the post holder was frequently used to fill gaps in staffing. On the day of our inspection they were helping on the ward due to the shortage of a healthcare assistant for which it had not been possible to secure cover.

In the day care unit, we were told staff worked well as a team but were coping with a stressful workload. Because of work pressures, band 5 nursing staff in particular had not been able to take time out during work time to complete mandatory e-learning training and had to do this in their own time. We noted, nevertheless, that staff were up to date with most of their mandatory training, although the majority had yet to complete refresher training in infection control.

Ward managers at QEH used a computer-based e-rostering programme to ensure the ward was appropriately staffed, taking account of absences for leave, sickness and training.

There were differing views about the effectiveness of the system. Some found it worked well and was a useful tool for ensuring staffing levels; others found it less effective. It was not clear that there was consistent approach to determining surgery needs to ensure staffing was based on dependency levels. We noted also that a safer staffing review report was presented to the board in January 2014 of the outcomes and recommendations from a trust-wide review of nursing and midwifery ward establishments for inpatient areas. The report identified the need and associated costs for some uplift in current staffing levels across the trust (including surgery) to ensure that there were safe staffing levels to deliver safe quality patient care.

There were vacancies on all QEH surgery wards. On Ward 17 a number of nurse vacancies and there had been no ward clerk for some months. On Ward 18 there were three band 5 and three healthcare assistant vacancies, some of which had been vacant for three months. On Ward 19 there were 1.9 nursing vacancies at 1.7 healthcare assistants. We were told that vacancies were put to a recruitment panel. A recruitment campaign was in progress jointly with medical ward recruitment but ward staff did not know the current status of this. We were told by senior surgery managers that recruiting and retaining nursing staff in London in a competitive recruitment pool was a key challenge to the directorate. There had also recently been a recruitment campaign in Spain and Portugal and 18 posts were due to be filled shortly as a result.

At the QMH site, staffing was shared between Lewisham and Greenwich NHS Trust and the host trust Dartford and Gravesham. We were told there were theatre vacancies that were being filled by the host trust. There would also be a recruitment campaign to fill trust-funded posts but managers at the site did not know details of the number or grades. Senior staff on the surgery wards at QMH told us the wards were adequately staffed. Agency staff were used in most cases to cover staffing shortfalls, most of whom had worked at the hospital before.

Monitoring safety and responding to risk

The surgical directorate kept an up-to-date risk register that was reviewed at monthly governance meetings. The register identified what action was being taken and timescales. Directorate audits and service risks were also fed into the Trust Board via trust level governance committees.

Surgery

Patients were required to provide written consent before they underwent any procedure, which was obtained by the clinician carrying out the treatment. We looked at consent forms on patient records and saw these had been completed and signed appropriately,

In the theatre areas we visited, we saw examples of where the WHO surgical safety checklist had been appropriately completed. However, in four patients' records we looked at on Ward 18 at QEH we found no checklist in one record and two where the 'sign out' stage had not been completed. At QMH we observed the completion of the 'sign in' stage of the checklist for one patient and looked at two patients' records where we saw the checklist had been appropriately completed.

We noted from information provided by the trust in its surgery risk register, a documentation audit of completion of the checklist had been reporting 100% compliance. But a separate observational audit challenged the validity of this data and identified a risk to safety, particularly with the 'sign out' stage of the checklist. We discussed this with the clinical governance lead for surgery who told us that an action plan was in place to address this issue and there would be a further audit to follow this up. We saw the discussion and identified actions of the issue in the December 2013 surgical clinical governance committee meeting minutes and related updated action list. We were told also of a cross-site review being undertaken with a view to improving compliance by the introduction in particular of a 'team brief', involving a review of the operating list with all members of the operating team present, immediately prior to commencement of the list. This was awaiting approval from the surgery clinical governance committee.

Observations to check people's vital signs were used on each surgery ward to ensure that patients who may be becoming unwell were escalated appropriately. The frequency of observational checks depended on the needs of each person. We saw some examples of appropriately completed checks on patients' records. However, in some cases the monitoring forms were not being completed properly. On one ward at QEH we saw the daily audits of patient records but it was not evident how these audits were followed up. The patient records we reviewed were of variable quality. On one ward at QEH, patients' nursing records were appropriately completed but their medical records were difficult to read. On another ward, the surgical

nursing care plan was not always completed correctly. Instead of completing sheets relating to specific aspects of care as required, nurses were writing some of these elements in the notes section of the plan. In particular, the pressure ulcer section of the care plan was not completed on a daily basis for five of the patient notes that were seen. Staff we spoke with told us this was due to lack of time related to work pressure. On one ward a patient's daily skin assessment had been recorded on the day of admission but there was no record of any assessment since then.

There was a resuscitation trolley in each ward or clinical area and we saw these were checked daily in most cases, although we saw some gaps in the records where the check had not been completed on some days.

Most patients we spoke with on the wards at QEH and QMH felt safe and were confident in the competence and expertise of staff. However, on Ward 17 a patient was worried about getting an infection from an intravenous cannula tube and felt that staff did not do enough to allay these fears. On Ward 19 a patient was concerned about disturbances from a confused patient in the bed next to them.

Anticipation and planning

Serious incidents were reviewed by the Trust Board and trends identified. For example, in the October 2013 Patient Safety report, it was noted there were a noticeable number of incident reports showing that patients were not always wearing identification wristbands while on the wards. Some managers' reports were implying that some of these patients were confused patients who removed the wristbands. In other instances, the wristbands had not been applied by staff. The board recognised there was a foreseeable risk that a patient would receive the incorrect procedure or medication if the issue was not addressed.

Day to day on the wards we visited, we were told that managers took action to ensure patients' needs were met in response to changes in staffing levels due to absences such as sickness. However, on QEH wards we were told of difficulties in ensuring staffing resources matched patients' needs. We were told that, on all surgery wards, it was difficult to get bank (overtime) or agency staff. On Ward 17 there was concern about the support from management when shortfalls were experienced and the lack of flexibility in moving staff from other wards to provide cover. We observed lunch time on this ward and saw that there was

Surgery

not enough staff to give people who needed it support in eating and still provide a good service to other patients. Some people had a long wait for their food and the food was not hot when it reached them.

During our follow-up visit to the QEH day care unit, we were told of problems relating to the availability of the notes of urology patients from the Princess Royal University Hospital pre-assessed at the unit. The patients had their surgery at the Princess Royal or QMH and their notes were expected to accompany them when they moved between QEH and the two other hospitals. However, the notes were frequently not available when they came to QEH for pre-assessment and could not be traced with the other hospitals. This led to delays and cancellations of surgery. We were told the QEH day care unit had escalated the matter to the matron and surgery directorate management.

Mandatory training for trust staff included training in the safeguarding of children and vulnerable adults. We noted from data provided by the trust at February 2014 the majority of staff in the surgery directorate at QEH site had received appropriate training. However, 80% of eligible clinical staff still had to undertake required training in safeguarding adults and 62% safeguarding children and young people Level 2. At QMH we were told that most staff had completed safeguarding training, although we did not see any data to confirm this.

Are surgery services effective?

(for example, treatment is effective)

Not sufficient evidence to rate 

Due to the recent dissolution of South London Healthcare Trust, there are not enough current data to rate this service

Evidence-based guidance

Evidence-based guidelines and pathways were used by surgical services, including the fractured neck of femur (hip fracture) care pathway and the enhanced recovery programme for orthopaedic and colorectal patients. Both aimed to improve the speed of recovery and long-term outcome for people following surgery.

Under the CQC's 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) there were no surgical procedures flagged as outside expected ranges (statistical anomalies). This indicated that there were no surgical procedures performing outside statistically significant levels.

Monitoring and improvement of outcomes

The trust performance in surgery was measured against a number of national indicators.

The trust participated in a number of national audits. However, audit data was not yet available for QEH and QMH as it related to the trust before October 2013.

We noted from the surgery directorate risk register that an entry had been made in January 2014 about QEH non-compliance with General Medical Council (GMC) best practice for medical documentation due to a lack of clinician engagement in the trust's mandatory annual medical documentation audit and the absence of an action plan for improvement. A recovery plan was in place involving the introduction of a new electronic records system in March 2014. Training of all staff was underway alongside a communication strategy. A clinician had been involved in the development and introduction of the system.

QEH and QMH were not meeting the standard set out by the British Orthopaedic Association that 95% of patients receive surgery within 48 hours for fractured neck of femur. For the two months where data for both QEH and QMH were included, the trust was only performing surgery on 79% and 75% of patients within 48 hours.

People we spoke with confirmed that, before and following surgery, they had been given effective pain relief when they needed it.

Sufficient capacity

On the day of our inspection, the ward and theatre areas we visited at QMH had an appropriate number and skills mix of staffing. Patients we spoke with felt staff were always busy but their needs were met by nursing, doctors and other staff without any undue wait. However, the adequacy of staffing resources at the QEH was variable and we noted in the General Medical Council National Training Survey 2013, the trust performed worse than expected for workload in trauma and orthopaedic surgery.

Surgery

The trust had arrangements for the ordering and supply of equipment. However, on Ward 18 we were told there were not enough raised toilet seats for people who had had hip operations. We noted also a shower and toilet room on the ward had not been in use for over three months. We were told this had been raised with the matron and estates team but remained unresolved. We noted storage space on Ward 19 was limited. Two treatment rooms on the ward were cluttered by the storage of equipment such as hoists, fans and weighing chairs, which could restrict movement in the room when treating patients.

The unit did not have an electrocardiogram (ECG) machine, which was required at least twice a week for some of the inpatients currently occupying beds in the unit. An ECG machine had to be borrowed from the acute medical unit.

Multidisciplinary working and support

Multidisciplinary team meetings took place regularly. We observed effective meetings taking place on two of the QEH wards we visited, attended by therapy and clinical staff. However, we were told there were difficulties in communication between nurses and orthopaedic doctors and consultants which inhibited multidisciplinary working. On Ward 17 there were 10 orthopaedic consultants and doctors on the ward but there was no systematic ward round schedule which nursing staff told us created significant problems in discussing care planning. On Wards 18 and 19, nurses had similar problems and told us they spent a lot of time trying to make contact with orthopaedic doctors and consultants. There were six different orthopaedic teams the wards had to deal with and we were told they often came to the wards without the knowledge of nursing staff and left without making any contact with them. Patient discharges were delayed when waiting to get in touch with orthopaedic doctors to arrange or find out the results of x-rays or to get them to prescribe medication for patients waiting to leave.

Are surgery services caring?

Requires improvement 

During our visit we saw mixed examples of caring. We saw staff that were highly caring and making efforts to care for patients; and in some areas we saw those standards falling short.

Compassion, dignity and empathy

The trust used the NHS Friends and Family Test to gather people's experiences. The aggregate score at QEH for the period October to December 2013 was 41, but is not necessarily representative as the response rate was only 9% (three out of a potential 81 patients). The latest data showed Ward 18 at QEH scored 33 which was below the trust average of 36. The trust was considering ways of encouraging an improved response rate, for example, by giving patients the form to complete while they were awaiting discharge. On one ward we were told comments from patients on daily ward rounds allowed opportunities to correct problems.

NHS Friends and Family Test results for the surgery services at QMH were included within the data for the host trust and were not available for the services provided specifically by Lewisham and Greenwich NHS Trust. However, we saw comments from the test displayed on the surgery wards at QMH.

We spoke with 14 surgery patients at QEH during our inspection and their comments were mostly positive about the care, treatment and support they received. They told us the staff have been "very efficient", "kind" and "brilliant". One person told us, "I would recommend the ward to my friends and family". Another person said, "The nurses are very busy but always smile and take time to cheer me up".

At QMH we spoke with four patients on the surgery wards. They told us the staff "were nice and reassuring", "looked after me well", and "treated me with respect." One person told us, "Everything went smoothly. I was really anxious but the staff put me at ease".

A matron we spoke with at QEH told us they had (with two other matrons) introduced a 'tea club' in the afternoons, three times a week on three of the wards. This was to assist patients with their nutrition and increase calorie intake to aid recovery. Initially, the matrons had bought cakes and biscuits themselves but a local supermarket was now providing these.

One person on Ward 17 and another on Ward 19 told us the ward was noisy at night time and they were tired from lack of sleep. Another person on Ward 17 told us that they felt ridiculed when they raised concerns with a nurse about getting an infection, although when they became upset the nurse did reassure them. A person who had to remain in the recovery area overnight because no bed was available

Surgery

on the wards said their family was extremely concerned about what was happening as they were not allowed into the recovery area. The person also had no access to food, although a family member was eventually allowed to visit briefly late in the evening to bring food. Overall they felt staff showed a lack of care and compassion towards their family.

On Ward 17 we saw a patient had been provided with water but the glass was out of reach. We observed lunch time on this ward and saw there was not enough staff to give people who needed it support in eating and still provide a good service to other patients.

One person's relative told us they could not fault the care provided by day staff in the day care unit. However, there had been two occasions when the standard of care provided by night staff had been below the standard they expected and their relative's dignity had been compromised.

Involvement in care

In most cases, people we spoke with at both QEH and QMH were supported to make decisions about their care and relatives were involved when appropriate. However, a number of patients raised concerns about communication.

People who attended a pre-assessment appointment were asked about their communication needs and whether they needed an interpreter to support them during their stay in hospital. There were interpretation services available to support people during their hospital stay if needed.

The majority of people we spoke with at QEH and QMH felt fully informed and involved in decisions about their treatment. They told us doctors, nurses and other staff took time to explain the treatment planned and the risks and benefits, and checked to ensure they understood the operation or procedure and how they could expect to feel later. They were also given clear advice about eating and drinking before and afterwards.

Some people reported they were not involved sufficiently in their care. One person felt communication was poor in the post-operative recovery room where they had stayed overnight due to bed shortages. They said they kept asking when a bed would be available but got no answers and felt ignored. Another person told us they felt staff on Ward 17 were too busy to explain things to them and they did not understand fully about an assessment they would be having. On the same ward, a person told us they were not

sure when they would be discharged and did not know how it would this would be decided. On Ward 19 a patient had been told they would be transferring to another ward but there was a delay because no bed was available. They were told a doctor was supposed to be coming to see them but they had been waiting since the day before and had heard nothing more. Two people we spoke with in the day care unit were happy with the care they received from staff. However, they had had their operations cancelled twice and on both occasions had waited all day before being told of the decision and the reasons for it. During this time they had been able to eat or drink, in the expectation they would be having their operation on the day.

People we spoke with confirmed they were asked to sign a consent form for their surgery and we saw these in patient records we reviewed. However, the patient's copy was still in the set of notes we looked at. We observed staff asking people's consent to treatment on the ward, for example, when offering medication.

Trust and respect

At both QEH and QMH we observed most people were treated with dignity and respect and people we spoke with confirmed that staff were polite and considerate. Curtains were closed when staff were providing care and they spoke quietly to maintain privacy and avoid others overhearing conversations. People occupying side rooms told us staff always knocked before entering and closed the door when care was being provided. Each patient had their named doctor and nurse identified on a board above their bed. People we spoke with said they knew the names of the staff treating them.

On Ward 17 at QEH we observed a porter coming to take a patient to theatre. They did not explain what was happening to the patient but a nurse spoke to the patient to tell them what was going on. On the same ward we observed a phlebotomist taking blood from a patient. They introduced themselves to the patient but offered no explanation about what they were doing and did not engage further with the patient during the procedure.

Emotional support

Most people we spoke with at QEH and QMH told us that doctors, nurses and other staff were always around and available to deal with any worries or concerns they had. However, six patients at QEH we spoke with felt a lack of communication about their treatment had increased their

Surgery

anxiety. One patient in the day care unit who had had their operation cancelled twice and had been sent home told us they had been left feeling “very depressed” when told of the decision after waiting all day for their operation.

