

Lewisham and Greenwich NHS Trust

Quality Report

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

Ratings

| | | |
|--|----------------------|---|
| Overall rating for this trust | Requires improvement |  |
| Are acute services at this trust safe? | Requires improvement |  |
| Are acute services at this trust effective? | Requires improvement |  |
| Are acute services at this trust caring? | Requires improvement |  |
| Are acute services at this trust responsive? | Requires improvement |  |
| Are acute services at this trust well-led? | Requires improvement |  |

Summary of findings

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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:

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 (Greenwich) site the A&E environment is not considered by the inspecting team to be fit for purpose.

On the Queen Elizabeth (Greenwich) 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.

Trust-wide issues around waste management were identified. The inspection team identified a number of areas where clinical waste was stored (including bins containing used hypodermic needles) that were not securely locked. We saw this in a number of places at various times. We considered this to be a risk to safety of patients and public.

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.

During our visit, members of the Patients Association looked at the way the trust handles complaints. Much of their findings are in the appropriate sections of this report; however in summary they found that:

- The Trust demonstrated a number of areas of good practice which support their approach to patients and the public and their management of complaints. The staff we met had a positive approach and indicated that teams work together. There is a focus on meeting the needs of patients. Current workshops on values and behaviour were also commendable
- The new governance structure has clear objectives, but there is significant work needed to engage all Divisions and to improve complaints response times, follow up actions and learning. Complaints handling needs to be streamlined to ensure documentation is complete and tracked. The new combined IT system may support this.
- Whilst patients indicated their awareness of PALS and complaints, there were real concerns about staffing levels and waiting times.
- The review of complaints files demonstrated some aspects of good practice and we heard good examples of local learning. An underlying challenge is the need to ensure complaints handling is rigorous, that staff learn from complaints and that information is shared widely. Continued training in both complaints handling and investigation for those involved in complaints and customer service training will ensure that processes are improved and consistent across the Trust.
- The Trust has a number of committees and interested groups with good patient representation and involvement. A review of roles and how the patient's voice can be strengthened would further support learning across the Trust.

Staffing

In some wards (particularly medical wards) patients told us that they felt there was a lack of staff as call bells were sometimes not answered for 30 minutes. Patients use call

Summary of findings

bells to alert staff to an issue or request help. It is not possible to judge the severity or significance of the request until the call bell is answered. Response to call bells should therefore be prompt.

There are shortages of staff in many areas. In some areas, there were insufficient staff to meet the needs of patients. Programmes are in place to fill some of these vacancies; but these staff are not yet in post. In A&E at Queen Elizabeth, there is a staffing review underway, but we noted a heavy reliance on agency staff.

The trust had lost some posts on the QE site when it was part of the previous South London Healthcare trust. Work was underway to address this and nurse specialists were being employed to address the issues identified.

The scope and role of Health Care Assistants (HCA) within the trust was clearly understood. HCA's were never expected to work beyond the scope of their role and training. This ensures patients are treated by an appropriately trained individual.

We did observe that the e-rostering system can generate an unworkable shift patterns, for example by rostering too many long days in succession. This risks staff health and also compliance with the rotas.

Cleanliness and infection control

We saw that hand hygiene and personal protective equipment (gloves etc) were available in clinical areas. This means the trust are ensuring staff are able to use infection control procedures. However we saw that compliance with hand hygiene (particularly amongst medical staff) was poor. This causes a risk of cross infection for patients.

We saw that the trust system for managing clinical waste were poor. Many areas with clinical waste were easily accessible by the public, and we observed this on numerous days. This presents an infection control and safety risk to the public.

Patient Flow

The acute medical pathway is based on a different model for each of the two main sites. Neither model appears to provide optimal flow. This is restricting egress from A&E.

Despite acknowledgement and appreciation of the Executive's approach to the formation of a single, inclusive organisation on the QE site, staff at all of the focus groups on that site remained concerned in view of their recent experiences.

Summary of findings

The five questions we ask about trusts 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.

We saw clinical areas where access to used syringes was not well controlled. We also saw poor control to areas where chemicals and cleaning fluids are stored. We saw that the trust system for managing clinical waste were poor. Many areas where clinical waste was stored were easily accessible by the public, and we observed this on numerous days. This presents an infection control and safety risk to the public.

