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 services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Requires improvement
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

This is the second comprehensive inspection of Lewisham and Greenwich NHS Trust; our first being carried out in 2014. At that inspection, we rated the trust as requires improvement across each of the five key questions; safe, effective, caring, responsive and well-led.

Due to CQC receiving increased number of complaints and concerns being reported by patients, relatives and staff, we undertook a further inspection of the emergency department and medical services at the Queen Elizabeth Hospital in June 2016. We rated both services as requires improvement.

This most recent inspection was carried out to determine whether the hospital had made progress following their 2014 comprehensive inspection and 2016 focused inspection.

Following this most recent inspection, we have again rated the trust as requires improvement across the five key questions and requires improvement overall.

We rated both of the main locations as requires improvement overall.

Community services was rated as outstanding overall; this was attributable to the effective care and leadership of children, young people and family community services provided in the borough of Lewisham.

In light of the concerns which existed with regards to the emergency care pathway at Queen Elizabeth Hospital, a system wide risk summit was convened shortly following the announced inspection period. Stakeholders across the health economy committed to work with the trust to address the concerns including patient flow across the emergency pathway. A subsequent visit to the trust on 19 May 2017 by a small team of inspectors and a specialist advisor for emergency medicine confirmed that a number of changes had been made to the emergency pathway. This included increased monitoring of the quality of care provided within the emergency department; improved access to physical beds as compared to trolley's, so as to reduce the risk of patients developing pressure damage; improving ownership and relations of the challenges faced by those working in the emergency department. The trust acknowledged that significant work was still required across the emergency care pathway however representation of key members of the health system were present on 19 May 2017 and all were committed to working together to improve outcomes for patients.

Our key findings were as follows:

- Despite a period of three years since our last comprehensive inspection, there remained areas of unresolved risks and areas for significant improvement. This included the acute emergency pathway at Queen Elizabeth Hospital. In part, a lack of decisive decision making by the trust leadership team contributed to a lack of overall progress across the organisation.
- In some areas, safeguarding training rates and mandatory training rates fell well below the trust's target.
- There were significant shortages of medical, nursing and allied health professional staff in most departments which were having an impact on delivery of care and patient safety. Although the trust was actively trying to recruit into vacant posts there was limited evidence of success.
- In some areas, principally surgery, medicines management processes were not in line with hospital policy or national guidance.
- In medical care, infection control processes, including waste management and adherence to the control of substances hazardous to health guidance, was variable.
- In surgery, we observed numerous breaches of Infection Prevention and Control (IPC) policy, potentially placing patients at significant risk of infection.
- In maternity and gynaecology we found the cleanliness of the environment and some equipment to be of a poor standard, even where green 'I am clean' stickers had been used to show that surface areas and equipment had been cleaned that day.
- In outpatients the environment in general diagnostic imaging was not fit for purpose.
- Whilst care was in line with relevant National Institute for Health and Care Excellence (NICE) and other national and best practice guidelines, there was a risk

Summary of findings

to clinical outcomes and patient safety due to maternity guidelines not being merged across the Lewisham and Greenwich sites and some guidelines also being out of date.
- The hospital was not providing responsive care in all areas.
- The provision of end of life care across the organisation was inadequate. There was variation in the level of understanding of services provided to patients.
- Some progress had been made in meeting the needs of patients living with dementia including increased activities, improvements to the environment and the introduction of a team volunteers who were being trained in working with people with dementia, which included providing enhanced care.
- Staff had a good understanding of consent process and recognised when the best interests of the patients had to be considered. Staff obtained consent from children and young people and parents involving both the child and the person with parental responsibility in obtaining consent where appropriate.
- Services had risk registers, but not all of the risks identified during the inspection were recorded on the registers and some risks, critical care and services for children and young people, had been on the register for up to three years without any action being taken. We also found a lack of ownership of the registers in some services with no evidence that risks were regularly reviewed.

We saw several areas of outstanding practice including:

- The speech and language therapy manager had implemented a risk feeding protocol following a successful research pilot project. This resulted in demonstrable outcomes for patients, including a 10% reduction in the admission of patients with dysphagia through more effective feeding regimes. As part of the project new guidance was issued for patients and staff and a risk feeding register was implemented to help the multidisciplinary team track patients cared for under the new protocol.
- Staff in the Trafalgar Clinic provided care and treatment for patients in a nearby prison. Each patient's records were maintained on the service's electronic patient record system. This meant when a patient left the prison service, there was no disruption in care or treatment because clinical staff always had access to this. In addition, if the patient moved out of the area, the electronic records could easily be shared with pharmacists and health workers in the offender resettlement programme. This meant patients received continual care and were at reduced risk of developing health problems associated with an interruption to antiretroviral therapy.
- In the two years prior to our inspection, sexual health and HIV services recruited up to 50% of the participants for the trust's whole clinical trial and research portfolio. This resulted from a policy of proactive and early-adoption participation that was part of a two-year strategy to improve participation in research in other hospital departments and services.
- In critical care there was a dynamic programme of research and development enabled by the full time appointment of a research nurse working with doctors including consultants. Examples of research studies completed in the past year included a study exploring the relationship between family satisfaction and patient length of stay, and a pilot study looking at the improved physiotherapy outcome measure by the use of cycle ergometry in critical care patients. The trust recognised only a small sample size was used for each study.

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

Importantly, the trust must:

- Review and improve the systems for monitoring and improving the quality and safety of care including attendance at key meetings in ED, surgery, critical care, services for children and young people and end of life care.
- It must ensure all risks are included on risk registers and are regularly reviewed and updated and carry out audits to monitor the effectiveness of treatment and care. The trust must introduce mechanisms designed to assure the board that any mitigations instigated are implemented and reviewed regularly.
- Ensure all relevant risk assessments are carried out on patients.
- Ensure medical and nursing staffing levels are in line with national standards and service specifications.

Summary of findings

- Ensure that patients are cared for in areas that are appropriate to their needs and have sufficient space to accommodate all equipment and does not compromise their safety and staff have the relevant skills and knowledge to care for them.
- Ensure patients requiring end of life care receive appropriate and timely care.
- Improve patient flow across the organisation.

In addition the hospital should:

- Work to share and embed learning from incidents in all services and cross site.
- Ensure staff comply with infection prevention and control policies and procedures.
- Ensure staff working on medical wards and in end of life care have the values and attitude necessary to treat patients, their relatives and visitors with dignity and respect. This includes staff treating them in a caring and compassionate way at all times.
- Ensure medical patients are appropriately reviewed when they are cared for on other wards and that all staff know who is responsible for them and they are contactable.
- Ensure that patient records are stored and held securely in one document.
- Ensure all patients have their pain assessed and receive analgesia in a timely manner
- Improve compliance with mandatory training completion rates for modules that are below the trust target in all staff groups.
- In critical care consider ways to introduce multidisciplinary meetings and ward rounds to review care and treatment of patients.
- Ensure there are ongoing arrangements for measuring and reporting patient satisfaction in critical care.
- Review the arrangements for bereavement services.
- In critical care, ensure formal arrangements for emotional and psychological support of patients and families including access to clinical psychologists are in place.
- Review the environment and waiting times for women using the gynaecology service
- Ensure patients who are at the end of their life, and their relatives, are afforded privacy.
- Improve cross site working in all services.
- Work to reduce the number of cancelled operations and improve referral to treatment times and reduce the 'did not attend' (DNA) rate for outpatient appointments.
- Respond to complaints within agreed timescales.
- Improve communication and working relationships between different staff groups.
- Provide sufficient staff to care for patients who need one to one care.
- Identify ways to empower and support staff to make improvements and take the lead in decisions and improvements in their services.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

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 has main services on both its Lewisham and Greenwich sites; additionally it has some surgery and some outpatient clinics at Queen Mary Hospital in Sidcup.

The Trust is an integrated trust, providing community health services across the borough of Lewisham.

Number of beds

The trust has a total of 1,083 beds spread across various core services:

- 600 Medical beds (594 Inpatient, 6 day case)
- 211 Surgical beds (191 Inpatient, 20 day case)
- 97 Children's beds (81 Inpatient, 16 day case)
- 123 Maternity beds (123 Inpatient)
- 36 Critical Care beds (36 Inpatient)
- 16 End of Life Care beds (14 Inpatient, 2 day case)

Population served

The trust primarily serves a population of 500,000 covering (in the main) the boroughs of Lewisham, Bexley and Greenwich. The trust serves an area of high deprivation.