Two people at QEH told us they were bored during their stay in hospital. They could not afford to pay for television and felt that newspapers and books should be made available.

There were set times for visiting wards but visits outside of these times could be negotiated for particular groups, including critically unwell patients, and patients whose visitors were personally involved in the delivery of care outside visiting hours.

Are surgery services responsive to people’s needs?

(for example, to feedback?)

Requires improvement 

Meeting people’s needs

The trust surgery director told us all national targets were kept under review through the divisional surgery scorecard and action was in place with a view to improving performance in all areas. This was reviewed at monthly clinical governance meetings and reported through the trust’s wider governance structure to the Trust Board. A key part of the trust’s transformation programme was the creation of an elective surgery centre at the UHL site over the next two years. Plans were in place and approval had recently been given for the first phase of this for orthopaedic surgery. This would impact on both the QEH and QMH sites. The elective surgery provided by trust staff at QMH would be transferred to the UHL site within the next year. Staff at QMH told us they had been kept up to date with developments regarding the transfer.

The day care unit provided a range of services with conflicting demands and priorities. These included daily pre-assessment clinics, a pain management clinic, a weekly anaesthetic clinic, recovery for endoscopy patients, flexible cystoscopy, and (on alternate weeks) a lithotripsy clinic (a procedure that uses shock waves to break up stones in the kidney, bladder, or ureter). The unit also received patients

for urology and gynaecology, general anaesthesia, and non-urgent orthopaedic trauma surgery and patients referred for non-urgent day surgery or procedures from the accident and emergency department.

The unit had 23 beds available for preparing patients for day surgery and also for accommodating patients kept overnight after late surgery or whose surgery had been cancelled. However, some beds were frequently occupied by non-surgery patients because of the lack of availability of beds elsewhere in the hospital. On our first visit to the unit, 10 beds were free, which we were told was not typical as most of the time they were full. On our follow-up visit, only three of the beds were free to receive new day surgery patients. One bed was occupied by a medical patient who had been in the unit for two months. Two other beds were occupied by patients admitted to the unit pending their transfer to wards elsewhere. Staff told us they had been pursuing their transfer repeatedly since their arrival about a week ago but without success.

The pressures on bed availability within the unit meant many patients had to be admitted away from the bedside using rooms elsewhere in the unit where privacy and confidentiality could be maintained. The sister’s office, a staff seminar room, pre-assessment rooms and an anaesthesia clinic room were all used daily, if available, for this purpose. These rooms were not designed for this purpose. If, for example a patient needed to be examined, or their blood or urine needed to be taken, they would need to move into the ward area. However, we were told that some doctors had been carrying out examinations in these rooms and a meeting was taking place on the day of our follow-up visit to discourage this practice.

We received mixed views about the food provided at QEH. Some people were happy with the quality and choice of food available. Others did not like the food. At QMH the two people we spoke with liked the food and one person told us the vegetarian menu met their needs.

We were told the day care unit did not have a phlebotomist in the unit and this meant that nurses already carrying a heavy workload, or sometimes doctors, had to take blood. Nursing management was seeking to secure phlebotomy services for the unit.

Access to services

The trust was performing within national expectations with regard to cancelled operations compared to other trusts.

Surgery

However, the service carried out its own monitoring of cancelled operations (both elective and emergency) for non-clinical reasons. The latest surgery scorecard made available to us before the inspection showed for October 2013 a cancellation rate at QEH of 0.82% against a target of 0.80% which indicated that people who needed surgery did not always have their operations as planned. However, our indicators rated these as 'no evidence of risk'. The information available from the trust did not include such data for QMH. However, we saw data displayed at the site for the week of 28 February 2014 showing that, of 210 planned admissions, 194 were admitted for surgery, four did not attend, and seven were cancelled by the hospital and five by patients.

The surgery director told us the directorate had established a theatre efficiency board which met monthly to review theatre performance. Cancellation rates were under close scrutiny by the group. There was also a weekly meeting with surgery service heads to review cancellations on a case-by-case basis.

The majority of people we spoke with who had undergone an elective surgical procedure did not raise any significant concerns about the timing of their outpatient appointments or the scheduling of their surgery. People who had their surgery at QMH were, in most cases, pre-assessed for surgery at QEH and commented positively about these arrangements and the processes from admission at QMH through to discharge.

Surgical patients were cared for on dedicated surgical wards at both QEH and QMH. The bed occupancy rates for QEH were higher than target ranges (around 87-90% in the past few years and anything above 85% is considered high) and it was evident that this impacted the flow of patients between surgery and the surgical wards.

In the QEH theatre unit we were told of delays in moving people out of the recovery area and, in one recent case, a patient had been there until 3am awaiting transfer to a ward. On some occasions, patients were being recovered in the anaesthetic room. One patient told us they had stayed in recovery overnight because a bed was not available on the ward and this had caused them and their family distress. The theatre manager met daily with the site manager to try to resolve these issues.

In the QEH day care unit we were told of bottlenecks due to the number of patients and lack of space and beds. The

unit received daily lists of patients for day surgery but frequently were not informed of non-urgent orthopaedic trauma patients who had been added to the list. The arrival of unexpected patients added to the pressures of accommodating them in the unit and led to cancellations of operations on a daily basis. This caused patients expecting to have surgery considerable upset and distress. A trauma coordinator had been appointed recently which, we were told, had improved communication with the day care unit about the orthopaedic trauma surgery list, but the coordinator was not always informed that patients had been added to the list. We were told the trauma coordinator was preparing a letter to patients explaining the possibility of surgery cancellations and reasons for this, to help manage patients' expectations.

In the day care unit, two day theatres had been closed since December 2013 due to ventilation problems. As a result, elective day care patients were being referred to QMH or went to the main theatres at QEH for their surgery. We were told at our follow-up visit to the unit that the ventilation problems had been resolved. However, due to the planned reconfiguration of the unit, they would not be re-opening.

Vulnerable patients and capacity

There were systems in place to protect patients from the risk of abuse. Safeguarding training was mandatory for all staff and attendance was monitored through each area's performance dashboard (performance reporting and tracking system). There were patient care pathways available and visible for patients with 'confusion' or 'communication issues' and we saw clear displays around the wards and signage to indicate patients who were on the pathway.

On Ward 17, there were a number of patients with complex needs, including patients with dementia. Staff told us that there was insufficient staff on the ward to meet the needs of all these patients at all times. Our observation of lunch time on the ward confirmed this. Staff struggled to support several patients who required assistance with eating and drinking while providing lunch to all other patients. We were told the dementia care lead nurse was unable to provide support to the ward for these patients and the ward had to rely on monthly sessions provided an occupational therapist for such support.

Surgery

Staff followed the Mental Capacity Act 2005 and a patient's ability to make decisions in relation to their care, particularly with regard to the consent process prior to surgery.

Leaving hospital

At QEH and QMH the discharge process was started as soon as a person was admitted to hospital. Surgical nursing care plans included a discharge plan which was reviewed daily and there was a discharge planning checklist to ensure patients received any additional support post-discharge. This included referrals to social services, the district nurses team or community rehabilitation services.

There were daily handover meetings held to discuss discharging patients. We observed staff on one ward liaising with a care home and providing detailed information on how best to help the patient being discharged to the home. We also noted consultation with family members and discussion of how best to help the transition of a patient back into their own home. Each patient had a patient assessment form which detailed how they should be cared for which was used in conjunction with the surgical nursing care plan.

We visited the QEH discharge lounge during our inspection and found that it was appropriately staffed and run. People's needs were also met while awaiting discharge in the lounge, for example, by ensuring the availability of sandwiches and refreshments. Most patients arrived in the lounge with their medication but if not staff collected this from the pharmacy to minimise delays. Staff provided advice to patients about their medication before leaving and checked that arrangements were in place to support them when they returned home. However, sometimes patients who were expecting to be discharged were transferred from the ward to the lounge whilst still waiting for a doctor to sign off their medication prescription. They could be left waiting a long time for this which we were told caused bottlenecks in the discharge lounge. It was not a suitable environment for some patients to sit for extended periods, for example those with neck of femur fractures. There were no toilet facilities in the lounge and staff had to take patients back to the ward if they needed to use the toilet.

At QMH patients were discharged directly from the day or short stay ward. Neither staff nor patients raised any concerns about the discharge arrangements. We spoke with one patient who was being discharged on the day of

our inspection. They told us the arrangements had gone smoothly, the doctor had signed them off and the pharmacist had visited them the day before to arrange their medication.

Learning from experiences, concerns and complaints

The service encouraged feedback from patients and their relatives through the NHS Friends and Family Test. The results were displayed in ward areas showing what had been said and what had changed as a result of patients' comments. The trust also published a 'you said we did' section on its website which recorded improvements in response to patient feedback. In relation to surgery, this included: the introduction of a governance manager in the directorate to manage the governance agenda at directorate level; the introduction of new Crystal Marked (plain language) leaflets for most procedures; and the appointment of a complaints coordinator to improve the process of complaints handling.

The service had a complaints policy in place. Staff attempted to resolve issues as they arose, but there was a complaints escalation procedure and action plan for the surgery directorate if they were unable to. Complaints were logged, investigated and responded to following this procedure. Service managers allocated complaints to the relevant service clinical lead to investigate and compile a draft response within stated timescales. All complaints were logged and monitored by the divisional complaints coordinator, who passed them down to the manager responsible. The complaints coordinator reported that some managers needed training in complaints-handling as they were not experienced in this. We noted that, as of February 2014, none of the four eligible staff in surgery at QEH had undertaken mandatory training in managing risk, complaints, claims and business continuity.

Complaints were monitored through the surgery and wider trust clinical governance structure and at Trust Board meetings. There was also a trust complaints steering committee which met monthly and reported to the board. We noted from the minutes of the December 2013 meeting that, since the trust merger, there was a rise in complaints in all areas, and that dissatisfaction through patient encounters was highest in surgery. We noted further that 39 overdue complaints were reported in surgery at QEH where procedural timescales had not been met. The surgery, elective surgery centre and critical care divisional scorecard

Surgery

reported complaints resolved within agreed timescales at 44% for November 2013. This was also reflected in the surgery risk register which reported, at November 2013, poor complaint management performance and the potential risk for poor patient experience and loss of opportunity to help staff learn. A recovery plan was put in place involving a request for data from each responsible lead and additional time and resource being enabled to deal with an inherited backlog.

At ward and theatre level, complaints were discussed at weekly team meetings to review lessons learned. People on wards we spoke with said that they had not had cause to make a formal complaint. Some were aware of the Patient Advice and Liaison Service for dealing with complaints and there were signs and notices around the hospital promoting the service.

Are surgery services well-led?

Requires improvement 

Vision, strategy and risks

The trust had a stated vision and values and had been running a series of behaviours and values workshops for staff at all levels. We saw values displayed in the areas we visited and some staff we asked about this knew and understood them. However, it was not possible to say from relatively small sample of staff we spoke with whether the vision and values had been yet been fully embedded within the organisation. Managers and staff acknowledged there were still issues to be resolved since the merger and it would take time and effort to achieve the 'one trust' vision. We heard comments at QEH such as, "There have been no meetings or introductions to surgical service staff on the Lewisham site". and, "Senior managers spend more time at Lewisham". Some staff clearly still held this perception, however the trust was working towards addressing this.

Surgery management told us there was a "big focus" on improving staff morale and felt the position was much more positive now. On the surgical wards and theatre areas some staff we spoke with were positive about the support they received and felt there was good teamwork to ensure patients' needs were met. However, others were less positive. One member of staff commented, "I first heard about our work being moved to the Lewisham site at a team meeting and had not realised decisions had already

been made about this". On one ward, staff told us they had good support from their managers but there were not enough staff to meet the complex needs of the patients. This led to a huge workload and there was not enough time to complete training which staff were having to do in their own time.

Incidents were reviewed at both service and trust level. Where necessary, root cause analyses were undertaken or the trust commissioned investigations. Surgery management were able to tell us about the key risks to the surgery directorate and what action was being taken. However, we noted from the November 2013 surgical clinical governance committee minutes that there were issues where action had been rolled over repeatedly and concern was expressed regarding the lack of assurance, for example, in relation to an audit of swab counting.

Quality, performance and problems

We noted from information provided by the trust that since merging in October 2013, the new Lewisham and Greenwich NHS Trust had a number of strategies which were under review. The trust's quality improvement strategy was therefore currently under review. This review was being undertaken by the deputy director of governance.

A new divisional clinical governance structure had recently been put in place within the surgery, anaesthesia and critical care directorate following a review by the clinical quality committee in October 2013. This was to provide assurance to the trust's Clinical Effectiveness, Patient Safety, and patient experience committees, together with providing assurance to the trust integrated governance committee and Trust Board.

The monthly Trust Board performance report was delivered through this structure. The December 2013 report identified a number of concerns relating to surgery. QEH surgery cancellations were above target, due in the majority to "no bed available". The second biggest reason was "previous list overrun". A direct link was seen between the two issues – both were steered by lack of inpatient bed capacity on the QEH site for complex elective and trauma care which could either result in direct, on-the-day cancellation or a delay to list start times, resulting in a knock-on compromising effect to activity and efficiency

Surgery

throughout the day. It was anticipated that the introduction of an emergency surgery facilitator role on the QEH site from 30 December 2013 would support improvements in this area.

Leadership and culture

The director of nursing reported that they had undertaken a consultative process and had just put out the nursing structure for the organisation. There was some work to do around culture and behaviour but management were “taking the nursing workforce with them.” We heard from nursing staff at one of our staff focus groups that the whole focus before the merger was on saving money but now staff were much more positive and happier and felt part of the new trust.

During our visit to the day care unit at QEH, we were told that day care services would cease at QEH and be moved to UHL. The day care unit would be re-configured to enable expansion of the endoscopy unit and other potential uses, for example, the set-up of a surgical assessment unit. Decisions on this, including the timescales and impact on staff, were part of the ongoing planning process. Staff we spoke with told us they had heard about some of the changes being considered. However, they did not feel sufficiently informed about the plans being made and the impact it would have on them.

Patient experiences and staff involvement and engagement

The service actively encouraged feedback through the NHS Friends and Family test from people who used the service. Procedures were in place to respond to complaints about surgery services. Staff received feedback about lessons learned and reflective sessions took place to secure practice improvements. However, there was some concern about the time taken to respond to complaints in some surgery areas. One manager commented, “There is not a culture of dealing with complaints at ward level and we need to embed this in the organisation”.

Some staff told us they felt able to discuss any concerns or anxieties with their manager and felt engaged with the trust’s aim to provide the best service possible to patients. Others felt less engaged and did not feel supported by their managers. One manager commented, “Duty of candour is a challenge and staff will need encouragement to change”.

Staff we spoke with at QMH told us that there was good communication with managers at the main trust sites about the planned move of their work to UHL and they had regular visits from them to receive updates on progress with the move.






Learning, improvement, innovation and sustainability

Staff at our focus group told us they had received an appraisal but we were unable to confirm how many staff in the surgery directorate had been appraised from data made available to us by the trust. However, the Trust Board performance report for December 2013 reported the appraisal completion rate at 47.9% against a target of 90%. Action was being taken with line managers to ensure appraisals were completed.

We noted from data provided about mandatory surgery training at QEH at February 2014, there were several areas where the training was incomplete. Low completion rates included conflict resolution 20%, consent 9%, and first responder resuscitation training 0%. We were told, however, that mandatory training at QEH had been put on hold prior to the merger with UHL but practice development nurses had been appointed on wards and were now moving this forward.

Complaints were monitored through the surgery and wider trust governance structure, trust complaints steering committee and also at Trust Board meetings. Feedback and lessons learned from complaints were also reviewed at ward and theatre staff meetings.