Checks to clinical equipment should be carried out regularly to ensure that when they are required they will be working. These check 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.

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

Requires improvement



Are services effective?

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. However, subsequent investigation by the trust showed all appropriate measures were taken in this case. 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 were 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.

Requires improvement



Summary of findings

Staff used 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. One patient described being late for an outpatient appointment and staff were highly understanding and made efforts to accommodate them.

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. One patient described how their fears of acquiring an infection in hospital were belittled by a nurse. Additionally on one ward we saw that a glass of water was out of reach from a patient and the glass was empty.

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

Requires improvement



Summary of findings

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 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.

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 develop.

Requires improvement



Summary of findings

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 has a single governance process, however it appeared from talking to staff that they felt governance arrangements 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 people who use the trust's services 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 trust **MUST** take to improve

- Ensure that it has the appropriate levels of staffing in all areas to allow the staff to safely and effectively discharge their duties.
- Ensure that appropriate hand hygiene procedures and 'bare below the elbows' practices are followed at all times by all staff groups.
- Review its medical and upper GI pathways to ensure they are effective.
- Improve the management of its clinical waste and storage of waste following use.

- Review capacity in the radiology service to ensure it is able to provide timely and responsive imaging.
- Review the capacity, constraints and escalation process for A&E.

Action the trust **SHOULD** take to improve

- Improve the checks to clinical and medical equipment to ensure they are checked at all times
- Review the approach of some of its staff to the care for vulnerable groups.
- Secure access to chemical products.
- Review its bed capacity in line with demands.

Summary of findings

- Pursue strong relationships with community, CCG and external partners to improve discharge arrangements.
- Review the outputs from the e-rostering system
- Review the interpretation facilities available for some groups of users

Good practice

Our inspection team highlighted the following areas of good practice:

- Volunteer programme for feeding assistance on the dementia wards
- Learning from complaints and complaints management process
- Incident and learning programme
- Staff engagement and development of trust wide culture through merger
- Commitment to staff development and training

Lewisham and Greenwich NHS Trust

Detailed Findings

Hospitals we looked at:

Lewisham and Greenwich NHS trust; University Hospital Lewisham; Queen Elizabeth Hospital Greenwich; Queen Marys Hospital Sidcup

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 Lewisham and Greenwich NHS Trust

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 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.

Detailed Findings

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 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 chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This 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. Using this model, the previous organisations University Lewisham and South London Healthcare Trust were 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 a range of information we held about the hospital 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

Detailed Findings

patients and members of the public were given an opportunity to share their views and experiences of all the trust locations. Further unannounced visit were carried within the following two weeks

Are services safe?

Summary of findings

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.

We saw clinical areas where access to used syringes was not well controlled. We also saw poor control to areas where chemicals and cleaning fluids are stored. We saw that the trust system for managing clinical waste were poor. This presents an infection control and safety risk to the public.

Checks to clinical equipment should be carried out regularly, in some areas the checks were 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.

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

for example we heard that A&E services on each site work as two separate services and there are very few times that patients are diverted from A&E when the service is under pressure. We heard of a patient who presented in A&E with bleeding from his upper gastrointestinal system. We heard that the system to transfer him to another trust was not in place.

Lack of access to radiology was creating issues for making clinical decisions. Radiologists were short of capacity and the ability to respond promptly. We were told that the x-ray equipment (especially the CT Scanner) breaks down regularly. We were told that one radiologist refused to answer their bleep because they had been 'bleeped' too many times; it took 90 minutes before a response to a request for advice was answered. Patients need prompt care and those giving it need prompt advice from specialist staff.

Doctors told us there was not a common system for all policies to be accessed by everyone. Some staff told us they were still not sure which policy to use (South London Healthcare Trust or Lewisham and Greenwich Trust).

Staff rostering systems lead to gaps in shifts in some clinical areas. This is seen as unsafe by many people we spoke to.