Health and deprivation

The health of people in Lewisham is varied compared with the England average. Lewisham is one of the 20% most deprived districts/unitary authorities in England and about 26% (16,300) of children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in Greenwich is varied compared to the England average. Deprivation is higher than average and about 25% (13,600) children live in poverty. Life expectancy for both men and women is lower than the England average.

Clinical Commissioning Group

The trust's main CCGs are: (Clinical Commissioning Group) is Lewisham CCG, Greenwich CCG and Bexley CCG.

Budget and spending

For the latest financial year, 2015/16, the trust had an income of £519 million, and costs of £529 million, meaning it had a deficit of £10 million for the year. The trust predicts that it will have a deficit of £23 million in 2016/17. For the period October 2015 to September 2016 the trust had a deficit of £12 million.

Summary of findings

Inspection history

We previously inspected the trust using our comprehensive inspection methodology in February 2014. We chose to inspect the trust in 2014 because both University Hospital Lewisham and Queen Elizabeth Hospital were identified as being high risk services according to our intelligent monitoring model. This model 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. We did not inspect the community services provided by the trust at the time of the 2014 inspection. As a result of the inspection, we rated the trust as requires improvement overall and across each of the five domains; safe, effective, caring, responsive and well-led.

Due to CQC receiving increased number of complaints and concerns being reported by patients, relatives and staff, we undertook a further inspection of the emergency department and medical services at the Queen Elizabeth Hospital in June 2016. We rated both services as requires improvement.

This most recent inspection was carried out to determine whether the trust had made progress following their 2014 comprehensive inspection. We inspected each of the eight core services across both University Hospital Lewisham and Queen Elizabeth Hospital. We also inspected the community services for children, young people and famillies and community adult services.

Our inspection team

Our inspection team was led by:

Chair: Dr. Timothy Ho (Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Nick Mulholland, Care Quality Commission

The team included CQC inspectors, inspection managers, assistant inspectors, pharmacist inspectors, inspection planners and a variety of specialists.

The team of specialists comprised of a consultant in emergency medicine, consultant rheumatologist, general and vascular surgeon, consultant in neuroanaesthesia and critical care, consultant obstetrician, consultant neonatologist, consultant paediatrician, consultant clinical oncologist and a consultant in palliative care medicine. We were also supported by: senior sister for emergency care; general emergency nurse; infection prevention and control lead nurse; assistant chief nurse; major trauma and orthopaedic nurse specialist; theatre manager; intensive care nurse; head of midwifery; paediatric modern matron; paediatric staff nurse; district nurse; health visitor; occupational therapist; physiotherapist and a senior quality and risk manager.

How we carried out this inspection

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

- Is 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
- Medicine
- Surgery
- Critical care
- Maternity & gynaecology
- Children and young people
- End of life care
- Outpatients and diagnostic imaging
- Community children, young people and famillies
- Community adult health services
- We also reviewed sexual health services as part of this inspection due to the overall activity of the service. Leadership and governance arrangements for this

Summary of findings

service fall within the scope of the Women's and sexual health division of the trust and so we have reported our findings within the maternity and gynaecology reports.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Lewisham and Greenwich NHS Trust. These included local clinical commissioning groups (CCGs); local quality surveillance groups; the health regulator, NHS Improvement; NHS England; Health Education England (HEE); College of Emergency Medicine; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; Parliamentary and Health Service Ombudsman; Public Health England and local Healthwatch groups.

We carried out an annnounced inspection of the trust between 7 and 10 March 2017. We undertook additional unannounced inspections on 11, 12, 21, 22 and 25 March 2017. We visited both the Queen Elizabeth Hospital and University Hospital Lewisham, as well as spending time speaking with staff and patients who were accessing community services within the London Borough of Lewisham.

Both prior to and during the inspection we undertook a range of focus group meetings with staff from different roles and grades. We also facilitated focus groups with staff from black and ethnic minorities.

We spoke with approximately 550 members of staff from across a range of specialities and grades of seniority. We interviewed members of the executive and non-executive board including the chief executive and the chair. We spoke with approximately 300 patients and relatives and reviewed a wide range of documentation submitted before, during and following the inspection.

What people who use the trust's services say

Friends and family test

The trust's Friends and Family Test performance (% recommended) was generally about the same as the England Average between December 2015 and November 2016. In latest period, November 2016 trust performance was 95 % compared to the England average of 95 %.

Cancer patient experience survey

For Lewisham and Greenwich Trust in 2015, there are 50 scored questions. Lewisham and Greenwich Trust did not score any questions above the expected range; it was below the expected range in 9 and within the expected range on the other 41.

Those question in which the trust was below the expected range include:

- Hospital staff gave information about support groups
- Hospital staff gave information about impact cancer could have on day-to-day activities
- Groups of doctors or nurses did not talk in front of patient as if they were not there
- Patient had confidence and trust in all doctors treating them
- Hospital staff definitely did everything to help control pain
- Given clear written information about what should / should not do post discharge
- Staff told patient who to contact if worried post discharge
- Patient definitely given enough support from health or social services during treatment
- Hospital and community staff always worked well together

Patient Led Assessments of the Care Environment

The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Food, Privacy/dignity/wellbeing and Facilities. Trust scores were in line with the England average in relation to food; 85.52% compared to 85% nationally.

CQC Inpatient Survey 2015

In the CQC Inpatient Survey 2015, the trust performed better than other trusts in none of the 12 questions examined by the CQC, about the same as other trusts for ten questions and worse than other trusts in two questions.

The trust performed worse than other trusts for the following questions:

Summary of findings

- Were hand-wash gels available for patients and visitors to use?
- When you had important questions to ask a nurse, did you get answers that you could understand?

Facts and data about this trust

Activity and patient throughput

From August 2015 to July 2016 the trust had:

- 213,271 A&E attendances.
  - Queen Elizabeth hospital – 92,771
  - University Hospital Lewisham – 120,500
- 128,155 Inpatient admissions.

From July 2015 to June 2016

- 626,852 Outpatient appointments.
  - Queen Elizabeth Hospital – 338,572
  - University Hospital Lewisham – 288,280

From April 2014 to March 2015

- 8,151 Births.
  - Queen Elizabeth Hospital – 4,200
  - University Hospital Lewisham – 3,951
- 1,903 Referrals to the specialist palliative care team.
  - Queen Elizabeth Hospital – 1,092
  - University Hospital Lewisham – 555
  - Community services - 256
- 22,361 Surgical spells.
  - Queen Elizabeth Hospital – 9,501
  - University Hospital Lewisham – 11,005
  - Queen Marys Hospital – 1,855

Safe:

Between January 2016 and December 2016, the trust reported three incidents which were classified as Never Events.

In accordance with the Serious Incident Framework 2015, the trust reported 48 serious incidents (SIs) which met the reporting criteria set by NHS England between January 2016 and December 2016 Of these, the most common type of incident reported was Sub-optimal care of the deteriorating patient meeting SI criteria, 15% (7) of all incidents reported. The second highest categories reported were Diagnostic incident including delay meeting SI criteria (including failure to act on test results), 10% (5) of all incidents and Maternity/Obstetric incident meeting SI criteria: mother only, 10% (5) of all incidents reported.

There were 11,232 incidents reported to NRLS between January 2016 and December 2016. 8,410 incidents resulted in no harm/near miss; 2,579 resulted in low harm; 231 resulted in moderate harm; 10 resulted in severe harm and 2 resulted in death.

There were two cases of Meticillin resistant Staphyloccous aureus (MRSA) reported between August 2015 and July 2016. Trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within this period. Additionally, the trust reported 16 Meticillin sensitive Staphylococcus aureus infections and 23 Clostridium difficile (C.DIff) infections during the same period.

Responsive

The main reasons for delayed transfer of care at the trust were “Waiting Further NHS Non-Acute Care” (33.3 %), followed by “Awaiting Nursing Home Placement or Availability” (26.3%). This was recorded between December 2015 and November 2016.

From Q1 2015/16 to Q1 2016/17 bed occupancy rates at the trust were higher than the England average with the exception of Q4 2015/16 when occupancy rates were equal to the England average. In Q2 2016/17 occupancy rates were lower than the England average. The overall trend shows slight variations from Q1 2015/16 to Q1 2016/17 though occupancy rates have declined to below the England average in Q2 2016/17.