Intensive/critical care

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

Information about the service

The critical care unit included an intensive therapy unit (ITU) which had 10 beds and five high dependency unit (HDU) beds. The ITU and HDU bed spaces were interchangeable and located in three separate areas on the same corridor but divided by doors.

As part of the inspection, we visited the critical care services and spoke with four patients, two who had recently been discharged to the ward and three relatives. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, physiotherapists and the senior management team. We reviewed performance information about the hospital.

Summary of findings

We saw poor examples of hand hygiene and failure to follow the trusts 'bare below the elbows' policy. We also saw shortages in both medical and nurse staffing levels.

Patients' needs were being met by the service, care was delivered by experienced and skilled staff in a caring manner. Patients' care and treatment was delivered in line with national guidelines and evidence-based practices. Many families we spoke with were complimentary about the care their relative received. However, there was a lack of relatives' facilities in the critical care unit.

Staff participated in a range of audit and monitored patient outcomes to improve the quality of care provided. There was evidence that staff had learnt from incidents and made changes which had improved the quality of care patients received.

There were not always enough trained and experienced staff to deliver care, due to nursing agency shifts frequently not being filled.

Intensive/critical care

Are intensive/critical services safe?

Requires improvement 

Safety and performance

The Intensive Care National Audit and Research Centre (ICNARC) data provided to us by the trust showed that the unit acquired Methicillin-resistant *Staphylococcus aureus* (MRSA) was within statistically acceptable levels. Staff we spoke with told us that all patients were screened for MRSA on admission to the unit and that patients admitted from other critical care units or hospitals were nursed in individual side rooms until test results confirmed that they were infection free; this reduced the risk of cross infection.

The unit has an on-going issue with *Pseudomonas aeruginosa* in the water supply we noted that the taps in the unit had filters attached to reduce the risk of water being contaminated. The hospital was working through a plan to deal with this.

The resuscitation equipment was checked on a daily basis against a checklist to ensure all drugs and equipment that may be required in the event of an emergency were available and in date. Staff we spoke with were clear about which member of staff was responsible for checking this equipment and who collected emergency drugs from pharmacy to replace any that had been used. For example we observed a support worker delivering emergency drugs to the unit; this ensured trained staff did not have to leave the unit to collect drugs.

All nursing and medical staff used the trust wide electronic incident reporting system to log incidents and near misses. The staff we spoke with told us that the unit had an open, no blame culture and that they were encouraged and felt able to report incidents. This approach meant that lessons were learnt and changes in practice implemented. Staff were able to provide examples of incidents that had been investigated and the actions that had been taken to reduce the risk of a similar incident occurring. We saw evidence that staff received feedback on incidents reported in the unit and across the trust and were encouraged to implement appropriate learning from other areas. The matron received a monthly incident report which was cascaded to staff via the directorate meetings; this highlighted any trends across the trust or learning from other areas that could be implemented in the unit.

National safety alerts were circulated to all staff via email and the matron told us and we saw that he also printed out the email and placed it at the nurse's station for all staff to read. The unit required all staff to sign to confirm that they have received and read the safety alert.

Systems, processes and practices

During our inspection we found some areas of the ITU to be cluttered, this included fluids stored in the corridors at the entrance to the unit. We observed that in two of the three areas the majority of the bed areas had limited space around them and could impact on the delivery of patient care. For example due to the limited space when the curtains were closed during the delivery of care and treatment there was a risk of cross infection as the curtains could contaminate treatment trolleys. Staff told us that they mitigated this risk by removing additional equipment or repositioning equipment when procedures were being undertaken. In the third area the bed areas were well organised, light and tidy, which promoted an area in which effective patient care could be delivered.

Staff told us that in between each patient all bed spaces were deep cleaned to reduce the risk of cross infection. There was a designated cleaner based on the unit who reported that he felt part of the team and that staff gave him clear instructions about what was required, he was very proud of the standard of work he delivered. Staff told us that they had access to the equipment they needed and it was cleaned in-between patients and maintained centrally to ensure it was fit for use.

There were sufficient numbers of hand wash sinks in the ITU and HDU. Hand gel was readily available at the bedside, outside cubicles and when entering each of the three areas. However, there was a lack of hand gel on entering the unit; staff told us that this was due to the risk of patients or visitors ingesting the gel. Nursing staff were observed wearing personal protective equipment, such as gloves and aprons, when delivering care, to reduce the risk of cross infection. We saw that staff followed agreed hand washing guidance but not all staff were 'bare below the elbow', we observed some members of staff wearing wrist watches.

Medicines, including controlled drugs, were securely stored in each of the three areas; this ensured that they were readily available. We noted that the room used to store intravenous and dialysis fluid was unlocked and therefore accessible to unauthorised people. We also noted that

Intensive/critical care

some fluids were stored in the corridors. Staff told us that the room used to store fluids was unlocked to allow easy access to fluids. However, there was no risk assessment completed or action put in place to mitigate the risk of unauthorised people entering the room and tampering with fluids.

The data provided for use prior to our inspection showed that there were very few reported prescribing error in ITU and HDU. Staff we spoke with described the cross checking practice that was in place to reduce the risk of drug errors. We were told about a drug admission error that had recently occurred and how staff had learnt from this incident to prevent it reoccurring in the future. For example there were regular debriefing sessions that all staff were encouraged to participate in following incidents that occurred on the unit. The purpose of these sessions was to encourage staff to reflect on the incident and consider learning that would assist in avoiding a similar incident occurring in the future.

The patient records were recorded in paper form. We found that all five sets of patient notes we looked at were poorly organised with information not recorded in chronological order. Some entries were not always timed and dated and the critical care ward round template did not include a space for staff to enter the time the entry was made. We also noted that medical staff were not always recording or auditing the time when the decision was made to admit a patient to ITU or when the patient was initially reviewed by the consultant when admitted to ITU. This lack of systematic recording could result in decisions being made on information that is not the latest decision and could result in inappropriate care being delivered.

Monitoring safety and responding to risk

There was no trust wide early warning score tool in use to identify those patients transferred out of HDU to the clinical ward areas, who become acutely unwell. The units used the National Early Warning Score (NEWS) to drive a step change improvement in safety and clinical outcomes for acutely ill patients. While the Lewisham Hospital ITU used the Modified Early Warning Score (MEWS). This is a multi-parameter physiological scoring system which is used to identify patients who are becoming unwell. There was a trust wide group that had been established to decide which system should be used, however, at the time of our inspection this group had not yet met.

Anticipation and planning

The unit had recently completed a bed occupancy review and identified the need for an additional three beds. We were informed that a business case had not been prepared or submitted to the trust board to obtain for the additional nursing and medical staff as this decision had been taken by the Director of Nursing and Clinical. However, at the time of our inspection staff told us these three additional beds were open and being staffed by agency nurses who had ITU skills and experience.

We were told that there was a high number of nurse vacancies on the unit, around 50% of junior nursing posts in the ITU were vacant at the time of our inspection. This high vacancy rate was attributed to staff leaving before the recent merger with Lewisham Healthcare trust and the pay differences between the trust's two ITUs. The unit had a recruitment and retention strategy in place and was in the process of actively recruiting ITU nurses to fill the vacancies. This recruitment included overseas recruitment and newly qualified nurses without ITU experience. We were told that this change in skill mix would result in additional pressure on experience staff as they would have to support and develop staff who may not have the appropriate ITU skills. To address this issue the unit had a range of courses including induction to critical care, which had been validated by a local university and included practical assessments of skills. Staff who completed this course were then able to attend the university based critical care course, which developed their skills and experience in ITU nursing. We were told that the unit supported between five and eight nurses on this course annually.

The unit had a dedicated practice development nurse post responsible for a range of unit level training including the staff development programme and new staff induction. We were told that this post had been difficult to recruit to; but arrangements were in place to cover this role. Mandatory training for all staff had been identified in areas such as infection prevention, resuscitation and medicines management; this training ensured staff had the skills and knowledge to provide safe care to patients. Advanced life support (ALS) training was provided, and evidence provided showed that the majority of staff had completed this course. However, we were told that the range of

Intensive/critical care

mandatory training provided by the trust was wider than their previous employer had required. Therefore not all staff had completed the necessary mandatory training but were in the process of attending these training sessions.

Staff were responsible for booking themselves on training and had access to their on line study record, there were systems in place to alert staff when they were required to attend refresher training and that managers were alerted to this training need. We were told that this on line system was often out of date and staff sometimes received incorrect notification that they needed to update their training. To address this issue we saw that the unit maintained its own staff training records which reflected the training staff had completed.

We found that there was a named consultant in charge of the unit seven days per week. A lack of medical resources were currently being covered by locum doctors. This lack of appropriate levels of consultant time placed the unit at risk of having unsustainable medical rotas.

The ITU and HDU was only able to achieve appropriate levels of staffing by using a significant number of agency nurses. We noted that some shifts were uncovered. This resulted in vacant beds not being used to admit patients into and patients being placed at risk of not always receiving care in a timely manner due to a lack of staff. Each of the three areas had an experienced nurse in charge who provided support to the other members of staff, to facilitate care and treatment being delivered.

The majority of nursing rotas we looked at showed that nurse staffing ratios were in line with the Royal College of Nursing's guidelines. These ratios were usually achieved by the use of experienced ITU agency staff, however, when it was not possible to obtain agency staff these ratios were sometimes compromised. To mitigate the risk of shifts being left unfilled the manager told us they blocked booked agency staff, which also facilitated consistency of agency staff who knew the unit.

E-rostering, an electronic system used to schedule staffing, had been introduced, however staff we spoke with reported that this system was generating unsustainable rotas that did not take into account mentoring or staff preferences. This resulted in senior staff having to spend significant amounts of time reviewing and amending the rotas manually to ensure they met the needs of both patients and staff.

There was an appraisal system in place for all staff, nursing staff and managers we spoke with stated that at times due to workload it was difficult to complete appraisals. The records we saw showed that 80% of staff had received an appraisal in the last 12 months.

Are intensive/critical services effective? (for example, treatment is effective)

Good 

Using evidence-based guidance

The unit participated in a range of clinical audits including monitoring of compliance with National Institute for Health and Clinical Excellence (NICE) and other professional guidelines. For example NICE Core guidance 50, a standard for identification of patient's needing critical care was in place. Staff told us that the unit was compliant with NICE Core guidance 83; regarding how care was provided to patients once they left the critical care unit. There was a 'Beyond critical care group' and a nurse led follow up clinic to collect the patient's and their families views on the care they had received in ITU/HDU. Views were also collected via a patient diary that was given to the individual to comment on their care. These views were used to make improvements and learn from patient feedback.

We noted that care bundles such as ventilator care bundles were in place and reviewed to improve patient outcomes.

Performance, monitoring and improvement of outcomes

The hospital mortality data for critical care services showed that the ITU's rate was within statistically acceptable levels but towards the upper limits. The unit held regular mortality meetings, at which specific cases were discussed and any learning identified. Staff told us that these meetings were led by the consultant and attended by a range of nursing and medical staff.

The hospital submitted data to the Intensive Care National Audit and Research Centre (ICNARC). The data for adult critical care for 2012/2013 showed that the number of unplanned readmissions within 48 hours to the ITU was similar to than other similar units. This indicated that patients were not discharged too early before they are medically fit.

Intensive/critical care

Staff, equipment and facilities

The unit had a range of equipment that was kept on the unit to ensure it was readily available. The shelves storing disposable equipment were labelled and there was an index to inform staff of the location, ensuring equipment was obtained in a timely manner. There was also a blood gas machine on unit, we were told that this was for ITU or HDU use only and that all staff who used the machine had individual log in codes for the machine. All staff completed training and an assessment to demonstrate they were competent to use the machine as part of their induction training.

Multidisciplinary working and support

We were told that the multidisciplinary team supported each other to deliver safe and effective care. For example the unit had an identified physiotherapist and pharmacist who joined the daily ward rounds to ensure they were briefed on any changes in the patients' plan of care and could provide specific advice to the medical and nursing team.

The unit worked closely with the outreach team who followed up patients on the wards post discharge from ITU or HDU and who are responsible for identifying any patients who may require the support of HDU or ITU. All patients transferred out of ITU or HDU were followed up.

Are intensive/critical services caring?

Good 

Compassion, dignity and empathy

Patients were treated with dignity and respect. We observed staff providing care in a kind and respectful manner, for example curtains were closed around the bed when care was being delivered to maintain their dignity. There was a separate room that nurses and doctors used to speak to relatives in private to maintain confidentiality. However, this room was also used for other purposes. There were no relative facilities on the unit. We observed that nursing staff spoke to relatives in a kind and compassionate manner.

While relatives we spoke with commented that all the doctors and nurses were caring and very good. Some relatives commented that they would have like more continuity with the nurses who cared for their relative. They

reported that even when a nurse was on duty for several shifts, the same nurse or team of nurses were not always assigned to their relative. They said this meant that they had often repeat information to several nurses within a few days.

Involvement in care and decision making

Trust and communication

Some of the relatives we spoke with reported that they were provided with conflicting information by nursing and medical staff. They found this confusing and were unsure who was providing the correct information. There was a limited record of communication between staff and relatives in the patients notes, therefore not all conversations about the patient's care, treatment and decisions made were recorded, this could result in conflicting information being provided.

Emotional support

Patients and relatives we spoke with said they felt support by staff.

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

Requires improvement 

Meeting people's needs

The unit did not have any relative's overnight accommodation or a relative's room with access to drinks. Staff told us and we saw that the identified relative's room was being used as an equipment store by another department. This meant that relatives had to wait outside the unit in a public corridor when not at their relative's bedside.

During our inspection we noted that there was limited written information and leaflets for patients and their relatives. The information available included advice for patients and relatives about the unit and on discharge from the ITU. We noted that these leaflets were photocopies of the original document and some had the name of the previous trust on them. There was no information or photographs displayed in the unit about the staff who worked on the unit, therefore some relatives were unclear

Intensive/critical care

about the role of some staff or who to approach if they had a concern. There was also no information about who they should raise any concerns or complaints with, which could result in an under reporting of concerns or complaints.

Vulnerable patients and capacity

Staff applied the Mental Capacity Act 2005 and Code of Practice in relation to capacity and consent. We saw evidence that this was documented in patients notes.

Access to services

The bed occupancy rates for the three months available for Lewisham and Greenwich NHS Trust were significantly higher than the England average. In November and December 2013, the bed occupancy rate reached 100%, which is well above the England average for both months of 85.4% and 77.1% respectively. This is also well above the Royal College of Anaesthetists' recommendations for safe bed occupancy.

Staff we spoke with stated that the bed managers were working with the unit to identify ward beds but it was frequently difficult to discharge patients to the ward areas due to lack of bed capacity. During our inspection we were informed that four patients were fit for discharge, one of whom had been ready for discharge for four days, but no beds were available to transfer these patients to. These delayed discharges resulted in patients and their families being cared for in an inappropriate area and could potentially delay admissions to the ITU as this patient would need to be discharged and the bed space cleaned before the critically ill patient could be admitted. It was unclear from the evidence collected during our inspection what action the hospital planned to take to reduce the number of delayed discharges which would impact on the length of stay in ITU and HDU.

Leaving unit

Patients were discharged from HDU and ITU to other clinical areas in the hospital. All patients and their relatives were offered an appointment at the nurse led follow-up clinic. At this appointment feedback from patients and their relatives on their experience of ITU and HDU was collected. This information was used to identify any issues that may have impacted on their experience to ensure action was taken to reduce the risk of a similar issue occurring in the future. The unit monitored any readmission of patients and reported this data to the ICNARC. The data provided during our inspection showed that the numbers of unplanned readmissions were within a statistically acceptable range.