Monitoring safety and responding to risk

We saw clinical areas where access to used syringes was not well controlled. We also saw poor control to areas where chemicals and cleaning fluids are stored. We saw that the trust system for managing clinical waste were poor. Many areas where clinical waste was stored were easily accessible by the public, and we observed this on numerous days. This presents an infection control and safety risk to the public.

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

Anticipation and planning

Clinical services appeared to be partly reactive to issues as a result of staffing shortages.

Our findings

We found that hand hygiene practices were variable; with some people following good hand hygiene and other (mainly doctors) not. We saw staff not following the 'bare below the elbows' good clinical hygiene practices. Patients should be protected from the risk of infection and all staff have a responsibility in this.

Learning and improvement

We found that hand hygiene practices were variable; with some people following good hand hygiene and other (mainly doctors) not. We saw staff not following the 'bare below the elbows' good clinical hygiene practices. Patients should be protected from the risk of infection and all staff have a responsibility in this.

Systems, processes and practices

We found that the trust had limited systems for fast escalation of problems in clinical management of patients;

Are Services Effective?

(for example, treatment is effective)

Summary of findings

We saw an example where in one specific case there was not an effective pathway for managing a patient who required care in other organisations. Where the trust is unable to offer care, effective pathways to other hospitals are important.

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 were 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.

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 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.

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.

Performance, monitoring and improvement of outcomes

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.

Staff used appropriate tools and systems (e.g. Paediatric Early Warning System). Staff had an appropriate level of training for the roles they carried out.

The ability to discharge patients from care in the hospital is seen as a problem. Capacity in primary care/community services remains a challenge. Bed shortages (especially in rehabilitation wards) was seen by many clinical staff as a major challenge.

Staff, equipment and facilities

We saw and heard that in many areas the staffing numbers were insufficient. People told us that it felt like they were doing two peoples jobs. Adequate staffing is important to ensure time for good quality care is available. 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. Ensuring access to medication is often a major reason for delays in discharging patients from hospital. We saw this was working well.

The ambulatory care unit, the hospital at night team at QE and the specialist nurses were all seen to be highly effective by the junior medical staff.

Multidisciplinary working and support

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.

Our findings

Using evidence-based guidance

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 were possible.

Are services caring?

Summary of findings

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 it. 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. One patient described being late for an outpatient appointment and staff were highly understanding and made efforts to accommodate him.

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. One patient described how their fears of acquiring an infection were belittled by a nurse. Additionally on one ward we saw that a glass of water was out of reach from a patient and the glass was empty.

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.

Additionally on one ward we saw that a glass of water was out of reach from a patient and the glass was empty.

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. We saw that on both sites the mortuary team made immense efforts to be supportive to patients, especially parent who had lost a child. We saw that they made huge efforts to ease the burden of grief; but saw that there had been lack of investment in updating small items (cots, toys etc) to allow parents to see their child in an appropriate setting.

Involvement in care and decision making

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.

Trust and communication

Overall, we saw that communication was good between patients and staff.

One patient described how their fears of acquiring an infection were belittled by a nurse.

One patients wrote to us to share their experience. They told us of assumptions being made about how her anxiety disorder was managed and did not give her the opportunity to communicate with the staff. Another carer told us of diagnostic screening' approach to his son with learning disabilities; his view was that the staff assumed all his sons problems as being related to his learning disabilities rather than communicating with his father and looking beyond the obvious condition.

Emotional support

We saw that the chaplaincy service provided good multi-faith services with access for all patients. We saw that the wards were respecting the different cultural needs of patients and giving space for grieving relatives. We were told that bodies could remain on the wards after death where at all possible.

Our findings

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 it. 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.

Compassion, dignity and empathy

Many patients we spoke to praised the caring nature of staff in all the hospital sites. They were appreciative of the care provided. One patient described being late for an outpatient appointment and staff were highly understanding and made efforts to accommodate him.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

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.

Delays and excessive waiting times in clinics were a challenge for many patients.. 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 triple booked.

There was a buggy service staffed by volunteers on the QE site to help patients move around the hospital when they had limited mobility.

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 trust has an OWL (outcomes with learning) group that allows learning from incidents to be shared and reflected back. The executive team were able to give clear examples (e.g. maternity Bathroom cleanliness) where they had listen to and acted upon patient feedback.