Between December 2015 and November 2016 there were 872 complaints about the trust. The trust took an average of 56 calendar days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be responded to within 25 days.

Well-led

The trust’s sickness levels between September 2015 and July 2016 were lower than the England average. Rates for the trust were below the England average from September 2015 to April 2016 with a noticeable decline in

Summary of findings

January 2016. Rates were slightly higher and marginally worse than the England average in May 2016 and July 2016. The overall trend for the period remained mostly stable with only slight variations month on month

In the 2016 NHS staff survey, the trust staff engagement score was 3.79; this was similar to the trust's engagement score for 2015 (3.78). The response rate for the 2016 staff survey result whilst marginally higher when compared to the 2015 response rate (29.5% vs 27.2%), the trust response rate was significantly worse than the national average of 44%.

In the NHS Staff Survey 2016, the trust performed better than other benchmarked trusts in two questions, about the same as other trusts in 14 questions and worse than other trusts in 16 questions.

The top 5 key findings for the 2016 staff survey results were:

- Key finding 6 - Percentage of staff reporting good communication between senior management and staff
- Key finding 7 - Percentage of staff able to contribute towards improvements at work
- Key finding 12 - Quality of appraisals
- Key finding 13 - Quality of non-mandatory training, learning or development
- Key finding 32 - Effective use of patient/service user feedback.

The bottom 5 key findings for the 2016 staff survey results were:

- Key finding 11 - Percentage of staff appraised in the last 12 months
- Key finding 16 - Percentage of staff working extra hours
- Key finding 17 - Percentage of staff feeling unwell due to work related stress in the last 12 months
- Key finding 27 - Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse
- Key finding 28 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safe as requires improvement because: • Vacancy rates, turnover and sickness absence were all above the trust's planned levels. Bank and agency staff covering shifts received varying levels of support to enable them to be effective. • Medicines were not always managed and maintained in a safe and effective way. • Learning from incidents was varied across the organisation. • There was limited assurance about the safety of patients in particular in relation to the 'monitored bays' on the Medical Admissions Unit (MAU) and the Coronary Care Unit (CCU). Patients in these areas had clear level two needs but the hospital did not recognise these areas as level two areas. This meant patients did not receive the standard of care they would normally receive under the Faculty of Intensive Care Medical (FICM) guidance. • Mandatory training completion rates mostly fell below the hospital's target of 85% for both medical and nursing staff. • The standard of infection control processes, including waste management and adherence to the control of substances hazardous to health guidance, were variable. Hazardous waste was not always managed in line with national and international best practice safety guidance, including in storage and access control. **Duty of Candour** • The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. • The trust was aware of its role in relation to the duty of candour regulation which is regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It sets out specific requirements providers must follow which includes an apology to patients.	**Requires improvement** 

- Staff we spoke with had a good knowledge of duty of candour or the concept of the regulation. Senior staff were clear about the requirement of the duty and were able to describe examples where-by they had been required to discharge their responsibilities to apply the regulatory requirements.

Safeguarding

- There existed an established adult and children & young people safeguarding committee which was chaired by a non-executive director. Meeting quarterly, the committee considered all elements of safeguarding both vulnerable children and adults. A review of meeting minutes confirmed appropriate challenge and the holding of account existed from the committee to relevant members of staff. For example, the committee considered the trust's compliance with ensuring that all staff were in possession of a recent disclosure and barring service check. As of September 2016, 97% of bank staff and 98.3% of substantive staff were compliant with the trust policy in terms of having undergone a DBS check within the preceding three years.
- The Director of Nursing and Quality was the named executive safeguarding lead for the trust. There were named safeguarding nurses, midwives and doctors in post at the time of the inspection.
- The committee further considered trust compliance with mandatory safeguarding training.
- The trust set a target of 85% for completion of safeguarding training.
- The trust have reported 7 different modules for safeguarding for medical & dental staff at QEH.

They are:

- Safeguarding adults – non clinical level 1, of which compliance was at 100% for the pathology team.
- Safeguarding adults clinical level 2, of which there were 6 staff groups within medical and dental at QEH attained a mean compliance rate of 79%.
- Both reported staff groups for CYP Level 1 were at 100%
- Mean training compliance rates for level two children and young people training was 68%.
- Mean training compliance rates within medical and dental services at QEH for CYP L3 core safeguarding was 81%.

- Mean training compliance rates within medical and dental services at QEH for CYP level 3 specialist training was 57.5%. However, one staff group (197L3 Children services) were reported within the L4 CYP module attained 100% training compliance.
- Nursing and midwifery staff at Queen Elizabeth Hospital exceeded the target of 85% for all four modules for which data were provided.
- At University Hospital Lewisham, compliance with safeguarding within medical and dental services was as follows:
- 100% compliance with safeguarding adults, level 1 non clinical for the sole staff group required to undertake the training.
- Safeguarding adults Level 2 (clinical); 7 different staff groups within medical and dental. Overall mean compliance rate of 72%
- Two staff groups within medical and dental required to undertake safeguarding children and young people level 1. Overall mean compliance rate of 100%.
- Four staff groups within medical and dental required to undertake safeguarding children and young people level 2. Overall mean compliance rate of 52%. However, it is important to note that corporate services and children services both attained 100% in safeguarding children and young people, level 3 core.
- 79% mean compliance across the 6 medical and dental staff groups requiring safeguarding children and young people, level 3 – core training.
- 87.5% compliance across the two staff groups required to undertake children and young people L3 specialist training.
- 100% compliance across the single staff group required to undertake level 4 children and young people training.
- Nursing and midwifery staff at University Hospital Lewisham had a 100% completion rate for three of the seven modules. Three modules met and exceeded the trust target of 85%. The remaining module, Safeguarding Children & Young People Level 3 – Specialist, had a training completion rate of 41% well below the trust target.

Incidents

- The trust had a current incident and serious incident reporting and management policy and procedure in place. This policy had been developed by the heads of governance and patient safety and had been reviewed by a range of professionals including the medical director, patient safety managers head of clinical effectiveness and divisional governance managers. The policy had been approved by the quality and safety committee

on 1 December 2016 and was scheduled for ratification by the Integrated governance committee on 31 January 2017. A review of the Integrated Governance committee to the board on 14 February 2017 confirmed that the policy had been duly ratified. The policy clearly defined roles and responsibilities for all staff across the organisation.

- Staff from across the organisation were aware of their responsibilities in regards to reporting witnessed incidents and were conversant with where to locate the incident reporting policy. However, there was varying performance in regards to how staff learnt from incidents. Whilst we observed some areas of good practice in terms of how learning was shared, some clinical areas were no so good. Some staff reported not receiving feedback from incidents they had reported whilst other staff were able to describe scenarios when they had reported incidents and could describe the learning that had taken place as a result.
- The board was sighted on deep dive incident reports including an annual report into serious and red incidents and monthly serious incident report updates. Following receipt of the June 2016 serious incident report, the board had requested a comprehensive review of the wider safety and quality issues arising from within the radiology service. A thematic review was therefore carried out by the the clinical director for radiology, two governance managers and the head of governance. Four key themes associated with the quality and safety of radiology services were identified including workforce, infrastructure, communication and information technology. Discussions with members of both the executive and non executive team during the inspection confirmed that the board had been sighted on the findings of the thematic review and were aware of the 5 year imaging strategy including a drive to attain an award of the Imaging services Accreditation scheme.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between January 2016 and December 2016, the trust reported three incidents which were classified as never events. We reviewed the route cause analysis and investigation details for two of the three never events. One never event occurred within the surgical division and related to an epidural pump which was wrongfully connected to an intravenous cannula. The patient subsequently received one dose of local anaesthetic and opiate via the incorrect route. Lessons learnt included

retraining for staff and a set of protocols shared across both hospital sites to ensure this did not happen again. The trust had applied the duty of candour with the patient and family and they had received a finalised version of the investigatory findings. The resulting action plan was monitored at the surgical clinical governance meeting.

