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
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospital Lewisham is a district general hospital providing a full range of services including emergency department, medical, surgery, critical care, maternity and gynaecology, services for children and young people, outpatients and diagnostic imaging and end of life care. It serves the population of the London Borough of Lewisham and the wider area of south east London. Community health services for adults and children and young people are also provided for Lewisham.

We carried out a comprehensive announced inspection at the hospital between 7- 10 March 2017 as part of our planned acute hospital inspection programme. We carried out further unannounced inspections during March 2017.

We rated critical care, and services for children and young people as good. We rated urgent and emergency services (A&E), medical wards, surgery, maternity and gynaecology, outpatients and diagnostic imaging, and end of life care as requires improvement.

In addition we rated community services for adults as good and community services for children and young people as outstanding.

We rated effective care and caring as good and safe care, responsive care and leadership as requires improvement.

We rated University Hospital Lewisham as requires improvement overall.

Our key findings were as follows:

- In some areas, safeguarding training rates and mandatory training rates fell well below the trust's target.
- There were significant shortages of medical, nursing and allied health professional staff in most departments which were having an impact on delivery of care and patient safety. Although the trust was actively trying to recruit into vacant posts there was limited evidence of success.
- In some areas, principally surgery, medicines management processes were not in line with hospital policy or national guidance.
- In medical care, infection control processes, including waste management and adherence to the control of substances hazardous to health guidance, was variable.
- In surgery, we observed numerous breaches of Infection Prevention and Control (IPC) policy, potentially placing patients at significant risk of infection.
- In maternity and gynaecology we found the cleanliness of the environment and some equipment to be of a poor standard, even where green 'I am clean' stickers had been used to show that surface areas and equipment had been cleaned that day.
- In outpatients the environment in general diagnostic imaging was not fit for purpose.
- Whilst care was in line with relevant National Institute for Health and Care Excellence (NICE) and other national and best practice guidelines, there was a risk to clinical outcomes and patient safety due to maternity guidelines not being merged across the Lewisham and Greenwich sites and some guidelines also being out of date.
- The hospital was not providing responsive care in all areas.
- Emergency and urgent services (ED) did not meet the wait to treatment time of one hour during the 12 months from October 2015 to September 2016.
- The hospital breached the admit or discharge within four hours of arrival each month between December 2015 and November 2016
- Waiting times for treatment were well above the England average.
- There were insufficient systems in place to manage the fundamental issues of capacity and flow within the ED. ED performance was below the objectives set out in the delivery plan.

Summary of findings

- In medical care, referral to treatment (RTT) times was not met in rheumatology where 80% of patients were seen within the target of 18 weeks.
- Cancer treatment times did not meet the national two-week standard in relation to lung cancer. In November 2016, 61% of patients were seen within two weeks.
- There were higher than national average numbers of delayed discharges due to problems with access and flow within the hospital. Bed occupancy was also higher than the national average which could limit the service's ability to provide a bed in the event of an emergency.
- In critical care there were higher than national average numbers of delayed discharges due to problems with access and flow within the hospital. Bed occupancy was also higher than the national average which could limit the service's ability to provide a bed in the event of an emergency.
- In outpatients and diagnostic imaging, many patients complained about the waiting times in the outpatient clinics.
- The hospital took significantly longer than their target to investigate and respond to complaints which were not responded to in a timely manner.
- There was limited cross site working with Queen Elizabeth Hospital (QED) For example ED staff did not support each other across sites when there was capacity to do so
- There was a lack of shared working across the trust within outpatients and diagnostic imaging.
- There were issues around local leadership at the hospital. For example on some of medical wards, staff said they were demoralised which they attributed to high vacancy rates, increased workloads, being constantly moved around to cover other wards, and a lack of support from matrons who staff thought should have been doing more to support them.
- Staff across medical wards reported a culture where they were not valued, or respected by matrons.
- There was no documented strategy for the critical care service, and there were concerns around the medical leadership and governance arrangements.
- There was no clinical ownership of the risk register within the surgical directorate.
- In services for children and young people, there were low levels of attendance at governance and safety boards which reduced opportunities for sharing of information to the appropriate people.
- In surgery, the leadership team were unaware of the issues with medication within theatres.
- The leadership team in maternity had overlooked basic issues of cleanliness and infection control.
- Some BME members of staff that we spoke with felt opportunities for staff development, promotion, training and support wasn't always afforded to them in the same way that it was given to their Caucasian counterparts.

