Care Quality Commission

Lewisham and Greenwich NHS Trust

University Hospital Lewisham

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Accident and emergency	**Requires improvement**
Medical care	**Requires improvement**
Surgery	**Requires improvement**
Intensive/critical care	**Good**
Maternity and family planning	**Requires improvement**
Services for children & young people	**Good**
End of life care	**Requires improvement**
Outpatients	**Requires improvement**

Summary of findings

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Summary of findings

Overall summary

The hospital provides services to the residents of Lewisham, an approximate population of 275,000 people. it is part of the recently formed Lewisham and Greenwich NHS Trust, and as a whole the trust provided healthcare to a wider population of over 550,000 people of Lewisham, Greenwich and Bexley.

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

Elements of the acute medical pathway (which is based on a different model on each site) are not providing optimal flow of patients through the hospital. This includes difficulties in accessing critical elements of some patient pathways provided externally to the Trust; as part of forming the new merged trust, some of these external pathways are needing to be reset and agreed.

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

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

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

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

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

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

We noted lack of important clinical equipment in some areas.

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

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

Are services effective?

Requires improvement

There was not an effective pathway for managing patients who required care in other organisations. Where the trust is unable to offer care, effective pathways to other hospitals are important.

The trust participates in many clinical audits and the results are shared within teams. This demonstrates that clinicians are keen to examine clinical practice and improve outcomes were possible.

We saw staffing levels in some areas below those that would be required for effective care. The trust discussed a recruitment plan; but this was not yet fully in place.

We observed good multi-disciplinary team working in many areas. A team that works well together and values each other's roles is likely to be more effective.

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

In outpatients, the number of times a patient needs to attend to see a consultant for follow-up after their treatment is being reduced. This is in line with national best practice and reduces the impact of travelling to hospital regularly.

We saw a shortage of beds for admission to the hospital. This created a block in the system particularly for patients from A&E. this meant that their admission was often delayed.

Summary of findings

Are services caring?

Requires improvement

The Friends and Family Test is a measure of whether people using the service would recommend that service to their friends and family should they require it. The A&E service scores well in the friends and family test. Some wards also scored well; but others were less likely to be recommended. The maternity unit scored below the England average in this area.

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

Staff largely made an effort to keep people informed on progress of their care. Patients told us the staff spoke to them with respect and dignity. However, this was not universally true. One patient described how their fears of acquiring an infection were belittled by a nurse. Additionally on one ward we saw that a glass of water was out of reach from a patient and the glass was empty.

We visited the mortuary and spoke to the staff. they described the process of caring for the deceased person and ensuring their families had a positive experience after death. We saw the effort they made and were impressed by their attention to detail.

Are services responsive to people's needs?

Requires improvement

The waiting times in the A&E services regularly fall below the national standard of 95% of patients being admitted or discharged within 4 hours. The ability of this service is constrained by its facilities and the pathway from A&E to an admission on a ward. Additionally, bed occupancy in the trust is regularly over 85%, which is a figure regarded as a marker of effective bed usage.

Delays and excessive waiting times in clinics were a challenge for many patients.. Delays of 90 minutes were common. One patients on the day of our visit had waited two and a half hours for a routine ultrasound scan. Staff told us that clinics often ran late as appointments were often double and triple booked.

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

We heard examples of excellent practice responding to patient's needs. One person at on the Queen Elizabeth site described a service where they had taught volunteers to feed patients on a dementia ward. These patients often need extended time to encourage them to eat. This approach also developed a social interaction with these patients that also met their needs. We heard of the potential to extend this widely across the trust; and we would encourage the trust to consider this.

Summary of findings

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

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

Are services well-led?

Requires improvement

The board set early priorities for the new merged trust and were clearly seen to be working towards them.

We heard from some staff groups about the positive environment supportive culture. Staff felt the organisation engages with them in many areas. Staff at the trust felt positive about the merger and welcomed the opportunity to develop. Through our focus groups we heard from staff in the non-clinical workforce who felt undervalued. These staff play a vital role in maintaining core services; engaging with them is critical for the success of the trust.

We were regularly told of a challenge for the trust of Lewisham attracting the higher 'inner London weighting allowance' while staff working on the QE site attract the lower 'outer London' allowance.

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

Currently, governance arrangements at the trust are managed separately on both sites. This is likely to cause confusion and increase risk if staff are expected to work across site.

Summary of findings

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

Accident and emergency

Requires improvement

Our inspection team spent one and a half days in the department at UHL. During our inspection of the department we were able to speak with 15 patients and 7 relatives who were waiting with them, about their experiences in the hospital. We also spoke with 17 members of hospital staff. This included doctors and nurses of various levels of seniority, porters, four members of the London Ambulance Service and two people who were working for the company contracted to provide cleaning services for the trust. The majority of the patients that we spoke to during our inspection were very positive about their experience within the department. They told us that staff were kind and caring; they kept them informed about what was happening and they felt involved in discussions about their treatment. We saw that there were processes in place to learn from past experiences although there was no formal pathway to disseminate this information to all the staff. We found the department to be clean and tidy however we did raise some concerns about the cleanliness of some of the equipment being used and the safe and secure disposal of clinical waste. People's safety was maintained within the department and staff had all received training in the protection of vulnerable adults and children. We saw that there were good training programmes in place for both doctors and nurses.We did have some concerns regarding staffing levels within the department. Vacancies for consultants limit consultant cover and few patients were reviewed by consultants or senior doctor's prior to discharge. There was also some reliance on agency nurses. We found a lack of information available for people who were unable to read or understand English and our information showed that too many people were waiting over four hours to be seen.

Medical care (including older people's care)

Requires improvement

Most of the patients we spoke with had a positive experience of UHL. Although there were some comments that patients were not treated with dignity and respect such as being talked over, most comments praised the staff that looked after them and our observations corroborated that staff were caring towards their patients.UHL could improve the safety of its care and treatment. Data we received before our inspection suggested that there were concerns with how safe the hospital was. Although the hospital had undertaken some learning and improvement initiatives to improve its safety record, they were limited and did not always go cross trust. There were times where basic safety requirements such as pre assessment checks and reviews were not being followed. Staffing levels were a concern across both doctors and nursing. However there was generally good planning for patients through their treatment pathways. UHL could improve the effectiveness of its care and treatment. UHL did not always follow best practice guidance regarding some of its medical interventions and specialist medical input was not always provided when required. Patients did not always feel they received care when they required it. Care and treatment at UHL was not always responsive. There

Summary of findings

was normally a lack of bed capacity at the hospital despite escalation wards being utilised. Patients were regularly at hospital for longer than they required as although length of stay was monitored, it did not always seem to be acted upon. Well planned discharge arrangements were in place in most cases but there were times when the system failed. Patients who were vulnerable who had additional non-physical needs had access to additional services but these were not always timely. Medical care was not always well-led. There was a vision and objectives in place but these were not always achievable due to the workload required from staff and it was not always cross trust. Performance was monitored but there was sometimes a lack of comparison cross wards or trust. Training was highly regarded but was not easily accessible outside of mandatory training. Staff mostly felt well supported but only within their own teams or directorates and not pan hospital or trust.

Surgery

Requires improvement

People we spoke with during our inspection were mostly positive about the care and treatment they had received. They were complimentary about the staff in the service and felt informed and involved. One person told us, "I would recommend the ward to my friends and family". Another person said, "The nurses are kind and always available". Some people, however, raised issues about communication and we were told of, or observed, instances where patients' needs were not met as well as they could have been.

There were arrangements in place to ensure that patients were kept safe and people we spoke with told us they felt safe in the hospital. However, there was evidence in national and trust data – and also in practice found during our inspection – which indicated these arrangements were not sufficiently robust. For example, an observational audit of the completion of World Health Organization (WHO) surgical safety checklist had identified a risk to safety, particularly with the 'sign out' stage of the checklist. Work was being done to address this.

Nationally recognised guidelines and pathways were followed and we found evidence of good multidisciplinary working. However, a number of issues reduced the effectiveness of the service. Single-sex guidelines were breached in the waiting area of one theatre. Relative risk re-admissions to surgery had been variable and greater than expected in general surgery. Day surgery was falling short of a number of national targets. A long backlog had arisen in clinic letters reaching patient medical records within the orthopaedic service. There were longstanding vacancies and staff shortages in some areas and high usage of bank (overtime) and agency staffing. The surgery discharge lounge was an unsuitable facility for patients waiting to leave the hospital.

We saw that caring was mixed. We heard of, and saw elements of good care; we also observed poor examples of caring by some staff. People we spoke with felt that staff were kind and caring and promoted their dignity and respect. We observed this on the wards and theatre areas we visited but there was a significant shortfall in meeting the needs of a patient awaiting surgery.

Summary of findings

The trust was not meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing general surgery and trauma and orthopaedic surgery. The bed occupancy rates for the hospital were higher than target ranges and this impacted on the flow of patients between surgery and the surgical wards. There were some delays in the discharge of patients. The surgery risk register reported poor complaints-management performance and the potential risk for poor patient experience and loss of opportunity to help staff learn. There was a recovery plan to address this.

Staff were mostly positive about the trust merger and the leadership aims for the new organisation but felt there was still work to be done to achieve the 'one trust' vision. There were new clinical governance arrangements in place and managers were aware of the risks in their area and what action was being taken to reduce them. However, it would take time for the new arrangements to become embedded and for all staff to fully engage with them.

Intensive/critical care

Good

We saw a lack of agreed discharge process in ITU and HDU. We saw bed capacity issues from the rest of the hospital were significantly affecting the ability of the critical care unit to meet the patients requirements.

Patients' needs were being met by the service, care was delivered was delivered by experienced and skilled staff in a caring manner. Patients' care and treatment was delivered in line with national guidelines and evidence-based practices. Many families we spoke with were complementary about the care their relative received.

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

There were enough trained and experienced staff and appropriate equipment to provide care to patients.

Maternity and family planning

Requires improvement

We saw areas of safety in this service that gave us cause for concern. We saw lack of important equipment (foetal heart monitors). We saw lack of appropriate check on equipment and poor record keeping. We saw incomplete handovers to staff from one shift to another.

We also saw that the bed occupancy rate was higher than is recommended for this type of service.

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

Summary of findings

We found a number of positive features of the maternity service at UHL. The birth centre received high praise from patients, and was a sought-after resource. Midwives and clinicians were positive about working at the hospital, and many stated that there had been an improvement in management support, visibility, policy and practice since the merger with QEH.

We were told, and saw evidence, that staffing levels had improved, however, it was of concern that a notable number of shifts were covered by agency or bank (overtime) staff. For example, on one night shift on the labour ward, more than 50% of the midwives were agency or bank. Staff told us there had been a big improvement in supervision, and all now had a named supervisor. Junior doctors told us of good support; while preceptor midwives said there was a good induction programme.

While staff reported an improvement in direct line management, we found that, at a more senior level, improvement was needed with regard to data collection and analysis, risk assessment, staff training and consultant ward rounds.

Services for children & young people

Good

We spoke to a four parents with their children, two clinicians, eight nursing and five ancillary staff. We received positive feedback from parents and children with regard to the care they received, and the interaction between them, nurses and doctors. Staff were proud of the care they gave. The education provision for children whilst in hospital was good. Facilities were child friendly. There was evidence of good multidisciplinary working across specialities, but little evidence of joint working across the two hospital sites. We found however that staff shortages were impacting on the quality of care that was being provided. This, coupled with some equipment shortages, lack of learning from incidents, and lack of action following audits meant that the service was not performing as well as could be expected.

End of life care

Requires improvement

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

There were about 670 deaths a year at UHL. Staff were unable to tell us how many deaths were related to cancer and how many related to other long term illness that required end of life / palliative care. Therefore we were unable to ascertain whether every patient who was on an end of life care (EoLC) pathway was treated by the palliative team at the hospital. We also could not

find out how many of those people were patients receiving oncology services or patients receiving care for other long term conditions such as COPD, heart failure or dementia. The patients and relatives we spoke with told us they felt supported and involved in decisions. We found that the palliative care team (PCT) were caring and supportive. They were aware of the people under their care and we saw records which showed they reviewed a patient's care, amended their medication accordingly and instructed the ward staff in any changes such as recording pain scores at observations checks. We found that recording in people's care plans for observations such as pain scoring, modified early warning score (MEWS), anticipatory medication and do not attempt to resuscitate (DNACPR) was mixed. Some staff recorded information very well, while others omitted to record the outcome. This meant we could not be sure that every patient had been involved in conversations about what to do in the event that their breathing or heart stopped. It also meant we could not be sure that all patients were receiving adequate reviews of their medication. Most of the staff on the ward treated patients and their relatives with compassion and thought. However we were told of two occasions in the previous two months where relatives did not find out about their family members prognosis or decline in an appropriate manner. The PCT felt that ward staff did not always engage in palliative care and EoLC training and would like to see a greater understanding of how to support people at this time of their life. The staff at the bereavement office and mortuary went out of their way to ensure that the deceased were treated with respect and dignity, and families and friends were treated compassionately. However, they found this hard to do within the environment they worked in as it was in need of redecoration and the walk to the mortuary and bereavement office was unpleasant. An issue was also raised with us about ward staff wrapping bodies too tightly before they are transferred from the ward to mortuary. This caused marks and possible disfigurement to the deceased and was distressing to anyone who wished to view the person after they had died. There were no audits or assessments to monitor how well the team, including the bereavement office and mortuary staff, performed or to identify any concerns or issues.

Outpatients

Requires improvement

We spoke with a number of patients, clinicians, nursing and administrative staff. We received positive feedback from patients with regard to the care they received from administrative staff, nurses and doctors. Patient's described the staff as "kind, caring and informative." Staff were supportive of one another and felt they went the "extra mile" to ensure patients were cared for well and their privacy maintained. There was evidence of staff ensuring patient's safety in some clinics however we found some areas for concern, such as staff at clinic reception areas not being able to view patients who were vulnerable. We also found that patient's privacy was not maintained in some clinics. Therefore although the staff's interactions with patients were seen as very good, some of the processes and systems in place were not as caring as you would expect. There was evidence of local divisional meetings between

clinical staff where learning was shared. There was also evidence of multidisciplinary working at a senior level. However there was little evidence of joint working across all the divisions, including the administration services, within the outpatients department. This meant the outpatients department clinics were not sharing learning or practises together which meant there was an inconsistent approach to the Trust's policies and procedures amongst some staff. Patients were asked their views about the service in regard to division they were receiving their care and treatment from. However there was no formal system in place to identify patients' views of the outpatient services alone. This meant we were unable to ascertain any issues or concerns relating to the outpatients department. However, all staff and patients agreed that the main issue for patients were the clinic waiting times, particularly in the pre-assessment, fracture and phlebotomy clinics. The outpatients department responded to a high demand in appointments where possible by arranging longer clinic times or extra clinics on additional days. Satellite speciality clinics were provided by other London hospitals so that patients from area could see specialist consultants locally

Summary of findings

What people who use the hospital say

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

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

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

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

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

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

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

Against the 5 domains that CQC look at:

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

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

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

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

Areas for improvement

Action the hospital MUST take to improve

- The hospital must have a clear process in all areas for learning from previous incidents and near misses, and sharing that learning throughout the teams.
- The hospital must ensure that appropriate levels of staff with the required competencies are available in all clinical areas.
- The hospital must have manage the disposal and storage of clinical waste effectively. Bins with clinical waste and hazardous materials be must be locked safely stored.
- The hospital must ensure that there is appropriate clinical equipment available in all areas.
- The hospital must have a consistent policy for end of life care patients and it must be understood by all staff that are required to implement it.
- The hospital must improve its hand hygiene practices, especially by medical staff.

Action the hospital SHOULD take to improve

- The hospital should review its clinical capacity for inpatients.

Summary of findings

- The hospital should improve the timeliness of its discharge processes for end of life care patients.
- The hospital should improve discharge planning for its patients.
- The hospital should ensure that OP clinic appointments run to time and avoid undue delays.
- The hospital should ensure that all staff take appropriate handover from the preceding shift before beginning their care of patients.

Good practice

- there is a strong participation in audit in many areas.
- There is generally good use of national guidance in many areas
- generally, we saw very caring staff, many of whom were recognised and praised by their patients.
- the pharmacy support worker (runner) is seen as a good response to supporting access to medication before discharge.
- there is good MDT working amongst and across teams.
- There is a positive approach to the merger of the two hospitals.

University Hospital Lewisham

Detailed Findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Dr Nigel Acheson Regional Medical Director, NHS England

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

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

Background to University Hospital Lewisham

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

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

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

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

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

Important note on use of data in this report

It is important to note that since the new organisation was created in October 2013, there is very little current data available that describes the new organisation. There are data available for the previous organisations both for the University Hospital Lewisham and for the South London Healthcare Trust. Whilst these data give an indication of

previous healthcare within these buildings; they must be used with caution when drawing conclusions on the new trust as they do not describe the current management and clinical arrangements that now exist.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, University Hospital Lewisham was considered to be a high risk service.

How we carried out this inspection

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

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

The CQC inspection model focuses on putting the service user at the heart of our thinking. We therefore held a well-publicised listening event on 25 February 2014. This was held before the inspection began and helped inform the thinking of the inspection team. Over 40 local residents and service users attended the listening event, and each had the opportunity to tell their story, either in small groups or privately with a member of the inspection team.

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

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

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

The inspection team at inspected the following core services:

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

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

Requires improvement

Accident and emergency

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

Information about the service

The Accident and Emergency (A&E) Department provides a 24-hour service, seven days a week, with the purpose of treating emergency patients. The present department was opened in 2012 as part of a £12 million project to upgrade the hospital. It is the 7th largest A&E department in England, by attendances and between December 2012 and November 2013 saw 112,000 people. Of these attendee 26% were children under the age of 16. The hospital is a recognised trauma centre.

The department has an Urgent Care Centre (UCC) area where people who walk into the department with minor injuries and illnesses are assessed and treated by doctors and emergency nurse practitioners. The main department has a major injuries (Majors) area and resuscitation area. People who arrive by ambulance via another entrance are directed to the most appropriate department. There is also a rapid assessment and treatment unit. Patients who have been seen and assessed by staff as requiring a further period of observation can be cared for in this area. Originally intended for up to 12 patients, the area was accommodating up to 13 people when we inspected the hospital. Staff told us this was making it a bit cramped for space.

Summary of findings

Our inspection team spent one-and-a-half days in the department at University Hospital Lewisham (UHL). During our inspection of the department we were able to speak with 15 patients, and seven relatives who were waiting with them, about their experiences in the hospital. We also spoke with 17 members of hospital staff. This included doctors and nurses of various levels of seniority, porters, four members of the London Ambulance Service and two people who were working for the company contracted to provide cleaning services for the trust.

The majority of the patients we spoke to during our inspection were very positive about their experience within the department. They told us that staff were kind and caring, and kept them informed about what was happening. They also felt involved in discussions about their treatment. Our Intelligent Monitoring showed that there was a good reporting system for incidents. We saw that there were processes to learn from past experiences.

We found the department to be clean and tidy, however, we did raise some concerns about the cleanliness of some of the equipment being used and the safe and secure disposal of clinical waste. We brought this to the attention of trust representatives who addressed our concerns during the inspection visit.

People's safety was maintained within the department and staff had all received training in the protection of vulnerable adults and children. We saw that there were good training programmes in place for both doctors and nurses.

Requires improvement

Accident and emergency

We did have some concerns about staffing levels within the department. Vacancies for consultants limit cover and few patients were reviewed by consultants or senior doctors prior to discharge. There was also some reliance on agency nurses.

We found a lack of information available for people who were unable to read or understand English. Our information showed that too many people were waiting over four hours to be seen.

Are accident and emergency services safe?

Requires improvement

The trust had good mechanisms in place to report incidents which occurred in the department. We were able to see evidence to show that these incidents were discussed at board level. However, there were not always robust mechanisms in place to ensure that this information was disseminated among all of the staff.

We were able to see examples of where care had improved as a result of incidents and audits.

The department was very clean and tidy, however, there were some instances where infection control measures may have been compromised by porters not complying with the 'bare below the elbows' guidance for staff. We also raised concerns about the storage of chemical products in the paediatric area, the cleanliness of a piece of equipment in the department and the processes in place for the safe and secure disposal of clinical waste. We brought this to the attention of trust representatives who addressed our concerns during the inspection visit.

There were good security measures in place in the department and plans in place to escalate concerns to senior staff.

Safety in the past

The National Reporting and Learning System (NRLS) collects data on patient safety incidents. Between July 2012 and June 2013 the trust reported that there were 29 incidents which were specific to the A&E department. Of these, 27 were rated as 'moderate' or 'no harm'. This reflects the good reporting mechanisms in place as the trust is reporting incidents of low harm. The top three categories were regarding the implementation of care, clinical assessment and disruptive or aggressive behaviour.

There was also one death relating to the paediatric A&E, where a child was wrongfully discharged.

Learning and improvement.

We spoke to some of the nurses about how they reported incidents and how learning from complaints and untoward incidents was shared. We were told that any of

the staff were able to enter information regarding incidents on the hospital's computer-based system and these were graded by an investigator. Where the incidents were considered to be high risk, a root cause analysis was undertaken. Staff told us that the morning handover was used as an opportunity to share information about incidents and give feedback. One of the matrons was able to give us an example of where a drug error had occurred. A patient had been given the wrong medication, intravenously, because it was stored in the wrong box. Once the patient had been treated, the error was investigated. Staff were then all able to discuss the incident, and the importance of cross-checking medication was highlighted.

However, when we spoke with doctors, the method for disseminating information about incidents was less clear. Senior doctors seemed to know what had happened but there were no clear systems for sharing issues with more junior doctors or other colleagues within the trust.

The department's matron told us that those people who were risk assessed as being susceptible to pressure sores, due to their frailty or comorbidity (having multiple disorders), were moved on to pressure-relieving mattresses as soon as possible. Staff were also able to bring beds down to the department for these patients. A body map assessment had also been introduced as part of patient records. Staff were able to identify any deterioration in people's skin integrity or any bruises or pressure sores that they had when entering the department.

Systems, processes and practices

We looked at staffing rotas to see if there were enough staff available in the department to meet the needs of patients. The College of Emergency Medicine (CEM) acknowledges that there is currently a general shortfall of emergency medicine consultants. Their recommendations are that all emergency departments should have a minimum of 10 full-time equivalent consultants in place. For larger departments, their recommendations are that there should ideally be up to 16 consultants. This would allow a greater level of cover. However, they say in order for this to be achieved there would need to be a programme of consultant expansion.

Information from the trust was that there should be 77.9 whole-time equivalent nurses of various grades employed within the department. We were told that currently there were 64.91 whole-time equivalent nurses in post, leaving a shortfall of 12.99. This did not take into account any nurses who were about to start in post. Interviews had not been held, but there was a shortlist of 16 nurses to fill all of these posts. A staffing review was also underway, although the results were not available at the time of our inspection.

The shortfalls in staffing were being filled by agency staff. The matrons told us that, as far as possible, they tried to employ agency staff with appropriate experience, and permanent staff were encouraged to provide feedback if there were any issues regarding the competence of agency staff. During the month of December 2013 the trust had needed 215 shifts filled by registered nurses and 79 had been filled by bank (overtime) staff.

We were told that, on night duty after 8pm, there were less nursing staff on duty and this sometimes led to delays in treatment for patients.

One of the consultants we spoke with told us that the current staffing establishment was for eight full-time equivalent posts in the department plus two consultants in childrens emergency care, although currently there were only 6.5. They said that there were appropriate numbers of middle-grade doctors for the number of consultant posts.

During our walk around the department, we noted that there was a trolley in the paediatric area containing substances that may have been harmful to people's health which were not appropriately locked away. We pointed this out to the nurse in charge and it was addressed promptly.

We noted that two porters within the department had not adhered to the 'bare below the elbows' guidelines for hygiene. This could have posed a risk of cross-contamination.

Records on the resuscitation trolleys we looked at did not provide evidence to show that they had been checked on a regular basis.

The department was very clean and tidy when we visited. There was hand gel available for use, and toilet facilities throughout the department had liquid soap dispensers and paper towels. The matron told us that regular infection control audits were undertaken. However, we raised concerns about some of the equipment in use in

the department. We saw that a blood analysing machine within the department was not being cleaned between use, contrary to the manufacturer's guidelines. This meant that blood samples might have been contaminated and results inaccurate. We brought this to the attention of a trust representative at the time of our inspection and they took immediate action.

We saw that some clinical waste bins, including some containing sharps, were unlocked and some were overflowing. We also saw that compounds where the bins were stored, awaiting collection, had been left unlocked. These were in areas that were easily accessible to the public. We were concerned about the potential for people gain access to used needles and syringes. Also, there was a possible risk of infection arising from clinical waste. During our inspection we brought this to the attention of the person responsible. When we checked again, before we left the site, the issue had not been addressed. We checked again the folowing day and by that point this had been addressed.

When we returned, two days later, we saw that that the clinical waste bins were locked and stored appropriately. Issues around the cleanliness of the blood analysing machine were being addressed. However, when we returned a week later, one of the compounds used to store clinical waste bins was again unlocked. We acknowledged that this was the responsibility of another provider, albeit on the hospital site. Our concerns were that internal monitoring systems were not identifying these issues.

Monitoring safety and responding to risk

We saw that there were good security measures within the department. All the main doors had a keypad or needed a swipe card.