- In accordance with the Serious Incident Framework 2015, the trust reported 48 serious incidents (SIs) which met the reporting criteria set by NHS England between January 2016 and December 2016. Of these, the most common type of incident reported was Sub-optimal care of the deteriorating patient meeting SI criteria, which contributed towards 15% (7) of all serious incidents reported. The second highest categories reported were diagnostic incidents including delay (including failure to act on test results) which accounted for 10% (5) of all serious incidents and Maternity/Obstetric incidents which impacted on the mother only accounting for 10% (5) of all serious incidents reported.
- Mortality and morbidity meetings were set to take place monthly, in order to review patient deaths in a timely manner. There was variation across the trust in terms of the frequency and quality of these meetings. The Medical Director was striving to ensure that a robust and effective review process existed across the organisation, however acknowledged that some directorates performed better than others and that this variation was being addressed. The board had been sighted on the concerns of the medical director in terms of the quality of reviews of deaths; the medical director provider a report to the trust board on 13 December 2016 which concluded that whilst the trust mortality review committee was reviewing the quality of care and identified themes, some clinical areas were not investigating deaths appropriately. The trust had identified a clinician to lead the improvement agenda and included the introduction of a mortality review tool endorsed by a Royal College.

Staffing

- As of January 2017 Lewisham and Greenwich NHS Trust reported a vacancy rate of 17% which equated to 1,159 vacant posts.
- Nursing and midwifery reported the highest vacancy rate with 346 vacant posts.
- As at January 2017, the trust reported a turnover rate of 14% which whilst in-line with the national average of 14.1%, was higher than the trust target of 12%.

Summary of findings

- Despite the vacancy rate within critical care, the service was able to maintain a nurse to patient ratio in the ITU at 1:1 and in the HDU; the nurse to patient ratio was always 1:2.
- In addition, whilst the highest number of vacancies existed within nursing and midwifery, as of January 2017, the trust reported average fill rates for registered nurses was 95.9% in the day and 102.1% at night. For care staff, the average fill rate was 94.7% during the day and 109% at night. The trust reported an overall excess of 0.4% against planned hours; this was a marginal improvement against previous performance.
- The neonatal unit (NNU) did not meet national guidelines for staffing. An additional 12 nurses were required in order to meet the demand on the unit.
- As of January 2017, the trust sickness rate was 4.8% against a target of 3.5%. WhilsA review of sickness rates over time would suggest a deteriorating picture for the trust, with increasing sickness rates apparent over time for 2016.
- Between April 2016 and November 2016, the trust reported a bank and agency usage rate of 13%; A&E reported the highest agency and bank staff usage of 21%. Outpatients reported the lowest usage rate of 4%. Surgery (15%) and Maternity (14%) both reported usage rates above the trust average of 13%. Queen Elizabeth Hospital reported the highest agency and bank staff use within Critical care (20%), Children's Services (19%) and Surgery (18%). Outpatients reported the lowest usage of 5%. The remaining core services reported usage rates between 12% and 16%. Agency and bank usage reached a highpoint in April 2016 (16%) then a decrease from May to November 2016 to between 11% and 14%.
- Lewisham and Greenwich NHS Trust reported their medical staffing below establishment as of December 2016. During December 2016 the trust employed 155 (17%) fewer medical and dental staff than the level determined by the trust to provide high quality care.
- As at September 2016, the proportion of consultant staff reported to be working at the trust were lower than the England average. The proportion of junior staff (foundation year 1-2) working at the trust were higher than the England average.
- Out of hours cover arrangements for consultants providing end of care services were unclear. Ward staff had varying levels of understanding of the end of life care provision overnight and at weekends.

Are services at this trust effective?
We rated effective as requires improvement:

Requires improvement

- There was not a comprehensive rolling audit programme for the inpatient medical wards. This meant care and treatment were not benchmarked against national best practice guidance.
- The hospital performed variably in the 2015 Heart Failure Audit and the National Diabetes Inpatient Audit. This included performance better than national average in discharging patients following cardiac care but worse performance in ensuring patients received a specialist foot review within 24 hours of admission.
- Staff spoke of poor communication within some areas of the hospital that negatively affected patient outcomes. This included contradictory messages to patients by doctors and allied health professionals and a lack of understanding of the use of the rehabilitation care pathway. Further, significant improvement was required for ensuring that cross site working occurred across all specialities and at all professional grades.
- Not all staff were qualified or had skills they needed to carry out their roles effectively and in line with best practice, including in the medical admissions unit (MAU) and coronary care unit (CCU). In addition, the learning needs of staff were not always identified and training put in place to meet those learning needs.

Evidence based care and treatment

- Care was delivered in line with National Institute of Health and Care Excellence (NICE) guidance in relation to their specific service, including in care of the elderly. However as there was no substantive audit programme, there was not a system in place to monitor compliance with this.
- Patients in the Trafalgar Clinic received HIV testing and care in line with national guidance from the British Association for Sexual Health and HIV and NICE guidance 60.
- Local audits in the Trafalgar Clinic included participation in a national British HIV Association syphilis audit, checking cardiovascular disease competencies for HIV positive patients and a qualitative audit of patient attitudes to their medicine plan in preparation for a presentation at a national conference.
- There was a lack of structured audit activity on inpatient medical wards, which meant senior staff could not be assured care and treatment was benchmarked against local standards.

Patient outcomes

Summary of findings

- Between March 2015 and February 2016, patients had a lower than expected risk of readmission for the top two specialties for elective admissions; medical oncology and clinical haematology.
- For elective gastroenterology and all non-elective admissions, the risk of readmission was higher than expected.
- The hospital performed variably in the 2015 Heart Failure Audit. This included better than national average in one of the four standards and worse than national average in two of the four standards relating to in-hospital care. In the seven standards relating to discharge, the hospital performed better than the national average in four standards and worse than the national average in two standards.
- The hospital performed variably in the 2015 National Diabetes Inpatient Audit. For example, performance was better than the national average in eight metrics and worse than the national average in nine metrics. The largest variation was in the guidance that patients be seen by the multidisciplinary diabetic foot team within 24 hours of admission. In this metric the hospital performed at 42%, compared to the national average of 69%.
- The trust participated in the 2015 lung cancer audit and the proportion of patients seen by a cancer nurse specialist was 56%, which was worse than the audit minimum standard of 90%.
- Between June 2016 and November 2016, 71 patients experienced a transfer between the hours of 10pm and 7am. National guidance suggests overnight transfers are related to poor patient outcomes and should be avoided wherever possible.
- Although the hospital's overall performance in the national Sentinel Stroke National Programme (SSNAP) audit had been downgraded from A to B in the most recent results (March 2017), a grading of B was still above the national average.
- Queen Elizabeth hospital was level three UNICEF Baby Friendly accredited. The Baby Friendly initiative is based on a global accreditation programme of UNICEF and the World Health Organization.
- A review had been undertaken in June 2016 that was based on the recommendations of the National Paediatric Diabetes Audit of 2014/15. It found that the hospital had met all of the recommendations except for one which was partially met.
- The "Mothers and babies: reducing risk through audit and confidential enquiries" (MBRACE) showed the trust was up to 10% lower than average for neonatal mortality in the country.

- The number of under one year olds readmitted following an elective admission of children between September 2015 and August 2016 was too low to be compared to the England average.
- Readmissions following an elective admission, for children aged one to 17, for the same period was similar to the England average.
- For readmissions following an elective admission of children aged one and under, between September 2015 and August 2016 no one treatment speciality reported six or more readmissions.
- Audit programmes for end of life care services fell significantly short for services provided at the Queen Elizabeth hospital.

Multidisciplinary working

- HIV consultants in the Trafalgar Clinic worked with colleagues across the hospital to provide coordinated care for HIV positive patients who may be admitted to or seen in other medical or surgical services. This included well-established links with consultant intensivists in critical care and respiratory consultants. This ensured HIV positive patients with complex conditions, such as co-morbid tuberculosis, to be treated by a multidisciplinary team of specialists. This team also demonstrated significant scope for working with teams outside of the hospital. For example, an advanced nurse practitioner led a prisoner treatment and care programme that provided coordinated care for HIV positive or at-risk prisoners. This service was provided with specialists in drug addiction, social needs and homelessness to ensure patients in prison received targeted care.
- Clinical nurse specialists provided a sexual health screening service in a community clinic in Greenwich on a weekly basis. The Trafalgar Clinic's clinical director maintained oversight of this and nurses provided a seamless pathway from the community clinic to the hospital service if patients presented with an HIV risk.
- Sexual health, HIV and contraception staff held a monthly MDT meeting that included all sites in the trust. Where a patient was admitted as a medical inpatient and HIV was the primary cause, they could be cared for in this hospital through multidisciplinary relationships between consultants. This team also maintained close relationships with colleagues at another NHS trust, which would accept patients transfers if more specialist HIV inpatient care was needed.
- Child and adolescent mental health service (CAMHS) support was provided by two local teams dependent on which borough

the patient was from. We were told by staff that this support was good during the day Monday to Friday but there were challenges for assistance out of hours and at weekends. Out of hours provision was through the adult psychiatry team, with CAMHS advice provided by an adult psychiatry consultant who would contact the CAMHS consultant if required. No CAMHS doctor attended after-hours or at weekends.