However:

- Staff were caring and compassionate and patients were treated with dignity and respect.
- Emotional support was provided by the chaplaincy or multi-faith services.
- Patients expressed a positive view of the care and treatment they received.
- Interactions between staff and patients were individualised, caring and compassionate. Patients and their relatives felt they were treated with dignity and respect. However there were aspects of caring in medical care wards that required improvement.
- There were good examples showing that the needs of people living with mental health issues were being addressed. For example, in ED the child and adolescent mental health services (CAMHS) transformation had improved care with the majority of referrals being seen on the same day (Monday to Friday).
- In medical care, there were various initiatives to increase awareness of dementia through the hospital's dementia strategy.
- In maternity and gynaecology there was good support from The Kaleidoscope Team which worked with vulnerable women and those with mental health needs.
- There was a positive incident reporting culture, and learning from incident investigations was generally shared with staff in a timely manner in ED, critical care and services for children and young people.

Summary of findings

Importantly, the hospital must:

- Ensure effective systems to assess and monitor the quality and safety of the care and treatment in all services across the hospital.
- Address and improve issues of medicines management in surgery and services for children and young people.
- Address and improve issues of cleanliness and infection control in medical care, surgery and maternity and gynaecology.

In addition the hospital should:

- Ensure mandatory training targets are met in all services at the hospital.
- Improve its recruitment processes to mitigate vacancy levels in medical, nursing and allied health professional staff.
- Merge maternity guidelines across both major hospital sites and within community midwifery.
- Address performance targets currently not being met as detailed above.
- Ensure complaints are dealt with in accordance with trust timeline targets.
- Ensure that service and department leaders are aware of issues and concerns within their departments and act to rectify them.
- Identify ways to empower and support staff to make improvements and take the lead in decisions and improvements in their services.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	• Safeguarding training rates and mandatory training rates fall well below the trust's target in many areas. The number of Black breaches was reported at on a steady upward trend during 2016. • The department did not meet the seven day working standard requiring 16 hours consultant presence, seven days a week. Consultant presence in the ED was 15 hours a day Monday to Friday and 14 hours a day at weekends. The ED did not meet the wait to treatment time of one hour during the 12 month from October 201 to September 2016.The ED breached the admit or discharge within four hours of arrival each month between December 2015 and November 2016. • There were insufficient systems in place to manage the fundamental issues of capacity and flow within the ED. ED performance was below the objectives set out in the delivery plan.
Medical care (including older people's care)	Requires improvement 	
Surgery	Requires improvement 	• There were significant issues with medication management within theatres. Including breaches of CQC regulations and The Misuse of Drugs Regulations 2001. • Information governance practices were poor, with patient records being left unlocked and unattended in public areas throughout the hospital. • We observed numerous breaches of Infection Prevention and Control (IPC) policy, potentially placing patients at significant risk of infection. • There were significant vacancy levels within the service, and high staff turnover. • The senior leadership team were unaware of the issues with medication within theatres.

Summary of findings

Critical care

Good

- There was a positive incident reporting culture, and learning from incident investigations was generally shared with staff in a timely manner.
- The environment was clean, infection rates were low and staff complied with infection prevention and control practices. Nursing staffing levels met national standards.
- Systems were in place to ensure the safe supply and administration of medicines.
- Records were safely secured and contained documentation in accordance with national and local standards.
- Care and treatment was delivered in line with national guidelines and best practice guidance.
- There was an ongoing programme of clinical audit which included measurements of patient outcomes.
- Interactions between staff and patients were individualised, caring and compassionate. Patients and their relatives felt they were treated with dignity and respect.