There was a process for the discharge and transfer of patients but due to a lack of bed capacity in the hospital, discharges were frequently delayed. The 2012/13 ICNARC Report also showed that the unit had a rate below the England average for out of hour's discharges. All patients discharge from the HDU or ITU patients were seen within 24 hours by the outreach team, this team was available seven days per week

Learning from experiences, concerns and complaints

The staff we spoke with told us that they received either written on comments cards or verbal feedback directly from patients or their family as they did not participate in the Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment. We were told that the unit had received very few complaints, these mainly related to the restricted visiting hours and the lack of relatives' facilities. We saw that in response to these comments staff were flexible regarding visiting times to meet individual's needs. For example we observed a gentleman's son visiting before he went to work as it was not possible for him to visit in the units visiting hours.

Staff told us that they received very few complaints and that the majority related to the lack of relatives facilities. They also told us that the lack of relatives' facilities was often raised when on the unit's comment cards. The unit had previously tried to escalate the issue of the lack of facilities but as they had not received a response from senior management they had stopped escalating the issue. At the time of our inspection, we were told that despite staff raising the issue with senior managers there were no plans to provide any relatives' facilities in or near the unit.

The hospitals ICNARC data showed that the unit had a significant number of delayed discharges. It was unclear from our discussions with staff what action was being taken to address the issue of delayed discharges. However, we did note that there were very few out of hours, after 22.00, discharges to the wards. By avoiding transfers out of hours, patients were transferred and handed over to ward areas at a time when there were sufficient medical and nursing staff to review their care needs and provide care that met the individual's needs.

Are intensive/critical services well-led?

Intensive/critical care

Requires improvement 

Vision, strategy and risks

Both nursing and medical staff we spoke with told us that the unit was well organised. The senior staff welcomed the involvement of the director of nursing and felt that when she spent time on the unit this was for a specific purpose and had a measurable outcome. For example she had contributed to the unit's nursing skill mix review, challenging staff which had resulted in a clear rationale for the numbers of senior staff the unit required.

There was no strategy or vision at the time of our inspection regarding how the trust's two critical care units would work together to learn from each other and improve the quality of patient care. Some work at matron level across the two ITUs was taking place there was no interaction between nursing staff at this ITU and the trust's other ITU based at Lewisham Hospital.

Governance arrangements

There were clinical governance arrangements in place. For example there were critical care governance meetings every two months, at which a range of topics were discussed including themes of incidents. Staff were able to explain that patients received care and treatment according to national guidelines and this was monitored. We were told that there were clear arrangements for cascading information to staff. This included the circulation of the unit's newsletter that included updates on incidents and changes to practice. The unit had regular staff meetings at which information was cascaded. To ensure as many staff as possible were able to attend, the meeting was held twice on the same day, one for those staff working on night duty that took place early morning and another later in the day for those staff on a day shift.

We were told that risks identified by staff were entered onto the risk register for surgery, anaesthetics and critical care directorate and that an action plan to address the risk was developed. The trust provided us with the risk register for the directorate however; this register did not include any specific ITU or HDU entries. Therefore we were unable to identify what systems and processes were used to report and monitor the implementation of action plans to mitigate the risks identified in the ITU and HDU.

Leadership and culture

There were clear leadership roles in the unit led by consultants who had specialised in ITU medicine, as recommended by the Faculty of Intensive Care Medicine (FCIM). There was always at least one senior member of staff leading the team and a matron. The staff we spoke with were happy with the support they received. Some of the staff we spoke with commented that 'the leadership post merger was better, more open and visible.' They found the director of nursing approachable and supportive.

Staff we spoke to said that the matron and consultants were approachable

The outreach team was not managed by critical care but was part of the corporate services directorate. Several members of staff felt this service would better in critical care as there were separately consultants, which could result in a lack of continuity of care.

Nursing staff we spoke with commented on the lack of clarity from the trust board regarding the different pay staff doing the same role were on. We were told this discrepancy in pay was due to one hospital in the trust being located in an inner London borough and therefore staff working at this trust were paid an inner London weighting, an additional payment to support the high cost of living in London. While the Queen Elizabeth's was located in an outer London borough and staff were paid a lower additional payment. Staff understood the reason for this but stated that they had received mixed messages from the trust board about what if any action would be taken to address this.

Patient experiences, staff involvement and engagement

All the patients and relatives we spoke with were complimentary about the staff and the care they had received. Some commented on the improvements in care since the hospital was now part of Greenwich and Lewisham trust.

Learning, improvement, innovation and sustainability

The critical care unit participated in the ICNARC data collection and recorded close to 100% data completeness, according to the 2012/13 Annual Quality Report. At the time of our inspection there were currently no data available on the outcomes of the GMC training surveys of trainees'

Intensive/critical care






experiences of Intensive Care Medicine. However, the junior doctors we spoke with stated that they felt well supported and that consultants and nurse were approachable and supportive.

Doctors and nurses had the appropriate skills and training to deliver safe and effective care. We were told that staff could access development programmes and that there was a weekly consultant teaching programme. The staff we spoke with told us that staff development was seen as a high priority by managers. They found the training programmes were effective in preparing them for their

specific roles. Information was cascaded through a range of approaches including team meetings, email and information on the staff notice board. The Matron had begun to work with his peer at the trust's other hospital site and was sharing learning to improve the quality of care.

Staff we spoke with commented that there were no formal systems or processes for recognising good practice, which could be shared with other areas of the trust. They also felt that there was a lack of any system for rewarding or appreciating staff. They felt staff recognition would improve morale and assist with raising standards in the trust.

Maternity and family planning

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

Information about the service

The recently formed Lewisham and Greenwich NHS Trust provides maternity services at its two main sites at UHL and QEH in Greenwich. Since the two sites merged into a single Trust in October 2013, the trust will look to cater for in excess of 9,000 deliveries per year, including antenatal and postnatal care. Home births are also available.

Acute maternity services at QEH provide care in its acute ward for women in Greenwich and Bexley. The service comprises of an acute labour ward, pre and post natal wards. A birth centre is currently under construction and is due to open in September 2014.

Summary of findings

We felt that more action should be taken with regard to concerns highlighted on the risk register. The team had concerns on the accuracy or way these data were collected which would impact on their use.

There was a lack of forward planning with regard to staffing levels.

We talked to a number of patients, to midwives and preceptors (instructors), to matrons, ward coordinators and senior manager, clinicians at all grades and ancillary staff.

We found a number of positive features of the maternity service at QEH. Midwives and clinicians were positive about working at the hospital, and many stated that there had been an improvement in management support, visibility, policy and practice since the merger with Lewisham. Some staff stated that they had returned to work at the hospital post-qualification because they had enjoyed it previously and had been well supported.

There were a number of specialist midwives available, including those specialising in infant feeding, HIV and bereavement. The hospital had a popular e-midwife service – Edie – an experienced midwife able to answer all pregnancy-related questions online via social media, and also a well-used ‘call the midwife’ facility which gave direct access to a midwife.

Staff on labour ward were well organised into teams, with each team led by a registrar. We saw positive multidisciplinary working, and effective postnatal follow-ups.

Maternity and family planning

Are maternity and family planning services safe?

Good 

Safety in the past

In terms of safe staffing levels, QEH has reported a midwife-to-birth ratio (per annum) of 1:31, which is slightly above recommended guidelines of 1:28. The level of consultant cover at QEH is within Royal College of Obstetricians and Gynaecologists guidelines for a unit of its size at 68 hours per week. We note that the quality and safety programme maternity services, London quality standards, Feb 13, recommend one midwife to 30 births

Learning and improvement

Staff felt there was a good incident reporting culture, and regular monthly learning sessions were held to review what could be improved and lessons learned. They anticipated that there would be a lot of changes going forward, due to the recent merger, but were positive about this.

Systems, processes and practices

The level of consultant cover at QEH was 68 hours, which is considered acceptable for a unit of this size. Nevertheless clinicians expressed a wish to have this increased, so as to provide better cover at weekends. There are 10 full-time equivalent consultant posts at QEH, however, one of these is covered by a locum. Junior medical staff were divided into three teams, each with registrars as leads. Staff reported access to consultants was good. Consultants do daily ward rounds on delivery suite and gynaecology. We were concerned, however, that the consultants did not carry out a daily antenatal ward round. We were informed that this did not form part of their current job plan, albeit this was under review.

There was a consultant midwife in post, who is supernumerary to the establishment and has a role to oversee practice. Midwives saw this as a positive addition. We were told there was a 10% vacancy rate at the hospital and, although staff were confident these posts would be filled, (we were told six posts had recently been advertised), they also expressed concerns at frequent staff shortages, particularly within the community team, and staff working long shifts without a break. Despite this, staff said they felt well-supported overall.

QEH has an early assessment unit, which is midwife-led, with a registrar on call. Screenings for abnormalities were carried out, although if any invasive procedures were required, the patient would be transferred to Kings College Hospital. Information from screenings was shared and reviewed promptly and follow-up appointments quickly arranged. Terminations of pregnancy could be performed, and follow-up counselling was provided if required.

The labour ward provided 18 delivery beds. It is overseen by a coordinator who is supernumerary but if the ward is full and staffing levels drop they are allocated patients. On the day of our inspection, the staff team was one midwife short. The postnatal ward had 31 beds, while the antenatal ward provided eight beds. Staff on the labour ward told us if they felt staffing levels were becoming unsafe they would escalate the issue. They said they had a good bank of midwives, and rarely had to resort to using agency staff.

Monitoring safety and responding to risk

Matrons told us they had clear escalation protocols, in the event of staff shortages. They were also enabled to bring more staff on duty if there was an anticipation of a busy shift. They had a designated high-risk maternity team, one of whom was always on duty. Midwives in this team all had intensive care experience.

Staff felt confident the care they provided was good. Links to safe start and local councils were in place, which allowed for easy liaison in the event of, for example, a safeguarding matter.

Anticipation and planning

We saw evidence of appropriate and consistent use of the midwifery early obstetric warning scores, and use of neonatal assessment charts. The hospital also had a Best Beginnings team to advise and take proactive action where necessary.

Maternity and family planning

Are maternity and family planning services effective?

(for example, treatment is effective)

Good 

Evidence-based guidance

The midwifery department had achieved Baby Friendly level 1 status (an external accreditation), and hoped to achieve level 2 by the end of the year.

Monitoring and improvement of outcomes

There was a trust-wide compliance team in place, made up of a range of staff at various bandings, who at the time of this inspection, were carrying out an audit of compliance with NICE postnatal care standards. Use was made of the maternity dashboard (performance reporting and tracking system) at UHL but we did not see good use of it in evidence at QEH. Staff told us there were regular quality audit meetings and weekly review meetings were held where lessons learned were discussed.

QEH has not as yet been subject to the CQC maternity outliers programme given its recent incorporation to the trust. However, its maternity dashboard has reported an emergency caesarean rate of 17.1% from October to December 2013 which, though above the England average, is lower than the rate at UHL. Consultants told us they had assessed the data and felt the high rate was due to the wide range of cases they treated. Nevertheless staff told us they were reviewing different methods of induction and whether these were affecting the rate.

Reviews of all caesarean sections were carried out the morning after surgery, and postnatal clinics held. Midwives and clinicians met weekly to discuss cases. A weekly vaginal birth after caesarean clinic was run by a senior midwife. Consultants thought that they also had a higher than average rate of elective caesarean sections, but this was due to a capacity issue at another relatively local hospital which had necessitated women being transferred to QEH.

The maternity unit showed a normal vaginal delivery rate of around 62%, which is above the England average.

Postnatal re-admission rates were high in comparison to the national average. Measures had been introduced to

address this. While consultants felt this was mainly due to the wrong coding being entered in the data, they had nevertheless introduced a policy where all re-admissions were seen by a consultant.

We saw the trust had responded to the 2010 National Patient Safety Agency rapid response alert 'Reducing harm from omitted and delayed doses' by doing yearly audits to check how doses were omitted or delayed and what proportion of these were on the critical list (drugs that should be administered as soon as possible and must be administered at the latest within a maximum of two hours of the prescription being written). In response to the last audit results undertaken in November 2013, a pharmacist now visited the maternity wards at QEH every week day, after it was identified that the division for women and sexual health had the highest rates of omitted and delayed medication doses.

Multidisciplinary working and support

Staff we spoke with were confident that the recent merger would lead to improved multidisciplinary working and support. A number of them commented on the sharing of good practice which was already taking place. Midwives told us local policies and procedures were disseminated for comment, revised and then implemented. They felt practice evolved and changed in line with national standards and guidance.

Staff told us of positive multidisciplinary working. They commented on good support from the outreach and pains teams for example. We saw an excellent haematology database, and a number of joint clinics were run, for example, in mental health, substance misuse, HIV, diabetes and safeguarding. Handovers and meetings were attended by a range of professionals. For example, the perinatal care pathway meeting was attended by a pathologist.

We reviewed the availability and maintenance of equipment in all maternity areas. Emergency resuscitation equipment was available and regularly checked across all areas. These checks were recorded. Midwives were pleased that they had recently been provided with a telemetry machine which enabled women who had previously given birth via caesarean section to give birth naturally in a birthing pool.

A number of staff expressed concerns about the lack of suitable equipment. For example, the lack of electric beds worried staff from a manual, patient-handling perspective.

Maternity and family planning

They told us they kept the few electric beds they had for patients who had undergone a caesarean section. We were also told that one of the theatres did not have piped oxygen.

The lack of equipment was seen as a considerable challenge. Staff highlighted the difficulty in getting hold of a breast pump, as there was only one at the hospital. One midwife told us they had wasted 45 minutes trying to find an appropriate size cuff so they could measure the blood pressure of one patient. Community midwives commented on the shortage of suction kits, and said they had to come into the hospital to get one. Staff also commented on the lack of computers and administrative support.

Are maternity and family planning services caring?

Good 

Compassion, dignity and empathy

Lewisham and Greenwich NHS Trust scored well below the England average on the new Maternity Friends and Family Test in December 2013, although response rates were extremely low (between 3–4%). This data is still experimental so should be treated with extreme caution. However, the trust did achieve a response rate of 34% of the test question on postnatal care, though only managed a score of 38 out of 100, which is well below the England average of 66.

There is a designated bereavement room outside the labour ward and a bereavement midwife who coordinates care for all women with pregnancy loss. Home visits were offered to help support parents.

Involvement in care

Feedback from the patients we spoke with was generally positive. Positive interactions were observed between staff and patients. Staff told us that, although the care had not changed, feedback over the last six months had improved.

Prior to booking, patients can access the trust website for information. Patients can use the e-midwife system, Edie, to seek non-urgent advice and information via social media. They could also access a 'call the midwife' service which gives direct access to a midwife.

Patients appreciated the facilities for partners, who were enabled to stay in the hospital. Recliner chairs were provided for partners, and had proved popular.

Pregnancy information evenings were run each month which enabled the midwives to get to know their patients and also gain feedback on the service being provided. Once a patient had been admitted, supervisors and managers carried out patient experience rounds when they spoke with patients to seek their views.

Trust and respect

Patients valued the friendly approach of the clinicians. We observed patients being greeted by a consultant who recalled their names as they passed by each other on the unit. We saw a wide range of information on display on the labour ward. This was very well presented.

Emotional support

As well as a bereavement midwife, patients had access to a chaplain. To ensure cultural needs were met, the chaplain could carry out naming ceremonies where requested and also liaised with clergy from other faiths if required.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Good 

Meeting people's needs

In terms of antenatal care, the unit has consistently shown a low rate for women booking their deliveries with the service by 12 weeks and six days of gestation. According to its maternity dashboard, QEH has shown a booking rate for this time period of around 70–75%, though this has risen in the most recent quarter (quarter 3) to 77.3%.

The maternity unit offered a range of pain relief methods, including the availability of epidurals 24 hours a day, seven days a week. The unit also had a dedicated anaesthetist for maternity services.