Staff told us that they had all received training about the protection of children and vulnerable adults and they were able to tell us who the safeguarding lead for the trust was. The practice development nurse provided us with records of this training. A paediatric staff nurse was able to explain how they would contact the appropriate people should they have concerns about the health, safety or welfare of any children attending the department. This included any worries that they might have about the parents of children being victims of domestic violence. Nurses in the adult areas were able to explain how they would contact social services where they had concerns about a vulnerable adult. We were told that there was an alcohol liaison nurse within the hospital. They visited the department three times a day and could be easily contacted. There was also a psychiatric liaison nurse.

Anticipation and planning.

There were escalation procedures in place to alert senior staff when the department became exceptionally busy. These might be instigated when there were no available beds to move people out of the department or when ambulance handover times were not being met. The site manager would then look at how they might maximise bed capacity throughout the hospital. One of the senior nurses told us that this process happened on most days. They said that the department rarely closed or asked ambulance staff to take people elsewhere. Once alerted, the management team were usually able to create some bed capacity throughout the hospital.

There was a major incident plan in place and staff we spoke to were familiar with the procedures to be followed. We were told that it had recently been revised. There was also a Chemical Biological Radiological and Nuclear (CBRN) plan in place. Staff had attended training provided by the London Ambulance Service.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The information we had from the College of Emergency Medicine (CEM) showed that not all patients attending the department were receiving pain-relieving medication in a timely way. Very few people were seen by a consultant or senior doctor prior to being discharged. This suggested that consultant staffing levels in the department were insufficient.

The department was taking part in a number of clinical audits and the senior doctors told us that they were producing good results. However, there did not seem to be any clear ways for sharing this information with staff or across the trusts.

Accident and emergency

There was some reliance on agency nurses within the department, however, an active recruitment plan was in place to fill the vacancies.

Staff within the department seemed to have created good links with other healthcare professionals.

There was a well-led paediatric area within the department. This meant that all children were seen by suitable qualified and experienced staff.

Evidence-based guidance

The hospital had good results in the CEM Renal Colic National Audit 2012–13 for analgesia provision for patients with moderate pain in comparison to the rest of England (75% of patients were provided analgesia within 60 minutes),although their results for patients in severe pain could be better. However, their performance on CEM's similar Fractured neck of femur audit 2012–13 was much worse, especially for provision of analgesia in patients in severe pain. Only 6% of patients were provided analgesia within 20 minutes, which is concerning. The department failed to meet standards in the CEM Consultant sign-off audit 2013, with very few consultants or ST4 or more senior doctors seeing or reviewing patients before discharge. The hospital was placed in the lower quartile for most of the standardised measures when compared to the rest of England. There was a high unplanned re-attendance rate between October 2012 and September 2013, ranging from 7–9%. CEM guidance suggests that a rate higher than 5% could be indicative of poor quality care; however, a rate of around 7% is the England average.

The information from CEM showed that people were not always having their vital signs recorded within the first 20 minutes of their arrival. Also, that people were not always receiving medication for pain in a timely manner.

Overall the data suggests that the department is less effective than expected, performing in the England lower quartile on many aspects of the audits. In addition, the number of unplanned re-attendances highlight some issues which should be improved upon.

Monitoring and improvement of outcomes

The consultants we spoke with were aware of all the previous audits. They told us that measures were being undertaken to improve on them and the results were showing that the outcomes for people were getting better. For example, they said that they had developed a care pathway in conjunction with the haematologists for managing deep vein thrombosis (DVT). The audit results were discussed at divisional governance meetings which then fed into the audit committee.

Other examples of good practice that the consultants described included work around discharge planning in order to maximise bed capacity and audits for head injuries, intravenous fluid administration, sickle cell and the clinical practice of GPs. Nurses working in the urgent care centre were being trained and assessed to enable them to prescribe simple analgesia to patients who were waiting. However, we were told that, at times, people in the major's area still had to wait for pain relief.

All of the patients we spoke with during our inspection confirmed that, if appropriate, they had been offered pain relief as soon as they had arrived in the department.

We were told that data from audits was shared among medical and nursing staff, however, there was not any formal mechanism for this. We were also told that the sharing of information with neighbouring trusts was not well managed either.

One of the consultants and the practice development nurse explained to us how they were working to address staff shortages. The trust was encouraging junior staff to come to work at the hospital by organising planned teaching and development programmes for both doctors and nurses. This "grow your own" approach was providing staff with support and supervision as they gained their experience.

The consultants we spoke with told us that they had undertaken various audits in order to monitor and improve care for patients. Although, there were concerns about how information from these audits was shared, there were examples of it being used to make improvements in care. One of these was where patients were known to have sickle cell disease. There was now a 'sickle cell champion' – a nurse with particular expertise who could be called when a patient came to the department.

UHL has the 7th largest A&E by attendance in the NHS. Of A&E attendees at the trust, 20% are aged between 0 and 9 years and 11% are between the ages of 10 and 19 years old. The area demographics in the trust data pack show that 0—9 years and 10—19 years make up approximately 7% and 6% of the population respectively.

Requires improvement

Accident and emergency

Patients aged 16 years and younger were consistently well above England average for being seen within four hours at UHL's Children's A&E, averaging over 99% of patients being seen within this time. Prior to the inspection, no negative evidence was obtained about the trust within this domain.

Sufficient capacity

Consultant cover was provided from 8am until 7pm during the week and 9am until 2pm at the weekends. Middle-grade doctors were in the department 24 hours a day with a consultant on call. The trust was experiencing difficulties in recruiting to all of its available consultant posts, which may have contributed to the shortfalls in number of patients who were seen by a consultant or senior doctor prior to their discharge. Increasing the number of senior doctors would have allowed consultant cover to be increased to cater for more patients.

In order to provide the best care for children attending the department, the children's area was staffed by paediatric trained nurses.

Multidisciplinary working and support

The staff in the department worked closely with a team of social workers, nurses and consultants in elderly medicine to try and minimise the admission of elderly people into hospital. They were able to access support at home from community services and obtain specialist equipment in order to avoid people's admission into hospital.

One of the senior nurses told us that getting a psychiatric referral for patients needing to be sectioned (under the Mental Health Act)was sometimes difficult. Psychiatric services were on site but not provided by the trust. The psychiatric unit had no assessment centre. The nurse told us that they were able to call a psychiatrist for patients but often getting a second healthcare professional to agree the section was a lengthy process. This meant that the patient, who may have needed constant support, was left in the department for some time.

Ambulance personnel we talked with confirmed that they were always welcomed promptly and efficiently. One told us, "if it was me [needing emergency care], I would want to come here".

Are accident and emergency services caring?

Good

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

Compassion, dignity and empathy

On the NHS Friends and Family Test, the A&E department at UHL had a very good aggregated score of 75 between the months September 2013 and December 2013, compared to the England average score of 55 (which means that, overall, patients seem to be pleased with the care that they have received). During this time, 4,330 people returned surveys, which was a good response rate, at 18.5% (compared to the England average of 14.4%) This shows that the hospital is actively encouraging people to respond, which is positive.

the trust opened its urgent care centre in 2013. At this point there was an improvenment in patient satisfaction.

These good results contrast with the UHL's poor scores on the CQC A&E survey – which covers 197 respondents between January and March 2012. For the 'travel by ambulance', 'care and treatment', 'tests' and 'hospital environment and facilities' areas of questioning, the department's score ranged between 6.9/10 to 8.5/10 which was rated as 'worse than other trusts'. This showed that UHL had lots of room for improvement. Overall, the A&E did not perform well in any of the areas of questioning, placing either 'worse than expected' or 'similar to expected'. Most of the people we spoke with during our inspection provided us with positive feedback. They told us that staff had been "very friendly", "kind" and "really caring". One person told us that they attended frequently with their relative and staff were "always superb". Another person commented "it's a brilliant hospital, we're extremely grateful, and very happy with the level of care". One person did tell us they had been waiting for 50 minutes and they didn't know why. They had decided that they would leave soon if nothing happened.

Requires improvement

Accident and emergency

People told us that staff checked to make sure that patients had had a drink and something to eat if they had been waiting for a while.

Those people who had taken children into the paediatric area all spoke positively about the experience. We saw that it was a well-designed, well-managed and well-equipped department and ensured that children were seen by appropriately skilled staff.

Involvement in care

All of the people we spoke with confirmed that staff had kept them informed about what was going on. Those people waiting for results of blood tests and x-rays understood why they were waiting. They said that, where there had been choices to be made about how they were treated, they felt included in the decision-making process. One person told us, "Staff are so good here, really nice, they keep popping in to make sure I'm OK and telling me it won't be long ... just waiting for some blood tests to come back".

Trust and respect

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

Emotional support

There was a dedicated 'relative's room'. It was comfortable and led directly to a separate viewing room for end of life care. This meant that distressed families did not have to walk through the main department to see a deceased person. We also heard that small baskets had been provided in which staff could put the babies of women who had miscarried; this allowed the trust to support parents in a compassionate way The department had a nurse who had undertaken specialist training in bereavement who could be called on where needed.

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

Requires improvement

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

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

There was a process in place to respond to peoples complaints in a timely manner.

Meeting people's needs

Trusts in England are tasked by the government to see, admit or discharge 95% of their patients within a four-hour target time. Waiting times at UHL were below target in winter, with about 93% of patients being seen at UHL within four hours or less. An analysis of waiting times by patient group showed that it was the elderly (60+), patients arriving by ambulance and admitted patients who were waiting the longest. It is expected that admitted patients wait longer since they are waiting for a bed in a hospital ward, which may suggest trust-wide issues of bed occupancy and capacity. Bed occupancy at UHL overall has been around 87%– 90% in the past few years. Anything above 85% is considered high and may impact on a hospital's ability to manage its beds effectively. In addition, CQC's Intelligent Monitoring (which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations) has rated the trust as a 'risk' for A&E waiting times from October to December 2013 via the Care Quality Commissions Tier 1 indicator, which agrees with this analysis**.** An analysis of attendances against waiting times suggest that waiting times aren't due to the A&E department itself, but rather an issue of capacity in the rest of the hospital.

At UHL, between 3%–5% of patients were leaving before being seen, which is less than the 5% CEM 'target', suggesting that waiting times weren't longer than expected. This was in line with the analysis that over 95%

of patients who were not admitted (that is, patients with minor injuries) were being seen within four hours and it was usually the patients with minor problems who left before being seen. We saw information to show that some ambulance handovers were being delayed over 30 minutes. This means that patients were not being handed over to hospital staff in a timely way and treatment may have been delayed. However, the Tier 1 indicator from CQC Intelligent Monitoring for ambulance delays over 60 minutes showed that the trust was performing within expected levels when compared to the England average. Data for this area suggested that the trust overall (not just A&E) wasn't as responsive as it should be. Too many patients were waiting more than four hours to be seen.

Many patients at the trust overall were waiting between four and 12 hours for a bed. This means that they had to wait in a busy department rather than being transferred to a ward.

On the day that we inspected the department people we spoke with told us that they had not had to wait too long to be seen. They confirmed that they had been assessed promptly and the majority of them knew what they were waiting for. Those people who were waiting to be admitted confirmed that they had been kept informed about what was going on and that someone had made sure that they were comfortable and had a drink.

Vulnerable patients and capacity

In the waiting room of the UCC we saw that there were various health information leaflets available for people to read. However, we noted that leaflets and signage throughout the department were written in English only. For many of the people who attended UHL, English was not their first language. There was a picture board available so that patients could point things out to staff. The department also had access to interpreting facilities via the LanguageLine telephone interpreter service.

The UCC had comfortable seating arrangements. We saw that relatives accompanying people in the Majors area were able to sit while they were waiting. The paediatric department had a play area to keep children amused. We asked staff about how they would support people with particular needs. For those people with physical disabilities, the department had a hoist to help transfer them. Toilet facilities had adaptations to help those with limited mobility. Nurses we spoke with admitted that caring for people with dementia was sometimes challenging if the person was not accompanied by a relative or staff member. They said that, where people came from a residential setting, the standards of the patient information that came with them was variable.

Access

Patients waiting in the UCC considered that they were seen in a timely manner and this was supported by the data that we had.

One of the consultants told us that they did experience problems in the main department when the rapid assessment and treatment area was full. Patients who would have been suitable to be admitted for a further period of observation had to remain in the department.

Leaving hospital

Staff told us that there was good integration with community health services. This enabled them to liaise with other healthcare professionals and discuss any concerns that they might have prior to discharging a patient. Also the 'prevention of admission team' were able to access equipment and community services in order to provide support for people returning home.

Learning from experiences concerns and complaints

We asked the matron of the department about the complaints process. They told us that many of the verbal complaints that they received were often because people were anxious and didn't understand what was happening. They said they were often able to resolve these within the department by talking to people and explaining what had happened. Where people remained dissatisfied and wished to make a formal complaint, they were given the details of the Patient Advice and Liaison Service. Information about the service was also displayed in the waiting area.

A&E received 21 complaints during the period 1 October 2013 to 13 January 2014.The majority related to medical or surgical treatment or nursing care. The trust produces a report on these figures 25 days after the last day of the month, therefore the latest figures they were able to provide related to October and November of 2013. During this time all of the complaints received were responded to within 25 working days. The trust was also able to

provide us with details about the outcome of the complaints and, where the complaint had been closed, what had been done to share the information with staff to minimise the risk of any future occurrences.

Are accident and emergency services well-led?

Good

Staff were aware of the 'trust vision' and were supportive of their values. There were examples of forward planning in order to mitigate risk.

There was not a robust pathway to disseminate information about serious incidents to all staff.

Vision strategy and risk

The trust published their vision for the future on their website. It explained that they intend to unite services and staff in Lewisham and Greenwich to build on what they do well. They state that this will ensure that they meet the needs of demographically challenging, diverse and rapidly growing local populations. Trust Board meetings were open, in part, to the public and papers and minutes were available to read and download.

Staff we spoke with told us that this view was promoted by senior management and one newly appointed staff member told us that it had formed part of their induction process.

We asked nursing staff how they made decisions regarding the number of staff that the department needed. We were told that they were in the process of developing an acuity tool to determine this, however, it was not currently in place.

Quality performance and problems

All reported serious incidents were investigated and we were told that the staff involved were offered extra training as part of the learning outcomes. All of the staff we spoke with told us about the good team work in the department. There were regular yearly appraisals for all staff. Nurses in the department were supported by a practice development nurse who worked alongside them and offered support and training. Both doctors and nurses said that they were given opportunities to gain further training and experience.

Leadership and culture

Staff told us that they felt supported by the senior staff within the department. Comments we received included: "this is a great department to work in" and "this is the best department in the hospital". Staff retention appeared to be good; several of the staff members had been in post for some years and others told us that they had returned after working in other places.

Doctors we spoke with felt that the Trust Board listened to their views and that partnership working had increased. They said that where problems had arisen there had been an opportunity for one-to-one discussions to address them.

Patient experiences, staff involvement and engagement

Several staff told us that patients' views and experiences were key in the trust's vision. Staff also said that they felt involved in the decision-making process. They confirmed that there were regular departmental meetings.

In the UCC waiting area, we saw that there was an opportunity for patients to provide feedback about their experiences on a computer-based system.

Learning, improvement and sustainability

Staff told us that learning from serious incidents was disseminated through emails and at the staff handover sessions. However, we found that, while senior staff were aware of any incidents that had happened, this did not always seem to have filtered down to more junior staff. This meant that these personnel were not always kept informed about everything or given the opportunity to participate in discussions about how improvements might be made.

Requires improvement

Medical care (including older people's care)

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

Information about the service

We inspected medical care (including older people's care) at University Hospital Lewisham (UHL) over two days. In total we visited nine wards, including Chestnut Ward (Medical Assessment Unit - MAU); Aspen Ward (winter pressures); Cherry Ward (cardiology ward and coronary care unit); Beech Ward (stroke unit); Oak, Laurel, Ash and Elm Wards (elderly care wards); and Mulberry and Alder Wards (general medical wards). We also visited the discharge lounge and the pharmacy.

We spoke with 21 patients, three visitors, reviewed 22 patients' nursing and/or medical records and spoke with 44 members of staff from a wide range of disciplines.

Before our inspection, we received data and information that we used to determine our key lines of enquiry. This included information such as high reporting of grade 3 or 4 pressure ulcers, the Heart Failure Audit 2012 showed that there was a low rate of specialist input and discharge planning for patients with heart conditions, low admissions for non-ST segment elevation myocardial infarction (NSTEMI or coronary condition or angina) - although it is recognised that these patients are usually admitted on a pathway with Kings or GSTT; high performance in Sentinel Stroke National Audit, lowering medication errors but lowering staff awareness for diabetes patients, slightly high re-admission rates, mostly poor Cancer Patient Experience Survey scores, high average length of stays for acute cerebrovascular disease (which may relate to specialist onsite services) and myocardial infarction (or heart attack), high bed occupancy rates and average staff sickness rates.

Summary of findings

We saw in the data provided to us and we observed in clinical areas that flow of patients through medical care is a challenge for the trust.

Most of the patients we spoke with had a positive experience of UHL. Although, there were some comments that patients were not treated with dignity and respect, such as being talked over, most comments praised the staff who looked after them and our observations corroborated that staff were caring towards their patients.

UHL could improve the safety of its care and treatment. Data we received before our inspection suggested that there were concerns with how safe the hospital was such as lack of handwash facilities and staff feeling overworked. Although the hospital had undertaken some learning initiatives to improve its safety record, they were limited and did not always operate across the trust. There were times when basic safety requirements, such as observation assessments and reviews, were not being followed. Staffing levels were a concern across both doctors and nursing. However, there was generally good planning for patients through their treatment pathways.

UHL could improve the effectiveness of its care and treatment. such as lack of handwash facilities and staff feeling overworked Specialist medical input was not always provided when required as patients did not always get allocated a specialist for their condition. Patients did not always feel they received care when they required it.

Requires improvement

Medical care (including older people's care)

Care and treatment at UHL was not always responsive. There was normally a lack of bed capacity at the hospital, despite escalation wards being used. Patients were regularly at the hospital for longer than they needed to be as, although length of stay was monitored, it did not always seem to be acted on. Well-planned discharge arrangements were in place in most cases but there were times when the system failed. Patients who were vulnerable who had additional, non-physical needs had access to further services but these were not always timely.

Medical care was not always well-led. There was a vision and objectives in place but these aims were not always achievable due to the workload required from staff particularly in older people wards and it was not always implemented across the trust. Performance was monitored but there was sometimes a lack of comparison across wards. Training was highly regarded but was not easily accessible outside of mandatory requirements. Staff mostly felt well-supported but only within their own teams or directorates.

Are medical care services safe?

Requires improvement

Safety in the past

Before our inspection, some data indicators showed that the medical wards had no Never Events (an event so serious that it should never happen) since December 2012 but a number of serious incidents, including at least nine grade 3 pressure ulcers, with a further 54 grade 3 pressures sores, where the trust was unable to determine their location. Pressure ulcers had just increased above the England average in July 2013 across the trust, although this may relate to an increase in reporting rather than absolute numbers, additionally, the trust provides community services that also report these and much of the reporting may relate to this elemnt of the care pathway. Medical specialties reported 109 incidents to the NRLS between July 2012 and June 2013 equating to 23.35%. Of these, 40% were incidents involving care of older people. There had also been above average reports of new venous thromboembolisms (VTEs or blood clots), urinary tract infections and falls with harm from November 2012 to November 2013. This was despite a demographic of a lower than national average of elderly people living in the local population. Bacterial infections such as MRSA and clostridium difficile (C. difficile) were average comparable to other trusts. A higher percentage of staff said they worked extra hours than the NHS staff average.

A lower percentage of staff than the NHS average said there were always hand-washing facilities available. The trust was in the top 20% for staff reporting errors or near misses (which indicates a positive patient safety culture) and in staff recommending the trust as a place to work and receive treatment. The trust is performing similar to other trusts for medicine errors.

Learning and improvement

The trust had systems in place to report and monitor incidents, including near misses, incidents that resulted in harm, Never Events and allegations of abuse. We found the trust had appropriately reported incidents when they had occurred. Between June 2012 and July 2013, the trust reported 430 patient safety alerts, 32.5% of which related to medical specialties. Reporting of incidents was within expectations.

Medical care (including older people's care)

Staff used the trust's computer-based system to report incidents, and we found evidence that the trust collated this information and fed back to senior staff any trends or ongoing concerns so that improvements could be made. Various meetings were held to review incidents and other patient feedback, such as complaints, to a range of staff, including ward manager and department meetings. The trust had a clinical governance committee that reviewed all serious incidents. However, the records we saw showed that only incidents that had occurred on medical wards within the UHL were reported to floor-level staff at ward meetings.

One ward manager told us they recently had a shortage of pressure-relieving mattresses at a weekend which had been reported as an incident. Another patient told us they were admitted with a grade 4 pressure ulcer but were unable to have a pressure-relieving mattress for most of the day, although they felt they received good wound care otherwise. There was specific tissue viability nurse support for medical wards.

Procedures were in place to reduce the amount of falls, such as provision of no-slip socks. We saw that there had been a historical reduction in falls over the last two years in the medical assessment unit.

Systems, processes and practices

We checked a sample of patients' nursing and medical records. Some of them showed appropriate assessments and checks had been completed such as VTE, falls risk, MRSA , do not attempt resuscitation (DNACPR) consent forms and modified early warning scoring, with reviews and relevant prescriptions or equipment supplied as needed. Most medical notes we read were detailed and legible. Patients who required it had a full observational check every 15 minutes. However, some notes were temporary and loose-leaf and had not been bound into the permanent records which meant there was a risk they could be lost. We were told that sometimes notes were not put together fully into the patient's file until they were discharged. Some records showed assessments had either not been completed or not been reviewed as required. Two patients had not had their falls, skin and nutrition reassessed in over a week. Other notes did not clearly show who was in charge of the patient's care.

We saw evidence that staff providing care on older people's wards received wound care training. Clinical indicators showed that they had low pressure ulcer levels.

Wards were required to report clinical indicators on a daily basis which audited various aspects of the ward, such as vulnerable patients, nasogastric tubes in situ, resuscitation trolley checks, mixed-sex bays, staff vacancies, missed or late medicines, patients needing one-to-one care or help to eat, completed falls and nutritional assessments, number of falls, pressure ulcers both before and after admission and C. difficile and MRSA screening, and percentage of patient recommendations. However, we noted some of the clinical indicators had either not been completed on some days or had not been reported. We also noted that the clinical indictors showed there had been concerns in the last few weeks with some patients not receiving nutritional and falls assessments, a fall with an injury, patients without food charts, nasogastric tubes in situ and a large number of staff shifts unfilled.

There was a concern that records of referrals from A&E to the medical wards were sometimes lost, although we were told these were normally found and highlighted by the allocated registrar.

As part of this inspection, we looked at the medicine administration records for 22 people on four wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. If people were allergic to any medicines this was recorded on their medication administration record chart. This meant people were receiving their medicines as prescribed.

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

Monitoring safety and responding to risk

We saw that patients who required isolation or who may be an infection risk were placed in a side room with appropriate signage to show why. One patient we spoke with said they had contracted MRSA during their last visit in September but that had been managed well once they acquired it, including being put in a side room. Patients

who were assessed as needing additional equipment such as low-rise beds, bed rails and air mattresses received them, although, on one ward, staff told us that there was a shortage of bed rails.

On most of the wards we checked, staff said (and patient to staff ratios showed) that there were concerns regarding staffing levels. Although wards were sometimes able to follow staffing level guidance by having a ratio of 1:2 or 1:1 registered nurses to patients who were considered high risk and 1:6 for patients on medical wards during the day. On the days we inspected, and in last two months, a number of wards had ratios of 1:10 or over due to staffing vacancies and either bank (overtime) or agency staff being unable to fill shifts. For example, one ward had two nurses and one healthcare assistant when they were scheduled to have three nurses and two healthcare assistants, despite having 28 beds. This meant that there was a risk patients would not get the care and treatment or monitoring they required.

In addition, most staff told us, and staffing rotas showed, that there was a reliance on using bank and agency staff due to staffing vacancies and that efforts to get bank and agency staff were sometimes unsuccessful which meant wards were short-staffed. Although there had been an effort to bring in additional permanent staff, the number of new recruits meant a lot of staff on shift were new and so were either still being supervised and needed a lot of training days away from the ward, or were still not fully familiar with how the ward operated. Aspen Ward in particular had a high reliance on around 60% non-permanent staff. Most of the staff we spoke with told us they worked over their shift hours. At the weekend, there was an elderly care and general medical consultant on call, with a house officer, senior house officer plus a registrar covering both A&E and medical assessment unit.

We were told that any patient with a gastrointestinal bleed would be seen by either a registrar or consultant and they would be transferred to an elderly care or medical assessment unit ward.

On each of the wards we visited, we checked the suitability and safety of equipment and the environment. Resuscitation trolleys on each of the wards had been checked on a daily basis and personal protective equipment was available outside each bay and side room, apart from on one ward. All the areas of the medical wards we checked were clean and tidy and patients confirmed this was the case. Information and signage for hand hygiene for both staff and patients was displayed in visible areas. In many wards, hand gel was at the end of patients' beds so staff could clean their hands without necessarily having to go to the hand-washing sink every time. We observed staff cleaning their hands in between seeing patients. We were advised of, and observed, that staff had personal hand gel on them at all times (due to the hand hygiene dispensers being emptied by patients) but this did not conform with infection control guidelines. Although the trust had risk assessed this, there was no evidence that they had considered using non-alcoholic hand gels to dissuade patients from removing them. All the patient bays and rooms had hand-washing facilities.