- Peer review of the critical care service identified that multi-disciplinary meetings were not taking place for long-term patients. This continued to be the case during the inspection however the trust subsequently reported that MDT working was starting to take place in order to assess and plan care for long term patients.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff used the abbreviated mental test (AMT) on admission for each patient and used the score to refer to specialised dementia services if needed. We saw the AMT in use in all of the inpatient records we looked at.
- The dementia lead monitored Deprivation of Liberty Safeguards (DoLS) applications on a weekly basis at each hospital and circulated a list to the senior medical team each Friday. This meant there was always a record of inpatients with an active DoLS and staff working on a weekend had ready access to this information. The dementia and safeguarding lead had recently completed work with staff at the Queen Elizabeth Hospital to improve their reporting of DoLS applications to the trust's safeguarding team following an audit in July 2016 that indicated DoLS were inconsistently reported.

Are services at this trust caring?

We rated caring as requires improvement

Requires improvement 

Compassionate care

- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England Average between December 2015 and November 2016. In latest period, November 2016 trust performance was 95 % compared to the England average of 95 %.
- We observed examples of staff interacting with patients and those close to them with kindness and dignity. Staff told us they remembered that they were also supporting the families of the dying. However, there were also examples where the level of care in terms of ensuring patients were treated with compassion and dignity fell far below the expected standard.

Summary of findings

Cancer patient experience survey

For Lewisham and Greenwich Trust in 2015, there are 50 scored questions. Lewisham and Greenwich Trust did not score any questions above the expected range; it was below the expected range in 9 and within the expected range on the other 41.

Those question in which the trust was below the expected range include:

- Hospital staff gave information about support groups
- Hospital staff gave information about impact cancer could have on day-to-day activities
- Groups of doctors or nurses did not talk in front of patient as if they were not there
- Patient had confidence and trust in all doctors treating them
- Hospital staff definitely did everything to help control pain
- Given clear written information about what should / should not do post discharge
- Staff told patient who to contact if worried post discharge
- Patient definitely given enough support from health or social services during treatment
- Hospital and community staff always worked well together

Patient Led Assessments of the Care Environment

- The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Food, Privacy/dignity/well being and Facilities. Trust scores were in line with the England average in relation to Food; 85.2% compared to 78%.

CQC Inpatient Survey 2015

- In the CQC Inpatient Survey 2015, the trust performed better than other trusts in none of the 12 questions examined by the CQC, about the same as other trusts for ten questions and worse than other trusts in two questions.

The trust performed worse than other trusts for the following questions:

- Were hand-wash gels available for patients and visitors to use?
- When you had important questions to ask a nurse, did you get answers that you could understand?

Are services at this trust responsive?
We rated responsive as requires improvement

Service planning and delivery to meet the needs of local people

Requires improvement

Summary of findings

- The trust had a sustainability and transformation plan (STP). The plans were place based, whole system plans. Under national guidance, the trust had established a leadership team of four individuals from across each part of their system, which included local commissioner's members of the local council and a member of another NHS trust. An initial STP submission was made in June 2016, which was reviewed by NHS England, and a final STP was submitted in October 2016, which recognised that the detail would continue to evolve through public engagement and discussion with stakeholders. Some elements of the STP, such as their proposal to develop two elective orthopaedic centres and potentially changes to specialised commissioning, required formal public consultation. Having dedicated centres meant offering more procedures and patients spending less time in the hospital as there would be fewer cancelled operations.

Meeting people's individual needs

- The trust had developed a dementia strategy in conjunction with members of the public and external agencies. Whilst the dementia score within the PLACE assessment for UHL was in line with the national standard, QEH fell marginally below. The trust had embarked on an improvement plan including the introduction of more suitable signage including pictograms, dementia friendly clocks and the encouragement of use of china cups as compared to paper/disposable cups.
- There was a process in place for identifying patients with learning disabilities; flags were included on the electronic patient record system which enabled the specialist learning disability team to trace patients and provide appropriate support to care staff and individual patients.

Access and flow

- The main reasons for delayed transfer of care at the trust were "Waiting Further NHS Non-Acute Care" (33.3 %), followed by "Awaiting Nursing Home Placement or Availability" (26.3%). This was recorded between December 2015 and November 2016
- From Q1 2015/16 to Q1 2016/17 bed occupancy rates at the trust were higher than the England average with the exception of Q4 2015/16 when occupancy rates were equal to the England average. In Q2 2016/17 occupancy rates were lower than the England average. The overall trend shows slight variations from Q1 2015/16 to Q1 2016/17 though occupancy rates have declined to below the England average in Q2 2016/17.

Summary of findings

- NHS England data (December 2015 to November 2016) for the referral to treatment time (RTT) indicated, the trust was worse than the England overall performance.
- The latest figures for November 2016 showed 61% of this group of patients were treated within 18 weeks versus the England average of 71%. From December 15 to April 16, the variance between the trust average and the England average was between 1% and 9%. From May 2016 to September 2016, the variance between trust and England averages increased to between 15% and 22%.
- The worst referral to treatment times at the trust was in June, July, August and September 2016 when on average only 52% of patients were referred for treatment within 18 weeks. The percentage of patients referred for treatment within 18 weeks decreased by 15% over the twelve month period.
- The following surgical specialties were better than the England average for admitted RTT. Plastic surgery result was 90% against the England average of 82.6%, general surgery with 83.1% against the England average of 75.9% and urology with 80.7% against the England average of 79.8%.
- The following surgical specialities were worse than the England average for admitted RTT, with ophthalmology at 16.7% against the England average of 78.2%, ears, nose and throat procedures was 34% against and England average of 69.9% and trauma and orthopaedics being 35.7% against an England average of 66.5%.
- Between April 2015 and March 2016 the average length of stay for medical elective patients was 4.2 days, which was similar to the national average of 3.9 days. For non-elective patients, the average length of stay was 6.7 days, which was similar to the national average of 6.6 days. For clinical haematology, the average length of stay was six days longer than the national average.
- There was a consistent focus on avoiding unnecessary inpatient admissions. For example, a speech and language therapy (SaLT) post had been introduced on a Saturday morning to review AMU patients and those seen in the emergency department. Using a risk feeding protocol, the SaLT therapist could implement a plan of care and avoid the need for an inpatient admission.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard

and the patient should be offered treatment at the time and hospital of their choice. For the period, Q3 2014/15 to Q2 2016/17 Lewisham and Greenwich NHS Trust cancelled 653 surgeries. Of the 653 cancellations, 4% were not treated within 28 days.

- The emergency pathway across the organisation required improvement and this was recognised as an area for improvement by the trust. The trust had rated the emergency pathway risk as being extreme with a current score of 25. This suggests that despite the mitigations listed by the trust, the executive team have considered that the likelihood of risk manifesting is almost certain.
- We acknowledged the work being undertaken by the trust including the re-design of the front door of QE. However, there was a question as to whether there was sufficient pace to address the issues within the emergency pathway. There had been some improvements to the emergency pathway at Lewisham hospital however due to external engagement with ECIST, transformation plans were limited at Queen Elizabeth Hospital. We considered that in light of the fact that the emergency pathway required significant improvement at Queen Elizabeth, it was appropriate for the trust to instigate any necessary action so as to ensure the safety and welfare of patients at Queen Elizabeth.
- The trust recognised that the emergency pathway at QE was under immense pressure with continued increases in activity year on year. The trust was seeing an increase in “Blue calls” to the department which was further increasing the acuity of patients within the QE; when considering the wider implications of having only limited consultants to support the critical care unit, the level of risk within the QE campus is increasing. The trust reported, and we have seen that the QE is a significant outlier for diagnostic testing. We found that whilst imaging practices within the radiology department are, in the main, safe, patients are potentially being exposed to tests which were un-necessary. Again, when factoring in the longstanding issues of quality and governance within the imaging department, as well as the fact that imaging equipment was running at full capacity, there existed residual significant risk within the emergency pathway. At the time of the inspection, we were not assured by the actions and mitigations being undertaken by the trust to tackle these issues. Discussions with the executive team suggested they were aware of the problems they faced within the emergency pathway however we were not receiving definitive timescales for change. Additionally, there were wider system issues which further increased the risks within the pathway. This included

the poor flow of patients through the hospital due to a lack of community capacity. We found that the trust was accommodating some 120+ patients who were either fit for discharge or were awaiting assessment but could be transferred to a sub-acute healthcare setting. This congestion within the hospital led to bottle-necks within the ED department which further impacted on the quality of care patients could expect to receive. We fed back to the trust and wider stakeholders following the inspection that whilst the trust acknowledged the flow issues they faced, the trust was not wholly in control and timely, system-wide intervention was essential.