We heard that the executive team were very proactive in managing complaints and compliments.

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 triple booked.

We were told that letters from the Speech and Language Therapist now clearly sets 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.

Vulnerable patients and capacity

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

We saw that the trust had developed good systems for learning from complaints and sharing finding through a multi-disciplinary group. All divisions were represented. Learning from this was shared.

The trust has an OWL (outcomes with learning) group that allows learning from incidents to be shared and reflected back.

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.

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.

Our findings

Meeting people's needs

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

Are services responsive to people's needs?

(for example, to feedback?)

One person told us that it would be better on the wards if staff could be trained to take patients to the toilet to encourage self-caring and mobility; however, with staff shortages it was quicker to use a commode. We felt this was not offering a responsive service to this patient group.

Access to services

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% indicates that there is insufficient capacity in the hospitals bed numbers to respond to demands. The bed occupancy for maternity should be much less (owing to the defined nature of a period of labour). In maternity, bed occupancy should be around 60%. The trusts bed occupancy in maternity is closer to 80%.

We saw that work had been undertaken on outpatient waiting times; looking at both the length of waits and also clinic utilisation. The trust has also looked at those patients who failed to attend for their appointment (as they are blocking capacity in clinic), and looked at the reasons why they did not attend.

Leaving hospital

Many people described the challenges of discharging patients from the hospital. People described the process as 'long'. Capacity in community services is poor, and discharge arrangements seem uncertain. People we spoke to in a focus group before the inspection told us that the discharge process was one of the areas they were most concerned about; they gave examples of where the hand-over between teams had not worked well.

One lady wrote to tell us of the challenges she had with delays for hospital transport for discharge. She told us she waited 8 hours for transport. Eventually a relative phoned the ambulance service and resolved the problem.

Are services well-led?

Requires improvement 

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

Summary of findings

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 develop. 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 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.

The trusts commitment to staff development and training was seen as a high priority by many people. We saw good mentorship support to staff in training. We also observed good support to Health Care Assistants in their development

Currently, 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.

quickly to a 'known' position. This not only manages the risks, but creates a sense of certainty and risk management amongst the teams. We are clear that the trust is aware of its major issues; but needs clarity of the daily management issues arising from a new organisation.

The nursing strategy includes a focus on the 6C's set out by the NHS Chief Nurse.

Governance arrangements

We saw that the trust is putting good governance structures into place. This is led by a deputy medical director (who has a lead role for governance) and the director for knowledge and governance. There is a good relationship between the clinical and managerial processes and an attempt to secure a strong system in the new trust. We did however note that there were a number of layers of reporting of patient experience and safety; and considered that the message may get diluted. We would urge this not to be the case.

The trust have developed an escalation plan for complaints to improve responsiveness. The Chief Executive signs off all complaint letters personally. This allows an overview of the themes.

We were also told that the Chief Executive has led complaints roadshows, encouraging staff awareness and understanding of the and improving the approach of staff to patients in order to reduce complaints..

The trust is implementing two new Electronic Patient Record systems (EPR). This is about to begin on the QE site. once both are implemented, a merger of the two systems is planned. We saw that good plans were being made for this. We were aware that the operating platforms may be slightly different on each site. We were told that this would not cause operational difficulties and could see the trust had a focus on this.

Leadership and culture

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 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.

Our findings

Vision, strategy and risks

The board set early priorities for the new merged trust and were clearly seen to be working towards them. The board are dealing with the PFI issues directly.

The inspection team did recognise that this was the early stages of a complex merger. The trust vision is managing that and maintaining its integration. The organisations early priorities and vision (create one organisation, live within resources, implement EPR, improve quality and safety) were therefore clearly aimed at integration.

The executive team talked often about the "unknown unknown's"; that is to say the operational challenges that are not yet clear in a new organisation. We understand the view being taken, but would encourage the trust to move

Are services well-led?

Requires improvement



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

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.

The trust has set a clear leadership in managing standards of behaviour in response to previous complaints. The new staff ID badges are pre-printed with the standards expected of all staff. these are regularly reinforced.

Some staff described the merger as positive and that the pace of change was rapid. They said the new management structure now listens much more.