The falls protocol did refer to national guidance. It showed that patients were risk-assessed if they were aged over 65 and had a history of falls. Indicators were used for all patients over 65-years-old and they were scored and reviewed to show how at risk of falls they were. Each patient at risk of falls had a falls care plan with multidisciplinary team input. Each potential factor in a fall was taken into consideration – including foot, bone, mental and eye health, any therapy input and any aids or equipment needed. We checked the bed rails policy which showed that all patients who may need to use bed rails were fully assessed.

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

The National Diabetes Inpatient Audit 2012 showed there had been a decrease in medicine errors but increase in prescription errors.

Anticipation and planning

Patient boards were in place in all the wards we checked. Wards for older people included information on diabetes, dementia, feeding support. However, others had much more limited information. Any changes to a patient's condition was highlighted at handover with priority given to the most acute patients. Most handovers were recorded either in handwritten or electronic form. We observed a handover on Cherry Ward and this was well managed

Medical care (including older people's care)

where both the current and the leaving ward manager highlighted any changes to patient conditions plus any concerns staff should be aware of. There was a more detailed handover for new and acute patients.

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

Good

Evidence-based guidance
Staff told us they received updates on any changes to medical guidance via their professional regulator such as the Royal College of Nursing and these were also highlighted in ward meetings and on the trust's intranet.

The trust had a set of hospital forms listing medication the pharmacy stocked with guidance on prescribing. This was used to promote rational, cost-effective prescribing and any amendments had to be approved by the drug and therapeutics committee. We saw this set of forms, along with the trust antimicrobial prescribing guidelines, was easily accessible to all staff via the trust's intranet.

Monitoring and improvement of outcomes
Intelligent monitoring data showed that the trust had no indicators of risk related to re-admissions or mortality, although re-admission rates across the trust for general and geriatric medicine were slightly above the national average in quarter three of 2012/13. The National Heart Failure Audit of 2012 showed fewer patients at UHL were likely to receive input from a specialist or cardiologist consultant than the national average but were more likely to be referred to cardiology follow-up on discharge. The Myocardial Ischaemia National Audit (MINAP) 2011/12 found that the proportion of NSTEMI patients admitted to a cardiac unit or ward was lower than expected at UHL, however the agreed pathway is to UHL or Kings

The Sentinel Stroke National Audit for 2013 found that UHL had improved to above the national average in five out of eight domains and so was now in the upper quartile of trust performance, particularly with regard to adult care organisation, specialist roles, interdisciplinary services, quality improvement training, and research and communication with patients and carers. However, it scored below the national average around organisation of care, transient ischemic attack/neurovascular clinic and team meetings. Staffing levels were also above the national median, although there was no six- or seven-day working for at least two of the different types of therapists. The stroke unit was purpose-built for therapies with a patients' and carers' room and meeting rooms.

The trust participated in all required audits relating to medical wards.

There had been a fall in the scores for meal timing and suitability, although meal choice had increased. Staff awareness, provision of emotional support, working together, staff knowledge and overall satisfaction scores all fell.

Sufficient capacity
Many wards were general medical wards, where consultants were allocated to patients on admission, rather than to wards. This meant if a patient was admitted with one condition but their diagnosis changed, their consultant would not change. It also meant that some consultants had patient numbers up to 80 at a time across several wards. We saw that consultants had patients on up to 9 different wards; this led to ward rounds that were an ineffective use of time and process . Although this meant a continuity of care, ward rounds were at different times of the day and there was no guarantee of nurse input as it would depend if relevant nurses could be found at the time the consultant saw patients on their ward. This meant that nurses were not always aware of any changes from a ward round, and doctors were not always aware of changes in between their ward rounds. Doctors were also taking calls, so their time was not always dedicated to the patients they were seeing. Additionally, one patient told us that, despite being on a specialist ward, but when they had questions their doctor was not able to answer many of them. The same patient said that they had access to the pain team but it 'took ages' to see them. However, when we checked patients' medical notes, most showed that patients received specialist input within 24 hours of a referral and there was access to therapies when required, including speech and occupational therapy and physiotherapy.

Multidisciplinary working and support
The stroke unit had a fully integrated multidisciplinary team service and had recently received nationally recognised awards for care provided.

Are medical care services caring?

Requires improvement

Medical care (including older people's care)

Requires improvement

Compassion, dignity and empathy

The CQC's Adult Inpatient Survey 2012 found that the trust performed worse than other trusts in some questions, particularly in regard to hand gel availability, support for meals, doctors and nurses talking over patients, speaking to staff about worries/fears, time taken to answer call bells, and discharge delays. The patient-led assessments of the care environment found UHL scored below 87% for food, privacy, dignity and respect and facilities.

Some comments we received were positive about how staff had treated patients, particularly regarding their privacy and dignity and access to fluids. Although many wards were mixed-sex, all the bays we saw were either male or female only.

We received concerns from two patients about the food provided – they commented that the pureed food was "poor and repetitive". Some patients also told us that the Caribbean food was not "varied" enough. Another said their water was not always refilled, while one patient said they had asked for intravenous fluids as they struggled to swallow water but it never arrived and they were not told why. One family told us the nurse was going to take away their food when they had not eaten it. However, we found patients were supported to eat when we observed them, and this was usually done by volunteers.

We heard of a pilot programme to train volunteers to help dementia patients with eating to ensure someone had time to devote to supporting these patients with their nutritional needs. We saw this as a really positive response by the trust to supporting vulnerable patients with their nutritional needs.

We observed good interactions between staff and patients, particularly a positive telephone conversation between a ward clerk and a family where they were treated with empathy and consideration. However, one patient told us that they felt "talked over" by staff at times. Most complaints at the trust related to communication between staff and patients.

We found call bells were answered promptly on older people's wards but, due to low staffing levels, particularly healthcare assistants on some wards, we received a few concerns from patients that call bells were not being answered – sometimes waiting long periods of time for a response. One patient commented that, although they were seen by a consultant soon after admission, it was in the early hours of the morning. Two patients told us that there were patients with delirium symptoms in regular ward bays so they could be heard by the other patients on the ward.

Visiting times were clearly displayed on each ward we visited.

Involvement in care

The CQC's Adult Inpatient Survey 2012 found the trust performing worse than other trusts in some questions, particularly relating to lack of involvement in treatment. Most patients we spoke with were positive about their involvement in their own care. They told us that treatment options were discussed with them, as well as an expected discharge date, and this was done in terms they could understand. They told us staff were knowledgeable about their condition if they were on a ward that had a specific specialty, such as cystic fibrosis.

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

Trust and respect

The Adult Inpatient Survey 2012 found the trust performing worse than other trusts regarding patients not getting answers from nurses. This meant there was a risk that patients were not getting the support from staff they needed.

The ward showed good practice in identifying the allocated nurse and consultant on a sign next to the patient's bed.

Emotional support

The Adult Inpatient Survey 2012 found the trust performing worse than other trusts for emotional support. This meant that there was a risk the trust did not provide the emotional support that patients needed.

Requires improvement

Medical care (including older people's care)

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Average length of stay for acute cerebrovascular disease and myocardial infarction was above the national average (it was too long), although the Sentinel Stroke National Audit 2013 showed outcomes rated better than expected. The diabetes average length of stay was below the national average. Results for chronic obstructive pulmonary disease was in line with the national average.

Bed management meetings occurred twice daily with additional meetings or communication if there was a capacity concern.

NHS England data showed that bed occupancy was regularly above 85% (the nationally accepted figure where it is accepted that quality of care and the running of the hospital can be affected is where bed occupancy is greater than 85%). Most of the wards we saw on inspection were at, or near, 100% capacity. This included escalation and winter pressure wards, which we were told were in use most of the year. Staff in the medical assessment unit advised us that the patients' length of stay could sometimes be up to 18 days and there was no target, despite mostly being a throughput ward between A&E and the general medical or specialist wards.

Link nurses were available in a variety of specialties so patients could get the specific care they required. This included link nurses for dementia, infection control, wound care, psychiatric care and nutrition. However, one patient told us that, although they received physiotherapy support, they did not receive support to manage stairs, despite having stairs in their house. There was also no plan for occupational therapy to make adjustments to their home.

Access to services

The trust was above the 92% standard for 18 weeks between referral and treatment in medical specialties. Most of the patients we spoke with told us they saw a doctor at least once a day while on a ward.

Pharmacists visited all wards each week day. For example, the medical admissions ward was supported by a team of three pharmacists. We saw pharmacists completed the medicines management section on the medicines administration record for every patient to confirm medication reconciliation had occurred.

On three wards, including the medical assessment unit, there was the facility for pharmacists to dispense take home prescriptions so discharges were not delayed by patients waiting for their medication (the pharmacy scorecard indicated an average wait of only 30 minutes). There was also a support worker who acted as a 'runner' in between wards and the pharmacy to deliver prescriptions. However, data from the UHL pharmacy scorecard showed that, for the period from April 2013 to January 2014, only an average of 53% of 'to take away' prescriptions were completed by the dispensary within the agreed turnaround time of two hours; the target was 75%. The data also showed that the average percentage of the workload in the dispensary after 4pm every day was around 14%, against a target of 10% which confirmed the majority of discharge prescriptions were written by doctors after midday.

Vulnerable patients and capacity

Safeguarding information was displayed on most of the noticeboards in the wards we checked, and included how to report and refer a suspicion of abuse to the relevant hospital safeguarding team. Staff noticeboards also included information relating to treating people with learning disabilities and access to chaperones to ensure staff were informed and updated. All the patients we spoke with felt safe on the wards.

Patients who needed additional support, for example, if they had challenging behaviour, delirium or required acute care, were able to have extra staff booked to help meet their needs. There was psychiatric nurse support which was supposed to be available within 24 hours of referral, but we were told their support was not always arranged when needed. None of the patients we spoke with had acquired a pressure ulcer or infection during their stay at the hospital.

Elderly care wards had access to nurses who specialised in caring for patients with dementia. All staff on these wards received dementia training.

Leaving hospital

The CQC's Adult Inpatient Survey 2012 showed there was a risk of discharge delays of more than four hours. Social services attended the medical assessment unit on a daily basis and had access to a discharge doctor and nurse so

discharges were not delayed. Urgent discharges were completed within 120 minutes and the normal discharge or transfer time in the unit was 72 hours, with a specific bed management meeting if patients breached this time on the ward. We were aware of one patient transferred from MAU around midnight to Cherry Ward, and saw this at the early morning handover. We were told this was not uncommon.

Board meetings were held daily which included updating the patient's estimated day for discharge. However, one patient told us they were due to have been discharged four days earlier but this had been delayed as the physiotherapist and doctor did not agree on whether they were ready for discharge.

The chief pharmacist told us that, three weeks prior to our inspection, the trust had employed a "pharmacy runner" whose role was just to collect and deliver take-home medication to the wards to reduce the length of time patients had to wait for medication prior to discharge. They also explained that funding had just been obtained to put in patients' own drug lockers on all wards in the hospital (currently only available on three wards) which would enable "one stop dispensing". This meant the majority of patients' medication could be dispensed in advance and so would also help to reduce discharge waiting times.

There was a lack knowledge and understanding of the process for homeless discharge amongst some staff.

Learning from experiences, concerns and complaints

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

The last complaints report we could access was for November 2013. This showed the directorate which covers medical wards received the most complaints and second-highest number of concerns for the hospital's Patient Advice and Liaison Service, mainly relating to nursing care or treatment. The report gave examples of the types of complaints received and the outcome of their investigations, including some changes implemented, such as additional staff training.

Are medical care services well-led?

Good

Vision, strategy and risks

The ward philosophy was displayed on Beech Ward which included specific behaviours for staff that would be required on a stroke ward. Other wards also displayed their vision on their noticeboards or in leaflets. Staff we spoke with were aware of the risks for their particular ward, such as whether they had patients at risk of falls or urinary tract infections. Some staff were able to tell us medium- and long-term objectives with their ward. One example was an objective to prevent 100% of avoidable pressure ulcers.

Some staff told us they were aware of changes starting to happen since the merger with QEH – such as interviewing new staff with the QEH model – but the main changes they expected had not yet occurred. Some staff were unaware of the services offered at QEH. Some Trust policies had not yet been updated since the merger, so were printed with the old trust name.

Governance

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

Quality, performance and problems

All the ward we visited had noticeboards which displayed a variety of information that highlighted both guidance and performance. This included the clinical performance indicators, such as falls and infections. We were told that only clinical indicators data was shared between UHL and QEH medical wards to compare their performance.

Leadership and culture

Although most staff told us that they felt well-supported and that there was a good team ethic in each ward, they felt overworked and understaffed and so had a low morale, particularly on wards caring for older people. Some staff told us they were working when sick due to the lack of staff

on some wards. Junior doctors told us that there was an over-reliance on locum consultants (with refrence to A&E), particularly at the weekend, and locums did not give them quality support.

There was a culture of training at UHL. Most staff told us that training was embedded in the trust and that internal training (training run by the trust eg for mandatory training) was undertaken in 'protected time' for staff so it did not interfere with shifts on the ward. If a staff member was not up to date with part of their training, this was highlighted to the ward manager who could prompt the staff member to complete it. Staff told us they felt supported through their induction process, particularly healthcare assistants. However, there were concerns that there were not enough training days or career development for non-nursing roles, and study days for external training were taken in staff's own time. As the hospital needed to recruit additional staff to deal with shortages, there were many new recruits at the hospital and a shortage of professional development nurses to train them. This meant that new staff were taking longer to get used to the standards and operational needs for each ward.

Staff responsibilities were clearly identified on each ward with personnel allocated for each duty.

Patient experiences and staff involvement and engagement

Sickness absence rates for staff were in line with the national average at UHL between August 2011 and 2013.

However, workload, local training, and overall satisfaction were identified as worse for junior doctors than expected in the General Medical Council National Training Survey 2013 in some medical areas. The hospital performed better than expected in patient feedback, workload and overall satisfaction in other medical areas.

Feedback was actively encouraged from both doctors and consultants. However, when we requested staff exit interview information from the trust (which should show one-to-one interviews with staff covering the reasons they have left), we were provided with surveys that were sent to staff after they had left. This suggested there was a risk that the trust was not fully aware of the reasons staff were leaving, as few staff will have completed a survey.

Learning, improvement, innovation and sustainability

Staff told us that they received feedback on any complaint and incidents investigations concerning their ward. (We saw that this was clear from the ward minutes). Discussions in all ward minutes included infection control, records, patient surveys, clinical indicators and audits. Specific information for the ward was also communicated at these meetings. For example, a continence check had not been completed the previous week correctly, so a reminder was given during the meeting.

Requires improvement

Surgery

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

Information about the service

University Hospital Lewisham (UHL) offers a wide range of planned and emergency surgeries, including: ear, nose and throat (adult and paediatric); endoscopy; general surgery; gynaecological surgery; obstetrics; orthopaedic surgery (including emergency paediatric); urology surgery; and vascular surgery. The hospital also now provided a bariatric and metabolic (weight loss) surgery service.

There were eight adult and two children's theatres, providing both elective and emergency surgery. There were also three endoscopy rooms, a minor procedure treatment room, an admission area with consultation rooms, patient waiting room and a day surgery discharge facility.

There was a first stage recovery room (located in both theatre suites) – an area where patients were cared for immediately after a general anaesthetic.

There were three surgical wards.

A key part of the trust's transformation programme is the creation of an elective surgery centre at the UHL site over the next two years. Approval had recently been given for the first phase of this for orthopaedic surgery and plans were being put in place for this. This would require the relocation of some surgery services currently provided at the QEH and Queen Mary's Hospital (QMH) sites.

We spoke with 19 patients and 20 staff, including senior and junior medical staff, senior and junior nurses, care assistants and therapy staff. We visited all theatre areas, endoscopy, the admissions unit, recovery, and the three surgical wards. We observed care and treatment and looked at records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed the performance of the service.

Requires improvement

Surgery

Summary of findings

We saw that caring was mixed. We heard of, and saw elements of good care; we also observed poor examples of caring by some staff. People we spoke with felt that staff were kind and caring and promoted their dignity and respect. We observed this on the wards and theatre areas we visited but there was a significant shortfall in meeting the needs of a patient awaiting surgery.

The trust was not meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing general surgery and trauma and orthopaedic surgery. The bed occupancy rates for the hospital were higher than target ranges and this impacted on the flow of patients between surgery and the surgical wards. There were some delays in the discharge of patients. The surgery risk register reported poor complaints-management performance and the potential risk for poor patient experience and loss of opportunity to help staff learn. There was a recovery plan to address this.

There were arrangements in place to ensure that patients were kept safe and people we spoke with told us they felt safe in the hospital. However, there was evidence in national and trust data – and also in practice found during our inspection – which indicated these arrangements were not sufficiently robust. For example, an observational audit of the completion of World Health Organization (WHO) surgical safety checklist had identified a risk to safety, particularly with the 'sign out' stage of the checklist. Work was being done to address this.

Nationally recognised guidelines and pathways were followed and we found evidence of good multidisciplinary working. However, a number of issues reduced the effectiveness of the service. Single-sex guidelines were breached in the waiting area of one theatre. Relative risk re-admissions to surgery had been variable and greater than expected in general surgery. Day surgery was falling short of a number of national targets. A long backlog had arisen in clinic letters reaching patient medical records within the orthopaedic service. There were longstanding vacancies and staff shortages in some areas. The surgery discharge lounge was an unsuitable facility for patients waiting to leave the hospital.

Staff were mostly positive about the trust merger and the leadership aims for the new organisation but felt there was still work to be done to achieve the 'one trust' vision. There were new clinical governance arrangements in place and managers were aware of the risks in their area and what action was being taken to reduce them. However, it would take time for the new arrangements to become embedded and for all staff to fully engage with them.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

Safety in the past

There were three Never Events (serious events that should never happen) at the trust between December 2012 and November 2013, all of which related to surgery. Two Never Events occurred at UHL, one of which was in trauma and orthopaedics and involved a patient receiving an incorrectly sized acetbular cup during a total hip replacement. The second Never Event at UHL involved the accidental burning of a patient during varicose vein surgery. During the 12-month period to November 2013, there were a total of eight serious incidents at the trust. These were categorised as unexpected death (3), surgical error (2), grade 3 pressure ulcer (2), and communication issue (1). There was evidence in board and clinical governance meeting papers of root cause analysis of these incidents and action planning by the trust to ensure that these events never happened again.

The National Reporting and Learning System (NRLS) collected data on patient safety incidents. Between July 2012 and June 2013 the trust reported that there were 33 incidents specific to surgery, of which three were severe and 29 were moderate harm. The top three categories of incident were: treatment procedure; implementation of care and ongoing monitoring/review; and clinical assessment (including diagnosis, scans, tests and assessments). The high number of moderate reports to NRLS indicated apparent good reporting processes and culture. However, the trust's October 2013 Patient Safety Report recorded NRLS feedback showing, for the period April 2012 to March 2013, that the former Lewisham Healthcare NHS Trust had slipped to the bottom 75% compared with other same sized (medium acute) trusts, despite increasing its reporting in the second six months.

Learning and improvement

There were systems in place to ensure that incidents were reviewed to learn from mistakes and improve safety standards. We saw from minutes of recent Trust Board and surgery clinical governance committee meetings that serious incidents and Never Events had been discussed and lessons learned identified. The clinical governance lead for surgery, anaesthesia and critical care showed us the action plans put in place for the two Never Events at the UHL site. We noted that training for theatre trauma staff was overdue as a result of learning from one event, and the clinical governance lead would be pursuing progress on this.

The trust's latest surgery risk register recorded, in November 2013, that action plans developed from serious incident investigations prior to the appointment of a surgical clinical governance manager had not been adequately monitored, nor was there robust evidence of completion. This was being addressed.

The implementation of the action plans for serious incidents was reviewed at monthly governance meetings, including the communication of lessons learned. For example, as part of this process (and to facilitate learning for one of the Never Events) the patient involved had visited UHL to speak to surgery staff about their experience. Key outcomes from serious incidents were also reported to staff at all levels through team and unit meetings and through a quarterly staff newsletter, Reflect, which we saw on display in some of the surgery areas we visited.

Staff on wards and in the operating theatres told us of the computer-based system for reporting incidents. Information on each incident was graded by an investigator. Where the incidents were considered to be high risk, a root cause analysis was undertaken A specific tool made available by the National Patient Safety Agency – 'Learning through action to reduce infection' – was used by staff when a patient had a confirmed MRSA, Clostridium difficile (C. difficile) or other life-threatening infection. This enabled a comprehensive analysis of factors or events that led to the infection, and a plan for reducing the risk of it happening again. We saw an example where the tool had been used to investigate a C. difficile infection that had not been identified early enough. As a result of the review, changes were identified to improve practice, including improved antibiotic documentation.

On Juniper Ward, staff told us the practice development nurse ran reflection sessions with each nurse following reported incidents. For example, they reviewed the policy for blood transfusion management with a member of staff where the appropriate procedures had not been followed adequately. Themes identified were put into training programmes. When there were medicine-related errors, the practice development nurse also ran reflection sessions with junior doctors.

Requires improvement

Surgery

Systems, processes and practices

Measures were in place to ensure patients were protected from the risk of infection. The trust's infection control rates for C. difficile and MRSA were within expected ranges when compared with other trusts. To promote safe practices, there were infection control nurses for each area. They were responsible for carrying out audits and disseminating key messages to staff. We saw evidence of regular audits in areas we visited. However, it was not always clear how the findings were shared with staff or what action plans were implemented.

Health Protection Agency data for surgical site infections was only available for one quarter in 2012/13 and did not contain sufficient data on which to draw conclusions. However, based on previous benchmarking data from Public Health England, within the former trust, UHL had a relatively low incidence of orthopaedic surgical site infections. There were no infections for hip replacement surgery in the report for the period July–September 2013 or for the previous four reports dating back to July–September 2011. There was one infection for knee replacement surgery for the period July–September 2013. Although this may indicate good practice, it must be noted that the number of operations reported to Public Health England was low, and no data was submitted for repair of fractured neck of femur.

Each ward we visited had dedicated domestic staff who were responsible for ensuring the environment was clean and tidy. Patients we spoke with were complimentary about the cleanliness of the hospital. Some patients told us there were always cleaning staff around and we saw this during our visit. We also observed ward areas to be clean and there was hand gel available for use and toilet facilities had liquid soap dispensers and paper towels.

We saw that there were appropriate systems in place for the cleaning and decontaminating of equipment, such as mattresses and commodes. When a piece of equipment had been cleaned, a green sticker was applied to show the date it had been cleaned. In the theatre areas we visited, we noted that processes were in place for the cleaning of surgical instruments, including endoscopes which were cleaned off-site by a private contractor.

Patients with infections were accommodated in side rooms on wards we visited. Signage was in place to reflect this and we saw staff wearing appropriate personal protective equipment. However, we observed the doors to these rooms were left open, which was not in line with best practice and may put other patients at risk of infection.

On the wards we visited, there were appropriate systems in place for ordering and storing medical supplies and equipment, and staff reported no concerns about their availability. We observed appropriate storage of medication on the surgery wards. The medication room door was secure and the keys were held with the nurse in charge. Controlled drugs were stored in locked cabinet and there were separate keys for this. Temperature-critical medicines were stored in a locked refrigerator and we saw records of daily checks to ensure the temperatures were within the required range.

In the Riverside treatment centre, staff told us that storage was limited and we observed equipment placed in corners and against walls. At one end of the unit, a desk, fan and resuscitation trolley were stored in narrow space between a recovery bed and wall. This restricted ready access to the resuscitation trolley which could place patients at risk in the event of an emergency.

Ward managers used a computer based e-rostering programme to try to ensure the ward was appropriately staffed, taking account of absences for leave, sickness and training. There were differing views about the effectiveness of the system. Some found it worked well and was a useful tool for ensuring staffing levels; others found it less effective. It was not clear that there was consistent approach to determining surgery staffing needs to ensure staffing was based on dependency levels. We were told by senior staff on one ward that the trust planned to introduce the 'Safer Nursing Care' tool to determine staffing levels in the future. We noted also that a safer staffing review was presented to the board in January 2014 reporting on the outcomes and recommendations from a trust-wide review of nursing and midwifery ward establishments for inpatient areas. The report identified the need and associated costs for some increase in current staffing levels across the trust (including surgery) to ensure that staff levels were sufficient to deliver safe, quality patient care.

There were vacancies on all wards and theatre areas. On Larch Ward, there were three vacancies dating back to October 2013 and we were told that typically there was a wait of around four months to receive approval to fill a vacancy. On Cedar Ward, there were two vacancies for

which there had been an unsuccessful recruitment campaign. In the Riverside treatment centre, there were eight vacancies. Staffing shortfalls in all areas were covered by ward staff, bank (overtime) or agency staff. On Larch Ward we were told it was easier to fill early shifts but it was extremely difficult to get late bookings filled. On Juniper Ward, only 50% of requests to use bank staff cover were met. Data provided by the trust showed that there was significant use of agency staff to fill shifts across the surgery wards and theatres at UHL.

We were told by senior surgery managers that recruiting and retaining nursing staff in London in a competitive recruitment pool was a key challenge to the directorate. There had recently been a recruitment campaign in Spain and Portugal and 18 posts were due to be filled as a result.