Learning from complaints and concerns

- Between December 2015 and November 2016 there were 872 complaints about the trust. The trust took an average of 56 calendar days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be responded to within 25 days . On average 72 complaints were received per month. From December 2015 to October 2016 an increase in trend can be seen Complaints received decreased in November 2016. Complaints received varied between 47 and 90 complaints per month. High numbers of complaints were received in February (84),March (87), August (90) and October 2016 (84).Out-patients and in-patients accounted for 33% each while emergency services accounted for 22% of all complaints received.
- We reviewed five randomly selected complaints to determine whether the trust was following their own policy in regards to the handling and management of complaints and to determine whether the trust was complying with the Health and Social Care Act 2008. We found that each of the five complaints had been acknowledged within three working days. Three of the five complainants had received a written response within the 45 day time period. One complaint had received an update as to why the investigation had taken longer than expected. There was no evidence of a final response for the fifth case however there was evidence of multiple attempts to send a copy of the route cause analysis and serious incident investigation report to relatives as well as inviting the family in to the hospital for a local resolution meeting.
- Whilst the trust had a complaints policy, a review of five randomly selected complaints identified deviation away from the policy. For example, the complaints policy stated that all complaints should be awarded a risk grading to enable

appropriate management of the complaint. We found that this stage of the complaints process had not been completed for any of the five complaints we looked at. We noted that in two of the five files there existed a final risk grading as per the policy.

Are services at this trust well-led?

We rated well-led as requires improvement

Requires improvement

Leadership of the trust

- There was a well-established senior executive team; staff reported that some members of the executive were more visible than others. The chief executive was held in high regards by all groups of staff.
- Whilst the director of nursing and quality was in a substantive post at the time of the inspection, the post holder was scheduled to leave the trust at the end of March 2017. The chief executive was sighted on the size of portfolios across the various executive leads, and considered a need to review portfolio's following the departure of the director of nursing and quality. Temporary arrangements included interim appointments being made including having separate post holders for the director of nursing and a separate lead for quality. The trust had commenced active recruitment to the director of nursing post.
- There was a balance with regards to the tenures of those individuals who formed the executive board with some individuals having been in post for circa twenty years, whilst also conversely, there were new appointments including the medical director who had taken up post some twelve months prior to the inspection.
- The Chair had undertaken two terms and was scheduled to step down from the role in May 2017. Interim arrangements had been made until a substantive appointment could be made. Non-Executive Directors had been in post for longer terms as well as those recently appointed, within the last two years.
- Local leadership was varied across the organisation. We saw examples of strong cross-site working, with the midwifery workforce acting as strong ambassadors for this working practice. Some clinical services operated in almost complete silo however there was recognition of the need to improve and enhance cross-site working relationships.
- We carried out a comprehensive inspection of the trust in 2014. The process of inspection is to assess quality and to identify areas of good practice and areas requiring improvement. We have noted that the pace of, and extent of change since our

inspection of 2014 has been slower than anticipated. Whilst there are many contributing factors as to why significant progress has not been made, we identified that a lack of decisive decision making by the executive was a significant factor. We held a multitude of interviews with executive members. These revealed that whilst people were conversant with matters which were likely to pose risks to the delivery of the organisations strategy, decisions had not been made which could have positively impacted on the quality and safety of services.

Vision and strategy

- The vision of the organisation was to be a "Consistently high performing and financially sustainable trust by 2020". The trust had set corporate objectives to enable the leadership to achieve the vision. These corporate objectives included:
  - **Make improvements in quality and safety** so we are one of the best performing Trusts in the country. This will include:
  - Improving performance for cancer patients so we meet the NHS standards for providing timely treatment
  - Working with partners to ensure everyone who needs emergency care gets treatment in a timely manner across the health and social care system.
  - Maintaining our performance in meeting the 18-week referral-to-treatment standard.
  - Putting into place the national recommendations for improving maternity services across the country (published in the National Maternity Review, published February 2016)
  - **Improve patient experience** and offer greater choice and personalisation.
  - **Improve staff experience** to support attraction and retention, and reduction in use of agency staff.
  - **Deliver the trust's financial target for 2016/17** as we move towards a balanced budget position by 2020. Our goal is to become one of the best performing Trusts in the county for efficiency and managing our resources.
  - Ensure our **workforce is resourced and deployed effectively** to meet the needs of patients at evenings and weekends.
  - Make the best **use of technology** to benefit patients and staff across the health system.
  - Work with partners to get the best usage of local **NHS estate**. Our priority is making improvements to the estate at QEH to ensure it is safe and fit for purpose.

  - Work with our partners to develop a **shared vision and plan** for the future of sustainable local health services to meet the needs of local people.
- Both the Chair and Chief Executive were clear as to the future of Lewisham and Greenwich NHS Trust. The organisations five year strategy was aligned to the South East London sustainability and transformation plan. The chief executive was sighted on the co-dependencies of external providers and stakeholders and the ability to deliver the aspirations of the STP. The senior leadership team were sighted on the challenges and external factors which were likely to derail the trust's ability to deliver their key objectives. Closures of community beds, proposed expansion plans of neighbouring NHS trusts and increasing health needs of the local population were all sighted as potential external risks.
- The majority of the executive and non-executive team spoke positively of the merger between University Hospital Lewisham Trust and Queen Elizabeth Hospital in 2013. It was apparent through our discussions with front line staff working at Queen Elizabeth hospital that of the three previous mergers and acquisitions they had experienced, the "Lewisham acquisition" had been the most positive experience. People spoke positively of the "Quick wins" including one unified staff pass which allowed access to relevant clinical areas on both sites; a pubic and staff transport system which operated from day one; and an executive team who spent equal time on both sites.
  However, some individuals were more candid and spoke of the challenges the organisation faced in terms of becoming one trust. Infrastructure, information technology and organisational memory all compounded the challenges of integrating both hospitals. Personal attitudes, historic working practices and a lack of wanting to develop robust cross-site working for some medical specialities had been acknowledged by the senior leadership team as influencing factors to driving forward the one trust agenda. A review of the organisations governance arrangements and consideration of the strategic direction identified that working to address clinical leadership and working with partners to plan future care provision was key to delivering the vision of the trust.
- External reviews of clinical specialties including critical care and obstetrics and gynaecology identified the need to strengthen and enhance cross-site working practices and strategies. Whilst we acknowledge critical care had arrangements for cross-site governance, a failure to address longstanding recruitment challenges within one unit over another was not acceptable.

Interim arrangements were in place including the sending of consultants from University Lewisham Hospital to support Queen Elizabeth Hospital however these arrangements were informal.

- We noted that a small number of health professionals were more aligned to one hospital and were not embracing the vision of the wider organisation which was to be one trust which served local communities.
- It was not clear from discussions with both front line staff and the senior executive team how care equality across the geography to which the trust provides services was being addressed. A lack of cohesive working amongst consultant grades across various specialities could lend itself to missed opportunities in terms of developing centres of excellence within the organisation. We were assured, through discussions with clinical leads and divisional directors that integration, sharing of learning and best practice and development of centres of excellence were being considered and enhanced where arrangements already existed however it was acknowledged that further work was required.