One member of staff described the journey through and beyond merger "like being given a new pair of boots".

We also note that some medical staff still see the trust as two separate hospitals.

The chief executive is seen as a very visible and approachable leader.

Patient experiences, staff involvement and engagement

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 trust's commitment to staff development and training was seen as a high priority by many people. We saw an excellent induction pack for new staff. It contained all the key information required in one single

booklet. It also set out expectations of behaviour. Allied Health Professionals staff told us they felt well engaged and supported. Student nurses told us they had good mentorship. HCA's said they had good support for level-3 training. One person at the listening event we held told us that "Overall the service has got better under the new management, but it will take time"

Learning, improvement, innovation and sustainability

The trust has one single governance structure, but the view of the inspection team (from discussion with staff) was it appeared 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.

The number of staff receiving an appraisal regularly was high; with the clear exception of medical staff which is significantly low at around 30%. Staff are unable to improve their skills and performance if their senior managers do not regularly give them feedback and support learning for future skill retention and development.

The trust commissioned an external management consultancy to support development of some learning priorities. Two examples of this are a staff 'newspaper' on one ward as a communication tool and a review of radiology services. The trust have committed to making this process part of their 'business as usual' work. Investment in this support has already happened.

Many staff individually expressed their concern for continuing with improvement of services through lack of capacity created by insufficient staff.

We saw evidence that the trust had led a mock CQC-style inspection. This had led to some themes emerging that the trust was addressing. We felt this was a good opportunity to lead change.

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 12 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2010. Control of Infection.</p> <p>People who use services and others were not protected against the risks associated through infection control systems and hand hygiene.</p> <p>All staff must at all times ensure they follow recommended hand hygiene and 'bare below the elbow' guidance.</p> <p>Regulation 12 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2010. Control of Infection.</p> <p>People who use services and others were not protected against the risks associated through infection control systems and hand hygiene.</p> <p>All staff must at all times ensure they follow recommended hand hygiene and 'bare below the elbow' guidance.</p> |

| Regulated activity | Regulation |
|--|---|
| Treatment of disease disorder or injury Diagnosis and screening | <p>Regulation 9 (1) (b) (ii) HSCA 2008 (Regulated Activities) Regulations 2010. Care and Welfare of Service Users.</p> <p>People who use services and others were not protected against the risks associated disposal of clinically contaminated and hazardous waste.</p> <p>Clinical waste and dangerous material must be disposed of safely and stored in a locked environment to protect service users from inappropriate contamination.</p> |

| Regulated activity | Regulation |
|--------------------|------------|
|--------------------|------------|

This section is primarily information for the provider

Compliance actions

Treatment of disease disorder or injury

Diagnosis and screening

Regulation 10 (2) (c) HSCA 2008 (Regulated Activities) Regulations 2010. Accessing and monitoring the quality of service provision.

People who use services and others were not protected against the risks associated with lack of capacity in A&E.

Capacity and timely response from the A&E service must meet the of the service user. There must be an escalation strategy and cross site working policy.

Regulated activity

Regulation

Treatment of disease disorder or injury

Diagnosis and screening

Regulation 10 (2) (c) HSCA 2008 (Regulated Activities) Regulations 2010. Accessing and monitoring the quality of service provision.

People who use services and others were not protected against the risks associated with lack of access to radiological imaging.

Capacity and timely response from the radiological service must meet the of the service user.

Regulated activity

Regulation

Treatment of disease disorder or injury

Diagnosis and screening

Regulation 10 (2) (c) HSCA 2008 (Regulated Activities) Regulations 2010. Accessing and monitoring the quality of service provision.

People who use services and others were not protected against the risks associated with poor pathways and relationships with external providers for onward referrals.

Pathways through medical care and particularly for Acute Upper GI Bleeds must be effective and responsive.

Regulated activity

Regulation

Treatment of disease disorder or injury

Diagnosis and screening

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing.

This section is primarily information for the provider

Compliance actions

People are at risk through the failure to provide sufficient numbers of suitably qualified, skilled and experienced persons in some clinical areas.

The provider must regularly review staffing and skills mix in all its clinical and non-clinical areas. An agreed staffing level should be set, and maintained.