Monitoring safety and responding to risk

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

Patients were required to provide written consent before they underwent any procedure, which was obtained by the clinician carrying out the treatment. We looked at consent forms on patient records and saw these had been completed and signed appropriately, although, in some cases the copy for the patient was still in the patient's record.

Operative checks carried out by theatre teams incorporated the World Health Organization (WHO) surgical safety checklist. The purpose of this checklist was to ensure that consent had been appropriately obtained and was for the correct procedure, and that the necessary checks had been completed before, during and after surgery. In the theatre areas we visited, we saw examples of where the checklist had been appropriately completed.

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

Observations to check people's vital signs were used on each surgery ward to ensure that patients who may be becoming unwell were escalated appropriately. The frequency of observational checks depended on the needs of each person. We saw examples of appropriately completed checks on patients' records. There was a resuscitation trolley in each ward or clinical area and we saw these were checked daily in most cases, although we saw some gaps in the records where the check had not been completed on the odd day. We observed also that surfaces on a trolley on Cedar Ward were dusty.

Patients we spoke to on the wards felt safe and were confident in the competence and expertise of staff. We noted in one case on Larch Ward, however, a patient had been prescribed an anti- coagulant for the past five days but was not measured for anti-embolism socks until the day of our visit. This contravened NICE guidelines and may have placed the patient at risk. The trust regularly carried out random safety audits in this area. The October 2013 audit for Larch Ward showed 7% non-compliance with the prescribing of socks and that socks were either not used or were the wrong fit for the patient.

The trust participated in a number of national audits. Audit data currently available for UHL showed the percentage of patients developing pressure ulcers at 0.5%. According to the Hip Fracture Audit, the trust was better than both the England (3.5%) and London (3.8%) averages.

We noted from the surgery directorate risk register that an entry had been made in November 2013 for a long backlog that had arisen in clinic letters reaching patient medical records within the orthopaedic service. This had been identified as a clinical risk as consultants did not have the last clinic letter available on the day of surgery. This letter contained the most recent decision making regarding surgery. This issue led to a near miss being reported when a

patient was booked for the wrong surgery. An action plan was put in place involving the input of additional resources to clear the backlog. The plan's implementation was being monitored by the surgical clinical governance committee and the latest information available in documents provided by the trust before the inspection indicated that progress was being made in clearing the backlog.

Anticipation and planning

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

Day to day, on the wards we visited, we were told that managers took action to ensure patients' needs were met in response to changes in staffing levels due to absences such as sickness. For example, staff were moved between Juniper and Larch wards to ensure appropriate coverage.

In other areas, however, we found a lack of forward planning. For example, during the time of our inspection, the Sapphire surgical admission unit was being closed early at 3.30pm due to staff shortages. This meant that patients were being sent to the Riverside treatment centre to await their surgery. During our visit we saw one patient who had been transferred in this way who was left untended and unsure of what was going on. In another case, on Juniper Ward a patient's operation had been cancelled several times. The patient was very anxious about this and did not know when the operation would take place. Staff on the ward told us they had tried unsuccessfully on a number of occasions to contact the locum consultant to get confirmation about the operation. The ward sister undertook to arrange for the consultant to attend the ward that afternoon.

Mandatory training for trust staff included training in the safeguarding of children and vulnerable adults. We noted from data provided by the trust in February 2014 that the majority of staff in the surgery directorate at UHL had received appropriate training. However, 30% of eligible clinical staff had yet to undertake required training in safeguarding adults and 30% safeguarding children and young people level 2. This may mean that the trust's arrangements did not ensure people were sufficiently safeguarded against the risk of abuse.

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

Requires improvement

Evidence-based guidance

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

Under the CQC's Intelligent Monitoring programme (which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations) there were no surgical procedures flagged as variations or statistical anomalies.

Monitoring and improvement of outcomes

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

Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery. Data for the trust for the period April 2012 to March 2013 was rated as 'no evidence of risk'. The trust was performing in line with the England average for PROMs. However, this is with the exception of the Oxford Knee score (an assessment to help patients understand the level of pain they are experiencing) where only 51% of patients reported a health increase, compared to the England average of 92%.

Relative risk re-admissions, measured by analysing the ratio of observed to expected emergency re-admissions in 30 days, highlighted the trust as having a variable performance over the 12 months to October 2013. Trauma

and orthopaedics had more 30-day re-admissions than expected for seven of the 12 months investigated. General surgery, on the other hand, had more emergency re-admissions than expected in four of the 12 months.

The British Association of Day Surgery has developed a number of measures to assess performance in day surgery. Of the 12 surgical procedure groups, UHL was falling short of the 90% target for seven of them. Head and neck surgery had the lowest day case rate at only 31%.

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

Sufficient capacity

On the day of our inspection, the majority of the wards and theatre areas we visited had an appropriate number and skills mix of staffing. Theatres were staffed in accordance with Association for Perioperative Practice guidelines. Patients we spoke with felt staff were always busy but that their needs were met by nurses doctors and other staff without any undue delay. We noted in the General Medical Council National Training Survey 2013, the trust performed worse than other areas for workload in trauma and orthopaedic surgery.

The trust ensured that there was sufficient equipment to enable staff to provide safe and effective care. Ward staff reported that equipment such as pressure-relieving mattresses and infusion pumps could be ordered quickly from the equipment library. Theatre staff told us theatre lists were reviewed carefully and all equipment was ordered in advance to prevent delays in operation start times. Materials management in the theatre areas was good. All items were bar-coded, well-labelled and well-organised. There were weekly informal meetings with procurement staff and monthly with head of procurement to discuss equipment ordering and supply.

Multidisciplinary working and support

Multidisciplinary team meetings took place regularly. We observed a meeting taking place on Cedar Ward attended by therapy, clinical staff and social workers. On Larch Ward a member of the physiotherapy team told us they felt part of the team and joined in ward rounds. They told us they referred hip and knee patients for bed-based rehabilitation and physiotherapy to Lewisham Adult Therapy multidisciplinary specialist community team. A recently appointed nurse felt the multidisciplinary working on Juniper Ward was good. However, we were told by other staff there were 10 different consultants covering 23 patients on the ward, and nursing staff did not know in advance when the consultants would be visiting their patients. This inhibited communication and multidisciplinary working between nurses and consultants.

The trust had a full multidisciplinary team able to offer a one-stop assessment at UHL with a consultant bariatric surgeon, a specialist nurse, a dietician and a consultant anaesthetist.

Are surgery services caring?

Requires improvement

WE saw that caring was mixed. where staff were caring, this was done well and patients appreciated this. However, we saw areas that were less so and examples of where this fell short of our expectations.

Compassion, dignity and empathy

The trust used the NHS Friends and Family Test to gather people's experiences and whether they would recommend the hospital to their friends and relatives. We spoke with 19 surgery patients at UHL during our inspection and their comments were mostly positive about the care, treatment and support they received. They told us the staff have been "very good", "perfect" and "fantastic". One person told us, "I would recommend the ward to my friends and family". Another person said, "The nurses are kind and always available".

Two people on Cedar Ward told us the ward was noisy at night time and they had not been offered help to cope with this. Another person told us they had been waiting for a long time to be discharged and were worried about being able to make definite arrangements with relatives to pick them up. On Larch Ward, one person told us that, because staff were so busy, patients often had to wait half an hour or more for staff to respond to call bells.

Involvement in care

In most cases, people were supported to make decisions about their care, and relatives were involved when appropriate.

Requires improvement

Surgery

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

The majority of people we spoke with felt fully informed and involved in decisions about their treatment. They told us doctors, nurses and other staff took time to explain the treatment planned and the risks and benefits, and checked to ensure they understood the operation or procedure and how they could expect to feel afterwards. They were also given clear advice about eating and drinking before and afterwards. However, one person on Cedar Ward told us they had been treated very well but were disappointed and anxious about the information they had been given about when and where their operation would take place. They had been told that they would have to be transferred to another hospital but had received little information subsequently. When we raised this with staff, they spoke with the person immediately to understand their concerns and provide reassurance, and they undertook to arrange for a doctor to come to the ward to clarify what would be happening.

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

Trust and respect

In the Riverside treatment centre, we spoke with one patient awaiting surgery who had been transferred from the Sapphire surgical admission unit because of early closure due to staff shortages. They told us they were expecting to have their operation that day but had been waiting for seven hours. They were worried they had been forgotten and had no idea what was happening. We observed they were lying across hard chairs and looked uncomfortable. They were dressed in a hospital gown and had been given a hospital blanket. They said they had been 'nil by mouth' since midnight. While we were checking with staff what was happening, the patient was taken down for their operation. We spoke with two other patients in the unit awaiting surgery who also told us they had not been kept informed of the situation about their operation.

We observed most people were treated with dignity and respect, and people we spoke with confirmed that staff were polite and considerate. Curtains were closed when staff were providing care and they spoke quietly to maintain privacy and avoid others overhearing conversations. People occupying side rooms told us staff always knocked before entering and closed the door when care was being provided. Each patient had their named doctor and nurse identified on a board above their bed. People we spoke with said they knew the names of the staff treating them. We observed one person discharging themselves from one ward. Although this was a tense situation, the nursing staff dealt with the matter with courtesy and sensitivity.

Emotional support

In the CQC's Adult Inpatient Survey 2012, the hospital performed worse than other trusts when patients were asked if they found someone on the hospital staff to talk to about their worries, and if they felt they received enough emotional support during their stay. However, this data did not identify which wards people had stayed on and whether it applied to surgery.

Most people we spoke with told us that doctors, nurses and other staff were always around and available to deal with any worries or concerns they had. One person told us there had been an emergency with another patient in the night which had been upsetting for all patients in the bay. However, nursing staff had spoken to everybody to reassure them and allay any anxieties they had about the matter. Four patients we spoke with felt a lack of communication about their treatment had increased their anxiety.

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

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

Some people were waiting longer for surgery. The trust was not meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing general

surgery and trauma and orthopaedic surgery. The NHS operational standard was 92% and the trust was achieving 89.3% and 89.2% respectively in these two areas. UHL was failing to meet the standard set out by the British Orthopaedic Association that 95% of patients receive surgery within 48 hours for fractured neck of femur, achieving less than 80% in November 2013.

The trust surgery director told us that all national targets were kept under review through the divisional surgery scorecard and an action plan was in place to improve performance in all areas. This was reviewed at monthly clinical governance meetings and reported through the trust's wider governance structure to the Trust Board. A key part of the trust's transformation programme was the creation of an elective surgery centre at the UHL site over the next two years. Approval had recently been given for the first phase for orthopaedic surgery and plans were being put in place for this.

During our inspection, we observed that single-sex guidelines were breached at the Riverside treatment centre. Entry to the theatre waiting area was meant to be single-sex but there two small areas separated by corridor, with no curtains or doors, which did not separate the areas for different sexes. We noted also that it was possible to walk in to the unit directly from the public corridor without seeing a nurse, which posed a potential security risk to patients and staff.

On Larch Ward we were told there was strong integrated team and morale was good but the ward had been short-staffed for seven months. One patient we spoke with felt there were not enough staff on the ward. They told us staff worked well as a team but there was too much work for them and people often had to wait a long time for staff to respond to call bells.

In the theatre recovery area, staff told us that a bed crisis had delayed discharges and patients were being kept overnight in recovery. The recovery staff could not meet their needs because there were not enough nurses or equipment, such as bed pans. The recovery nurses had written a letter to management about the matter six months ago and were told this was a temporary issue during an emergency period. However, staff told us that, six months on, nothing had changed and it remained difficult to meet the needs of patients kept in recovery overnight.

We found the surgery discharge lounge was unsuitable to meet patients' needs. At full capacity it could only accommodate seven people and, in the absence of a clear forward planning process for the referral of patients to the lounge, it could quickly become full. There was no resuscitation trolley in the lounge and the patient toilet was in the staff changing area where staff lockers were located.

Access to services

The trust was performing within national expectations with regard to cancelled operations compared to other trusts. However, the service carried out its own monitoring of cancelled operations (both elective and emergency) for non-clinical reasons. The latest surgery scorecard made available to us before the inspection showed for October 2013 a cancellation rate at UHL of 1.83% against a target of 0.80% which indicated that people who needed surgery did not always have their operations as planned. The surgery director told us the directorate had established a theatre efficiency board which met monthly to review theatre performance. Cancellation rates were under close scrutiny by the group. There was also a weekly meeting with surgery service heads to review cancellations on a case-by-case basis.

The majority of people we spoke with who had undergone an elective surgical procedure did not raise any significant concerns about the timing of their outpatient appointments or the scheduling of their surgery. However, one person told us it had been five weeks since they had been admitted to Juniper Ward and they did not know why they were still waiting for their operation. Senior nursing staff on the ward told us the consultant had not explained why the surgery had been delayed but they would pursue this further with the consultant immediately.

The Ravensbourne theatre suite accommodated four adult operating theatres and two children's operating theatres. Elective surgery took place between 8am and 5pm and the trust aimed to provide emergency or urgent surgery 24 hours a day, 365 days a year. The Riverside treatment centre accommodated four adult operating theatres, three endoscopy rooms, a minor procedure treatment room, an admission area with consultation rooms, patient waiting room and a day surgery discharge facility.

Surgical patients were cared for on dedicated surgical wards. The bed occupancy rates for the hospital were higher than target ranges (around 87%–90% in the past few years – anything above 85% is considered high and closely

linked to efficiency and effectiveness of bed use) and it was evident that this impacted on the flow of patients between surgery and the surgical wards. In the theatre recovery area, staff told us that, because of a bed crisis and delayed discharges, patients were being kept overnight in recovery. The recovery staff could not meet their needs because there were not enough nurses or equipment, such as bed pans.

There were shortcomings in discharge planning in the surgery discharge lounge we visited. There was no evidence of a forward planning process to ensure patients were automatically referred to the discharge lounge when they were ready to leave the hospital. Staff in the discharge lounge phoned around each day to find patients instead.

Vulnerable patients and capacity

There were systems in place to protect patients from the risk of abuse. Safeguarding training was mandatory for all staff and attendance was monitored through each area's performance dashboard (reporting and tracking system). On one ward, we were told there was an identified safeguarding lead. There were patient care pathways available and visible for patients with 'confusion' or 'communication issues' and we saw clear displays around the wards and signage to indicate patients who were on the pathway. We observed staff tending appropriately to the needs of a patient with severe learning disabilities. The ward manager told us they had been unable to get a registered mental nurse on the day of our inspection to support the patient but a student nurse had been given responsibility to sit by the patient and to call on other staff if needed.

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

Leaving hospital

The discharge process was started as soon as a person was admitted to hospital. Surgical nursing care plans included a discharge plan which was reviewed daily and there was a discharge planning checklist to ensure that patients received any additional support post-discharge. This included referrals to social services, the district nurses team or community rehabilitation services. Discharge planning was discussed in daily handover meetings and a spreadsheet was completed by each ward for bed meetings. Weekly multidisciplinary teams also discussed discharges and possible delays.

The trust was rated worse than expected in comparison with similar trusts in the CQC's Adult Inpatients Survey for September 2012 to January 2013 for patients who stated their discharge was delayed for more than four hours, due to waiting for medicine to see a doctor, or for an ambulance.

During our inspection we noted some delays in the discharge process. In the Riverside treatment centre, where discharges had to be completed electronically by doctors, delays sometimes occurred in signing off the discharge when waiting for medicines from the pharmacy. There were shortcomings in discharge planning in the surgery discharge lounge. There was no evidence of a forward planning process or a clear pathway to ensure patients were automatically referred to the discharge lounge when they were ready to leave the hospital. Staff in the discharge lounge were ringing around each day to find patients instead. On the day of our inspection, one patient in the lounge had been waiting three hours and was left unsupervised while the nurse went to chase doctors and pharmacy for medicines.

Learning from experiences, concerns and complaints

The service encouraged feedback from patients and their relatives through the NHS Friends and Family Test. The results were displayed in ward areas showing what had been said and what had changed as a result of patients' comments. The trust also published a 'you said we did' section on its website which recorded improvements in response to patient feedback. In relation to surgery this included: the introduction of a governance manager; new plain language leaflets for most procedures to provide the clearest possible information; the appointment of a complaints coordinator to improve the process of complaints-handling; and planned improvements to the Riverside treatment centre experience following receipt of the results of a day case survey.

The service had a complaints policy in place. Staff attempted to resolve issues as they arose, but there was a complaints escalation procedure and action plan for the surgery directorate if they were unable to. Complaints were logged, investigated and responded to following this

procedure. Service managers allocated complaints to the relevant service clinical lead to investigate to compile a draft response within stated timescales. All complaints were logged and monitored by the divisional complaints coordinator, who passed them down to the manager responsible. The complaints coordinator reported that some managers needed training in complaints-handling as they were not experienced in this. We noted in February 2014 that 70% of surgery staff at UHL had undertaken mandatory training in managing risk, complaints, claims and business continuity.

Complaints were monitored through the surgery and wider trust clinical governance structure and also at Trust Board meetings. There was also a trust complaints steering committee which met monthly and reported to the board. We noted from the minutes of the December 2013 meeting that, since the trust merger, there was a rise in complaints in all areas and that dissatisfaction through patient encounters was highest in surgery. We noted further that nine overdue complaints were reported in surgery at UHL where procedural timescales had not been met. The surgery, elective surgery centre and critical care divisional score card reported for UHL that complaints resolved within agreed timescales was at 44% for November 2013 against a target of 95%. This meant that the majority of complaints were taking too long to resolve, which risked further patient dissatisfaction. This was also reflected in the surgery risk register which reported at November 2013 poor complaint management performance and the potential risk for poor patient experience and loss of opportunity to help staff learn. A recovery plan was put in place involving a request for data from each responsible lead and additional time and resource being enabled to deal with an inherited backlog.

At ward and theatre levels, complaints were discussed at weekly team meetings to review lessons learned. People on wards said that they had not had cause to make a formal complaint but some were aware of the Patient Advice and Liaison Service complaints service.

Are surgery services well-led?

Requires improvement

Vision, strategy and risks

The trust had a stated vision and values and had been running a series of 'behaviours and values' workshops for staff at all levels. We saw values displayed in the areas we visited and some staff knew and understood them. However, it was not possible to say from relatively small sample of staff we spoke with whether the vision and values had been yet been fully embedded within the organisation. Managers and staff acknowledged there were still issues to be resolved since the merger and it would take time and effort to achieve the 'one trust' vision.

Surgery management told us there was a "big focus" on improving staff morale and felt the position was much more positive now. On the surgical wards and theatre areas we visited, most staff were positive about the support they received and felt there was good teamwork to ensure patients' needs were met. For example, a newly appointed nurse complimented the induction they had received and the accessibility of senior staff for advice and guidance. In other areas, however, staff raised concerns about the support they received. In the theatre recovery area staff told us they had written to management about their concerns over their ability to meet the needs of people kept in recovery overnight due to bed shortages but felt the response had not been satisfactory and their concerns remained unresolved.

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

Quality, performance and problems

A new divisional clinical governance structure had recently been put in place within the surgery, anaesthesia and

critical care directorate following a review by the clinical quality committee in October 2013. This was to provide assurance to the trust's clinical effectiveness, patient experience strategy, and patient experience committees, together with providing assurance to the trust integrated governance committee and Trust Board.

The monthly Trust Board performance report was delivered through this structure. The November 2013 report identified a number of concerns relating to surgery. UHL had had an exceptionally high level of Did Not Attend (DNA) for non-clinical reasons, predominantly due to patients not turning up for appointments, patients too unwell to attend, and a number related to unavailability of beds. Some specialties appeared to have been impacted on by patients' fitness issues that may have been corrected through pre-assessment. UHL had reintroduced pre-admission day telephone liaison in pain management (whose rate of cancellations was at times 40%) and introduced similar systems to other specialties. Pre-assessment was also under review. Theatre utilisation at UHL was recorded at 82.4% against a target of 85% but seen against a higher cancellation rate. Processes were being developed for greater patient contact prior to the day of surgery to reduce this number. The way in which utilisation was calculated was also being reviewed. In addition, a review of late-starting lists had been initiated alongside a review of all lists.

Leadership and culture

Consultants were aware that juniors worked too many long hours. Some junior doctors felt bullied by orthopaedic consultants. They didn't expect changes to happen overnight, but felt the trust was aware of the issues and wanted to help. Junior doctors also felt there were good opportunities for teaching and training. However, we noted that a London Deanery report in April 2013 had reported concerns about core surgical training and general surgery training at the trust. Action plans were in place to address these findings and progress was being monitored.

Patient experiences and staff involvement and engagement

The service actively encouraged feedback through the NHS Friends and Family Test from people who used the service. We saw the results of this displayed on wards and noted the latest scores for two surgery wards at UHL were well above the average score for the trust. Procedures were in place to respond to complaints about surgery services. Staff received feedback about lessons learned and reflective sessions took place to secure practice improvements. However, there was some concern about the time taken to respond to complaints in some surgery areas. The trust participated in the CQC's National Inpatient Survey 2012. Out of a total of 60 questions, the trust was rated better than other trusts in one question and worse than other trusts in 11 questions. The trust published a 'you said we did' section on its website which recorded improvements in response to patient feedback. Improvements were planned in the Riverside treatment centre as a result of such feedback.

Some staff told us they felt able to discuss any concerns or anxieties with their manager and felt engaged with the trust's aim to provide the best service possible to patients. Others felt less engaged and did not feel supported by their managers.

Learning, improvement, innovation and sustainability

We noted from data provided about mandatory surgery training at UHL at February 2014, that completed training ranged from 46% for medical gases – clinical, to 100% for other forms of training. Other areas of relatively low completion rates included fire safety 54%, health records management 54%, and first responder resuscitation training 58%.

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

We noted that the trust's 2012/13 annual report on complaints provided a brief description of some of the service improvements made during the year as a result of feedback received from patients and relatives. For surgery this included a new leaflet developed for patients due to attend for surgery which detailed the risks and benefits and the requirement for consultants to see all follow-up patients after surgery in orthopaedic clinics, and registrars to see new patients.

Good

Intensive/critical care

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

Information about the service

The critical care unit includes an intensive therapy unit (ITU) which has eight beds and a high dependency unit (HDU) with eight beds. There are also an additional two short stay recovery beds which are available Monday to Friday for specific surgical patients. The ITU and HDU units were located separate from each other, divided by a corridor.

As part of the inspection, we visited the critical care services and spoke with four patients and the relatives of another five patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, physiotherapists and the senior management team. We reviewed performance information about the trust.

Summary of findings

We saw a lack of agreed discharge process in ITU and HDU. We saw bed capacity issues from the rest of the hospital were significantly affecting the ability of the critical care unit to meet the patients requirements.

Patients' needs were being met by the service, care was delivered was delivered by experienced and skilled staff in a caring manner. Patients' care and treatment was delivered in line with national guidelines and evidence-based practices. Many families we spoke with were complementary about the care their relative received.

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

There were enough trained and experienced staff and appropriate equipment to provide care to patients.

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Safety and performance

The unit had systems and processes in place to monitor patient safety and reduce the risk of harm to patients. Between December 2012 and November 2013 there were no reported never events (mistakes that are so serious they should never happen) or patient safety alerts in the critical care services. The staff we spoke with told us that the staffing levels in both the ITU and HDU allowed them to make patient safety a priority and to facilitate the delivery of effective patient care.

There were eight Serious Incidents requiring investigation reported to STEIS between December 2012 and November 2013. These included Serious Incidents reported at Lewisham Healthcare NHS Trust as well as Serious Incidents that took place in the newly formed Lewisham and Greenwich NHS Trust (LGT) from 1 October 2013. Seven of these safety incidents were Grade 3 pressure ulcers. During our inspection we noted that these incidents had been reviewed and appropriate changes made to reduce the risk of a similar incident occurring in the future.

The Intensive Care National Audit and Research Centre (ICNARC) data provided to us by the trust showed that the unit acquired Methicillin-resistant Staphylococcus aureus (MRSA) was within acceptable levels. Staff we spoke with told us that all patients were screened for MRSA on admission to the unit and that single rooms could be used to isolate patients who were positive to MRSA; this reduced the risk of cross infection.

The resuscitation equipment was checked on a daily basis against a checklist to ensure all drugs and equipment that may be required in the event of an emergency was available and in date. The drawers on the resuscitation trolley were locked using plastic seals once the trolley had been checked, it was noted that the seals were difficult to break and this could result in a delay in commencing treatment.

Learning and improvement

The NHS Safety Thermometer and safety performance data for Lewisham hospital including community services which we reviewed prior to our inspection showed that there was a high level of pressure ulcers, over the previous 12 months. We found that the unit had taken action to reduce the number of pressure ulcers acquired during the patient's stay in the unit. This action included all patients being assessed on admission and the findings of this assessment being documented in their notes. We noted that the unit had made changes to mitigate the risk of patients developing pressure ulcers. This action included changing the type of nasal cannula used. we also noted that these data will include figures from UHL community services.

Staff were encouraged to report any identified risks to staff, patients and visitors. All nursing and medical staff used the electronic incident reporting system to log incidents and near misses. The staff we spoke with told us that the unit had a no blame culture and that they were encouraged and felt able to report incidents without fear of blame. This approach meant that lessons were learnt and changes in practice implemented. Staff were able to provide examples of incidents that had been investigated and the actions that had been taken to reduce the risk of a similar incident occurring. We saw evidence that staff received feedback on incidents reported in the unit and across the trust and were encouraged to implement appropriate learning from other areas. For example the matron received a monthly incident report which was cascade to staff via the monthly sister's meeting.