Governance, risk management and quality measurement

- The director for nursing and quality was the executive lead within the organisation and had responsibility for the quality governance agenda. A range of committees existed as a means of providing assurance to the board including the integrated governance committee (IGC), audit committee and the finance and performance committee. Non-Executive Directors chaired these committees and formal reports were submitted to the trust board on a regular basis. The integrated governance committee was supported by and received reports from formally constituted sub-groups of the committee including the Quality and Safety Committee, Patient Experience Committee and the Safeguarding Committee.
- The purpose of the IGC was to "scrutinise and ensure implementation of processes and structures for good governance at the trust, to assess the effectiveness of those processes and to seek their continuous improvement." The IGC was also responsible for monitoring the performance of the trust to ensure clinical governance processes were in place to assure the board of quality in clinical care. Corporate risk management and governance, compliance and research were also overseen by the IGC.
- A review of IGC meeting minutes confirmed the meeting was consistently quorate as set out in the terms of reference for the committee.

Summary of findings

- The trust was an active participant of the sign up to safety campaign. The trust joined this scheme in July 2014 with the intention of contributing to the saving of 6,000 lives nationally over the following three years. A sign up to safety plan was developed and instigated in January 2015. Overseen by the Medical Director, a report to the board summarising the progress of the initiative indicated an overall improvement in hand hygiene rates in some specialities. The trust was striving to achieve 95% compliance by the end of year 2 and 100% hand hygiene compliance by the end of year 3 of the programme. The progress report demonstrated compliance of 95.3% as at the end of year 2. The trust had seen improvements in the number of out of critical care "in hospital" cardiac arrests;
- The trust commissioned an external review of governance which was completed in June 2016.
- Whilst the trust had a multitude of policies and procedures, there was often deviation or non-compliance with said policies. We have referred to examples in this report including non-adherence to the complaints policy and the fit and proper persons procedure which supports this finding. Further robust audit programmes should be considered by the board to offer assurance to the board that organisational policies are clearly followed.
- The senior leadership team considered they were well sighted on the risks likely to impact on quality and safety. This assurance was driven via the governance and assurance framework which existed within the Trust. There were however shortfalls in the governance framework in terms of identifying risks. The trust were candid of the challenges faced by the critical care service at Queen Elizabeth Hospital and of staffing levels which was reliant on the goodwill of a small number of staff. Whilst the concern had been logged as a risk on the divisional risk register with mitigation recorded as including recruitment to vacant posts, the board was not sighted on the fact that active recruitment was not being undertaken, therefore creating gaps in the mitigation of the risk. The extent of concerns within critical care became apparent following an external peer review of the service. It is important to note that once sighted on the concerns, the senior leadership team took robust action to address the identified concerns. This is however, a reactive approach to managing risk. Further analysis of risk registers and through discussion with the senior team, it had not been considered that further scrutiny of local risk registers should have been undertaken following the issues identified within critical care, so as to ensure the recorded

mitigation of risk was actually taking place. Following the inspection, the trust have reported that such a review has commenced although had not been concluded at the time of writing this report.

Culture within the trust

- The Trust achieved the national CQUIN target for front line health care workers to have received the flu vaccination. 76.4% of LGT front line health care workers had been vaccinated meaning that 100% of the CQUIN has been achieved. This was a significant improvement on 2015/16 performance of 40.3%.
- The trust's sickness levels between September 2015 and July 2016 were lower than the England average. Rates for the trust were below the England average from September 2015 to April 2016 with a noticeable decline in January 2016. Rates were slightly higher and marginally worse than the England average in May 2016 and July 2016. The overall trend for the period remained mostly stable with only slight variations month on month
- In the 2016 NHS staff survey, the trust staff engagement score was 3.79; this was similar to the trust's engagement score for 2015 (3.78). The response rate for the 2016 staff survey result whilst marginally higher when compared to the 2015 response rate (29.5% vs 27.2%), was significantly worse than the national average of 44%.
- In the NHS Staff Survey 2016, the trust performed better than other bench-marked trusts in two questions, about the same as other trusts in 14 questions and worse than other trusts in 16 questions.
- The top 5 key findings for the 2016 staff survey results were:
  - Key finding 6 - Percentage of staff reporting good communication between senior management and staff
  - Key finding 7 - Percentage of staff able to contribute towards improvements at work
  - Key finding 12 - Quality of appraisals
  - Key finding 13 - Quality of non-mandatory training, learning or development
  - Key finding 32 - Effective use of patient/service user feedback.
- The bottom 5 key findings for the 2016 staff survey results were:
  - Key finding 11 - Percentage of staff appraised in the last 12 months
  - Key finding 16 - Percentage of staff working extra hours
  - Key finding 17 - Percentage of staff feeling unwell due to work related stress in the last 12 months

- Key finding 27 - Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse
- Key finding 28 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month

Equalities and Diversity – including Workforce Race Equality Standard

- The Chief Executive was the board lead responsible for the workforce race equality standard.
- The trust had submitted their compliance with the WRES standard in August 2016. 98.5% of staff had self reported their ethnicity.
- BME staff are just under 3 times as likely to enter into formal disciplinary compared to white staff. Whilst this was a marginal improvement when compared to the previous years data submission, the trust acknowledged the need to further address this disparity.
- BME staff were marginally more likely to access non mandatory training and CPD than white staff.
- 33.2% of white staff had reported experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months; 26.2% of BME staff reported the same during the same period. Of note, there had been an overall reduction in the number of BME staff reporting such abuse when compared to 2015 however there had been a 6 point increase for white staff.
- The number of BME staff experiencing harassment, bullying or abuse from staff was 27.1%. This was similar to the number of white staff reporting the same (27.3%). Again, the trust had reported an increase in the overall number of staff across both white and BME staff groups when compared to the previous years data submission.
- 72% of BME staff reported believing that the trust provided equal opportunities for career progression or promotion. This was lower than the number of white staff (88.4%) who reported against the same metric. Whilst there remains significant variation across the two staff groups, the trust has seen some improvement in the number of BME staff reporting against this measure when compared to the previous years data.
- 58% of the population which is served by Lewisham and Greenwich NHS Trust report being from a BME background. However, at the time of the inspection no board level executive director was from a BME background. One non-executive director was from a BME background.
- The trust reported that whilst they had been reporting on WRES data for three years, with clear differences existing across BME

vs white staff groups, no formal WRES action plan was currently in place at the time of the inspection. One executive director reported that there was no such requirement for an action plan to exist because it was considered all policies and procedures were applied consistently and fairly across the trust. There was no supporting information provided to determine how the trust had reached this decision.

Fit and Proper Persons

- The trust had a procedure in place for ensuring the trust discharged it's responsibilities as set out in the fit and proper persons regulation. The lead executive confirmed that no fit and proper person policy existed at the time of the inspection.
- We found that whilst there existed a procedure, a review of director and non-executive director personnel files identified missing information. This was contrary to the described procedure and was also contrary to Regulation 5(5)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Routine checks had not been carried out to determine whether individual directors (both executive and non-executive) appeared on insolvency or bankruptcy registers; this was rectified on 9 March 2017 following our feedback to the lead executive of the requirement for this to have been in place prior to the appointment of any director.
- There was poor understanding as to the level of DBS check required for executive and non executive directors. We found examples of where the procedure had been applied differently and contrary to the FPPR procedure.
- With the exception of directors and non-executive directors completing self-declarations stating that they considered themselves to meet the requirements of the FPPR, no annual checks of compliance with the FPPR regulation had been conducted by the trust.

Public engagement

- There was varied public engagement across the divisions. Women's and sexual health had clear public engagement plans including maternity open forums and routine pregnancy evenings all supported public engagement.
- The trust had an established patient experience committee which included representation from lay and public persons.

Summary of findings

- Public engagement events for 2016 included a dementia awareness and patient experience event. This event was an opportunity for members of the public and staff to discuss the trust's dementia strategy and resulted in the recruitment of some 30 dementia friends.
- The trust engaged with some 9,000 members who had been recruited from across the boroughs of Lewisham, Greenwich, Bexley and Bromley.