Midwives had devised a specialist pathway for obese patients called Pregnancy Plus. This project was linked to a national slimming programme and women were offered limited free membership post-delivery.

Maternity and family planning

Access to services

We saw there was appropriate care for people with complex medical needs through, for example, joint clinics.

Most antenatal bookings were carried out in the community, however, patients could also be booked in at the hospital if they needed a translator or were a late booking.

Staff felt that they served a diverse population well. As well as the Best Beginnings group, they had safeguarding midwives, a HIV specialist midwife and specialists in infant feeding. Interpreters could be easily booked and the LanguageLine telephone interpreter service was available on the wards.

Vulnerable patients and capacity

We saw that steps were taken to ensure good quality care for vulnerable patients. We were told that those with a mental health illness were provided with one-to-one support from a registered mental nurse where appropriate. We saw this to be the case, and the patient in question was given the privacy of a single room. Staff liaised with the community mental health team prior to the discharge of any vulnerable patient. The needs of patients with disabilities, such as sight or hearing impairments or a learning disability, were taken into consideration.

QEH operated a perinatal clinic each week to follow up women who have had any complications, such as a caesarean section, during birth. This clinic was consultant-led. We saw that a room was being developed to enable community midwives to have pre-labour contact with their patients.

Sufficient capacity

Though the trust's average bed occupancy was within the Royal College of Nursing guidelines, it was significantly above the England average. The maternity unit had had to close once within the last six months due to reaching capacity. Patients were then transferred to UHL.

Leaving hospital

Staff had prepared a comprehensive information pack for patients to take home post-delivery. The pack included information on, for example, the Meet a Mum Association, preventing a reoccurrence of postnatal depression, local breastfeeding support groups, baby jaundice, screening tests to come, registering a baby's birth and a satisfaction questionnaire which sought feedback from patients on the service they had received from the maternity department.

Learning from experiences, concerns and complaints

Patients who had used the maternity services could attend listening events where patient feedback was invited, and patients could meet and talk with staff. These events were used to as a measure of patient satisfaction.

Following complaints about delays, the induction and labour policy had been reviewed. Women had also complained that their partners were not able to stay with them around the clock. As a result, unrestricted visiting hours had been introduced for one partner for each patient.

Patients told us the quality of food had been reviewed due to a number of complaints. Hot food was now available 24 hours a day.

We saw how changes had been implemented as the result of a Never Event with a retained swab. These changes were themselves being regularly audited.

Are maternity and family planning services well-led?

Requires improvement 

Vision, strategy and risks

We felt that more action could be taken with regard to concerns which had been highlighted on the maternity risk register. There was a heavy reliance on using data for risk assessment and governance, however, this data had been either poorly collected and collated or was simply inaccurate. This impacted on the effectiveness of action being taken to improve the service.

Quality, performance and problems

Staff told us that one of the biggest challenges in the merger had been with regard to information technology (IT) integration. Staff did not have access to IT systems in Lewisham hospital, although this had been recognised as a risk.

At present the hospital does not have a Maternity Service Liaison Committee, as it was dissolved when they merged with Lewisham. Staff told us they were working with the local clinical commissioning group to address this.

Maternity and family planning

Leadership and culture

Midwifery staff said they felt valued, and welcomed the new trust leadership. Junior doctors were very positive about working in the unit. They told us they enjoyed working at QEH and chose to return. Staff said they felt the management was much more focused and engaged since the merger. They were supportive and staff felt that financial cost was not considered at the expense of patient care.

However, staff also told us that there could be better forward planning, particularly with regard to staffing levels and the provision of equipment. They thought, however, that the head of midwifery had an impossible workload, although this should improve once vacant posts were filled. Staff were complimentary about the head of midwifery, stating they found her calm, efficient and knowledgeable.

One of the matrons told us that cross site supervision group had been formed which had raised the whole profile of supervision, and had led to a reduction in the blurring of supervisory and management roles. Supervisor to midwife ratio was approximately 1:14. Annual reviews had been carried out and new starters told us they felt well-supported.

Patient experiences and staff involvement and engagement

Before they go home patients are given a discharge pack and this is gone through with them by a healthcare

assistant. We observed one assistant going through the pack with a group of patients. The assistant was knowledgeable, friendly and gave clear advice. After the session, patients told us they found it useful. Patients also fed back their satisfaction at the care they had received from the maternity department via a questionnaire.

Learning, improvement, innovation and sustainability






Staff told us that they receive specialty training sessions, and they felt they were up to date with mandatory training. The provider may find it useful to note that the take-up of mandatory training was approximately 80%.

To try to encourage women to book with the midwifery department early on in their pregnancy, a new initiative was about to start whereby staff were going to make use of the children's centre bus to go around the community and encourage early booking with the hospital.

We saw evidence of plans for improving links between the two sites and sharing best practice. For example, joint supervision of midwives. Staff told us separate policies had been kept at each hospital, but work was underway on taking the best parts of both going forward.

Everyone received a 'Just 5' weekly briefing email from the patient safety coordinator, and a 'risky business' newsletter once a month. This helped understand key risk areas. They viewed these as useful learning tools.

Services for children & young people

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

Information about the service

Lewisham and Greenwich NHS Trust provides a range of services for children and young people.

The QEH site has a children's assessment unit, a 24-hour paediatric emergency department, an inpatient ward of 20 beds, a neonatal unit and a comprehensive outpatient department which provides for a wide range of services. There is also a four-bed oncology unit.

Summary of findings

We were concerned at the incident reporting process. Learning from incidents is an important part of making services safer. Staff told us that only a few people were authorised to report incidents. This may lead to a reduction in reporting and learning, or mis-reporting. All staff should be able to report incidents.

Care plans were poor, with pre-printed generic versions that were not individually tailored to each child's needs.

There was a shortage of staff and those staff on duty told us that the shifts left them exhausted; this challenged their ability to deliver the care they felt they should. We found that staff shortages were impacting on the quality of care provided. This, coupled with some equipment shortages, lack of learning from incidents, and lack of action following audits, meant that the service was not performing as well as could be expected.

We found caring was mixed in this service. We spoke to a number of parents, children, clinicians, nursing and ancillary staff. We received positive feedback from parents and children with regard to the care they received, and the interaction between them, nurses and doctors. Staff were proud of the care they gave but this was tempered by the pressures they felt from low staffing levels, increased workload and low morale.

Facilities were child friendly. There was evidence of good multidisciplinary working across specialties, but

Services for children & young people

little evidence of joint working across the two hospital sites. There were examples of innovative practice – we were told that the oncology unit has one of the country's first paediatric oncology dietitians.

Are children's care services safe?

Requires improvement 

Learning and improvement

A recent death of a child had occurred at the Lewisham hospital. A further death, in similar circumstances, occurred at the QEH. There did not appear to be any dissemination of lessons learned from the previous serious incident. On reflection, it had appeared that the verbal handovers had not used a systematic tool such as SBAR (situation-background-assessment-recommendation); while junior staff did not routinely escalate matters to the consultant for further medical opinion. This meant that staff were not given the opportunity to improve practice as a consequence, and there was a risk to patients that issues could be overlooked if advice was not sought by junior clinicians.

One member of staff told us that, if an incident occurred, they reported to the nurse in charge. There was an online incident reporting tool but this required a log-in and only a small number of staff were authorised to do this.

Systems, processes and practices

The inpatient ward had 20 beds, and, at the time of our inspection, had children who were more acutely ill than at the Lewisham site. This caused us some concern with regard to observation, as the beds were arranged in cubicles which did not give the nursing staff clear vision of all patients. One nurse told us the cubicles were widely spaced which made it difficult to hear if something was happening. The ward operated with a staff-to-patient ratio of 1:5, however, staff told us that one-to-one care would be provided for high-dependency patients.

At the time of our inspection, there were three nurses on duty (one of whom had been 'borrowed' from the special care baby unit) and two third-year student nurses. Staff had been allocated six patients each during the morning shift, which they felt unreasonable. Staff talked of going home absolutely worn out, and disillusioned because they felt they could not give the care they would like to give. We observed that patients were left alone for long periods because staff were busy elsewhere.

We saw the nurse in charge at the time of our inspection not only had to manage the ward but had also been

Services for children & young people

allocated six patients. Staff spoke of their desire to provide high-quality care but felt that this was sometimes compromised because of the pressure of staffing levels and vacancies. The inpatient ward did not have a manager in post. We were told that this had been advertised without success, and so was being re-advertised.

Staff shortages were apparent in other areas of the service, such as in the day assessment unit. At the time of our inspection, the unit was running with a 50% staff shortage. This meant that one nurse covered the whole of the day's clinic, making it very difficult for them to even take a break. Staff on this unit were, nonetheless, positive and very proud of their nurse-led service.

The care plans we reviewed were poor. Staff used pre-printed plans which were impersonal and not reflective of the individual child. We saw intravenous alarms that were left unattended for 30 minutes, and one child left without fluids for between two and three hours. One nurse told us this was because not all staff had had intravenous training and, therefore, there were times when no one was available. This is unacceptable.

The outpatient department was busy, with patients having to wait up to three weeks for a blood test. We spoke to receptionist staff who explained that, due to staff shortages, they had to cover both outpatients and the inpatient ward. The department had a nurse staffing complement of two, but on the day of our visit we were told that often there was just one nurse.

The difficulty in recruiting specialist staff was highlighted on the paediatric oncology ward, where clinical nurse specialists worked long days to ensure cover. Staff from this unit also covered on the inpatient ward when needed, wherever possible. This impacted on the aim of the unit to build a permanent highly trained oncology team.

Staff on the inpatient ward confirmed they had access to a paediatric consultant around the clock, including at weekends. This meant that the service was as safe for children and young people out of hours as it was during the week. The oncology unit had a designated consultant, however, the post of deputy remained unfilled. If the consultant was unavailable, staff could call on the consultant for the inpatient ward. They could also call on the Royal Marsden Hospital's tertiary centre for support and guidance if needed.

We found there were clear safeguarding policies and procedures in place. Staff had clear guidance to follow. The trust was part of the multi-agency referral centre for young people mixed up in gangs. There were two designated nurses for safeguarding on the inpatient ward, and established communication channels with the local social service department. The safeguarding nurse attended daily rounds on the inpatient ward.

Monitoring safety and responding to risk

We saw that a pre-printed template was used to carry out risk assessments for children on the inpatient ward. They were used primarily to assess moving and handling risks, where there was a mobility reduction or the child had special needs. The assessments were not always being used appropriately. For example, we saw one was in place which had been used to assess a baby, but was clearly designed for a much older person. This meant that the specific needs of the child had not been taken into consideration, which potentially placed the child at risk.

We reviewed paediatric surgery and found that not all nursing staff were paediatric trained, which was contrary to Royal College of Nursing guidelines.

The head of nursing told us that each clinical and non-clinical area underwent a risk assessment annually. Matrons and ward or departmental managers carried out the clinical assessment while a representative from the trust's health and safety department performed the non-clinical assessment.

Some staff training in intermediate/advanced paediatric life support was out of date. We were told that two mandatory training dates had been set for this in the forthcoming month. We were unable to verify that all anaesthetists who cared for children and young people had up-to-date competencies in paediatrics.

We saw that surgical staff used appropriate surgical safety checklists and carried out a pre-assessment checklist. We noted the perioperative nursing template and anaesthetic chart were not paediatric specific.

Anticipation and planning

There was little evidence of advance planning, for example, to cover increased winter admissions. The service had little of the flexibility Lewisham hospital had with regard to bed numbers.

Services for children & young people

We reviewed records of monitoring and maintenance of resuscitation equipment. We found that there were some gaps in the monitoring checks which could potentially have a serious outcomes for patients.

Are children's care services effective? (for example, treatment is effective)

Not sufficient evidence to rate 

There are not enough recent reliable data to rate this element of the service

Evidence-based guidance

We saw that staff used the paediatric early warning system.

Monitoring and improvement of outcomes

The trust performed mostly above the upper England quartile in the children and young people's pain audit where patients in pain were given analgesia in a timely manner depending on their pain levels. This is indicative of effective care.

The trust is currently working towards attaining the Paediatric Diabetes Best Practice Tariff which was outlined in their governance minutes, although the trust has not yet met the standards.

The trust's re-admission rates were above the NHS average in October 2013 which was after the merger of hospital sites

The data pack did not include all the audits available for trusts to submit, and therefore did not give a conclusive assessment.

Sufficient capacity

We noted the inpatient ward was operating at full capacity. There were two additional beds on the oncology unit for overspill. The day unit had six beds available. Staff told us that if there was a bed crisis, children could be admitted to the day care unit initially.

We found the facilities were child-friendly. Paediatric resuscitation equipment was available and easily accessible in all areas where children and young people were treated.

We visited the paediatric oncology unit. This had four beds for inpatients, a treatment room a play room and an activity room for older patients. The ward was child-friendly, bright and colourful. At the time of our

inspection, there were no inpatients and no patients receiving chemotherapy (which was done on a day patient basis). We discussed with the clinical nurse specialist what steps would be taken if all the beds were full, and they needed to admit another oncology patient. We were informed that, if possible, a bed would be found on the adjoining inpatient paediatric ward, but ultimately, if there were no beds, it was probable a patient on the paediatric ward would have to be moved. This possible capacity issue had not occurred, however, there did not appear to be robust planning in place in the event that it did happen.

There was a shortage across the department of some equipment, such as blood pressure monitors. The oncology unit expressed their frustration at having to search for and borrow an ear, nose and throat trolley each time they had to carry out an examination of a child, which occurred frequently.

The day assessment unit was also short of equipment. We were told they had an insufficient number of thermometers, for example, and also a shortage of other equipment used for observations.

Multidisciplinary working and support

Staff on the inpatient ward told us that they now recorded their observations in the medical notes, which had improved communication between nurses and doctors. There were a number of joint clinics. Senior staff told us their focus was on integration and the provision of a seamless care pathway for children. That pathway could be from the acute setting to the community or vice versa. There was a designated integrated care pathway lead for children.

We saw evidence of good multidisciplinary working in the oncology unit. Monthly meetings were held between staff from the unit, dieticians, the hospital school, the paediatric pharmacist and the specialist community home care teams. This positive interaction was only marred by the refusal of the community home care team from Bromley to attend, deeming it too far to travel. The clinicians at QEH felt that this meant the Bromley patients were unrepresented.

There was little joint working across the two sites. It was notable that, generally, there were separate policies and procedures for each site. Staff told us that they were currently working on bringing these together, and creating new policies and procedures from the best parts of both.

Services for children & young people

Are children's care services caring?

Good



We saw caring was mixed. We saw areas of good practice and areas where the staff were struggling to provide the levels of care they should.

Compassion, dignity and empathy

We spoke with a number of parents on the inpatient ward. They described the staff as “fantastic” and “caring”. One mother told us, “my child loved the place. Loved the “robot for films”. Another mother told us “the day-to-day care is really fantastic”.

We observed the interaction between a consultant and a child in the oncology unit. The clinician was patient, gentle and made their examination fun for the child. The parent told us that they were very happy with the care being given.

We discussed the support available for children who had a life-limiting illness. The clinical nurse specialist in oncology explained the support systems in place for their patients, which included a multidisciplinary approach to information-sharing and care in the community. The systems in place were comprehensive, well thought through and effective.

Involvement in care

Parents told us they found the doctors professional, and the nurses took time to answer their questions. However, we observed that, due to staff shortages, time constraints and workload, staff were unable to interact with patients as much as they wished.

We saw that children on the oncology ward were given a range of information booklets on arrival, but we did not see similar literature in other paediatric areas. We saw no evidence that staff sought feedback from parents or patients.