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

Systems, processes and practices

During our inspection we found the intensive care unit to be clean and clutter free. There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. This included all bed spaces being deep cleaned in between patients by the unit's cleaner. Staff told us that this reduced the risk of cross infection but at times delayed the patient's admission into the unit. We were told by staff we spoke with that they experienced no issue with obtaining equipment and that equipment was cleaned in-between patients and maintained centrally.

In the ITU we noted that there were sufficient numbers of hand wash sinks and hand gels. In the HDU there were appropriate numbers of sinks but fewer hand gels, staff told

us that this was due to the risk of patients or visitors ingesting the gel. We saw that staff followed agreed hand washing guidance but not all staff were 'bare below the elbow', we observed some members of staff wearing wrist watches. Nursing staff were observed wearing personal protective equipment, such as gloves and aprons, when delivering care.

Medicines, including controlled drugs, were securely stored in a room that had swipe card access. However, the drug cupboards in this room were not locked. The matron told us that a risk assessment had been completed in relation to the unlocked cupboards and mitigating action taken to ensure that staff could access drugs in a timely manner but unauthorised people were unable to access this room. We noted that the room used to store intravenous and dialysis fluid was unlocked and therefore accessible to unauthorised people.

The data provided to use prior to our inspection showed that there were very few reported prescribing error in ITU and HDU. Staff we spoke with explained the cross checking practice that was in place to reduce the risk of drug errors. We also noted that the unit audited antibiotic usage and that the pharmacy completed a daily round to review the drugs patients were prescribed, highlighting any prescribing issues.

There were regular debriefing sessions that all staff were encouraged to participate in following incidents that occurred on the unit. The purpose of these sessions was to encourage staff to reflect on the incident and consider learning that would assist in avoiding a similar incident occurring in the future.

Monitoring safety and responding to risk

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

All patients admitted to the unit were assessed within two hours of admission, using a screening tool to identify potential risks of the individual developing pressure ulcers. This assessment was documented on a body map which was filed in their individual notes. All ITU patients were nursed on a special mattress to mitigate the risk of developing pressure ulcers.

The ITU and HDU had appropriate levels of staffing. However, with the recent increase in staffing there was a need to increase both the nursing and medical staff establishment At the time of our inspection appropriate staffing levels were maintained using agency and locum staff. We found that there was a named consultant in charge of unit seven days per week.

The nursing rotas we looked at showed that nurse staffing ratios were in line with the Royal Collage of Nursing's guidelines. To support staff we were told that there was always at least one band 7, experienced ITU nurse on the ITU and another on the HDU. Experienced ITU agency staff were used to ensure appropriate staffing levels. Staff we spoke with told us that at times there were issues with the agency not understanding the ITU's need for agency staff with ITU skills and would at times try to book staff without these skills. However, the team leader always ensured appropriate agency staff were employed.

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

Anticipation and planning

The critical care unit had recently obtained funding for an additional 11 nursing posts. As this funding for nursing posts had only been agreed in January 2014 but not all these post had been recruited to at the time of our inspection.

We were told that there had recently been a high level of nurse turn over and that the ITU had recently lost several band 6, experience nurse. The trust were in the process of recruiting eight nurses to replace these members of staff. However, we were told these posts were being replaced by

Good

Intensive/critical care

newly qualified band 5 nurse; this change in skill mix was reported to be placing additional pressure on the existing staff as the new nurses did not have ITU skills and experience.

The unit had a dedicated practice development nurse who was responsible for a range of unit level training including the staff development programme and new staff induction. Mandatory training for all staff had been identified in areas such as infection prevention, resuscitation and medicines management; this training ensured staff had the skills and knowledge to provide safe care to patients. Advanced life support (ALS) training was not provided, staff were trained in hospital life support. Staff stated that this half day training was not as effective as the ALS course but the trust had made a decision that this was the course that staff were required to complete.

Staff were responsible for booking themselves on training and had access to their on line study record, We were told that there were systems in place to alert staff when they were required to attend refresher training and that managers were alerted to this training need. The training data showed that not all staff had completed their mandatory training. Staff we spoke with reported that the central data base was not always up to date and staff sometimes received incorrect notification that they needed to update their training. Based on this conflicting information we were unable to accurately assess the percentage of staff who were up to date with their mandatory training.

There was an appraisal system in place for all staff, nursing staff we spoke with stated this had become a paper exercise and staff felt that it no longer facilitated their individual development, as it focused on trust targets and tasks. At the time of our inspection 70% of staff were engaged in the appraisal process.

Staff handover huddles took place during shift changes on a daily basis in a number of areas to ensure all staff had up-to-date information about risks and concerns. This allowed safety issues and planning issues to be raised and dealt with appropriately.

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

Good

Using evidence-based guidance

The unit participated in a range of clinical audits included monitoring of compliance with National Institute for Health and Clinical Excellence (NICE) and other professional guidelines. For example NICE Core guidance 50, a standard for identification of patient's needing critical care was in place. However, we found that the unit was not compliant with NICE Core guidance 83, regarding how care was provided to patients once they left the critical care unit as there was no longer the provision of a follow up clinic due to lack of funding.

We found that all the consultants were fully engaged with the Faculty of Intensive Care Medicine core standards and there was evidence that these had been implemented. For example the unit had a full time consultant on duty who was not allocated any other duties outside the unit. We also noted that care bundles such as ventilator care bundles were in place and reviewed to improve patient outcomes. We were told that there plans to employ two additional consultants who would be competent and skilled in intensive care. However, at the time of our inspection the job plans had not been progressed and these posts had not been appointed.

Performance, monitoring and improvement of outcomes

The ITU has bi-weekly mortality meetings attended by both doctors and nurses. The trust mortality data for critical care services showed that the ITU's rate was within acceptable levels.

The trust submitted data to the Intensive Care National Audit and Research Centre (ICNARC). The data for adult critical care for 2012/2013 showed that the number of unplanned readmissions within 48 hours to the ITU was higher than other similar units. From the evidence collected during our inspection the reason for these unplanned readmissions was unclear.

The trust participated in the National Cardiac Arrest Audit (NCAA) which aims to promote local performance management through the provision of timely, validated

comparative data to participating hospitals. However, from the data provided it was unclear if the unit contributed to this audit as no cardiac arrest were reported to have taken place in the ITU or HDU.

Staff, equipment and facilities

Nursing staff on the unit were allocated to one of three teams. Each team rotated on a eight weekly basis between ITU and HDU, we were told that this approach ensured staff gained a range of ITU and HDU experience.

The unit had a range of equipment that was kept on the unit to ensure it was readily available. There was also a blood gas machine on unit, we were told that this was for ITU or HDU use only and that all staff who used the machine had completed training and an assessment to demonstrate they were competent to use the machine. We were told that the unit only had one bronchoscope, when this was sent for sterilisation to a central department the unit had to borrow a bronchoscope from theatre if one was required. While the theatre was location in close proximity to the unit at times this could result in a delay in obtaining the equipment

Multidisciplinary working and support

The unit worked closely with the outreach team who followed up patients on the wards post discharge from ITU or HDU and who are responsible for identifying any patients who may require the support of HDU or ITU. All patients transferred out of ITU or HDU were followed up using the ward watch database to identify any patients who may be deteriorating. The outreach team were not managed by the critical care directorate but staff reported good working relationships.

There were two consultant lead ward rounds daily; members of the multidisciplinary team joined these rounds to provide specific expert advice. For example we were told that the microbiologist joined the round.

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

Patients were treated with dignity and respect. We observed staff providing care in a kind and respectful manner, for example curtains were closed around the bed when care was being delivered to maintain their dignity.

There was a separate room that nurses and doctors used to speak to relatives in private to maintain confidentiality. Relatives were spoken with in a compassionate and those we spoke with were positive about the care and treatment their relative received.

One patient told us all the doctors, nurses and cleaners were very good, ‘caring staff go the extra mile- second to none" Another relative described the service as wonderful and said ”I have no complaints" Those patients we spoke with told us they felt very well cared for and described the ITU and HDU as ‘marvellous’.

Involvement in care and decision making

The unit had effective systems and processes in place for recording Do Not Attempt Resuscitation (DNACPR) decisions. The DNACPR paperwork had been completed and filed in the individual’s notes; this included a date when the order should be reviewed.

Most relatives we spoke with felt involved in their relatives care. However, we spoke to a small number of relatives who did not feel their views had been taken into account and that they had been given conflicting advice and information.

Staff had the skills and knowledge to make best interest decisions for those patients who were unable to make decisions themselves. We were provided with an example of how the unit had taken legal advice to ensure the patient’s best interests were respected.

Trust and communication

There was a clear record of all communication staff had with relatives. All conversations about the patient’s care, treatment and decisions made were documented in an individual communication folder which was kept at the patient’s bedside. This information was recorded in date order and included a summary of who spoke with the relative, what was said and the relative’s response. This approach ensured that staff were aware of what the relatives had been told and reduced the risk of conflicting information being provided.

During our inspection we noted that there was a lack of written information and leaflets for patients and their relatives. There was no information or photographs of the staff who worked on the unit, therefore some relatives were unclear about the role of some staff. There was also no information about who they should raise any concerns or

complaints with. We were told that staff spoke a variety of languages and were used to translate day to day conversations. For discussions about treatment and care staff told us they would access a language interpreter.

Emotional support

The unit had access to a 24 hour, seven day a week bereavement service. This service provided support and guidance to both the family and staff. Following a death on the unit documentation is sent by the unit to the bereavement officer who aims to contact all families within 24 hours of a death within ITU to offer guidance and support.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

Patients' needs were being met by the service, and patients were cared for by experienced, skilled staff. Incident reporting data showed that patients were developing pressure sores from equipment, such as nasal sores from breathing tubes. The nasal cannulas used had been changed to reduce the likelihood of patients developing these sores. We saw risk assessments that informed staff how to reduce and prevent such deterioration.

Staff told us that they received very few complaints and that those they did receive related to the visiting area being too small or that their relative had developed a pressure sore. The unit tried to resolve these locally if possible but if the issue could not be resolved the complainant was informed how to raise a formal complaint.

Patients and relatives we spoke with said they felt supported by staff. The unit had overnight accommodation and shower facilities for relatives. There was also a small relative's room with access to drinks.

Vulnerable patients and capacity

We saw examples of appropriate use of the mental capacity act to support vulnerable patients..

Access to services

The bed occupancy rates for the three months available for Lewisham and Greenwich NHS Trust were significantly higher than the England average. In November and December 2013, the bed occupancy rate reached 100%, which is well above the England average for both months of 85.4% and 77.1% respectively. This is also well above the Royal College of Anaesthetists' recommendations for safe bed occupancy. This high bed occupancy rate could potentially have been the cause for the relatively high number of non-clinical transfers out of the critical care units which, was above the England average in the 2012/13 ICNARC Annual Quality report. However, more recent data from July to September 2013 show there were only two non-clinical transfers out from the unit.

The unit had recently completed a bed occupancy review and identified the need for additional beds. A business case had been developed and agreed. We were informed that funding for the additional nursing staff had been agreed but these posts had not yet been recruited to.

Leaving the unit

Patients were discharged to other clinical areas in the hospital. A follow-up clinic was no longer available due to lack of funding for this service. Therefore feedback from patients and their relatives on their experience of ITU and HDU was not collected via this route. Patients were however followed up by the outreach team. The unit monitored any readmission of patients and reported this data to the Intensive Care National Audit and Research Programme (ICNARC).

The trust's ICNARC data showed that the unit had a significant number of delayed discharges. However, we did note that there were very few out of hours, after 22.00, discharges to the wards. By avoiding transfers out of hours, patients were transferred and handed over to ward areas at a time when there were sufficient medical and nursing staff to review their care needs and provide care that met the individual's needs.

There was a lack of discharge processes in place in HDU. The average length of stay in ITU and HDU is above the national average. Staff we spoke with stated that the bed managers were working with the unit to identify ward beds but it was frequently difficult to discharge patients to the ward areas due to lack of bed capacity. During our inspection we were informed that one patient had been discharged home directly from the HDU as a bed had not been available on the ward to transfer the individual to. On other occasions we were informed patient's transfers to the wards were undertaken in a hasty manner due to the need

to admit another patient. This resulted in some patients and their relatives being unprepared for the transfer. It was unclear from the evidence collected during our inspection what action the trust plans to take to reduce the number of delayed discharges which would impact on the length of stay in ITU and HDU.

There was a trust process for the discharge and transfer of patients but due to a lack of bed capacity in the hospital, discharges were frequently delayed. In data from July to September 2013, UHL reported a rate of 80.7% of discharges being delayed by four hours or more. Information relating to the average length of stay and time to discharge was collected. Performance data showed that the average length of stay was above the national average and the majority of patients were not discharged in line with national guidance. The 2012/13 ICNARC Report also showed that the unit had a rate below the England average for out of hours discharges. All patients discharge from the HDU or ITU patients were seen within 24 hours by the Outreach Team, this team was available seven days per week

Learning from experiences, concerns and complaints

The staff we spoke with told us that they received feedback directly from patients or their family as they did not participate in the Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment. We were told that the unit had received very few complaints and had made changes in response to these complaints.

Are intensive/critical services well-led?

Good

Vision, strategy and risks

Both nursing and medical staff we spoke with told us that the unit was well organised and that the matron and consultants were approachable. There was as yet no strategy or vision at the time of our inspection regarding how the trust's two critical care units would work together to learn from each other and improve the quality of patient care. Some work at matron level across the two ITUs was taking place there was no interaction between nursing staff at this ITU and the trust's other ITU based at Queen Elizabeth Greenwich.

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

Governance arrangements

There were effective clinical governance arrangements in place and staff were able to explain how this had an impact on patients. For example patients received care and treatment according to national guidelines and this was monitored. We were told that there were clear arrangements for cascading information to staff. However, staff were unclear how risks documented on the unit's risk register were escalated.

Leadership and culture

There were clear leadership roles in the unit led by consultants who had specialised in ITU medicine, as recommended by the Faculty of Intensive Care Medicine (FCIM). There was always at least one senior member of staff leading the team and a matron. The staff we spoke with were happy with the support they received. One junior nurse told us "no question is too stupid". One of the junior doctors we spoke with told us 'there is always someone senior around to advise'.

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

Patient experiences, staff involvement and engagement

All the patients and relatives we spoke with were complimentary about the staff and the care they had received. We were told that at times the recovery area in theatres was sometime used as an overnight stay ward for the ITU was full.

Learning, improvement, innovation and sustainability

The critical care unit were a participant of ICNARC data collection and record close to 100% data completeness,

Good

Intensive/critical care

according to the 2012/13 Annual Quality Report. At the time of our inspection there are currently no data available on the outcomes of the GMC training surveys of trainees' experiences of Intensive Care Medicine. However, the junior doctors we spoke with stated that they felt well supported and that consultants and nurse were approachable and supportive.

Doctors and nurses had the appropriate skills and training to deliver safe and effective care. We were told that staff could access development programmes and that there was a weekly consultant teaching programme. The staff we spoke with told us the training programmes were effective in preparing them for their specific roles. Information was cascaded through a range of approaches including team meetings, email and information on the staff notice board. The Matron had begun to work with her peer at the trust's other hospital site and was sharing learning to improve the quality of care.

Requires improvement

Maternity and family planning

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

Information about the service

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

Maternity services at UHL are comprised of an acute labour ward, an antenatal ward and day assessment unit, a postnatal ward and a midwifery led birth centre and antenatal clinics.

Summary of findings

We looked at record and data provided to us and reviewed the results of national surveys.

We saw areas of safety in this service that gave us cause for concern. We found lack of important equipment (fetal heart monitors). We saw lack of appropriate check on equipment and poor record keeping. We observed incomplete handovers to staff from one shift to another.

We also saw that the bed occupancy rate was higher than is recommended for this type of service.

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

We found a number of positive features of the maternity service at UHL. The birth centre received high praise from patients, and was a sought-after resource. Midwives and clinicians were positive about working at the hospital, and many stated that there had been an improvement in management support, visibility, policy and practice since the merger with QEH.

We were told, and saw evidence, that staffing levels had improved, however, it was of concern that a notable number of shifts were covered by agency or bank (overtime) staff. For example, on one night shift on the labour ward, more than 50% of the midwives were agency or bank. staff did not fully engage in handovers and left the handover meeting without a full knowledge of all patients on their shift.

Requires improvement

Maternity and family planning

Staff told us there had been a big improvement in supervision, and all now had a named supervisor. Junior doctors told us of good support; while preceptor midwives said there was a good induction programme.

While staff reported an improvement in direct line management, we found that, at a more senior level, improvement was needed with regard to data collection and analysis, risk assessment, staff training and consultant ward rounds.

Are maternity and family planning services safe?

Inadequate

Safety in the past

There were no Never Events (incidents so serious they should never happen) reported in the maternity service from November 2012 to December 2013. There were 9 serious incidents relating to maternity services requiring investigation reported to Strategic Executive Information System (STEIS) between December 2012 and November 2013. This includes those reported at Lewisham Healthcare NHS Trust as well as serious incidents that took place in the newly formed Lewisham and Greenwich NHS Trust from 1 October 2013.

The most common serious incidents reported were unexpected admissions to the neonatal intensive care unit (NICU) (3) and unexpected neonatal deaths (3). In total, 159 patient safety incidents specific to maternity were reported in the period from July 2012–June 2013 at Lewisham Healthcare NHS Trust. One of these incidents resulted in no harm, the majority (152) resulted in moderate harm, four resulted in severe harm and two resulted in death.

Learning and improvement

The high number of incident reports to the National Reporting and Learning System (NRLS) – a central database of patient safety incident reports – indicates there are some areas for improvement in terms of patient safety and learning. The number of incidents recorded on the database does indicate a healthy culture of incident reporting at the trust.

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

Systems, processes and practices

The trust's level of consultant cover at UHL was 82 hours, which is considered appropriate for a unit of this size. Clinicians we spoke with felt that this gave them the opportunity to teach junior doctors. Of concern, however, was the lack of established ward rounds by consultants. We

were informed that this did not form part of their current job description, albeit this was under review. We were informed that revised job plans were due in March 2014. Staff on the antenatal ward confirmed that they had registrar cover but felt that they should have specific allocated consultant cover on a daily basis, as this would improve the level of service offered to patients and reduce any potential risk if there was a delay in contacting a consultant.

In terms of safe staffing levels, the midwife to birth ratio (per annum) at UHL is currently at 1:29. The average across London for workforce planning is 1:28. At the time of our inspection, staffing on the labour ward during the day consisted of eight midwives, one of whom was allocated to cover caesarean sections. There were 11 delivery rooms. Not all posts were substantive, and at least one on each shift was covered by agency staff. Overnight and at weekends, the staffing levels were seven midwives and one support worker. We observed the evening handover. While the information imparted was detailed and comprehensive, none of the incoming staff made any notes or even waited to see which patients they were allocated before leaving the handover. Four of the incoming seven midwives were bank (overtime) or agency staff. The handover was interrupted several times by the late arrival of staff, including doctors, which meant few of the incoming team received a complete handover.

The birth centre at UHL provides five suites, with a staffing establishment of two midwives. Clearly, in providing one-to-one care there is often a need to call in additional midwifery staff. These personnel would initially be sourced from the community midwifery team, however, we were informed that bank staff are often used. Efforts are made to use staff who are familiar with the centre.

The postnatal ward at UHL provided 31 beds. We were told that staffing is normally four midwives per shift, one of whom is nominally in charge. These numbers are supplemented by preceptors. Staff told us that the preceptors were a welcome addition, however the drawback was that time had to be allocated for their supervision.

The antenatal ward provided 10 beds, four of which were in single en suite rooms. We were told by the senior midwife on duty that staffing levels had recently improved. At the time of our visit, there were three midwives, a senior and two support workers. These staff also covered the day assessment unit. Plans to relocate the unit to the same floor as the antenatal ward would ease the pressure on staff, who lost valuable time moving between the two locations.

We were informed by the trust that staffing is based on expected births not on bed numbers.

Monitoring safety and responding to risk

We saw that there were clear escalation protocols, based on calculated numbers, in the event of staff shortages. Regular capacity assessments were carried out by ward matrons, who felt there was a clear chain of command and prompt action where necessary.

We found, however, evidence of poor record-keeping and equipment maintenance. For example, portable electric equipment should be tested annually. We found a Doppler machine (used for measuring blood flow) which was labelled as having been last tested in 2005. This was in use on the labour ward. We examined five of the delivery rooms. Each contained a manual blood pressure machine, none of which had any sticker to indicate they had ever been checked or calibrated. One of these machines was clearly broken. The defibrillator on the adult resuscitation trolley was last tested in 2012. Some equipment was not currently in use but it was not possible to tell if it had been cleaned and made ready for use as there were no labels attached to indicate its status. The lack of a structured maintenance programme and designated staff to take responsibility for ensuring equipment was safe, appropriate, well maintained and clean, puts patients' wellbeing at risk.

We found further evidence of a lack of attention to safety. Both doors to the testing and intravenous fluid room were unlocked when we went to the labour ward on our unannounced inspection. The fridge was also unlocked, as the padlock was left lying on the worktop. One of the medication cupboards in this room was also unlocked, and some ampules of medication were left on the worktop. This is poor practice and compromises patient safety and the viability of medication if not correctly stored.

We reviewed the availability and maintenance of equipment in all maternity areas. Emergency resuscitation equipment was available and regularly checked across all areas. These checks were recorded. We found gaps in the calibration and checking of the fetal fibronectin monitor on the labour ward. The matron told us this was carried out

daily, however, records indicated that no checks had been carried out since 7 February 2014, almost three weeks before our inspection visit. On our subsequent unannounced visit, we were given the calibration records and told that staff were now carrying out the checks. The records had been retrospectively completed, but even so, the monitor had not been checked in the six days preceding this visit.

Staff in the birth centre told us they had sufficient equipment, including a wheelchair and a trolley if they needed to transfer a patient to the labour ward. Staff on the labour ward commented that the lack of equipment impacted on their ability to provide high-quality care. For example, they told us they did not have a wall-mounted monitor for each bed in the assessment bay, (staff said good practice guidelines dictate this level of equipment was required) which meant if they were busy, the level of ongoing continuous assessment could be compromised. The ward did not have a sufficient number of fetal heart monitors, so staff told us they reserved their use for higher risk births. NICE guidelines gave examples of when electronic fetal heart monitoring should be carried out, including where a diagnosis of delay in the established first stage of labour is made, or when oxytocin is administered for augmentation. If the labour ward was full, there was a risk that some patients would not receive the electronic monitoring they ideally required.

We have concerns regarding patient dignity during transfer from the birth centre to labour ward. The route is through drafty, main corridors. Staff told us they could use an override key to enable the lifts to be used quickly. We walked the route with staff, but unfortunately the lift override key proved to be the wrong one and the lifts could not be operated as planned. This delay could have a serious impact on the health of the woman and, potentially, the unborn child.

Anticipation and planning

We saw evidence of appropriate and consistent use of the midwifery early obstetric warning scores. In the event of deterioration in a woman's condition, these score charts prompt early referral to an appropriate practitioner who can then undertake a full review, order appropriate investigations, resuscitate and treat as required.

Are maternity and family planning services effective?

(for example, treatment is effective)

Requires improvement

Evidence-based guidance

In talking with staff we found they were aware of the National Institute for Health and Care Excellence (NICE) guidelines on care for gynaecology, pregnancy and birth. These guidelines include the standards expected for routine antenatal care, including primary, community and hospital-based care. We requested documentation to further evidence compliance with these guidelines. Subsequent to the inspection the trust sent us a copy of their NICE guidance report carried out in November 2013. This indicated that, out of 45 pieces of guidance relevant to maternity, 17 had been fully implemented while 28 pieces of guidance had an action plan in place or further information was required to ascertain compliance.

We also evidenced that clinicians followed Royal College of Obstetricians and Gynaecologists safer childbirth guidelines.

Monitoring and improvement of outcomes

There is a trust-wide compliance team in place, including a range of staff at various bandings, who, at the time of this inspection, were carrying out an audit of compliance with NICE postnatal care. Use is made of the dashboard (performance reporting and tracking system), both to highlight where standards may have fallen, but also to indicate where good practice is being maintained. There is a designated midwife to review maternal deaths and perinatal mortality.

The CQC uses a statistical programme to scan the most recent health and social care information to identify unexpected performance (outliers) that may be linked to problems with the quality of care. If the data indicates there may be a problem, an alert is raised. The trust has recently been subject to two outlier cases for abnormally high rates of emergency caesarean sections and, more recently, for a high number of maternal readmissions. The trust highlighted significantly high rates of emergency caesarean sections in the data we received for July to September 2012. Data for UHL between April 2012 and June 2013 show

Requires improvement

Maternity and family planning

that the hospital's maternity unit continued to show a high rate of emergency caesarean sections at 19.3% of deliveries, compared to the England average of 14.5%. The trust has been requested to submit an action plan to the CQC to outline its approach to lowering this figure. The maternity unit shows a normal vaginal delivery rate of around 62%, which is slightly above the England average of approximately 60%. This can be accounted for at UHL by its relatively low number of instrumental deliveries.

We discussed the high emergency caesarean section rate with a number of senior midwifery staff and clinicians. We were informed that there had been no obvious reason for this, however, a number of steps were being taken to establish a cause, including a consultant-led review of medical notes (underway at the time of our visit) and investigating other NHS trusts with similar issues to evaluate and learn from the action taken. Senior staff on labour ward felt it would be beneficial to have a daily caesarean section handover, separate from the general handover, although, they recognised that time constraints may make this impossible.