Maternity and gynaecology

Requires improvement

- We found the cleanliness of the environment and some equipment to be of a poor standard, even where green 'I am clean' stickers had been used to show that surface areas and equipment had been cleaned that day.
- We observed that a number of key items of equipment were out of date for safety testing, such as CTG (cardiotocography) and BP (blood pressure) machines, incubators and resuscitaires.
- We found that local leadership at the hospital had overlooked the basic issues of poor cleanliness and out of date equipment checks and the potential clinical, infection control and patient safety risks they posed.
- While the service said it had enough Dopplers to assess babies' health, these appeared to the inspection team to be not readily accessible.
- IV (intravenous) fluids were unsecured in all ward areas, such as delivery rooms and emergency trolleys.
- Mandatory training levels were below the trust's benchmark of 85% compliance across a number of subject areas.

Summary of findings

Services for children and young people

Good

- There was strong evidence of good learning from incidents including sharing of methods cross-site to reduce errors across both sites. All areas we saw were clean and regular audits supported this process.
- Good hand hygiene was maintained rigorously including the introduction of specialist hand gel door dispensers in the neonatal unit to prevent infection. Patients and parents were positive about the compassionate care that they received and we observed kind and respectful care during the inspection.
- Changes had been made to patient pathways, such as the introduction of ward reviews, and referrals to the hospital at home team which had decreased length of stay. There were a low number of formal complaints made about the service and response rates to complaints received were within the agreed timescales. Since the last inspection there had been clear progress in developing cross-site governance structures, risk management and learning.

End of life care

Requires improvement

- End of Life Care (EoLC) did not appear to have a high profile at trust board level.
- The trust performed poorly in the End of life care Audit: Dying in Hospital 2016 and most staff whom we spoke with were unaware of the trust's performance in this.
- Utilisation of end of life care plans was not fully embedded.
- There was poor recognition of when a patient was at end of life.
- Responsibility for end of life care appeared to rest with the Specialist Palliative Care team, rather than being seen as a trust wide responsibility.

Outpatients and diagnostic imaging

Requires improvement

- Many patients complained about the waiting times in the outpatient clinics. They said they had not been given any update information about waiting times.
- There was a lack of shared working across the trust within outpatients. Not all staff were aware of how to use the electronic reporting system.

Summary of findings

- The environment in general diagnostic imaging was not fit for purpose. Some equipment was in urgent need of replacement.
- There was a shortage of radiographers and radiologists.

University Hospital Lewisham

Detailed findings

Services we looked at

Urgent & emergency services; Medical care; Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to University Hospital Lewisham

University Hospital Lewisham (UHL) is part of Lewisham and Greenwich NHS Trust. The trust operates across the London Boroughs of Lewisham and Greenwich and provides community health services in Lewisham operating out of 11 health centres.

UHL has 450 in-patient beds and mainly serves the population of Lewisham and other parts of South East London. It formally merged with Queen Elizabeth Hospital (QEH) Greenwich in late 2013 to form the current trust.

UHL is a district general hospital providing a full range of services including emergency department, medical, surgery, critical care, maternity and gynaecology, services for children and young people, outpatients and diagnostic imaging and end of life care. We inspected all of these services. We also inspected community health services for adults and children and young people in Lewisham. Community services are provided for adults and also for children and young people.

Lewisham is one of the 20% most deprived local authority areas in England with 26% of children defined as living in poverty. Ten out of 29 indicators for health and deprivation are worse than the England average in the borough. Life expectancy in Lewisham is below that of London and England, for both males and females.

The main clinical commissioning group (CCG) for UHL is Lewisham CCG.

In February 2014 UHL had a planned inspection using our new comprehensive methodology and was rated overall as requires improvement.