Overview of ratings

Our ratings for University Hospital Lewisham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Requires improvement	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Queen Elizabeth Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Our ratings for Lewisham and Greenwich NHS Trust

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

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	☆ Outstanding	Good	Good	☆ Outstanding	☆ Outstanding
Overall Community	Good	☆ Outstanding	Good	Good	☆ Outstanding	☆ Outstanding

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe Care and treatment.** 12 (1) (2) (a)(b)(c)(e)(g)(h) There were significant medicines management issues in main theatres and in services for children and young people. · There was a Controlled Drug (CD) not stored in a locked cupboard. Further, an anaesthetist was planning to use a vial of CD for more than patient, despite the vials being single use. The CD was not disposed of appropriately, and no record was made of the volume destroyed. · There were incomplete entries and missing signatures in the CD books for Theatres 2 and 3. During our inspection, we observed a member of staff asking another to sign as a witness for CDs that had been issued that morning that they had not, in fact, witnessed. {C}· In services for children and young people, medications were not locked within cupboards, which was not in line with best practice. {C}· Some medications were not stored in their original packaging, which meant that there was a risk of staff unknowingly administering out of date medications.

This section is primarily information for the provider

Requirement notices

{C}· Action had not been taken appropriately by staff when fridge temperatures had been recorded as being outside of the required ranges.

- In medical care, the standard of infection control processes, including waste management and adherence to the control of substances hazardous to health guidance, was variable. MRSA screening was inconsistent across medical care services. An audit carried out in December 2016 showed screening rates ranged between 67% and 97%. On our announced inspection we found a female patient toilet on Beech ward had human waste on the floor. There were no negative pressure rooms on the respiratory ward and staff expressed concerns that patients with tuberculosis (TB) were not always properly isolated as a result. On the day of the unannounced, there were two patients with TB on the respiratory ward. This meant there was a risk to other patients and staff.
- Hazardous waste in medical care was not always managed in line with national and international best practice safety guidance, including in storage and access control. For example, on Alder ward 12 sharps bins were stored in an unlocked sluice room despite there being a keypad on the door. On Ash ward, four closed sharps bins had been stored on the shelf in an unlocked dirty utility room. The storage of sharps bins in unlocked areas was against waste directive HTM 07/01 (2013).
- In surgery we observed numerous breaches of Infection Prevention and Control (IPC) policy, potentially placing patients at significant risk of infection. We observed poor adherence to trust hand hygiene policy and national guidance during our inspection. Staff did not routinely sanitise their hands between patients and on entering and leaving wards. Across the course of our inspection, we observed ten staff not adhering to hand hygiene policy on leaving and entering wards.
- A number of patients were in isolation to prevent the spread of infection. Staff should only enter an isolation room wearing advanced personal protective equipment

Requirement notices

(PPE), including a gown, gloves, cap and mask. During inspection, we observed a doctor leaving an isolation room while still wearing PPE to seek equipment that they had forgotten.

- We observed anaesthetists and surgeons taking their outdoor bags and briefcases into the anaesthetic rooms and theatres on three occasions. This presented an infection risk. On each of these occasions, we raised the issue with the nurse in charge.
- In maternity and gynaecology, we observed the cleanliness of the environment and some equipment to be of a poor standard, even where green 'I am clean' stickers had been used to show that surface areas and equipment had been cleaned that day.
- Emergency trolleys were all dusty and generally not clean, even though 'I am clean' stickers were in use. The instrumental trolley on the postnatal ward was generally unclean and dusty even though a dated 'I am clean' sticker was in use.
- In Delivery Room 2 on the labour ward, the computer on wheels had an 'I am clean' sticker dated 8/3/17 but it was visibly dusty and there were sticky tape marks on the console above the bed.
- A shared en-suite bathroom located between a delivery room and observation ward had been used but not cleaned and staff were not aware of when it was last used. We observed hair in the sink, the toilet had not been flushed and a dirty and scratched bowl on the floor that staff reported would be used for post caesarean section women.
- The sluice room opposite Delivery Room 9 on the labour ward was not secure even though it had a keypad lock. This meant that people and members of the public were able to gain free access. We noted blood spillage in the sluice area. Immediate cleaning was arranged when we brought it to the attention of the ward matron.

The hospital must take action in response to all of these issues and ensure it is compliant with Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe Care and Treatment.

This section is primarily information for the provider

Requirement notices

The hospital must take action to:

· Ensure that all staff, including agency and bank staff are fully aware of the Trust's CD and medication management policies. Reg 12(2) (g);

· Ensure that all CDs are disposed of appropriately. Reg 12(2) (g);

· Ensure that the CD books are fully and accurately completed, and are completed contemporaneously. Reg 12(2) (g).

· Ensure that medications are stored in locked cupboards. Reg 12 (2) (g)

· Ensure that there is no risk to staff unknowingly administering wrong or out of date medications due to removal of medicines from their original packaging. Reg 12 (2) (g)

· Ensure immediate action is taken when medicine fridge temperatures are recorded as being outside of the required ranges. Reg 12 (2) (g).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance. Regulation 17 (1), 17 (2) (a) 17 (2) (b) 17 (2) (f) {C}· The hospital did not have effective systems to assess and monitor the quality and safety of the care and treatment in all services across the hospital including ED, surgery, critical care, services for children and young people, end of life care and outpatients and diagnostic imaging.

This section is primarily information for the provider

Requirement notices

{C}· In ED there were insufficient systems in place to manage the fundamental issues of capacity and flow within the ED. ED performance was below the objectives set out in the delivery plan.

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· In medical care, systems and processes around incident reporting did not always ensure staff reported all incidents or near misses or that staff received feedback on incidents and there was no evidence of learning from serious incidents, particularly in relation to VTE assessments.

· Vacancies in medical care were high, in particular in relation to nursing staff and junior doctors. Five of the medical wards had nursing vacancy rates of between of 53% and 61% each as of March 2017.Some staff reported that high vacancy rates affected patient care and put patients at risk, in particular in relation to medicines being given late when wards were short staffed.

Although the hospital was actively trying to recruit into nursing posts, there was limited evidence of success.

· Systems and processes in medical care around incident reporting did not always ensure staff reported all incidents or near misses or that staff received feedback on incidents and there was no evidence of learning from serious incidents, particularly in relation to VTE assessments.

· The leadership on medical wards had failed to recognise that the standard of infection control processes, including waste management and adherence to the control of substances hazardous to health guidance, was variable. Hazardous waste was not always managed in line with national and international best practice safety guidance, including in storage and access control.

· There were discrepancies between what staff on the medical care wards said the risks in the service were and the understanding of risks in the leadership team.

This section is primarily information for the provider

Requirement notices

- In surgery, information governance practices were poor, with patient records being left unlocked and unattended in public areas throughout the hospital.

There were significant vacancy levels within the service, and high staff turnover.

· The hospital leadership team in surgery were unaware of the issues with medication within theatres.

- The hospital leadership team in surgery had failed to recognise or address breaches of Infection Prevention and Control (IPC) policy, potentially placing patients at significant risk of infection.

- There was no documented strategy for the critical care service, and there were concerns around the medical leadership and governance arrangements.

- There was no clinical ownership of the unit risk register in critical care, as this sat within the surgical directorate.

- There were no scheduled multidisciplinary meetings for the critical care team to review patient care and goals of treatment in a unified way. Frequency of ward rounds used for this purpose did not meet Faculty of Intensive Care Medicine (FICM) core standards.

{C}· We found that local maternity leadership at the hospital had overlooked the basic issues of poor cleanliness and out of date equipment checks and the potential clinical, infection control and patient safety risks they posed.

{C}· There was a risk to clinical outcomes and patient safety due to maternity guidelines not being merged across the Lewisham and Greenwich sites and some guidelines also being out of date.

This section is primarily information for the provider

Requirement notices

· In services for children and young people there were low levels of attendance at governance and safety boards which reduced opportunities for sharing of information to the appropriate people.

· End of Life Care (EoLC) did not appear to have a high profile at local senior hospital or trust board level. There was no named EoLC non-executive director on the board and the end of life care corporate target was not referred to in the trust's quality account 2015-2016.

· There had been lack of effective executive action to address issues of long waiting times in the outpatient clinics. There was a lack of shared working between ULH and the other locations across the trust within outpatients.

The hospital must take action in response to all of these issues and ensure it is compliant with Regulation 17 HSCA (Regulated Activities) Regulations 2014 Good governance.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014
Surgical procedures	Regulation 18 (1)
Treatment of disease, disorder or injury	· The ED, critical care, services for children and young people, end of life care did not have sufficient numbers of suitably qualified medical and/or nursing staff to care for patients. The hospital must take action to: · Ensure there are sufficient numbers of suitably qualified medical and/or nursing staff to provide safe effective care at all times.