The CQC maternity outlier surveillance programme has also recently flagged up the significantly high rates of maternal non-elective re-admissions (excluding re-admissions of less than a day) in April–June 2013. UHL showed 136 maternal re-admissions, compared to an expected number of 94. The staff we spoke with felt that this was largely due to inaccurate coding of patients, which led to a misrepresentation of the actual rate of re-admissions. This has now been submitted to CQC, and the trust have been informed that not further progress updates are required.

Multidisciplinary working and support

The majority of staff we spoke with were confident that the recent merger of the two hospitals would lead to improved multidisciplinary working and support. A number commented on the sharing of good practice which was already taking place. Policies and procedures were being reviewed and revised, and staff felt that the best parts of all of them were being taken forward to form new guidance. We received mixed views about the informal policy of the trust to rotate staff around the UHL midwifery unit. Some staff expressed concerns, and stated their preference was to stay in one area, although they also conceded there were benefits in being able to regularly update their practice in other areas.

We observed multidisciplinary meetings, handovers and ward rounds, and saw that there was effective joint working between departments. Teams felt there was good access to care from other specialties while a patient was in the maternity department. Joint clinics were held – for example, in haematology, safeguarding and diabetes. Positive feedback was gathered from staff in the emergency Department, who commented on the prompt response they received when midwifery input was required. Most midwives said they had established positive, professional working relationships with clinical staff, and found them prompt to respond to queries.

Are maternity and family planning services caring?

Good

Compassion, dignity and empathy

In February 2013, UHL surveyed132 women as part of the CQC Maternity Service Survey. The trust performed about the same as other trusts in most questions in the survey.

However, the trust performed worse than other trusts on questions around postnatal hospital care. Respondents answered particularly negatively to the question, "Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?" This question caused the trust to highlight a 'risk' against as part of the CQC Intelligent Monitoring programme (which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations). In the CQC survey all areas relating to labour and birth scored adequately; however two of the five areas relating to care after birth scored below average.

Lewisham Hospital scored well below the England average on the new Maternity Friends and Family Test in December 2013, though response rates were extremely low (between 3% and4%). These data are still experimental so should be treated with extreme caution. However, the trust did achieve a response rate of 34% of the question on postnatal care, though only managed a score of 38 out of 100, which is well below the England average of 66.

There is a designated bereavement room on labour ward, however, there was an unfilled vacancy for a bereavement

counsellor, although internal cover is provided. We had considerable concerns as to the level of support provided to staff in the distressing event of a maternal death (death of the mother in childbirth). Senior staff were dismissive of the effect on midwifery staff (midwives and clinicians) if a maternal death occurred outside of the midwifery unit, but within the hospital. We revisited this during our unannounced visit subsequent to the main inspection. We were told that hospital-based staff were offered support, although the matron did not know if the community midwives were offered any form of support or counselling. We felt this was an oversight and senior staff had underestimated the effect a maternal death could have on staff. This, in turn, could impact on staff wellbeing and morale.

Involvement in care

Feedback from the patients and partners we spoke with was generally positive. For example, one partner told us "everyone here is absolutely fantastic. They (midwives) explained everything at each step". Positive interactions were observed between staff and patients. Prior to booking, patients can access the trust website for information about the maternity services provided at UHL. With the exception of some patients accessing information on the birth centre, we did not find that patients used this option.

Trust and respect

We spoke to patients about their antenatal care. Feedback was again positive. One patient told us they had they had come to the birth centre several times thinking they were in labour but were (correctly) sent home. At one point they were sent to labour ward for assessment as there were not enough midwives in the birth centre. They were very happy that when labour did start, they were able to deliver as planned in the birth centre.

Emotional support

Patients told us staff were willing to answer questions and kept them informed. The said staff explained everything at each step. One patient in the birth centre said "I can't praise the midwives enough. I had one-to-one care". Another patient in the birth centre said, "it has been really good. The only issue was the midwife had the on-call phone on her which kept ringing and was very distracting whilst I was in labour". We spoke to one patient who had started her labour in the birth centre, but was moved to labour ward as some complications set in. She told us that the decision to transfer her was absolutely the right one, and she felt reassured by the action taken.

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

Requires improvement

Meeting people's needs

Maternity bed occupancy at UHL between July and September 2013 has been at 87.6%, which is well above the England average of 58.6%. Despite this high bed occupancy rate, the unit has not had to suspend its services in the last year due to having reached full capacity.

In terms of antenatal care, both units have consistently shown a low rate for women booking their deliveries with the service within 12 weeks and six days of gestation. According to its maternity dashboard, UHL has shown a booking rate of between 70%–80% for these patients, though this has risen significantly to 87% in January 2014, which was indicative of improving accessibility of antenatal care.

The maternity unit offered a range of pain relief methods, including the availability of epidurals at all times. The unit also had a dedicated anaesthetist for maternity services.

An electronic midwife (EDIE) has recently been introduced to UHL. This is a popular resource at the QEH. Patients can seek non-urgent advice and information via social media options. It was disappointing to find that midwives were not aware of the Information for Parents service on the NHS Choices website, as it is an extremely useful resource and patients could be signposted towards it.

Patients appreciated the facilities for partners, who were enabled to stay at the hospital. Kitchen facilities were also provided.

Access to services

Staff told us that bed occupancy was high (actually 87.6% against the England average of 58.6%. The Royal College of Midwives recommends the bed occupancy rate for maternity should be below 75%), and this sometimes led to patients being transferred between the birth centre and

Maternity and family planning

labour ward. We were informed that the transfer rate between the two clinical areas was 10%, however, the data provided to us indicated this was actually a much higher 30%. The reasons for transfer are varied, and include pain relief or fetal distress. If a patient was transferred, the birth centre midwife would accompany them. This provided continuity of care, but consequently left the birth centre with insufficient staff. We also saw, however, that if the birth centre was not at capacity, birth centre staff would assess patients on the labour ward to see if any met their criteria, resulting in transfer if appropriate.

Although the trust's average maternity bed occupancy falls outside the Royal College of Nursing guidelines, and is significantly above the England average, the maternity unit has not had to close due to being over capacity.

We saw that there was appropriate care for people with complex medical needs – for example, through joint clinics. The service has a safeguarding midwife and specialist in infant feeding.

Vulnerable patients and capacity

Staff have access to translation services if a patient does not speak English as a first language and needs assistance. Various initiatives are underway to reach and inform different sections of the community. For example, there is an outreach team for teenage pregnancies, and an outreach project working with the Vietnamese community. There is also ongoing work with GPs to ensure that people from all communities can access midwifery services in a timely manner.

We were considerably concerned to find that there were no follow-up clinics for women who had undergone an emergency caesarean section. Patients were seen by an F1 (doctor in training)_ grade doctor prior to discharge and given a written summary of what had taken place. Staff we spoke with felt that this, and a verbal explanation when they were in the recovery room, was adequate. This meant that patients were not given the opportunity to return to talk through with obstetricians any complications they may have had during their child's birth, to discuss any concerns, or even simply for reassurance.

Leaving hospital

Patients told us they were given information packs to take home, and staff ensured they were happy with breastfeeding (if that was their choice) before they were discharged. The pack contained information on, for example, cot cleaning, the community midwives and what to do in an emergency. One patient expressed concern that there may be a lack of information regarding postnatal care if there was a complicated delivery.

Patients were not provided with a personal child health record (an initiative in England often called 'the red book') on discharge, however, they were provided with the local equivalent. In the birth centre a number of midwives were trained in neonatal assessment, to help facilitate the discharge process.

Learning from experiences, concerns and complaints

Matrons told us they had monthly team meetings where they discussed practice issues, outcomes of incidents and complaints. Some recent complaints had been from women who had been admitted for elective caesarean sections, were kept 'nil by mouth', but then had their operations pushed back due to an emergency. To allay this, from the beginning of March 2014, the hospital increased its elective caesarean section list to three each week.

Are maternity and family planning services well-led?

Requires improvement

Vision, strategy and risks

The trust had a maternity services action plan in place, aimed at satisfying the required standard of care. The objectives of the plan included providing consistently safe, high-quality, patient-focused services, and creating a strong, unified, sustainable and well-governed organisation. Staff on the wards said that, for them, this meant providing safe, caring and effective care; they felt that the new trust had taken some initial steps to meet these objectives, such as acknowledging there were staffing deficits, and increasing the number of supervising midwives.

We found that some senior managers were vague about the risks they faced, and the action taken to address them. For example, the potential high level of risk associated with discharging women home after an emergency caesarean section without a follow-up had not been acknowledged. The lack of consultant ward rounds had been identified as

a cause for concern. Some managers were not fully aware of the areas they were responsible for, which meant it was difficult to establish that appropriate risk assessments had been carried out.

Quality, performance and problems

As part of its drive to improve the quality of maternity care, in 2013 the Royal College of Obstetricians and Gynaecologists published its first report describing variation in maternity care among maternity units in England, with over 1,000 deliveries per year, with the intention of enabling each trust to compare the performance of their unit against others and use it as a basis for reflection on current practice. Trusts were individually sent a copy of the report, asked to share the data with relevant staff and to take appropriate action where necessary. We requested feedback from the trust regarding the Royal College's report for UHL. This was not forthcoming as no one we spoke with appeared to know what the report was. This is of concern as the data collected for UHL indicated some improvements were needed. [Post inspection note: lead staff in the trust state that this information was not sent to the trust]

The hospital had an maternity services liasion committee with clinical representation.

Leadership and culture

UHL had shown a particular high rate of midwife absence through sickness of 6.7% in June 2013, compared to the England of 4.3%. This may be an indication of low staff morale. It should be noted, however, that in our focus group with midwives the feedback was positive. Midwives told us they had been sent an email about the focus group and were encouraged to attend. Staff told us they had a "good feeling" about the new trust and thought it was supportive of change.

UHL also showed a poor supervisor to midwife ratio, with one supervisor of midwives to 21 midwives, according to the local supervising authority midwifery officer annual report in March 2013. This compared unfavourably to the recommended ratio of one supervisor to every 15 midwives. At the time of our visit, the number of supervisors had been increased and the trust informed us they now complied with the recommended ratio. All of the midwives we spoke with told us that supervision had greatly improved, and they all had a named supervisor.

In terms of the training of junior doctors, the trust performed largely within expectations in the General Medical Council National Training Survey 2013 for Obstetrics and Gynaecology. However, it did perform worse than expected in the area of 'handovers'. One of the consultants on the labour ward told us they thought the trainees "were happy", and this was reflected in comments received from junior doctors.

Patient experiences and staff involvement and engagement

Midwives felt they provided a good service to what was, in their view, a high-risk population. Outcomes were viewed as good. We were told by staff that they often received transfer requests when people heard about the birth centre. One patient told us they had searched for the birth centre on the internet and, as a result, had requested a transfer to UHL.

The maternity department has an action plan in place which contained a number of objectives relating to, for example, quality of care and governance. The trust should note, however, that none of the staff we spoke with said they had been involved in any consultations or audits relating to the objectives. Their view was very much that governance was led by risk managers and clinicians, which made it difficult for them to take ownership.

Learning, improvement, innovation and sustainability

Everyone received a 'Take 5' weekly briefing email from the patient safety coordinator. They viewed this as a useful learning tool. How the briefing was used varied across the department: some managers used the briefing in team meetings and included clinicians; others used it for the basis of discussion between midwives. It was used across the department and the variation in approach showed that staff were tailoring the brief to meet their immediate working practices.

Staff at our focus group told us that they all received annual appraisals. They also said that training was good, and their mandatory training was up to date. However, the provider may find it useful to note that the training records did not reflect this, and indicated a low completion rate in a number of areas. For example, the completion rate of training in blood management was only 57%.

Senior staff in the birth centre outlined the improvements made to the student mentorship programme, which

included an increase in the number of mentors available, regular reflection meetings and teaching forums, the introduction of a 'champion' for each key area (such as the community and labour ward) and 'skills and drills' days where students were given scenarios to act through. Senior staff told us the feedback from students had been very positive.

Good

Services for children & young people

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

Information about the service

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

At the University Hospital Lewisham (UHL) site there is a 16 bed day care unit, a 24 hour paediatric emergency department; an inpatient ward of 16 beds; a neonatal unit and a comprehensive outpatient department which provides for a wide range of services.

Summary of findings

We spoke to a four parents with their children, two clinicians, eight nursing and five ancillary staff. We received positive feedback from parents and children with regard to the care they received, and the interaction between them, nurses and doctors. Staff were proud of the care they gave. The education provision for children whilst in hospital was good. Facilities were child friendly. There was evidence of good multidisciplinary working across specialities, but little evidence of joint working across the two hospital sites.

We found however that staff shortages were impacting on the quality of care that was being provided. This, coupled with some equipment shortages, lack of learning from incidents, and lack of action following audits meant that the service was not performing as well as could be expected.

Good

Services for children & young people

Are children's care services safe?

Requires improvement

Safety in the past

There were no Never Events (an event so serious it should never happen) at the trust relating to children and young people between December 2012 and November 2013. Between July 2012 and June 2013 there were 10 moderate National Reporting and Learning System (NRLS) incidents reported, which are not mandatory for trusts to report. This shows that there is a reporting culture at the trust. The trust reported one death through the NRLS system.

Both the NRLS death and serious incident related to patients being assessed and wrongly discharged or misdiagnosed, which led to the incident occurring.

Learning and improvement

As well as the NRLS-reported death, a further death, in similar circumstances, occurred at the Queen Elizabeth Hospital (QEH). There did not appear to be any dissemination of lessons learned from the previous serious incident. We saw that there were longstanding issues on the risk register but fthe trust was dealing with the one issue of equipment servicing. Staff told us that not all grades could report incidents, and there was a lack of explanation for changes. For instance, changes had been made to the way one particular medicine was administered. Staff had not been informed that this was as a result of a number of medication errors.

Systems, processes and practices

The inpatient ward had 33 beds, but had set its capacity at 16 due to the level of demand. This was supplemented by four short stay beds in the A&E department and 16 beds in day care. We were told that the ward was fully staffed, and provided care at a nursing ratio of 1 nurse to 4 patients. There was a supernumerary supervisor and a healthcare assistant.

Staff spoke of the pressure they felt due to vacancies, both among nursing staff and clinicians. Some staff had concerns that clinical standards would drop as a result. The matron told us that a recruitment drive was just concluding and he was hopeful that the vacancies would be filled.

The ward has a nominated 'consultant of the week' to covers the ward Monday to Friday during the day. Another consultant covered evenings and weekends. There was no requirement for the consultant to be physically on site for the whole of this time as a senior registrar was always available. Thereat least one consultant led ward rounds each day.

We found there were clear safeguarding policies and procedures in place. Staff had clear guidance to follow. The trust was also part of the multiagency referral centre for young people mixed up in gangs.

Paediatric resuscitation equipment was available and easily accessible in all areas where children and young people were treated. There was appropriate surgical equipment in theatres and we noted the surgical recovery bays were of a very good standard. The décor was child-appropriate. However, we did find that the servicing of equipment in general was an issue, and staff told us that they sometimes had to borrow equipment from adult wards. There was a shortage of some equipment such as blood pressure monitors.

We were informed that all staff underwent safeguarding training annually. The matron stated that this was compulsory for nursing staff and clinicians, and that all staff were trained to level 3 while safeguarding leads were trained to level 4.

Monitoring safety and responding to risk

We saw that safety was an important factor. On the day unit, for example, there were locks on utility doors, door handles were placed high up on doors to put them out of reach of small hands, and medicines were securely stored. On the inpatient ward, if a child needed to retain their own medication, it was securely stored in a locked cabinet at the bedside.

There was a cleaning rota for all toys and regular testing of electronic play equipment.

We saw that risk assessments were carried out by the Children and Adolescent Mental Health (CAMHS) team where appropriate, but that generally there was a lack of individual risk assessments for children – both on the inpatient ward and the day assessment unit.

We saw that staff used the paediatric early warning system. We reviewed paediatric surgery and found that not all

nursing staff were paediatric trained, which was contrary to Royal College of Nursing guidelines. We also noted that ear, nose and throat surgery was inappropriately carried out by surgeons who were not paediatric specialists.

Anticipation and planning

We were informed that, if a child was admitted who had high dependency needs, then the ratio of staff to patients would fall to 1:2. In such circumstances, the matron told us the capacity of the ward would be reduced until staffing levels could be increased. Bank and agency staff were used, but we were told that they were required to have previous paediatric experience.

We saw that the hospital had planned for additional pressure on the service during the winter. It was able to respond to demand by operating a flexible bed policy.

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

Good

Evidence-based guidance

We saw that most staff were trained in intermediate paediatric life support and some staff were trained at advanced level. All anaesthetists who cared for children and young people had up-to-date competencies in paediatrics.

Monitoring and improvement of outcomes

The trust performed mostly above the upper England quartile in the Children in Pain Audit where patients in pain were given analgesia in a timely manner depending on their pain levels. This is indicative of effective care, however, the trust performed within the England lower quartile for time taken from booking in to leaving the emergency department. The trust performed well in the national neonatal audit, however, this was carried out for the former trust during 2013.

UHL performed better than the England average for monitoring children with diabetes, with a higher percentage of patients having their blood tested by the trust. UHL measured 95.4% of patients with diabetes, whereas the England average was 92.5. This data was taken from the 2011 audit, and is only indicative of previous performance prior to the merger.

The trust is currently working towards attaining the Paediatric Diabetes Best Practice Tariff which was outlined in their governance minutes, although the trust has not yet met the standards. This will set out the best care pathways for patients and ensure the trust is best resourced to meet that care.

Consultant sign-off audit showed that the UHL performed in the lower England quartile in two indicators. The trust's re-admission rates were above the NHS average in October 2013, which is after the merger of hospital sites. The 2012 Feverish Children Audit showed that the trust performed similar to the England average or better, except for one indicator. This indicator was regarding the percentage of patients who have their temperature routinely measured and recorded as part of assessment. From the audits included in the pre-inspection data pack, the trust shows that the children and young people's care is effective, as most of the indicators are above the England average or have met the recommended standard.

Sufficient capacity

We found the facilities were child-friendly. Parents whose children had been admitted for day surgery were very positive about the care received, but critical of the length of time it took to get an appointment post GP referral – up to three months.

Staff explained that the population in their catchment area had expanded, however, the unit was operating at the same capacity level as seven years previously. There had not been any increase in theatre time, for example, which they said contributed to breached waiting time targets.

At the time of our inspection, the inpatient ward had 15 of 16 beds occupied. The assessment unit was 25% occupied, leaving three beds free, while the day care unit was 60% occupied which left six beds available.

We saw that a consultant-led a ward round each day, and children and young people admitted to the department were seen by a consultant paediatrician within the first 24 hours. There was access to a paediatric pharmacist round the clock.

Multidisciplinary working and support

The matron told us that the quality of handovers had improved, and information-sharing was comprehensive. We observed this during a multidisciplinary 'grand' ward round. This was attended by specialists from a number of departments including, for example, community nurses,

dieticians, pharmacists and microbiologists. The matron told us they used a multidisciplinary team approach for any child admitted with special needs, and a similar approach to pain management.

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

Are children's care services caring?

Good

Compassion, dignity and empathy

Parents described staff on the inpatient ward as "lovely". They said staff took time to explain everything to their child, to help allay their fears. We observed positive interaction between one of the ear, nose and throat consultants and parents. The consultant was clear in their explanation, friendly and professional.

We observed parents being well-supported by staff in the recovery room post-surgery. Parents were allowed in the anaesthetic room supported by a paediatric nurse.

There were separate areas on the inpatient ward for children and adolescents. If an adolescent requested, they could talk to a clinician without a parent present. There was no choice with regard to same- or mixed-gender accommodation.

Involvement in care

We saw that children were given an information booklet on arrival on the inpatient ward. This had been reviewed by librarians to ensure if was free of jargon. Staff completed a checklist which included orientating the child to the ward. Leaflets were available to describe different conditions.

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

The care plans we reviewed varied in quality. Where staff had written the plan specifically for the patient, we found the plan to be focussed and individualised. Staff also used pre-printed care plans. We found these impersonal and not reflective of the individual child. We also noted that staff did not always sign the care plans appropriately.

Trust and respect

We asked what facilities were available for older children. The matron told us that a child aged 16 and over would be assessed as to their capacity to determine if they wanted to be admitted to a paediatric ward or an adult ward. If they were deemed capable of deciding, they were given the choice. If they were admitted to an adult ward, they still fell under the care of the consultant paediatricians.

Emotional support

One parent told us that they had not been informed that there was a chaplain at the hospital, and this had impacted on them as they were missing their regular contact with their parish chaplain. This was brought to the attention of staff who immediately rectified this and provided the parent with relevant information.

Children and young people were able to use their mobile phones on the ward to keep in touch with family and friends. Wi-Fi was available for a fee. Play specialists were available, both on the inpatient ward and in the day unit.

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

(for example, to feedback?)

Good

Meeting people's needs

Inpatients can attend school while on the ward. There is a classroom, and teachers would also go to a child's bedside if they were unable to mobilise. The classroom was staffed by qualified teachers and there was good liaison with children's mainstream schools if the admission was lengthy. Mainstream schools were asked to email in work for the patients. Post-discharge, if a child was still not well enough to return to their own school, they could continue to attend the ward classroom. Teachers confirmed they followed the national curriculum, and they had been rated as 'good' by Ofsted.

Good

Services for children & young people

Access to services

A number of parents complained about the high parking costs at the hospital, although arrangements could be made to have this reduced on an individual basis. One also complained at the cost of the television service. Parents appreciated the accommodation that was provided to allow them to stay overnight. They said the accommodation was "great", however, there was not enough space to cater for all parents, so "you had to get there early". Parents also described having to "fight" over pillows as there were not enough to go around.

Vulnerable patients and capacity

Staff had access to the LanguageLine telephone interpreter service if any translations were required. There was a double phone available and interpreters could be requested. However, none of the hospital's information leaflets were available in languages other than English.

We saw that the hospital had a sickle cell specialist to meet the demands of the local population.

Leaving hospital

Discharge plans were discussed at multidisciplinary meetings and there was a multiagency planning pathway in place. The joint acute/community planning meant the discharge process was effective.

Learning from experiences, concerns and complaints

The head of nursing told us they reviewed all complaints received about the children's services, and that these were discussed at governance meetings. We were provided with the outcomes of patient surveys. Children are given a simple survey to complete based on 'Matron Mouse', and are asked to reply using Mouse Mail. The outcomes indicated that over 93% of patients found the staff kind. 77% of patients said they found the hospital a nice place. This was the lowest scoring of the questions asked

Are children's care services well-led?

Good

Vision, strategy and risks

Service managers were able to define their roles and responsibilities and understood potential risks to the service. Regular governance meetings were held and risks escalated but there was a little to evidence what action was taken as a result. Staff at ward level, however, did not have a clear understanding of the trust's vision and values or its strategy to deliver high-quality care to patients.

We were informed that audit 'afternoons' were carried out regularly. Clinical managers felt that there was good reporting of incidents but learning from incidents was not cascaded to ward staff, even though they considered it was dealt with well at an individual level. For example, changes had been made in the way one drug was administered after five errors were noted. Staff not directly involved were unaware of the reason for the changes.

Governance

Senior managers told us governance of both sites was being brought together and acknowledged that there needed to be better information-sharing. The clinical director told us that changes in policy and practice were emailed to all doctors, but they conceded that it would be more effective to disseminate information in a more interactive setting.

We were told the trust was currently evaluating the reporting structure as there were a number of possibly unnecessary levels. Their aim is to have a two-step reporting pathway.

Quality, performance and problems

The General Medical Council Training Survey 2013 questions that related to paediatrics rated all areas as 'similar to expected' except two areas: clinical supervision was rated as being 'better than expected'; however, handovers were rated as being 'worse than expected'. Prior to the inspection, no negative evidence was obtained about the trust within this area.

At ward level, the matron told us that a number of audits were carried out on a regular basis to assess quality. These included daily quality indicators. Staff were required to submit data to the matron with regard to, for example: the controlled drugs book; fridge temperatures; paediatric early warning system scores and pain assessments. The dashboard (performance reporting and tracking system) was checked every six weeks and used as a guide for showing both good practice and where improvement was required.

Leadership and culture

The matron said that senior management were visible. For example, the head of children's services regularly visited

and the chief executive officer had taken on the role of Father Christmas during the last Christmas festivities. Other staff were not as positive, although they did feel the head of nursing was very visible, and regularly 'walked the wards'.

Staff told us they were proud of the work they carried out. They believed they offered a holistic, family-centred service.

Staff told us there was a 'buddy' system in place for newly qualified staff or those new to the department. There was also a band 6 forum for sharing and disseminating information. Staff said they received an annual personal development review and they were offered a named clinical supervisor. In practice, however, they said there was a lack of clinical supervision as staff were left to arrange it themselves, and inevitably they did not find the time to do so. This meant that staff did not receive feedback or guidance about their practice which could impact on the quality of care they gave.

Patient experiences and staff involvement and engagement

We talked with several parents in the day care unit. They told us that they were provided with an information pack prior to admission, and once in the unit everything was explained fully. A pre-assessment had been carried out and they were given post-operative guidance.