This most recent inspection was carried out to determine whether the hospital had made progress following their 2014 comprehensive inspection. We inspected each of the eight core services across UHL:

- Urgent and emergency services
- Medical (including older people's care)
- Surgery
- Critical care
- Maternity and Gynaecology
- Services for children and young people
- End of life care
- Outpatients & Diagnostic Imaging

Detailed findings

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Nick Mulholland Care Quality Commission

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

The team of specialists comprised of a consultant in emergency medicine, consultant rheumatologist, general and vascular surgeon, consultant in neuro-anaesthesia and critical care, consultant obstetrician, consultant clinical oncologist and a consultant in palliative care medicine. We were also supported by: senior sister for emergency care; general emergency nurse; infection prevention and control lead nurse; assistant chief nurse; major trauma and orthopaedic nurse specialist; theatre manager; intensive care nurse; head of midwifery; paediatric modern matron and paediatric staff nurse and experts-by-experience.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about UHL. These included local clinical commissioning groups (CCGs); local quality surveillance groups; NHS England; Health Education England (HEE) and Healthwatch

We carried out an announced visit from 7 - 10 March 2017 and unannounced visits were carried out on 12, 20 and 25 March 2017.

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

Whilst on site we interviewed senior and other staff who had responsibilities for the frontline service areas we inspected, as well as those who supported behind the scene services. We requested additional documentation in support of information provided where it had not previously been submitted. Additionally, we reviewed information on the trust's intranet and information displayed in various areas of the hospital.

We spoke with patients and relatives and reviewed a wide range of documentation submitted before, during and following the inspection. We made observations of staff interactions with each other and with patients and other people using the service. The environment and the provision and access to equipment were assessed.

Facts and data about University Hospital Lewisham

At our last inspection published in May 2014 we rated University Hospital Lewisham (UHL) as requires improvement overall. We rated all the core services as requires improvement. Between April 2015 and March 2016 120,202 patients attended the Emergency Department at the hospital. There were 46299 in-patient admissions and 394,848 outpatient attendances during the same period.

Detailed findings

Between January and December 2016, a total of 2163 ambulance waiting time breaches (black breaches) occurred at UHL with 230 in December 2016. Between April 2015 and March 2016, of 191 trust wide complaints in ED, 42 involved ED at UHL. During the same period there were 16 complaints involving surgery at Lewisham. There were 3 reported serious incidents (SI) in maternity services at UHL during the same period.

In the same period medical vacancy rates at UHL were 9.7% against a trust wide rate of 7.6%. However the level of medical locums stood at 9% against a trust wide figure of 11%. Nursing staff vacancy rates were 20% at UHL compared with 15% for the trust overall. The level of bank and agency nursing staff was 11% compared with 13% trust wide. Nursing staff sickness rates were at 7% against a trust wide total of 6%.

Hospital activity included the following:

- From August 2015 to July 2016 ULH had 120,202 A&E attendances
- From July 2015 to June 2016 ULH had 394,848 Outpatient appointments.
- From March 2016 to February 2017, there were 11289 spells of in-patient care.
- From April 2015 to March 2016, there were 11005 surgical spells.
- From February 2016 to January 2017, there were 3866 births.
- From April 2015 to March 2016, there were 7118 spells of care for children and young people.
- From July 2015 to June 2016 ULH had 394,848 Outpatient appointments.
- From December 2015 to November 2016, there were 555 referrals to the specialist palliative care team.

Between January 2016 and December 2016, UHL reported two incidents which were flagged as a Never Events. These were: one in surgery (incorrect knee implant) and one in critical care HDU (incorrectly administered controlled drug).