We asked to see evidence of parent and, where appropriate, child involvement in care planning. We were told that care plans were drawn up at the bedside and parents and children were consulted. There was no evidence of this consultation on the care records we examined. Parents, and children if old enough, had not been asked to sign the care plans.

Emotional support

One parent told us they had had to leave their (sleeping) eight-year-old child to go to sort out a parking permit. They said they specifically informed the nurses of this, and asked them to tell the child. When the parent returned to the ward she found her child distraught as no one had told her where her mother had gone.

Are children's care services responsive to people's needs?

(for example, to feedback?)

Good



Meeting people's needs

Parents and children commented favourably on the classroom and play facilities. There was a large, clean, well-equipped playroom, and allocated play workers. We saw that the service worked closely with schools, including encouraging primary schools to ‘come and look’ and have a tour with one of the play specialists.

We did, however, receive a number of negative comments. Several parents complained of “appalling” food for the children, and small portions.

There were some facilities available for older children. The oncology ward had a separate ‘activity’ room for older patients, while the playroom on the inpatient ward had a separate area for adolescents. Staff told us an older child could request to talk to a clinician without a parent if they wanted to.

Work experience placements were offered for young people, and staff from the service visited local secondary schools to teach children first aid and resuscitation.

Access to services

A number of parents complained about the unavailability of food. There was nowhere for them to go to get food or refreshments. One parent told us a nurse had taken pity on them and had helped them access the staff canteen during the night so they could purchase something.

We found signage for visitors to QEH clear, making orientation easy.

Services for children & young people

Vulnerable patients and capacity

Staff had access to the Language-Line telephone interpreter service if any translations were required and interpreters could also be requested if needed.

Adjustments were made for children with mental health needs. For example, a registered mental nurse was engaged to provide one-to-one care for one child.

Leaving hospital

We spoke with parents whose child was being discharged. They told us they were given an explanation of the medication their child was prescribed, and stated that it had been a good experience. They had felt their child had been well looked after. They particularly appreciated being able to stay overnight with their child.

Learning from experiences, concerns and complaints

The head of nursing told us they reviewed all complaints received about the children's services, and that these were discussed at governance meetings. We were unable to determine what action might have been taken as a result of complaints as, although requested, we were not provided with action plans.

We did, however, see some evidence that staff had taken on board issues raised by parents and had acted on them. For example, staff on the oncology ward were going to start carrying a mobile phone so that, if the unit was empty and staff were covering elsewhere, parents could always reach them if they had concerns. Again on the oncology unit, we saw the measures that had been put into place to ensure that any advice given to parents over the phone was recorded in a specific log. This was in reaction to a complaint from a parent who alleged that staff gave her inappropriate advice.

Are children's care services well-led?

Requires improvement 

Vision, strategy and risks

Service managers were able to define their roles and responsibilities and understood potential risks to the service. Regular governance meetings were held and risks

escalated, but there was little evidence about what action was taken as a result. Staff at ward level, however, did not have a clear understanding of the trust's vision and values or its strategy to deliver high-quality care to patients.

Staff on the inpatient ward commented they felt there was a lack of direct management at QEH. They told us they did not have a direct line manager and rarely saw a senior manager. Conversely, staff in the day unit felt that the management structure was good. They had regular management and multidisciplinary meetings. They did say, however, that they had to use some of the designated clinical nurse specialist time for ward management purposes.

The head of nursing explained to us the strategies they were employing to remedy the staffing shortage. This included recruiting from Spain and Portugal, and exploring other avenues to advertise, such as social media, and providing accommodation for nurses. They were also looking at the personal development of staff already in post so as to retain personnel.

Quality, performance and problems

We saw that the service used a number of different monitoring tools, such as paediatric early warning system, maternity early warning system and monitoring pressure ulcer and falls incidents, to feed into the national data system. This was then used to inform future practice.

The imminent closure of the child assessment unit at QMH will have an impact on services at QEH. There were concerns that there was no bed expansion planned at QEH, which potentially would lead to a capacity issue.

Leadership and culture

Some staff told us they thought there was a little of a "victim mentality" at QEH, and some felt they were the poor relation. They said they saw the support behind Lewisham and felt a bit on the periphery. Management and the Trust Board were not visible to them so they felt it was harder to have their voices heard. We hear that senior management were trying to address this by carrying out a lot of 'walk rounds' and introducing an organisational development programme.

Staff on the inpatient ward told us they felt under pressure from staffing shortages and morale was low. There were doing extra bank (overtime) work to cover shifts and said they relied heavily on receiving additional cover from other parts of the department. They believed sickness absence

Services for children & young people

rates were rising. One nurse told us they did not know who to go to for support, be it clinical, regarding training or just for general advice. In spite of this, they believed they had a good team which worked together well.

Student nurses were positive about working at QEH. They said they felt supported and one told us, "I love it here". Some had also had placements at UHL and felt placements at QEH were more constructive and productive.

Patient experiences and staff involvement and engagement

Parent and patient feedback with regard to the care received was all positive. While parents raised various concerns, including food, parking and waiting times, everyone we spoke with felt the staff were kind, compassionate and professional.

Learning, improvement, innovation and sustainability






Staff told us that training was not always possible due to staff shortages and the departure of their practice educator.

As a result, some previously attended training was now out of date. They told us that, since the merger with Lewisham, steps had been taken to address this, and they had been provided with two compulsory, imminent dates where all mandatory training would be undertaken.

The head of nursing talked to us about innovations they were introducing to learn from incidents and to encourage a 'no blame' culture. For example, if junior staff noted medication errors and reported them, they were sent a 'thank you' email.

The open access policy on the oncology unit was greatly appreciated by parents. They were able to bring their child directly to the unit if they had any concerns regarding their health status. On the day of our inspection, we were able to observe this in practice. Staff on the unit encouraged close engagement with parents and patients. They were introducing a text messaging service so that they could remind parents to administer essential medication at the correct time.

End of life care

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

Information about the service

Queen Elizabeth Hospital (QEH) is supported in palliative care by a community hospice. The Hospice Outreach Team is a multi-professional team working in partnership with other healthcare professionals who work within QEH.

The team helps patients with their symptoms such as pain and nausea and helps them to make difficult decisions around their care. They also offer specialist advice, information, support and spiritual care and help patients to adjust to their diagnosis and the changes they may experience in the course of their illness.

The team consists of Clinical Nurse Specialists, a Specialist Psychosocial Worker, and Palliative Care Doctors, a Discharge Liaison Nurse, Counsellors and secretarial support. We spoke with some of the team, hospital staff, relatives and patients.

During October 2013 89 deaths were recorded at QEH, all within non-elective care. The Trust has a relative low number of deaths for both elective and non-elective patients.

Summary of findings

At the time of our inspection previous end of life care best practice guidance was under review. The trust had a policy, but we saw that the staff on the wards were uncertain and using guidance from a number of different national guideline bodies. There were no clear guidelines on when and how to involve the specialist palliative care team (SPCT) for people who reaching the end of their life. However, the Trust had plans to introduce a clear framework for all staff to use on the principles of care for the dying patient. A joint steering group between University Hospital Lewisham and Queen Elizabeth Hospital had been set up. It was planned to present the principles to the board in March or April 2014. The agreed principles would be fully supported with staff training.

It was hard for us to ascertain whether every appropriate patient who was receiving end of life care (EoLC) pathway was treated by the specialist palliative team at the hospital. We also could not find out how many of those people were patients receiving oncology services or patients receiving care for other long term conditions such as COPD, heart failure or dementia.

We found that the SPCT were caring and supportive. Most of the patients and relatives we spoke with told us they felt supported and involved. They were aware of the people under their care and we saw records which showed they reviewed a patient's care, amended their medication accordingly and instructed the ward staff in any changes such as recording pain scores at observation checks. We found that recording in people's care plans for observations such as pain scoring,

End of life care

modified early warning score (MEWS), anticipatory medication and do not attempt to resuscitate (DNACPR) was mixed. Some staff recorded information very well, while others omitted to record the outcome. This meant we could not be sure that every patient had been involved in conversations about what to do in the event that their breathing or heart stopped. It also meant we could not be sure that all patients were receiving adequate reviews of their medication.

Most of the staff on the ward treated patients and their relatives with compassion and thought. The SPCT felt that ward staff did not always engage in palliative care and EoLC training and would like to see a greater understanding of how to support people at this time of their life.

The staff at the bereavement office and mortuary went out of their way to ensure that the deceased were treated with respect and dignity, and families and friends were treated compassionately.

There were audits and assessments to monitor how well the palliative EoLC team performed and identify any concerns or issues. However, the multidisciplinary meetings did not involve the bereavement office so they were unable to discuss any issues, such as wrapping bodies too tightly, or share in any learning.

Are end of life care services safe?

Requires improvement 

Safety in the past

Given the recent merger of Queen Elizabeth Hospital, only one month of data is available for the period during which the site has been managed by Lewisham and Greenwich Hospital NHS Trust. .

Learning and improvement

At the time of our inspection there were no clear processes to understand how safe EoLC / palliative care was at QEH. Staff at QEH still referred to the South East London guidelines but it was not thought to be used by the staff as they referred to the SPCT for advice.

Systems, processes and practices

The trust had a policy for ensuring end of life (EoL) care; however we were unable to identify that this was implemented consistently across the whole of the hospital. The Trust policy and procedure was under review and there was a steering group reviewing Liverpool Care Pathway (LCP) recommendations. Staff at the hospital relied on the specialist palliative care team (SPCT) to advise and support them and people nearing the end of their life.

There was no policy or guidance to ensure that appropriate end of life care medication was prescribed where appropriate, this included reviewing the patient's notes. Nursing staff relied on the SPCT to advise them on appropriate EoLC medicines. We saw inconsistency in patient notes about what was seen as appropriate medicines and nutrition. For example: one patient's notes indicated that they were being given nutrition supplements, which was not appropriate in their case.

Although CPR can be attempted on any person prior to death, there comes a time for some people when it is not in their best interests to do so. Consultants / General Practitioners are responsible for making DNACPR decisions and they should make every effort to involve the individual in the decision, and if appropriate, other relevant people in making the decision. In most cases the DNACPR forms were completed appropriately notes clearly identified that discussions had taken place with the patient, however, we found a few with missing information. For example: there was missing information on the form about whether

End of life care

discussions had taken place with the patient as the space was blank. Therefore we did not know if the patient had refused to talk about DNACPR, and/or whether it was a recording error. Palliative care consultants were not aware of training for DNACPR completion. We also saw one form which stated discussions would take place with the family when they arrived. This was not amended or added to after the discussions, although we could see by looking through the notes that discussions had taken place several times. This meant it was hard for staff to readily identify the agreed actions on the DNACPR form.

One relative told us they had reported that their family member's bed had broken four days previous to our inspection. The bed had not been repaired or replaced.

Monitoring safety and responding to risk

There was not Trust or hospital guidance on anticipatory prescribing for symptoms of pain, respiratory tract secretions, agitation, nausea and vomiting, and dyspnoea. However we could see that this was usually done or advised by the specialist palliative care staff.

Out of hours advice and support was available through the local hospice. Hospital staff felt the relationship with the community hospice palliative care team was strong. There was evidence that hospital staff turned to them for support and advice at any time they required it. There was also a contractual arrangement with Guy and St Thomas' hospital for out of hours cover so that there is palliative care specialist available at all times at QEH.

Are end of life care services effective? (for example, treatment is effective)

Requires improvement 

Evidence-based guidance

In October 2013 South London Healthcare NHS Trust [SLHT] dissolved and Lewisham Healthcare NHS Trust merged with Queen Elizabeth Hospital. At the point of merger, Lewisham Healthcare NHS trust had a published 'Recognising the Deteriorating Patient Policy'. SLHT also had a published 'Early Warning Scoring and Vital Signs Policy'. Since merging in October 2013, the new Lewisham and Greenwich NHS Trust have a number of policies which are currently under review.

The Department of Health had also recently asked all acute hospital trusts to undertake an immediate clinical review of patients receiving EoLC. This was in response to the national independent review 'More Care, Less Pathway: A review of the Liverpool Care Pathway (LCP)' published in July 2013. At the time of our inspection the Trust was undertaking a review, working with the London Cancer Alliance Pathway Groups on the Principles of Care for the Dying Patient. A UHL and QE joint EoLC steering group were reviewing the principles and proposing Trust wide principles to the board in March or April 2014. Staff were aware of the review being undertaken and there would be a move to new guidance in the next few months. At the time of our inspection the hospital was not demonstrating consistent practice.

If patients were no longer able to eat or drink best interest MDT meetings were held with the involvement of the family to decide on the appropriateness of clinically assisted hydration and nutrition through PEG feeding.

Staff, equipment and facilities

The SPCT highlighted the need for more training and opportunities to engage nursing staff and consultants in the discussing and considering EoLC. They told us of their frustration of setting up training sessions and staff not attending. It had been identified that Sage and Thyme training, a course in communication, should be rolled out to all staff. The course was designed to train all grades of staff in how to listen and respond to patients or carers who are distressed or concerned. It places published research evidence about effective communication skills within a memorable structure for clinical practice. This was to help staff in how to have difficult conversations with people. There was also training in conflict resolution and 'breaking bad news' advanced communication skills.

The hospital was in the process of introducing safer syringe drivers as directed by the National Patients Safety Agency (NPSA) alert. A proposal to introduce them within the specified timescale had been proposed and was planned to be implemented by the end of 2014.

Staff told us they used to have emotional support through chaplaincy sessions. This helped them with dealing with situations they may have found emotional or difficult while supporting a patient. This service had stopped and staff told us they valued it and would like the option to have the support again.

End of life care

Senior staff told us there was no formal clinic supervision. Staff were expected to complete their mandatory training. Staff were also due to attend Sage and Thyme at Lewisham Hospital. This is a communication course designed to train all grades of staff in how to listen and respond to patients or carers who are distressed or concerned.

Multidisciplinary working and support

Multidisciplinary meeting took place for patients who had been seen by the specialist palliative care team. However, the bereavement services were not included in these meetings. Staff felt it would be useful to include them in the meetings as the bereavement services form part of the end of life care.

Are end of life care services caring?

Good



Compassion, dignity and empathy

There was little evidence of staff discussions around the “6Cs” (care, compassion, competence, communication, courage and commitment) which are the values of patient care as set out in the national nursing strategy for England. The ward staff we observed during our inspection appeared to be kind and caring in their approach to patients. The SPCT were described as “fantastic” and another person said, “they are very proud of the care they give”.

When patients were approaching the end of their life their family and friends were not restricted by visiting times and made to feel welcome to stay for as long as they needed. People were supported in eating and drinking for as long as they were able to. Patients had a good choice of food. If patients were no longer able to eat or drink best interest meetings were held with the involvement of the family to decide on the appropriate course of action.

The staff in the bereavement office were very caring, they described the ways that they considered the deceased and their family’s needs. For example, they were sensitive to different faiths and the need to prepare the body in a timely manner and issue the death certificate on the day of death.

Each patient had a named nurse, however the name of the nurse changed on a daily basis and was not the key nurse responsible for the person until which time they left the ward, as per the best practise guidance.

Involvement in care

Most of the patient’s records showed clinical staff had involved them in their care and we saw some evidence of relative’s thoughts and feelings recorded. We spoke with one family who told us initially they did not feel involved in their relative’s care, however once it became clear their relative was coming to the end of their life they said they received excellent support from the staff involved.

Trust and respect

The patients we spoke with told us the staff were helpful and kind. They told us staff had introduced themselves and had given them as much information as they could to make them feel comfortable. We observed staff speaking calmly and in a friendly manner. The staff we spoke with appeared to know the family members of the patients they were caring for and understood how to make them feel supported during their time with their relative.

Are end of life care services responsive to people’s needs?

(for example, to feedback?)