They felt that their child had been regularly observed, and staff had made sure they were able to take fluids before being discharged. A play supervisor had undertaken this role and had made it a fun assessment.

Staff told us feedback from patients was encouraged and they were given forms to complete. There was a lack of evidence to indicate that action plans were initiated as a result of feedback. The hospital had produced a specific, child-orientated questionnaire. The analysis of recent questionnaires indicated that children and young people were generally happy with their hospital experience.

Learning, improvement, innovation and sustainability

We saw that a new paediatric early warning system chart was about to be introduced. The previous chart been revised and the escalation procedure slightly amended. This meant that a consultant did not have to automatically come into the hospital when the warning system indicated a potential problem. More junior clinicians could now have a telephone conversation to seek advice and guidance, although the consultant is informed.

The chart used for children to indicate pain had also been revised. The matron commented that a more child-friendly Panda face had been introduced for illustration purposes.

Staff were in the process of devising a new care booklet for use in the department. We saw a draft of the booklet which contained all of the separate forms and records staff currently complete. The matron felt that, once introduced, this would reduce duplication and remove the risk of single sheets going astray.

The matron told us it was a good workplace for teaching and learning. They said there were regular education meetings and practice development sessions were held for pre- and post-registration staff.

Requires improvement

End of life care

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

Information about the service

The Lewisham Macmillan Palliative Care Team (PCT) provides a service to patients with progressive life limiting illness. Conditions include cancer, advanced organ failure (e.g. COPD, heart and renal failure) and neurological diseases.

The team provides end of life care (EoLC) directly to patients throughout the hospital, as well as supporting staff on the wards and providing some training to junior doctors. In the period from 1 April to 31 December 2013, 263 patients were admitted and identified as receiving EoLC or palliative care; and there were 104 deaths of people who were identified receiving EoLC or palliative care during the same period.

We spoke with a number of patients, relatives, EoL palliative care team, bereavement services, mortuary staff, clinical nurse specialists and consultants.

Summary of findings

At the time of our inspection previous end of life pathway best practice guidance was under review. The Liverpool CAre Pathway (LCP) was being phased out. A review on what would replace this was underway. This meant that the wards were potentially using guidance from a number of different national guideline bodies. There were no clear guidelines on when and how to involve the palliative care team for people who reaching the end of their life. However, the Trust had plans to introduce a clear framework for all staff to use on the principles of care for the dying patient. A joint steering group between University Hospital Lewisham and Queen Elizabeth Hospital was due to present the principles to the board in March or April 2014. The agreed principles were planned to fully support staff training.

There were about 670 deaths a year at the UHL. Staff were unable to tell us how many deaths were related to cancer and how many related to other long term illness that required end of life / palliative care. Therefore we were unable to ascertain whether those patients receiving end of life care (EoLC) were appropriate for treatment by the palliative team at the hospital. We also could not find out how many of those people were patients receiving oncology services or patients receiving care for other long term conditions such as COPD, heart failure or dementia.

The patients and relatives we spoke with told us they felt supported and involved in decisions. We found that the specialist palliative care team (SPCT) were caring and supportive. They were aware of the people under

Requires improvement

End of life care

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

Most of the staff on the ward treated patients and their relatives with compassion and thought. However we were told of two occasions in the previous two months where relatives did not find out about their family members prognosis or deterioration in an appropriate manner. The SPCT felt that ward staff did not always engage in palliative care and EoLC training and would like to see a greater understanding of how to support people at this time of their life.

The staff at the bereavement office and mortuary went out of their way to ensure that the deceased were treated with respect and dignity, and families and friends were treated compassionately. However, they found the environment they worked in was in need of redecoration and the walk to the mortuary and bereavement office was described as unpleasant for people attending this area.

An issue was also raised with us about ward staff wrapping bodies too tightly before they are transferred from the ward to mortuary. This caused marks and possible disfigurement to the deceased and was distressing to anyone who wished to view the person after they had died.

There were no audits or assessments to monitor how well the team, including the bereavement office and mortuary staff, performed or to identify any concerns or issues.

Are end of life care services safe?

Requires improvement

Safety in the past

Lewisham and Greenwich NHS Trust provides services at three main hospitals. The hospital recently merged with Queen Elizabeth Hospitals following the split of South London Hospital NHS Trust (SLHT). The new merged trust (Lewisham and Greenwich NHS Trust) began operating servics in October at these locations. From November 2012 to October 2013, 757 deaths occurred across the UHL site. Nine of these deaths occurred in elective care with the remaining 748 within non-elective care.

Learning and improvement

There was an EoL care steering group which reviewed complaints and identify any themes from them. The Clinical Nurse Specialists told us that this information is currently underutilised. However, there are plans to measuring quality through clinical quality indicators, metrics and dashboards, but staff were unsure of when this would be implemented.

Systems, processes and practices

The Department of Health had recently asked all acute hospital trusts to undertake an immediate clinical review of patients receiving EoLC. This was in response to the national independent review 'More Care, Less Pathway: A review of the Liverpool Care Pathway (LCP)' published in July 2013. At the time of our inspection the Trust was undertaking a review, working with the London Cancer Alliance Pathway Groups on the Principles of Care for the Dying Patient. A UHL and QE joint EoLC steering group were reviewing the principles and proposing Trust wide principles to the board in March or April 2014.

At the time of our inspection we found there was no clear understanding of which policy to follow for EoLC, this led to multiple approaches being taken to care for these patients. The Trust policy and procedure was under review and there was a steering group reviewing the 'More Care Less Pathway: A review of the Liverpool Care Pathway (LCP)' recommendations. In the interim we found some staff were still using the 'essence' of the LCP, while others were relying on their own experience and network guidance, such as Marie Curie, a 16 point palliative care plan or South East London Cancer Network, this varied across each ward.

Requires improvement

End of life care

Survival following Cardio Pulmonary Resuscitation (CPR) in adults is between 5-20% depending on the circumstances. Although CPR can be attempted on any person prior to death, there comes a time for some people when it is not in their best interests to do so. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to enable the person to die with dignity. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) refers to not making efforts to restart breathing and/or the heart in cases of respiratory / cardiac arrest. It does not refer to any other interventions/treatment/care such as fluid replacement, feeding, antibiotics etc.. Consultants / General Practitioners are responsible for making DNACPR decisions and they should make every effort to involve the individual in the decision, and if appropriate, involve relevant others in the making of the decision

In most cases the DNACPR forms were completed appropriately and there was evidence of clear conversations with the patient. However, we saw some case we saw forms had not been fully completed. Information such as when and what discussions had taken place with the individual, and if appropriate, with other relevant people, was missing from the form. It was difficult for us to identify whether discussions had taken place or not, or whether it was a recording error. We also found one form had the name of another patient crossed out at the top and the date had been altered. In another case the form had not been signed by the senior decision maker. This meant we could not be sure that every patient receiving EoLC, and if appropriate other relevant people, had been involved in discussions about the suitability of patient receiving CPR in the event that their heart or breathing stopped. However the staff we spoke with were aware which patients were not to be resuscitated.

There was an inconsistent approach to reviewing appropriate EoLC medication. Staff relied on the medical team to review the patient's notes. The palliative care nurse prescribers reviewed medication and made any adjustments. However the palliative care team felt the ward staff were sometimes slow in responding to the changes which meant people could be continuing with medication that was not required or not receiving an increased dose of medication to help with symptoms or pain in a timely manner.

The palliative care team typed their notes onto the IT system after their review. They printed a copy of the review and place it in the patient's file. Patient reviews/updates should be filed in time order so that it can be viewed chronologically and any improvement or deterioration can be easily identified. We found in some cases the palliative care teams typed review notes were refiled by nursing staff as they looked similar to test results. We also saw where typed notes were in the correct place the lines on the preceding pages of the patient's care record had not been crossed out to prevent someone writing on it. This meant another member of staff could write other updates in front of the most recent palliative care review and therefore the continuity of care notes would be out of time order. This meant staff could miss important information relating to the patient's care and welfare.

Monitoring safety and responding to risk

Guys and St Thomas' hospital provided consultant cover and there were clinical nurse specialists onsite for 24hours every day. Each patient had a named member of staff on a daily basis, however this was not as per EoLC best practise, which suggests that patients have the same member of staff as their key-nurse until they leave the ward.

One palliative care nurse had been on leave and was unable to have a face to face hand over with the previous nurse in charge. This meant they were required to read notes and rely on a written hand over sheet for all the information relating to the patients receiving palliative care.

The hospital introduced safer syringe drivers as directed by the National Patients Safety Agency (NPSA) alert.

Records showed that it took six weeks from admission for a dementia nurse to see the patient. Their records also indicated the name of their next of kin. However, this was found to be the patient's next door neighbour, who did not see themselves as the next of kin. Discussions relating to the patient's care pathway and resuscitation status had been had with them.

Are end of life care services effective?

(for example, treatment is effective)

Requires improvement

Evidence-based guidance

In October 2013 South London Healthcare NHS Trust [SLHT] dissolved and Lewisham Healthcare NHS Trust

merged with Queen Elizabeth Hospital. At the point of merger, Lewisham Healthcare NHS trust had a published 'Recognising the Deteriorating Patient Policy'. SLHT also had a published 'Early Warning Scoring and Vital Signs Policy'. Since merging in October 2013, the new Lewisham and Greenwich NHS Trust have a number of policies which are currently under review. The Recognising the Deteriorating Patient and Early Warning Scoring System Policy was currently under review by one of the Trust Groups - Aspiring to Excellence Groups.

The Department of Health had also recently asked all acute hospital trusts to undertake an immediate clinical review of patients on receiving EoLC. This was in response to the national independent review 'More Care, Less Pathway: A review of the Liverpool Care Pathway (LCP)' published in July 2013. At the time of our inspection the Trust was undertaking a review, working with the London Cancer Alliance Pathway Groups on the Principles of Care for the Dying Patient. A UHL and QE joint EoLC steering group were reviewing the principles and proposing Trust wide principles to the board in March or April 2014. Staff were aware that the hospital was reviewing the EoLC policy and procedures some staff were using the principles of the LCP, while other staff were using a matched alternative. This meant there was an inconsistency in approach across all the wards where patients were receiving EoLC.

We also noticed an inconsistent approach to anticipatory prescribing for symptoms of pain, respiratory tract secretions, agitation, nausea and vomiting, and dyspnoea. In some cases we saw written in the patient notes that their pain should be monitored and scored, however there was no evidence of the scoring during observations. We also saw some patients who were given morphine had not been prescribed anti-nausea medication as would have been expected.

Lewisham hospital used the Proactive Elderly Advance Care (PEACE) pathway for elderly patients who were coming to the end of their life. It clearly sets out the protocols and actions staff are required to follow to ensure that discussions with elderly patients, and if appropriate anyone else involved in their care and welfare (including the palliative care team), are had and the options are presented and recorded appropriately.

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

Some of the records we checked showed that the family had been involved in any do not attempt resuscitation (DNACPR) decisions. However, there were also a number of records with incomplete forms, or no written evidence of the family involvement.

Monitoring and improvement of outcomes

The National Care of the Dying Audit for Hospitals (NCDAH) scored the UHL as above the England average for access to information relating to death and dying in order to support care in the last hours or days of life (86% against 71%) and for access to specialist support, such as palliative care (88% against 63%) and communication with relatives or carers in regard to a person's plan of care to help understanding (79% against 71%). The areas the Trust scored lower than the national average in were related to the clinical protocols and provisions promoting privacy, dignity and respect up to and including after the death of a patient (67% against 78%), ongoing routine assessment of the patient, relatives or carers (71% against 76%) and compliance with completion of the Liverpool Care Pathway (or matched alternative) (60% against 67%). In all other areas they scored the same as the national average, this included, care of the dying continuing education, training and audits, and anticipatory prescribing for the five key symptoms that may develop in the last hours of days of life.

The patient experience steering committee meeting minutes from November 2013 identified some gaps in advice and knowledge and as a result the patient information leaflet was reviewed, advanced communication skills training was implemented, EoLC care training was being reviewed with consideration being given to integrate it into all staff training and consideration is being given to provision of a structured training programme to staff on cancer care and a psychologist was recruited for the assessment and support of patients psychological needs.

Staff, equipment and facilities

Sage and Thyme training, a course in communication, had been rolled out to all staff. The course was designed to train all grades of staff in how to listen and respond to patients or carers who are distressed or concerned. It places published research evidence about effective

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communication skills within a memorable structure for clinical practice. This was to help staff in how to have difficult conversations with people. Most of the multidisciplinary team had been trained in advanced communications skills.

The palliative care team (PCT) were frustrated in the lack of ward staff engagement in education surrounding palliative care and EoL planning. The PCT told us they discussed their role at the junior doctor induction course to make them aware when to involve the PCT in patient's care. However, they found that most doctors would involve the pain management or oncology teams and it would be those teams that would refer patients to the palliative care team.

Multidisciplinary working and support

Multidisciplinary meeting took place weekly between a community and a hospital Macmillan nurse, the principle for palliative care, a nutritionist, a counsellor or psychologist and chaplaincy. At the meeting they discuss the patients that have died in the previous week, new patients admitted to the hospital or being supported within the community. This means that patients were supported with their medical, social, spiritual and mental health, and staff had an opportunity to share their thoughts and feelings around the people they were caring for.

There was a fast track system between A&E and the wards to admit patients receiving EoLC to a ward quickly. Wards were also able to step down patients who were less ill to alternative wards for patients who required need appropriate support as they were coming to the end of their life.

The chaplains also report into the department for patient experience. This helps with monitoring any issues of concerns and allows a channel to suggest ways to improve the care and welfare of patients who have died and for people who are grieving.

Are end of life care services caring?

Requires improvement

The National Care of the Dying Audit for Hospitals (NCDAH) scored UHL lower than the national average in clinical protocols and provisions promoting privacy, dignity and respect up to and including after the death of a patient (67% against 78%) and ongoing routine assessment of the patient, relatives or carers (71% against 76%).

Compassion, dignity and empathy

We observed staff and patient interactions were respectful and kind. The staff we spoke with appeared to have a rapport with their patients and showed empathy and understanding for the family and friends. When patients were approaching the end of their life their family and friends were not restricted by visiting times and made to feel welcome to stay for as long as they needed.

People were supported in eating and drinking for as long as they were able to. If patients were no longer able to eat or drink best interest meetings were held with the involvement of the family to decide on the appropriate course of action.

The hospital had a chaplaincy services and could access different faiths. However patients were not routinely asked by staff if the service was something they would like to use and relied on patients and / or their families to ask.

The staff in the mortuary described how they prepared the deceased person prior to their friends or relatives viewing them. However, they told us there were some issues with nursing staff on the wards wrapping bodies too tightly after death prior for their transfer to the mortuary. Over wrapping of the body can mark and dent the body and this causes distress to families who wish to view their relative.

Involvement in care

Records / notes showed that patients and their next of kin, if appropriate, were involved in discussions about the patient's care, any deterioration, procedures, discharge plans and EoLC.

There was a mixed response from relatives as to how involved they felt in the care and support decisions. Some people told us they felt involved and informed while another person told us the doctors were vague and not clear in what they were discussing.

Trust and respect

Patients we spoke with talked highly of the staff with regard to the way staff spoke with them. Staff were described as "polite" and "informative". However, a family member told

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us they overheard nurses talking at the desk about their relative's prognosis which they had not been informed about. There had been no apology to the family for finding out about their relative's life expectancy in that way.

Emotional support

Staff told us there was no written guidance for staff on how to support families and friends after someone had died in hospital. However we were told the EoLC steering group reviewing how they can support families after someone had dies in hospital as part of the 'Principles of care for a dying patient'

The ward gave the families a booklet on what to expect after someone had died in hospital. However, the first page you turn to advertised a funeral directors which may not be seen as particularly caring. The book was full of factual information and the emotions you could expect to experience.

A chaplaincy service was available at the hospital and there were local links with other faiths, for example the local Islamic Centre. Staff could also contact the hospital operator who had a list of other faiths that could be accessed should patients require them. There was a multi-faith chapel. The service held an annual event called 'Forget-me-not' for children, and baby deaths during or post pregnancy.

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

(for example, to feedback?)

Requires improvement

Meeting people's needs

Meetings were held between different divisions within the hospital with regard to placing patients in the most appropriate ward/environment for their needs. Staff felt there was much more of a focus on discussing EoLC for some patients. For example, if it was identified that someone was nearing the end of their life the ITU department would not necessarily be seen as the most appropriate place for a patient to be moved to while they deteriorated. Or if a person within ITU was unlikely to make a recovery and was supported to live by means of equipment, it would be seen as appropriate to discuss alternative solutions on how to remain comfortable until their vital organs failed. This meant staff at the hospital accessed a hospital bed in a ward that was most appropriate for the patient's condition and supported them in a way that met their individual needs.

Some wards had a side room where family members could rest away from the patient bed bays if they needed to. Very few wards had rooms on the ward for private discussions and staff told us they would use the day room on the ward. However, in most cases there was access to a private room in another part of the floor the ward was located on.

The staff in the bereavement office and mortuary described the pathway that families of patients who die at the hospital would go through. This included visiting the mortuary to view the body if they wished and the collection of the death certificate and patient's belongings from the bereavement office. We walked the route that people would need to take to get to the two locations. The mortuary was difficult to find and the route took you past bins and rubbish. Staff told us that people were discouraged from visiting the bereavement office as the area was not conducive for people who were grieving. The staff in the mortuary were compassionate and empathetic to the deceased's family and friends. They went the extra mile to ensure deceased patients were treated with dignity and respect, and although the surroundings were not pleasant for people to visit, they made sure people were cared for. People's faiths were accommodated, for example Muslim or Hindu faiths require the body to be washed, this could be done by the staff or family if they wished to. There was a separate grieving room for parents who had a miscarriage or still birth. Moses baskets had been provided by the friends of the hospital to put babies that had passed away.

The A&E department had a separate quiet room for families whose relative had passed away. There was also a separate viewing room next to the quiet room for those who wished to spend some time with their family member or friend.

Bereaved families and friends were given a leaflet offering advice on what to expect in the first few days following a death in hospital. It was a new leaflet full of practical information and the emotional reactions your might experience. We noted that the booklet contained a number of advertisements for funeral directors, probate advice and charities suggesting donations in memory of a loved one.

Requires improvement

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These organisations helped fund the booklet by buying advertising space. Grieving families may not consider it is compassionate or appropriate to turn to the first page of the booklet to find a funeral directors advertisement.

Access to services

The Lewisham Macmillan Palliative Care Team provided a combined hospital and community specialist palliative care service, 7 days week. Advice from a healthcare professional was available 24 hours a day 7 days a week. The combined service also helped the co-ordination of care between hospital and community settings. The team worked closely with district nurse and GPs to support patients and their families for those who wished to die at home whenever it was possible. Hospital inpatient referrals were made with the agreement of the responsible consultant.

Vulnerable patients and capacity

Staff told us they can access an Independent Mental Capacity Advocate (IMCA). An IMCA supports and represents a person who lacks capacity to make a specific decision at a specific time and who has no family or friends who are appropriate to represent them. Regular best interest meetings with family where possible and people involved in patients care were held for people who lacked capacity to make decisions about their care and welfare. However we found one patient who had mental capacity issues had not been assessed or seen by an appropriate person to discuss their care plan. Staff referred to the safeguarding lead who could intervene if it was felt necessary by staff. Pictorial communication used with patients who had communication difficulties or could not speak English. .

Leaving hospital

Patients were discharged safely with the right care and support. The patient's palliative care needs were discussed in-depth, and included psychological and spiritual support, as well as EoLC. This included ensuring support services were in place so that the patient could return home safely or to a nursing home / hospice of their choice.

There was a fast track system available. The fast track co-ordinator told us they could usually get a patient to their home within one and three days, which may not be fast enough; hospitals that are good at end of life discharge can respond in less than one day However, this was reliant on all the relevant departments working together in a timely manner. Delays could occur if specific equipment, such as a hospital bed or commode were not readily available, or the hospice did not have any beds available immediately.

Learning from experiences, concerns and complaints

There was a newly set up steering group set up to review complaints and concerns specific to EoLC. It was too early to identify how well complaints and concerns were responded to.

Are end of life care services well-led?

Requires improvement

Vision, strategy and risks

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

Quality, performance and problems

There appeared to be a disconnection between the specialist palliative care team (SPCT) and the staff on the wards as the roles and responsibilities were not clearly defined. The SPCT told us that it could be hard to engage staff in responding to a patients change in care in a timely manner. For example: a patients medication could change and this can take sometimes for the ward staff to respond to, SPCT staff said they had experienced delays in response to medication changes. From what we were told there appears to be no mechanisms for monitoring the staff on a day-to-day basis to ensure they were responding to a change in a patient's needs appropriately and in a timely manner.

Leadership and culture

The Trust had a non-executive director for EoLC in place, as recommended by the LCP review 'more care, less pathway'. but, the palliative care staff we spoke with were not aware of who the lead was. However, the palliative care steering group did appear to be working hard towards a united approach to EoLC by reviewing EoLC policies and the way forward, including training nurses and doctors in the palliative care teams role and responsibilities.

Requires improvement

End of life care

From talking with UHL nursing staff there seemed to be no clear guidance on when and where staff should refer to the palliative care team. However there was clear evidence the palliative care team was visible on the wards and clinical staff were aware that policies and procedures were being reviewed

Patient experiences and staff involvement and engagement

The hospital used the 'friends and family' test to capture the patients experience of using the hospital services. Staff were involved in the transition the hospital was going through and reviews of procedures. Learning, improvement, innovation and sustainability

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

Requires improvement

Outpatients

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

Information about the service

The outpatients service at University Hospital Lewisham (UHL) was located in two different parts of the hospital over two floors, with areas identified by pink and yellow zones. There were nine suites at the site running a wide range of outpatient services. Clinics included phlebotomy (blood tests), cardiology, chest clinics, rheumatology, orthopaedics, diabetes, dietetics and children's outpatients.

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

Summary of findings

The department lacks space and is too small for the activity it is delivering.

We spoke with a number of patients, clinicians, nursing and administrative staff. We received positive feedback from patients with regard to the care they received from administrative staff, nurses and doctors. Patient's described the staff as "kind, caring and informative". Staff were supportive of one another and felt they went the "extra mile" to ensure patients were cared for well and their privacy maintained. There was evidence of staff ensuring patients' safety in some clinics, however, we found some areas for concern, such as staff at clinic reception areas not being able to view patients who were vulnerable. We also found that patients' privacy was not maintained in some clinics. Therefore, although the staff's interactions with patients were seen as very good, some of the processes and systems in place were not as caring as you would expect.

There was evidence of local divisional meetings between clinical staff where learning was shared. There was also evidence of multidisciplinary working at a senior level. However, there was little evidence of joint working across all the divisions, including the administration services, within the outpatients department. This meant the outpatients department clinics were not sharing learning or practices together, which meant there was an inconsistent approach to the trust's policies and procedures among some staff.

Patients were asked their views about the service and, in particular, the department they were receiving their care and treatment from. There was an electronic kiosk

Requires improvement

Outpatients

system in place to identify patients' views of the outpatient services alone. These pads were located in several places within outpatient's areas or corridors. The information gathered by this system was used to identify patient's views of their outpatient experience. Patients we spoke with had not used the kiosk system and told us they were unaware of it. However, all staff and patients agreed that the main issue for patients were the clinic waiting times, particularly in the pre-assessment, fracture and phlebotomy clinics.

The outpatients department responded to a high demand in appointments, where possible, by arranging longer clinic times or extra clinics on additional days. Satellite specialty clinics were provided by other London hospitals so that patients from area could see specialist consultants locally.

Are outpatients services safe?

Good

Safety in the past

There were no Never Events (incidents so serious they should never happen) reported between December 2012 and November 2013. This included two months of information for Queen Elizabeth Hospital (QEH)and Queen Mary's Hospital (QMH). Two serious incidents were recorded on Strategic Executive Information System (STEIS) for the trust. These related to a radiology/scanning incident where a case of pancreatic cancer was not detected upon first computerised tomography (CT) scan following high clinical and biochemical suspicion. This was later picked up on a second scan. The second incident involved delays in processing bloods.

Between July 2012 and June 2013 there were 17 patient safety incidents reported to the National Reporting and Learning System (NRLS): 15 were identified as causing moderate harm and two for abuse. These were all for the UHL site relating to the time period prior to merger. The largest number of NRLS incidents occurred within the 'other' category (foot health and orthotics) with six (of 17) incidents followed by five within obstetrics and gynaecology. Three of the six incidents in foot health and orthotics related to pressure ulcers.

Learning and improvement

The service learned from incidents. We were given an example of how the radiology department had implemented a mandatory monthly discrepancy meeting to discuss any inconsistencies in practices and procedures within the department. Staff told us they also used this meeting as an opportunity to share individual cases as a learning opportunity. Also, the foot clinic responded to safety data relating to pressure ulcers on the feet and, as a result, the community care team now carried pressure-relieving boots and additional dressings in their vehicles. However, we found that each outpatient department at the hospital was grouped with the division it represented. This meant any learning and improvement stayed within individual divisions. There was no formal opportunity for staff in each outpatient division to share concerns or examples of excellence and to learn from one another..

Outpatients

Governance meetings involving the senior management from each division at the hospital took place where they discussed complaints and the actions taken. Each division also presented a patient experience/story where any learning and actions were outlined. The outcome from these meetings was passed down through the division at departmental meetings. Records showed the outpatients department senior staff had meetings every two months and reported outcomes to departmental staff.