Requires improvement



Meeting people’s needs

The oncology ward provided fold up beds for relatives to use in a side room if they needed to rest while visiting their family member at the hospital. There were also reclining chairs available.

The Community Hospice is the foremost provider of specialist palliative care to patients in the London boroughs of Greenwich and Bexley. They provide support through a multi-professional team who work in partnership with QEH staff to provide specialist palliative care advice and support for patients in the hospital. They aim to work with the patient and the professionals involved in achieving the best quality of life possible for the patient and their family. The hospice team works alongside the hospital’s clinical professionals who usually lead in the patient’s care.

End of life care

Staff in the bereavement office described what happened to the deceased person and their belongings. Families would need to attend the bereavement office to collect the death certificate. They would then have to go to another part of the hospital to collect the deceased's property from the cashier's office. Staff told us they thought this process was inconvenient and insensitive to people who had just lost a family member or friend.

There were no guides produced specifically by the hospital about what to expect after a death in a hospital. However, the staff had access to a number of leaflets from other agencies to support relatives of patients that had passed away. These leaflets included contacts details for support agencies and counselling services as well as a guide in what a family needs to do when a relative has died. There was a multi-faith chaplaincy service at the hospital. There was a chapel of rest and a quiet room people could visit.

Access to services

Patients from the London boroughs of Greenwich and Bexley received specialist palliative care support through the Community Hospice at the hospital and within the community. The Community Hospice could access palliative care support in the community for patients at the hospital who lived outside these borough if they should require it when they went home.

Vulnerable patients and capacity

Staff referred patients to the SPCT and safeguarding for anyone who lacked the mental capacity to make decisions about their care and welfare. MDT meetings took places with families and / or advocates to discuss the best interests of patients who were unable to make decisions about their care.

Leaving hospital

The hospital had a fast track discharge process to allow patients to leave the hospital and go to the place of their choice to die if it was agreed to be appropriate. We saw in patient notes that the SPCT were involved in reviewing patients who wished to be fast tracked to see if they met the criteria. Staff told us the system was not as fast as it should be and patients can be waiting a number of days for it to be agreed. We saw in one patient's notes that it had taken six days to review a patient for the fast track discharge. This is not responsive to need for this patient group; trusts that are good can achieve this in hours not days.

Learning from experiences, concerns and complaints

Patients and other relevant people were directed to Patient Advice and Liaison Service (PALS) if they wished to make a complaint. The patients we spoke with told us they were not aware of how or who to make a complaint to if they needed to.

Are end of life care services well-led?

Requires improvement 

Vision, strategy and risks

At the time of our inspection the Trust was working toward having a Trust wide policy on the principles of care for the dying. The aim was to present this to the board in March or April 2014 fully supported by a training programme run by the palliative care team.

Quality, performance and problems

There appeared to be a disconnection between the specialist palliative care team (SPCT) and the staff on the wards. The roles and responsibilities were not clearly defined, there was an expectation that all the paperwork was done by the SPCT.






Leadership and culture

Staff felt there had been lack of consistency at QEH due to the management change. However they all said things had changed considerable and that things were better since the steering group had been formed. Staff told us they could see there would be consistency across the hospital and Trust as a whole in the future.

Learning, improvement, innovation and sustainability

At the time we inspected there had been one EoLC steering group meeting so it was hard to see what learning and improvement in service there had been at this stage. It was intended that the group meet seven times a year, alternating between the UHL and QEH so that everyone in the Trust was included and a joint approach could be sought.

Outpatients

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

Information about the service

The QEH outpatient's service was located in one area of the hospital. There were seven outpatient suites at the site, running a wide range of outpatient services every week day. Clinics included haematology, phlebotomy, cardiology, rheumatology and diabetes.

We spoke with patients and a range of staff at all levels at the hospital, and observed the clinics' waiting areas and interactions between staff and patients. We received feedback from our listening event and staff focus groups, and patients contacted us to tell us about their experiences. We also reviewed performance information about the trust.

The trust also provides some outpatients services on the Queen Marys site. they are included in this hospitals report as it is effectively activity from this hospital provided off-site.

Summary of findings

During our visit we found a number of areas that gave us concern. We saw lack of notes available for consultations and overreliance on temporary notes. We also saw poor security of patients notes. We observed poor infection control and security of clinical sharps, syringes and chemicals.

All the patients we spoke with talked highly of the staff working within the outpatients department at QEH. Patients felt staff were "wonderful" and "caring" and said they had the opportunity to ask questions to help them understand their care and treatment. Although the staff's interactions with patients were seen as very good, we observed that staff did not always speak to people in an appropriate manner or were aware of people who may need extra assistance.

Patients told us that staff made them feel safe and they thought the department was clean and tidy. However, we found there were some processes and staff attitudes within the department that meant patients' safety and privacy were not always protected.

There were no systems in place to assess what a patient's experience of using the outpatients department was, as opposed to the individual clinic they attended. Each division at the hospital responded to complaints and comments relating to the clinic they had attended. These were discussed at inter-divisional meetings, however, nursing and administrative staff told us there was little cross-learning between each of the outpatient clinics. Therefore, it was difficult for us to ascertain what the out patient's department did well or

Outpatients

what the main concerns for patients were. However, all staff and patients agreed that the main area for concern was the waiting time for the phlebotomy and anti-coagulation clinics.

Staff told us that the demand for clinics outstripped the number they could schedule. The department responded to the increase in demand by putting on additional clinics to ensure patient waiting times from referral to appointment did not breach the waiting time targets. The department had a high number of patients who did not attend their appointments and this meant staff double booked time slots to ensure the clinic was used to its full capacity. However, this could cause long waiting times for patients as clinics overran.

QEH staff were very positive about the merger with UHL in October 2013. We could see there had been some joint meetings across the two sites. However, it was too early to see how the shared working practices and learning could benefit patient care and welfare at each location.

Are outpatients services safe?

Inadequate 

Safety in the past

Due to the QEH having previously been part of the South London Healthcare Trust, we were unable to extract information from the previous trust in relation to this location specifically.

Learning and improvement

There were no mechanisms in place to identify how well the outpatients unit was performing in its own right. Any areas of concern, complaints or compliments were reported to the division the clinic related to. Any incidents or complaints were discussed at the monthly cross-division complaints meeting where specific incidents relating to outpatients could be identified and addressed. The senior management told us that, if they were made aware of any patient concerns, they would address them at the time.

Systems, processes and practices

We observed that, in line with national hygiene standards, staff were bare below the elbow, used the correct hand-washing procedure and wore the correct personal protective equipment, such as gloves and aprons. We checked a number of resuscitation trolleys and the oxygen cylinders throughout the outpatient department. We found they were regularly checked and audits of the checks were completed. Equipment in the department was in good condition. Staff told us an advantage of being located in a private finance initiative building was that faulty equipment was repaired or replaced immediately. The cleaning system was easily identifiable and staff were aware of their responsibilities. The staff we spoke with described the procedures in place to report any safety concerns or faulty equipment.

Patient notes and availability of results were often difficult to track down and the reception staff estimated that they could use temporary notes for up to 25% of patients. There were no robust systems in place to ensure that notes and results were always available for consultations within outpatients. When a patient's notes were not available, the clinical staff would resort to using temporary notes until

Outpatients

the patient's notes were traced. This meant the consultant would not have a patient's full medical history and presenting case, and this could cause a delay in a patient receiving their test results and possible treatment.

While we were walking around the department, we came across some areas for concern. We observed a trolley outside consultant room in clinic F for about five minutes. It had been left unattended with a patient care file and an open syringe. We were unable to see if it was a full or empty syringe as staff removed it immediately we went to look at its contents. In most cases we saw that sharps containers were stored in the correct way, however, we found an open sharps box in a room within area D which was easily accessible to people.

We saw patients' care files were stored in unlocked trolleys outside clinic rooms and in reception areas. Patients and visitors could walk past these trolleys. We were told that the trolleys were not left unattended by staff. However, when we returned to the department, there were no staff in sight of the trolleys for a number of minutes. This meant that patients' records were not always securely stored.

We found a door to a cleaning cupboard (ref: 10A 80) open and not locked (despite being stipulated on the door); when we pulled it, we found the lock was broken. Senior staff were unable to explain why the door had been left unlocked, stating that it was only a cleaning cupboard. A member of staff pointed out blood on the floor on an anticoagulant clinic, however, they made no move to clean it or arrange for it to be cleaned until we prompted them. It appeared that some staff were unaware of their role or responsibility in maintaining a safe environment.

Monitoring safety and responding to risk

Wherever possible, each division's outpatient clinic time, day and location remained consistent. This meant that staff working at the clinic and the location were familiar to the patients who regularly attended the same clinics for continuing treatment or follow-up procedures. We saw that administrative staff were fully aware of the changes to the clinics that day, and advised patients as they arrived about the alternative location for their clinic. It was the responsibility of the clinic nurse manager to allocate and manage the nursing staff across the outpatient clinics. The outpatients service manager allocated the administrative staff.

At the time of the merger, it was identified by the trust that nurses in the radiology department at QEH had not received Ionising Radiation (Medical Exposure) Regulations 2000 training. This training is important because inappropriate use of ionising radiation can have negative health consequences. All nurses who had not completed the training were immediately stopped from working in the department until they had completed the online training course.

At the time of our inspection, meetings were not held between the outpatients division for nursing staff to discuss policies, procedures or practices. The senior nursing manager explained that they presented any issues, concerns or reminders to staff through 'virtual' meeting minutes sent by email to all staff. The minutes outlined any issues, reminders and changes within the outpatients department at QEH. The nursing staff we spoke with said the email was a good way to keep up to date with anything related to the department, such as new systems, reminders to perform certain tasks, changes to policy or procedures or complaints and incidents. This meant that staff were regularly reminded of their role in patients' healthcare and safety.

Individual patients were assessed in advance of treatment. All the patients we spoke with told us their medical history was taken. General surgery pre-operative assessment questionnaires were sent to patients up to three months before their procedure. However, we found there was no clear policy or procedure for pre-operative MRSA screening and decolonisation. We also found the IP20 form staff completed was due for update in December 2013. We were shown a plan to introduce a robust screening policy and procedure but this had not been presented to any clinical meetings for approval at the time of our inspection. Therefore, the provider was not ensuring that all staff knew of and followed a trust written policy and procedure for MRSA screening. This meant that staff could be following procedures which were inconsistent and may mean putting patients at risk of becoming ill by contracting or passing MRSA to other patients.

Anticipation and planning

Staff were very positive about the merger between the two sites. We were told by many staff that they valued the support they were getting throughout the process. Staff at QEH had anticipated feeling 'taken over' by UHL. However, the reality was very different and staff felt it was a shared

Outpatients

experience between the two hospitals. They told us they felt valued and had been listened to. For example, staff had been concerned about travelling from one site to the other in traffic or by public transport. The trust had listened to this and provided a shuttle bus at regular intervals throughout the day.

As a result of the recent merger between UHL and QEH, a new IT system called CERNER was being implemented and would be installed at QEH from the end of March 2014, followed by Lewisham later in the year. Staff at QEH had received training on the new system, drop-in sessions were available to practice at times convenient to them (such as weekends) and staff were regularly reminded to check their log-in details ahead of going 'live'. Staff told us they felt confident they would be supported during the changeover. It had been identified that some patients' records might not transfer smoothly from the old to new system and information could be temporarily lost or filed in an incorrect manner. Staff had been identified to check that patient information was found in the correct areas of the new electronic system at changeover time. Staff were able to describe what systems were in place if patient information was lost or the system was to fail. At the time of our inspection, QEH outpatient IT system was in 'lock down' which meant staff had to go through specific manual processes to prevent patient details falling through any gaps during the IT changeover.

The senior service manager told us it was considered to be a risk to patients if their care files/notes were not available at the time of their consultation. This resulted in consultants using temporary notes, which meant consultants might not have all the information relating to the patient; this could cause a delay in treatment or further appointments. Delayed/missing notes were reported as a significant incident. This meant that the issue was dealt with seriously and a system to improve the issue could be explored with the individuals concerned.

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

Not sufficient evidence to rate 

Evidence-based guidance

Most nursing staff at QEH were able to identify the National Institute for Health and Care Excellence (NICE) guidance

which sets the standards for high-quality healthcare. Specialist staff knew the guidance in relation to their specialism, such as diabetes and foot care, and heart failure. A manager told us they would expect specialist nurses to know the area of the guidance their work relates to, but they would not expect all general nurses to know about it.

We found the clinical nursing specialist leads sought guidance through national meetings and membership to specialist bodies. Other nursing professionals told us they followed the Royal College of Nursing national guidelines or guidelines from other bodies relating to their own clinical interest if there were no trust guidelines to follow. This meant there could be an inconsistency in approach and understanding of what was best practice.

The patients we spoke with told us they felt informed and supported by staff in making decisions about their choices to treatment and procedures.

Monitoring and improvement of outcomes

A number of outpatient procedures are recorded as being undertaken across UHL; QEH and QMH. The largest number of appointment Healthcare Resource Groups relate to obstetrics and midwifery care across most sites. The largest remaining groups correspond with ear, nose and throat procedures, electrocardiogram or lower genital tract minor procedures.

Sufficient capacity

Senior staff told us that a large number of posts in the QEH outpatients department had been made redundant under the previous South London Healthcare Trust. This meant that the department had lost a number of specialist nurses, such as a tuberculosis or tissue viability specialist nurses. Since the merger, these specialist posts were being reinstated where it was identified that they were needed.

Each division from each site had met and systems of cross-learning were just starting to take place. Gaps in any learning or skills were being identified at each location. This meant that, in time, there could be a consistent approach, and shared learning and support. However, it was too early to judge the impact of the meetings at the time of our inspection.

Most outpatients department staff (clinical and administrative) had not received one-to-one supervision or annual appraisals for a number of years. Staff had ad hoc supervision unless there were performance issues that

Outpatients

required a more formal approach. Most of the clinical staff felt supported by their managers and thought they could approach them at any time about any concerns. Some of the administrative staff were unsure of their line manager but thought this would improve as a new outpatients manager had recently been employed.

Multidisciplinary working and support

Multidisciplinary team meetings between some of the departments at QEH and UHL had recently started. Staff told us they thought there would be a lot of value in sharing their systems and learning with one another. It was too early to identify any effect that the multidisciplinary meetings were having for QEH.

Are outpatients services caring?

Good



Compassion, dignity and empathy

Patients told us they found the staff to be kind and caring. They described the staff as “wonderful”, “very nice” and “lovely people”. We saw patients were seen in private consultation rooms with the doors shut. One patient told us they were 30 minutes late for their appointment and staff did not make them feel uncomfortable and fitted them in as soon as they were able to. We saw most staff talk with patients in a friendly and discreet way. However, we observed one patient in a communal area being asked by a nurse in a loud voice if they had emptied their bladder.

It was not always easy for patients to hold a private conversation with the receptionist as the reception areas were within the waiting area. Staff told us that side rooms were available to speak with people in private when required. These rooms were also used for prisoners from a local prison who attended the hospital for appointments. This meant patients’ dignity and privacy could be maintained when required.

Involvement in care

All the patients we spoke with talked highly of the information they received relating to their care. A majority of them told us they received information about what to expect at their appointment, including how long it may take, the name of the consultant they were seeing and contact details. Some patients showed us their letters

which identified the names of people working within the clinic they were visiting and which consultant they were seeing. People told us they were fully aware of tests, results and follow-up procedures for appointments.

We asked staff in the haematology outpatients department how they supported people who had disabilities, as it would be difficult for someone who had a visual or hearing impairment to know when they were being called for their appointment as the department was very busy and noisy. We were told that staff would look out for someone with a disability so they could support them. However, not all disabilities are very noticeable, so staff might not be aware of someone who required extra support. We sat with a patient who we saw was wearing a hearing aid. They told us they had received no extra support due to their hearing impairment. They had been waiting for an hour and viewed a DVD which explained the procedure they were going to have. The person was unable to hear the DVD and there were no subtitles displayed. When the patient was called to their appointment, the nurse came to them but spoke so quietly that the patient and our inspector both struggled to hear them.

Trust and respect

Patients spoke highly of the way staff talked with them and the care they received. The conversations we heard between staff and patients were friendly and caring. We heard staff sort out any issues in a helpful way. Staff told us that many of the people who came to clinics at the hospital were regular patients who they had come to know over the years.

The hospital had a chaperone policy: if someone was examined or treated by a person of the opposite gender, they could request that a person of the same gender was present.

Emotional support

Some of the patients using the service described how the staff supported them through any issues or concerns relating to their care in outpatients. One relative told us the staff had always included them (with the patient’s permission) in discussions relating to their relative so that they could support their relative when they returned home.

Are outpatients services responsive to people’s needs?

Outpatients

(for example, to feedback?)

Good



Around 15% of QEH patients fail to attend their appointment. Staff told us many of the clinics were overbooked to take into account people who might not arrive for an appointment. However, if all the patients attended their appointment, the clinics would overrun.

QEH outpatient services came under the management of Lewisham and Greenwich NHS Trust in October 2013. For this month it showed a higher than national rate of 16% for patients failing to attend their appointment. This is higher than the UHL site and will contribute to an increased trust rate if the trend continues. Eight of the top 10 specialties at the trust have non-attendance rates higher than the national average. Midwifery and ear, nose and throat non-attendance are almost double the national average. However, it should be noted that these figures also include cancelled appointments as the computer system used at this hospital cannot differentiate between the two, thus inflating the total figures. This will be rectified once the new CERNER IT system is implemented at QEH.

Meeting people's needs

Staff told us the demand for the outpatient services was at capacity and there was little room to increase the number of clinics to meet patients' needs. For example, the phlebotomy clinic saw between 600 and 700 patients every day. Staff told us there were audits planned for later this year to identify how many patients were being appropriately seen at an acute hospital. For example, some patients may benefit from community-based clinics for long-term chronic health conditions such as chronic obstructive pulmonary disease, cardiac monitoring and anti-coagulants.

Staff had identified that there was a large number of people from the Greenwich area who were referred by their GP to the hospital for blood tests. The staff perceived that this was because GP services in the Greenwich clinical commissioning group did not provide blood testing services at their practices. They told us this meant people requiring blood services could only use QEH or the

community hospital. People living in the Bexley catchment area were able to have blood tests in the community and therefore were less likely to attend the hospital's phlebotomy department.

The haematology outpatients department was a very busy area and a large number of patients had to stand in the waiting area. There was priority seating for children, patients having fasting blood tests and vulnerable people. We spoke with a patient who was having a fasting blood test. They told us they regularly attended QEH for the same test and had never been made aware of the priority seating area.

Most of the patients we spoke with told us they were not aware of how long the clinic they were attending was overrunning. Most of them told us they had not waited long to be seen. We saw that the waiting times were only displayed in one area during a walk around the outpatients area. (This could have been because all the clinics were running to time at the moment we were visiting.) Most of the people we spoke with did not complain about the amount of time they were waiting to see the clinician. However, patients waiting in the haematology department complained about the length of time they waited for appointments.

The outpatients department was situated in one area of the hospital. A reception area at the main entrance to the department was clearly identifiable and patients were not overheard speaking with the staff. The corridors were wide and the environment was clean and bright. There was a 'buggy service' run by volunteers at the hospital. This was available to people who had disabilities or found it hard to walk to be taken to and from their clinic.

The signage was mainly clearly identifiable, although in one place it was confusing and resulted in many patients walking into administrative offices. Patient waiting time was not clearly displayed in most of the clinics we visited. Where it was displayed it was hard to read as information was written on a whiteboard in coloured pens that were not clearly visible. In the haematology clinic, patients took a numbered ticket, but there was no indication as to how many people were ahead of each patient. The outpatients service manager told us that signage across the whole of outpatients was under review.

Each outpatient clinic environment was bright and most of the waiting areas were large enough to accommodate the

Outpatients

number of people who used it, the exception being the haematology clinic. All the clinics had accessible toilets. The paediatric outpatients department had a children's play area. Staff told us that patients had commented on the lack of refreshments available in the outpatient areas and they had recently installed a coffee shop.

There was good access to the hospital car park. There was clear signage to and from the car park area which had pay and display machines. People we spoke with said the car park facilities were adequate, however, they told us they would prefer to pay for their parking on exiting the car park as it could be hard to estimate how long you would be at the hospital, especially if your appointment overran or you had to wait at the pharmacy for medication.

We noticed as we walked from the car park to the main hospital entrance that patients had to walk through a porch area in front of the main doors. This area was marked clearly as a 'no smoking' area. However, we saw patients, contractors and hospital staff smoking in the area. We also observed a patient being transported on a hospital bed to a passenger transport ambulance through people smoking in the area. The main entrance doors were automatically opened on arrival, however, the right-hand door on the first set of doors was locked and the left-hand door was locked on the second set of doors. Staff told us that this was to reduce the wind coming into the main reception area. However, it was confusing to visitors as there was nothing on the door to state that it was closed and it caused some congestion between visitors and patients entering and leaving the area.

Most of the clinical staff have a secretary to dictate letters to; however, some clinical nurses had to write their own letters. The clinical nurses told us that this added to their busy workload and could cause some delay in the letters being sent. The hospital had a tracker system in place to identify when follow-up letters or letters to GPs have been sent. Any approaching the two-week deadline were flagged to a senior member of staff to escalate and ensure that the 'two-week wait pathway' was not affected. There was a department dedicated to identify patients who were close to the NHS 18-week referral to treatment time pledge and for those who required urgent appointments within the two-week timescale.

There were no processes in place for the QEH outpatients department to collect information about the patients' experience of the outpatients department and individual

clinics. This meant the department and hospital were unable to monitor how well the outpatients department was performing. However, complaints to staff had revealed that people were not happy with waiting times. Staff aimed to deal with concerns as they happened to try and avoid them from escalating.

Access to services

Referral to treatment time is an indicator of a trust's effective management of demand. This is a measure of the time taken for a patient to move through their pathway from GP referral to consultant-led treatment. The CQC Intelligent Monitoring (which looks at a wide range of performance data) Tier 1 indicators show no elevated risk for the five access measures. However, the NHS England reporting as of December 2013 indicates that, for patients whose treatment did not involve admission – for example, outpatient appointments – 97.6% of patients had started treatment within the target of 18 weeks. This is an achievement of the national target and above the national figure of 96.8%.

Extra clinics were set up to cater for patients who were close to the 18-week referral to appointment deadline. The patients we spoke with were satisfied with the length of time it took from GP referral to consultant referral. There was a mixed response about the ease of cancelling or changing appointments over the telephone. Some people told us it took some time to get through to speak with an operator. However, it was easy to change the appointment to another convenient date when they got to speak with someone.

The hospital aimed to accommodate patients who required more than one appointment at different clinics on the same day whenever possible. We heard patients arranging follow-up appointments on days that suited them and other patients told us they had been able to move an appointment to coincide with another visit to the hospital. The hospital also offered a 'one stop' service for some diagnostic test. For example, the breast and cardiac clinics offer patients all the tests they may require on the same day as their initial examination. This meant it was more convenient for patients as it cut down on the number of times they needed to visit the hospital for diagnostic tests.

The department offered 'hot slots' to A&E patients who required a follow-up procedure the following day, but did

Outpatients

not require being admitted to a ward. This was more convenient for patients, helped cut down on bed capacity issues and decreased the chance of patients catching a hospital-related infection.

The department had access to an interpretation service with prior notice. We observed one patient requesting a translator for their appointment. However, this had not been booked by the referring GP and therefore no arrangement was in place. We spoke with a relative of a patient who translated on their behalf. They told us they had been offered an independent translator but they had declined. Staff told us they preferred to use external translators so they could ensure the correct information was given and received. However, this was not always possible as it was hard to get a translator without prior notice (although LanguageLine service is available).

The complaints procedure was displayed in most of the clinics we visited. The hospital Patient Advice and Liaison Service was located close to the hospital's main entrance to maximise its visibility to patients and their families.

Vulnerable patients and capacity

The hospital had a safeguarding adults lead. The hospital also had a safeguarding children lead in the paediatric department and the staff we spoke with were aware of who they should go to if they had a concern relating to a child. However, staff were unaware whether there was a lead for safeguarding vulnerable adults. Most of the clinical staff we spoke with understood how to safeguard vulnerable adults and children. We were given an example of one nurse using the procedure. We asked administrative staff what their understanding of safeguarding vulnerable adults and children was. They told us they didn't know but would speak to a manager if they had any concerns. We pointed out information regarding the safeguarding procedure which was clearly visible on the department's wall. Staff were surprised to see it and told us they were unaware it was there, as it had been installed in the days before our inspection.

Learning from experiences, concerns and complaints

Patient comments and complaints were discussed at a monthly cross-division complaints meeting. Rather than being about staff interactions, most of the complaints within the outpatients department related to processes, such as waiting times, cancellations and wording used in letters to patients who had failed to attend appointments.

The department had responded by changing the letter sent to patients who had not attended their appointment and reminded staff of the importance of letting patients know how long they can expect to wait by writing the information on a board in the clinic.

Senior staff told us they would try and deal with any complaint or concern at the time it was brought to their attention. They gave us an example of a patient who complained by email while they were still at the hospital. The Patient Advice and Liaison Service responded to the patient by finding them at the clinic within 30 minutes of the email being sent.

Are outpatients services well-led?

Requires improvement 

Vision, strategy and risks

The staff we spoke with at QEH understood the values and vision of the merged trust. Staff were proud to show us the business cards they carried with the trust's vision written on it. They described the future as being "bright", "integrated" "inclusive" and "no longer feeling oppressive". They sounded very excited about the way the new merger had been handled and their role in it.

Most of the staff were aware of the management structure and who their managers were. Staff who did not have an immediate line manager in post at the time of our inspection were looking forward to the roles being filled. Many staff had met some of the executive and non-executives of the board at various focus groups about the integration. However, most of the nursing staff did not know who the director of nursing was, although they told us they received a lot of emails from them. Staff told us they were happy about the merger and had felt involved, listened to and supported throughout the process.

Governance, roles and responsibilities

Staff were supportive of one another. Many of them told us they worked 'like a family' and saw that they supported each other to go "above and beyond the call" to ensure patients were cared for. There was no system of reward or recognition, however, any positive comments made by patients were passed on to staff verbally.

Staff were encouraged to challenge each other on any poor working practices. One nurse gave us an example of

Outpatients

reminding a consultant of the importance of following the 'bare below the elbows' best practice for hygiene and asked them to follow the correct procedure. The consultant followed their advice.

Leadership and culture

The frontline staff were stable and established. Many of the nursing staff had worked in the outpatients department for many years and it was felt they were rich in knowledge. The senior sister (nursing manager) and service manager had also worked in outpatients for many years and had a clear understanding of each other's roles and how to support one another. They told us they had no issues in retaining staff or getting staff. The biggest threat to staffing in the department was retirement. All the staff we spoke with talked of working in a friendly environment with good team-working practices.

At the time of our inspection, the hospital was moving from a culture of divisions working in silos with little shared experience across the divisions, to one where the divisions

learned from one another. This was through senior management meetings and information disseminating down through the workforce. At this point it was too early to judge how well this information was being shared and whether it would bring a more consistent approach across the whole of the QEH outpatients department.

Learning, improvement, innovation and sustainability

Multidisciplinary meetings took place on a monthly basis. This allowed teams to share their experience, concerns and learning with one another. Gaps in knowledge regarding any new guidance were explored in divisional governance meetings.

Patients' experiences of outpatients and any concerns or complaints would be reported directly to the division the clinic related to – for example, oncology outpatient complaints would be direct to the oncology division. These comments, concerns and complaints were discussed at the multidisciplinary meetings.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease disorder or injury Diagnosis and screening	<p>Regulation 9 (1)(a)(b)(i)(ii) HSCA 2008 (Regulated Activities) Regulations 2010.</p> <p>People who use services and others were not protected against the risks associated through lack of appropriate care by all staff.</p> <p>Care was not always planned and delivered to meet the service user's individual needs or ensure their welfare and safety.</p> <p>In A&E, patients were waiting significant lengths of time on ambulance trolleys, causing delays in the assessment and treatment of patients.</p> <p>Care planning on the children's wards was impersonal and did not reflect the needs of the individuals. There was no evidence to show how children and families were involved in the planning of care.</p> <p>On the children's ward, patients were not being given their treatment in a timely way. Intravenous alarms were left unattended for up to minutes on the children's ward, with one child left without fluids for between two and three hours.</p> <p>On medical wards not all patients' risks had been assessed, or where they had been assessed, not reviewed to ensure there was a current record of patient risk.</p>

Regulated activity	Regulation
Treatment of disease disorder or injury Diagnosis and screening	<p>Regulation 10 (1)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010</p>

This section is primarily information for the provider

Compliance actions

People who use services and others were not protected against the risks relating to their health, welfare and safety as the systems designed to assess, monitor the quality of the services and identify, assess and manage risks were ineffective.

There was a large number of non-attendances at out-patients. Staff double booked appointments to ensure the clinic was used to its full capacity which could cause long waiting times for patients as clinics overran.

Learning from incidents was not widely and consistently shared across the hospital.

Following an incident in A&E, where a patient had left the department unnoticed, the trust had agreed to fit keypad access to prevent a recurrence. This had not happened and there was free access to all areas.

Regulated activity

Regulation

Treatment of disease disorder or injury

Diagnosis and screening

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010

People who use services and others were not protected from the risks of acquiring an infection

In A&E, we found that some hand gel dispensers were empty.

There was no hand towel bin in the female staff toilet.

In the area for clinical waste storage, yellow bins were overflowing. Gloves were not available to the porters to protect them when they were moving the waste.

We saw a nurse use the top of a bin as a shelf when preparing medicine.

Patients who may have been infectious were being cared for in 'the grey chair' area.

There was no hand gel available directly outside or inside two of the medical wards.

Regulated activity

Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease disorder or injury

Diagnosis and screening

Regulation 15 (1)(a)(c) HSCA 2008 (Regulated Activities) Regulations 2010

People who use services and others were not protected against the risks associated through lack of appropriate and maintained facilities.

In A&E, the area known as ‘the grey chairs’ was being used to treat people, which compromised their privacy and dignity. People were being cared for seated in chairs who may have benefited from being able to lie on a trolley or bed.

In the children’s department, the layout of the ward made it difficult for staff to observe patients.

Regulated activity

Regulation

Treatment of disease disorder or injury

Diagnosis and screening

Regulation 20(2)(a) HSCA 2008 (Regulated Activities) Regulations 2010

People who use services were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

In outpatients, patient notes and results were often difficult to track down. Staff estimated that temporary notes were used for up to 25% of patients. This meant that the consultant would not have a patient’s full medical history and could cause a delay in a patient receiving their test results and possible treatment.

Regulated activity

Regulation

Treatment of disease disorder or injury

Diagnosis and screening

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010

Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to meet the needs of service users.

This section is primarily information for the provider

Compliance actions

There was a significant shortage of nursing and medical staff in A&E.

There was a significant shortage of nursing staff across medical wards. Patients told us they had to wait a long time for call bells to be answered because there were not enough staff.

There was a significant shortage of nursing staff across surgical wards. There were not enough staff to support people to eat which led to delays in people receiving their meals.

There was a significant shortage of appropriately qualified nursing staff in children's services.