Systems, processes and practices

Staff told us that it was difficult to accommodate patients on stretchers without prior warning as many of the clinic rooms were too small. We saw that all the sinks in the consultation rooms in the cardiorespiratory suite were blocked by essential equipment which made it difficult for clinical staff to wash their hands.

We checked a number of resuscitation trolleys and the oxygen cylinders throughout the outpatient department. We found they were regularly checked and audits of the checks were completed. The cleaning system in the department was easily identifiable and staff were aware of their responsibilities.

We observed that most staff followed recommended hygiene practice and were bare below the elbow, they used the correct hand-washing procedure and wore the correct personal protective equipment such as gloves and aprons as per the best practice guidance. However, we saw that the clinical staff performing the anticoagulant tests did not wear an apron, or if they did, they did not change it between seeing each patient. We also saw that they were not bare below the elbow and did not wash or gel their hands between every patients, (although they did change their gloves each time). We also observed one member of staff write a patient's notes while still wearing the gloves they used to perform the test. They used the same pen without gloves on. This meant there was a risk of passing healthcare-associated infections between patients and staff. This same member of staff was also seen texting on their mobile phone between patients. They also did not wear their NHS identification badge as required as they had forgotten to put it on.

There was a system in place for the A&E department to pick up abnormal x-ray and scans urgently. All routine outpatients x-rays and scans were loaded onto the computer system within 24 to 48 hours. The system alerted the appropriate clinical and administrative staff with the imaging report and patient's condition. However, radiology staff were unable to identify whether the report had been read or received by the clinician. Staff told us that they could spend a considerable amount of time trying to locate clinicians to guarantee they had received any unexpected/ abnormal results to ensure there was no delay in consulting a patient. This meant there could be delays in informing patients of their results.

We found that clinics had appropriate safety checks in relations to patients' safety. For example, staff checked all electrocardiograms (ECGs) before patients left the cardiology clinic. Any changes could indicate a clinical concern so the ECG results were validated prior to the patient leaving the hospital. Most of the staff we spoke with understood how to safeguard vulnerable adults and children from abuse and who to report any concerns to. The managers felt confident that staff would raise any concerns regarding bad practice with them or challenge anyone should they see it. Staff members we spoke with gave us examples of times they had challenged colleagues regarding their working practices.

Monitoring safety and responding to risk

Staff told us that clinic times could be extended or additional clinics could be arranged for Saturday if the demand for the clinics was high. We were told of a cardiologist who complained about patients not being seen in a timely manner; they changed the clinic time to an early start to be able to accommodate more patients and minimise any delay in treatment or procedure.

The staff establishment was stable with many of the nurses having worked within outpatients for a number of years. There were no complaints about the number of staff available. Staff told us any unexpected absences were covered by the trusts staff. The outpatients departments were covered by the clinical nurse manager, four registered nurses (including a senior registered nurse who deputised for the deputy clinical nurse manager) and nine healthcare assistants. The staff schedule showed a consistent number of staff working on a fixed rota.

Anticipation and planning

Staff were very positive about the merger between the two hospital sites. We were told by many staff that they valued the support they were getting throughout the process. Each division from each site had met and systems of

cross-learning were starting to take place. Gaps in any learning or skills were being identified at each location. This meant that, in time, there would be a consistent approach, shared learning and support.

The clinic nurse manager told us they were currently proposing a flexible staff rota so the clinics could meet the service needs better. However, at the time of our inspection this proposal paper was being edited by the head of nursing prior to being submitted to senior management for consideration. Bank (overtime) staff were recruited to fill any staff absences. Where bank staff were not available, or last minute absences occurred, staff could cover from an alternative clinic or a senior healthcare assistant would be available, with a registered nurse in another clinic close by.

There was rarely a delay in the outpatients department receiving people's medical notes prior to their appointment. The patients we spoke with told us their notes were available at their appointments. The records office submitted and prepared people's notes three days in advance of the patient's appointment. There was a clear tracking procedure to trace any notes. This meant it was easy to trace who last had access to a patient's notes. If patients' notes ever went missing, a clinical incident form was used to raise the issue and identify if any procedures needed to be addressed.

As a result of the recent merger between UHL and QEH, a new IT new system called CERNER was being rolled out from the end of March 2014. QEH will implement the system first, followed by Lewisham later in 2014. Any learning from implementation at QEH will be implemented at Lewisham.

Are outpatients services effective?
(for example, treatment is effective)
Not sufficient evidence to rate

Evidence-based guidance

There was a mixed response from UHL nursing staff regarding their knowledge of the NICE guidance, which sets the standards for high-quality healthcare. Some specialist nurses knew the guidance in relation to their specialism, such as diabetes and foot care. A manager told us they would expect that specialist nurses to know the area of the guidance their work relates to, but they would not expect all general nurses to know about it. However, they would expect all nursing staff to meet the Royal College of Nursing standards for high-quality healthcare.

We found the clinical nursing specialist leads sought guidance through national meetings and membership to specialist bodies. Other nursing professionals told us they followed the Royal College of Nursing national guidelines or those from other professional bodies relating to their own clinical interest, such as the Royal College of Radiologists. This meant that, if staff resorted to their professional bodies' guidance before the trust's policies and procedures, there could be an inconsistency in approach and understanding of what was best practice within the trust.

The organisation reviewed care and treatment through local clinical audits and monthly performance dashboards by division. Reviews of care and treatment specifically for the outpatients department were contained within the division each clinic came under. The head of patient experience told us there was a plan in the future to introduce the NHS Friends and Family Test for the outpatients department so they could capture people's experience of the department and display the outcomes and planned actions along with positive comments. However, there was no time scale for this at the time of out inspection.

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

Monitoring and improvement of outcomes

There are three Best Practice Tariffs identified within the National Tariff Payment System 2014–15. The trust did not record any hysteroscopy sterilisation or diagnostic cystoscopies. In an outpatient setting, 394 diagnostic hysteroscopy tariffs were recorded between November 2012 and October 2013. Of these, 373 were at UHL and 10 at QEH. There was an average of 30 a week until October 2013 when the trust merged with QEH. The trust performed in excess of the England median of 282 per year.

A number of outpatient procedures were recorded as being undertaken across UHL; QEH and QMH. The largest number of appointment Healthcare Resource Groups related to

Requires improvement

Outpatients

obstetrics and midwifery care across most sites. The largest remaining group correspond with ear, nose and throat procedures, electrocardiograms or lower genital tract minor procedures.

From November 2012 to October 2013 Lewisham and Greenwich NHS Trust has one of the lowest new to follow-up ratios nationally, with one new patient to 1.43follow-up patients, against the national average of 2.23; this has shown a decreasing trend since August 2012 (including one month of data for QMH and QEH only from October 2013). Reduction in unnecessary follow-up appointments means fewer visits to hospitals for patients. Often a review may be possible by a GP, which could be more convenient. For the top 10 outpatient specialties by volume, the anticoagulant service has a significantly higher new to follow up rate. Seven of the 10 have lower than national average rates.

Staff mix and skills

It had been identified that some staff had not had regular performance reviews where they could discuss their working practices or any issues and concerns. Staff told us that, although they did not have formal performance-related meetings, they felt supported at a local level by their immediate supervisors. Since the merger of the two hospitals, all mandatory and further training, supervision and appraisals were being reviewed.

The cardiorespiratory department had changed provision of a test for chest pain following NICE guidance. The procedure under the guidance takes longer to perform, however, additional staff had not been allocated to assist with the change.

Multidisciplinary working and support

The proportion of patients in the CQC 2011 Outpatients Survey that answered that they were confident of receiving information and copies of letters sent between hospital, doctors and GP at UHL was 56%, which was about the same as other trust. Most of the people we spoke with told us they received a copy of any letters sent to their GP. Staff told us people could opt out of receiving the letter if they wished to. Patients who use the NHS Choose and Book (national electronic appointment system which gives patients a choice of place, date and time for their first outpatient appointment in a hospital) with their GP received a letter from the hospital confirming their chosen appointment time and date.

Records showed that multidisciplinary team meetings took place every month in the cardiology division. Recently meetings had started between UHL and QEH. These meetings, although very new, allowed staff to consider any joint working relationships or consolidation of specialisms, such as sharing radiology procedures and clinics or cardiac catheterisation.

Are outpatients services caring?

Good

Compassion, dignity and empathy

Patients told us they found the staff kind and considerate. Some people described the staff as “doing best they could considering how busy the hospital was”.

We observed staff shouting patients’ names out from the desk they were sitting at. The pin-prick procedure and conversations between the clinician and patient were in full view and hearing of the people in the busy waiting area.

Involvement in care

Most of the patients we spoke with talked highly of the information they received relating to their care. A majority of them told us they received information about what to expect at their appointment (including how long it may take), the name of the consultant they were seeing and contact details. Some patients showed us their letters which identified the names of people working within the clinic they were visiting and which consultant they were seeing. People told us they were fully aware of tests, results and follow-up procedures for appointments.

Trust and respect

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

Emotional support

Some people told us they felt confident that they could contact the clinic if they had any concerns. A parent in the

paediatric outpatients department gave us an example of where they were given a consultant's email address. This meant clinical staff could be contacted if patients or their relatives were worried.

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

Inadequate

Lewisham and Greenwich NHS Trust has a higher than national rate for patients not attending appointments – at 12% compared with the national average of 8% from November 2012 to October 2013. Outpatient services only commenced at QMH and QEH from October 2013 under the management of Lewisham and Greenwich NHS Trust. For this month, they both showed a higher than average national rate for non-attendance, with 17% and 16% respectively. This is higher than the UHL site and, if continues, will contribute to an increasing trust rate for non-attendance. However, it should be noted that the rate at QMH and QEH also included cancelled appointments, therefore, it cannot be ascertained whether the non-attendance or cancelled appointments rates are higher than the national average at these locations. Eight of the top 10 specialties have non-attendance rates higher than the national average. Midwifery and ear, nose and throat healthcare are almost double the national average. This could mean that some patients may not receive the healthcare they required, and the non-attendances wasted hospital resources.

The outpatients plan showed that the department had recognised the high rates. There were ongoing meetings and actions raised to address the situation and drive a lower rate. This included: calling patients to book their first appointment so they could get an appointment that suited their availability; the rebooking of appointments being handled directly by the consultants' secretaries so that any issues relating to their failure to attend their appointment could be identified and patients could choose an alternative appointment that suited them; and reception staff to check and update patient information such as addresses and telephone numbers at the time of appointment. Some of the departments sent text message reminders to patients prior to their appointment.

The percentage of cancelled appointments made by the UHL are in line with the national average. UHL cancelled 2,248 appointments from September 2012 to August 2013. This is an average of 187 a month.

The wait times from the request to test for diagnostic ultrasonography; fluoroscopy (an imaging technique that uses x-rays to obtain real-time moving images of the internal structures of a patient through the use of a fluoroscope) and MRI scans are higher than the England average wait. Between April 2013 to September 2013, Single Photon CT (a nuclear medicine examination) and CT scan waiting times were lower than the national average. This means that the speed at which patients can access diagnostic tests is variable and can mean waiting longer than the national average to receive their test.

According to the survey, the waiting time from test to result was better or comparable with the English average in all cases, except for fluoroscopy which was 0.6 days longer. While we were inspecting, we were told of a delay in people receiving their results of a musculoskeletal lower limb scans. We were told that patients could wait up to three months to find out if their injury had healed correctly. This delay could mean that patients were at risk of sustaining further damage to their injury.

Meeting people's needs

We found the layout of the outpatients department confusing as it was situated in two different buildings over two floors. In some places the environment was hard to navigate and this could make it difficult for people with disabilities. The signage did not always clearly identify where to go. There was a black footprint sticker system on the floor, introduced for patients to follow to the outpatient clinics. However, at one point, the foot prints went off in two different directions and it became confusing as to which one to follow. A volunteer was available at this crossroad to direct you to the service you required. We saw that part of the hospital's outpatients implementation plan included that clear signage was an issue being addressed.

Each outpatient clinic environment varied as many of the areas were restricted by space and the layout of the building. Some waiting areas were not large enough to accommodate the number of people who used it. All the clinics had accessible toilets. The paediatric outpatients department had a children's play area. Staff told us that patient's had commented on the lack of refreshments available in the outpatient areas.

Requires improvement

Outpatients

The main concern for patients was regarding the waiting time in clinics. Many people told us they took a whole day off work if they were attending outpatient clinics, especially the phlebotomy service. Staff told us when clinics were at their busiest people could wait up to 90 minutes to see a clinician. On the day of our inspection a patient waiting for an ultrasound had been in the clinic for 45 minutes before being given a ticket to indicate their place in the queue. It took them 2 ½ hours in total to be seen. We were also told that patients could be waiting for over 30 minutes to be taken back to the ward by porters.

Clinics in Suite 2 of the outpatients department ran up to an hour late at our first inspection. On the day of our second inspection eight patients did not arrive for their appointment that morning, this meant the clinic was very quiet. We revisited suite 2 in the afternoon and found there were about 10 patients waiting for their appointment. Staff told us the gastro clinic always ran late as patients were often double or triple booked to appointment times. We looked at the clinic list and saw that each patient was given a 15-minute appointment. However, many of the appointments had two or three patients allocated to it. This meant that either the consultant had to reduce the time allowed for each patient or the clinic overran to allow the time each patient needed. The clinic finished at 5pm, however, we were told it regularly overran and closed at 6pm. Staff rotas allowed for nursing and administrative staff supporting the clinic to work until this time.

People attending the pre-assessment clinic told us they were left waiting a considerable amount of time between the medical assessments they needed. They told us that staff did not communicate how long they would have to wait. One patient we spoke with at midday told us they had arrived at the hospital at 9.30am and they had had their first assessment procedure at 11am and were waiting for the next process. While another patient told us they had arrived at 10.15am and had their appointment at 12.25pm.

During our inspection we found that it was not always possible for patients to hold a private conversation with the receptionist due to the openness of the area or the volume of people waiting. In some places we saw signs asking patients to stand back from the reception area until it was their turn, however, people sitting in the waiting area could hear people speaking at the reception desk in some of the clinics. This meant that people's privacy was not always protected. Private rooms were available in most of the clinics for patients who wished to speak to a member of staff in confidence, however, we did not see signs telling people that they could request this.

Most of the clinics had private rooms where the door could be shut. However, the cardiorespiratory clinic had a three-bay area with curtains. This meant conversations could be overheard. We saw that the anticoagulant tests were performed in a bay within the waiting area. This bay had a curtain but was not used.

The hospital has two small car parks. Patients told us the parking facilities were inadequate for the size of the hospital. One person told us it was hard to get in and out of some of the spaces as there was little turning room. However, people told us it was convenient to be able to pay on exiting the car park as it alleviated any worry about over staying if their appointment overran.

The hospital had recently introduced a chaperone policy. If someone was examined or treated by a person of the opposite gender, they could request that a person of the same gender was present during their consultation. If patients did not wish to be examined by a clinician of the opposite sex, even with a female chaperone present, they were offered an alternative appointment with a clinician of the same gender at the closest hospital available.

Lewisham hospital provided a walk-in service for people referred from their GP for blood tests. There were responsive satellite clinics held at UHL. These clinics were provided by visiting specialists from other hospitals such as the Kings and Guys and St Thomas' hospitals. The satellite clinics included nephrology, a gut clinic and paediatric cardiology.

The outpatient suites and consultation rooms were of varying size. In some cases the waiting areas could not accommodate the number of patients attending the clinic, such as the fracture clinic, where some people had to stand. We found in the phlebotomy department that patients found it difficult to sit in the waiting area with children in push chairs, and patients who were in wheelchairs were lined up along a wall close to the automatic entrance doors. Staff told us that wheelchair patients were seated near the doors in case of an emergency evacuation. At one point during our visit we counted eight wheelchair users in this area. Many of them were sitting in the draft of the doors, which were

continually opening and closing. It was also difficult for patients to check in at the desk and for other patients to leave the area as the short corridor to the reception desk was heavily congested with wheelchair patients, their carer and people checking into the clinic. In the chest clinic and pre-surgery assessment clinic people waiting for appointment could not sit where they could be seen, therefore staff would not be able to quickly identify if someone required emergency assistance. We were concerned that the door to the paediatric outpatients department opened automatically on arrival. This meant that an unattended child could slip out through the opening when people approached the department doors.

Sufficient capacity

On the day of our first inspection, all the clinics we visited were busy. However, many staff commented on the clinics being quieter than normal. We made an unannounced visit two weeks later and found most of the clinics were quieter than at our previous inspection. At our first inspection the phlebotomy clinic was running a drop-in service along with appointments. This meant there were a large number of people waiting at some peak points during the day. Some people waited for up to 90 minutes during peak times. However, we noticed that patient queues cleared quite quickly and the clinic could be empty at certain points of the day. At the time of our second inspection, the phlebotomy clinic had appointments for new patients only and waiting times were between five and seven minutes.

The clinics which had a higher rate of patient non-attendance double-booked some time slots so that there were fewer wasted appointments. Some clinics also double-booked appointment times in order to fit in urgent cases or patients identified as needing a follow-up as soon as possible. This meant that, on some days, clinics were running over capacity, resulting in long waiting times.

Vulnerable patients and capacity

The hospital had access to interpreting services. With prior notice an interpreter could be arranged for face-to-face interpretation. The hospital also had access to LanguageLine, a telephone interpreting line. Clinical rooms had a pink telephone which connected them to the interpreting service immediately. There were also posters and leaflets available for people to point to and indicate which language they spoke.

There were no policies or procedures for dealing with people with dementia or learning disabilities. However, all the staff resorted to the safeguarding policy and procedure if they felt it was appropriate. Staff told us they would be able to make reasonable adjustments for patients with learning difficulties or dementia with prior warning. Information leaflets were available for people, however, they were not provided in accessible formats such as large print.

The hospital had a vulnerable patient's lead. They were responsible for identifying patients who may require extra assistance or care to attend their appointments. However, one person we spoke with whose relative had challenging behaviour, told us they had been discharged by one of the outpatient clinics their relative needed to attend. The person had been unable to get their relative to the appointment due to their refusal to go. The appointment had been re-arranged three times and as a result of non-attendance their relative was discharged despite staff knowing the circumstances. The person we spoke with was unaware of the vulnerable patient lead person.

Learning from experiences, concerns and complaints

Patient comments and complaints were discussed at governance meetings and any outcome or learning was shared within the division. For example, patients had commented on the lack of visual representation about waiting times for clinics or individual clinicians. We saw staff records reminding staff to ensure that all whiteboards should be clearly visible, updated frequently and staff members should verbally apologise for delays to patients on a frequent basis. However, during our inspection we noticed that many of the whiteboards did not have any information relating to waiting times, and some were positioned in places that could not be easily seen. Many of the patients we spoke with were not aware of how long they would be waiting as there was no signage and staff had not advised them.

During our inspection, we found examples of the hospital monitoring and reviewing performance and data. Some examples are: the cardiorespiratory division reviewed waiting times and responded by putting on extra clinics; the orthopaedic division's best practice was reviewed for implementation by another trust; the administration team reviewed the outpatients letter sent to patients who did not attend their appointment – patients felt it sounded

accusatory as they were blamed for not attending. The hospital amended the letter so that it took into account that some people may not have received the first letter detailing their appointment.

Staff in the rheumatology department told us that healthcare assistants had received phlebotomy training so that they could take patients' blood for routine tests relating to rheumatoid arthritis. This meant that patients were not inconvenienced by going to another department to have blood tests taken. This also alleviated pressure on the haematology department. We also saw that the cardiorespiratory department had changed provision of a test for chest pain following National Institute for Health and Care Excellence (NICE) guidance.

As part of the outpatients department improvement plan staff had recognised the need to capture information about patient's views of the outpatient clinics at the time of their visit. We saw electronic feedback systems around the outpatient area, however, they did not account for individual clinics as they were located in corridors to and from clinic areas. It was therefore hard to know which clinic the data related to. The system had identified that people were not happy with waiting times, but not the clinics that this related to.

Every month the divisions' clinical leads at UHL attended the Patient Experience Strategy Committee where they discussed issues patients had risen, such as the wording of letters, feedback about staff and services, a patient story and any plan of action. The hospital responded to patient forums, such as Healthwatch, about concerns and outcomes.

Are outpatients services well-led?

Requires improvement

Vision, strategy and risks

The staff we spoke with understood the values and vision of the merged trust. Most of the staff were aware of who their managers were. Many staff had met the executive and non-executives of the board at various focus groups about the integration. However, most of the nursing staff did not know who the director of nursing was, although they told us they received a lot of emails from them. Staff told us they were happy about the merger and had felt involved, listened to and supported throughout the process.

Quality, performance and problems

The outpatients department was overseen by the head of nursing and divisional deputy general manager, and reported to the division's general manager and director. The day-to-day nursing structure was led by the outpatient department nurse manager, who was located at UHL. The administrative staff were overseen by the outpatients service manager, who worked across both hospital sites but was located at QEH. The nursing and administrative lead worked together to ensure staff where supported in their roles.

The outpatient departments were covered by the clinical nurse manager, four registered nurses (including a senior registered nurse who deputised for the deputy clinical nurse manager) and nine health care assistants.

The nursing staff were supportive of one another. Many of them told us they worked "like a family" and saw that the whole team went "above and beyond the call" to ensure patients were cared for. However, there was no system of reward or recognition, and any positive comments made by patients were passed on to staff verbally.

Leadership and culture

At the time of our inspection, the hospital was moving from a culture of divisions working in silos with little shared experience across the divisions, to one where the divisions learned from one another through a structure of senior management meetings and information disseminating down through the workforce. This was a positive move to working in a more collaborative way, however, at this point it was too early to judge how well this information was being shared and whether it would bring a more consistent approach across the whole of the outpatients department.

There were separate meetings for the nursing staff and administrative staff, providing an opportunity to discuss issues relating to outpatient departments together and adopting a joint approach in relation to any changes or learning points. For example, following a complaint from a patient, nursing staff were reminded to consider how it looks to patients if too many of them are standing chatting

at the reception desk, especially if waiting times were long. This was not discussed with the administrative staff so that they could ensure they adopted the same procedures as the nursing staff.

Patient experiences and staff involvement and engagement

Electronic kiosks were available within the outpatient clinics for patients to relay their views and opinions of the department. It was planned to introduce the NHS Friends and Family Test, a tool used to measure satisfaction by asking if people would recommend services to their friends and relatives. Staff told us they tried to deal with issues as they arose so that they did not escalate to a full complaint.

We found there was consistency in what frontline staff and senior managers identified as the key challenges in outpatients. They identified waiting time for patients attending clinics and overcrowded waiting areas as the most pressing issue.

Learning, improvement, innovation and sustainability

Multidisciplinary meetings took place on a monthly basis. This allowed teams to share their experience, concerns and learning with one another. Gaps in knowledge regarding any new guidance were explored in divisional governance meetings. This information was disseminated from the outpatient department head of nursing and divisional deputy general manager to the outpatient department nurse manager during their monthly one-to-one supervision meeting. The nurse manager in turn discussed the points at the bi-monthly meeting for nursing staff. Records showed that these meetings took place and covered topics such as infection control, complaints and incidents, training, policies and procedures and updates from the senior nurses meeting. This meant that staff were regularly kept up to date with any relevant information relating to their working practices and the trust.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease disorder or injury Diagnosis and screening	Regulation 12 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2010. Control of Infection. People who use services and others were not protected against the risks associated through infection control systems and hand hygiene. All staff must at all times ensure they follow recommended hand hygiene and 'bare below the elbow' guidance.

Regulated activity	Regulation
Treatment of disease disorder or injury Diagnosis and screening	Regulation 10 (2) (c) (1) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. People who use services and others were not protected against the risks associated through lack of learning and sharing from previous incidents and near misses. The hospital must have a clear process in all areas for learning from previous incidents and near misses, and sharing that learning throughout the teams.

Regulated activity	Regulation
Treatment of disease disorder or injury Diagnosis and screening	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing. People who use services and others were not protected against the risks associated through lack of appropriate staffing levels in clinical areas..

This section is primarily information for the provider

Compliance actions

The hospital must ensure that appropriate levels of staff with the required competencies are available in all clinical areas.

Regulated activity	Regulation
Treatment of disease disorder or injury Diagnosis and screening	Regulation 12 (1) HSCA 2008 (Regulated Activities) Regulations 2010. Cleanliness and Infection Control. People who use services and others were not protected against the risks associated through waste bins not securely stored and the general public having access to contaminated clinical waste and needles. The hospital must have manage the disposal and storage of clinical waste effectively. Bins with clinical waste and hazardous materials be must be locked safely stored.

Regulated activity	Regulation
Treatment of disease disorder or injury Diagnosis and screening	Regulation 16 (2) HSCA 2008 (Regulated Activities) Regulations 2010. Safety, availability and suitability of equipment. People who use services and others were not protected against the risks associated through lack of availability of appropriate equipment. The hospital must ensure that there is appropriate clinical equipment available in all areas.

Regulated activity	Regulation
Treatment of disease disorder or injury Diagnosis and screening	Regulation 9 (b) (1) HSCA 2008 (Regulated Activities) Regulations 2010. Care and welfare of service users. People who use services and others were not protected against the risks associated through lack of understanding and consistent application of policy for the care of patients at the end of their life.

This section is primarily information for the provider

Compliance actions

The hospital must have a consistent policy for end of life care patients and this must be understood by all staff that are required to implement it.