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The emergency department (ED) at University Hospital Lewisham consists of an Urgent Care Centre (UCC), with eight consulting rooms, a patient waiting area with seating for approximately eight patients and staff work-station area. The main reception check in desk and associated office space for administrative personnel is co-located to the UCC. There are three triage rooms, one UCC waiting area with capacity for approximately 75 patients, major's area with 16 cubicles including a specifically designed designated cubicle for psychiatric patients with two doors, and one for isolation of infectious patients. Within the majors area there is an administrative desk where ambulances check in before being directed to the most appropriate clinical area.

There is a separate children's ED, with waiting room, clinical assessment rooms, four bedded overnight assessment ward and clinical rooms.

A 24 hour a day, seven days per week service is provided by the ED.

The department has a resuscitation area with four bays for adult patients and one bay for paediatric patients and two high dependency unit (HDU) cubicles.

A Clinical Decision Unit (CDU) comprising of 11 beds (six female and five male, with designated bathroom and toilet facilities) is provided. The dedicated imaging department is located between the UCC and majors areas. On the first floor there are four clinical offices for the consultants and matrons. The main ED is immediately adjacent to the children's ED.

The department provides emergency, urgent and non-urgent care to adult patients who attend via emergency ambulance, as transfers from other Healthcare providers, or who walk in. The children's ED consisted of waiting room, three clinical assessment rooms, and a four bedded overnight assessment unit and office space for the matron and consultants.

Between April 2015 and March 2016 120,202 patients attended the Emergency Department (ED) at university hospital Lewisham.

We carried out an announced inspection on 7 – 9 March 2017. We observed care and treatment, looked at 22 patient records, and spoke to 21 members of staff including nurses, doctors, consultants, administrative staff, domestic staff and ambulance crews. We also spoke with 14 patients and nine relatives who were using the service at the time of our inspection.

Urgent and emergency services

Summary of findings

We rated this service as requires improvement because:

- Safeguarding training rates and mandatory training rates were well below the trust's target in many areas.
- The number of Black breaches was reported at on a steady upward trend during 2016.
- In the consultant sign off audit summary from January 2017, the results showed that only 9% of patients were seen by a consultant.
- The department did not meet the seven day working standard requiring 16 hours consultant presence, seven days a week. Consultant presence in the ED was 15 hours a day Monday to Friday and 14 hours a day at weekends.
- The Emergency Department did not meet the national minimum staffing requirement for consultant cover.
- The trust did not meet the wait to treatment time of one hour during the 12 month from October 201 to September 2016.
- The trust breached the admit or discharge within four hours of arrival each month between December 2015 and November 2016
- Between November 2015 and October 2016 the trust's monthly average total time in A&E for admitted patients was consistently higher than the England average.
- The trust took significantly longer than their target to investigate and respond to complaints.
- Waiting times for treatment were well above the England average.
- Review of emergency ambulance cases from time of arrival to initial assessment was worse than the overall England average.
- There were insufficient systems in place to manage the fundamental issues of capacity and flow within the ED. ED performance was below the objectives set out in the delivery plan.
- Staff did not feel part of one trust. They did not support each other across sites when there was capacity to do so

However:

- The investigation, feedback and learning from incidents was demonstrated as good
- Medicines were audited and stored appropriately.
- Patient records and assessments were well documented, written legibly, with clear and concise notes of treatment and care provided.
- Care was in line with relevant National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.
- Food was readily available for patients within the ED at all times.
- Facilities were available in the children's ED assessment ward area for parents to make snacks and drinks for their children.
- The child and adolescent mental health services (CAMHS) transformation has revolutionised the care with the majority of referral being seen on the same day (Monday to Friday).
- Staff were caring and compassionate and patients were treated with dignity and respect.
- Emotional support was provided by the chaplaincy or multi-faith services.
- A play co-ordinator was employed to play with children waiting in the children's ED.
- There was a breastfeeding room within the children's ED.
- Yellow card system used to identify children that had not yet been triaged so that they were not missed.
- There was access to translation services 24 hours a day seven day per week.
- Staff felt well supported by local leadership and the local leadership felt supported by the executive, the departments were well managed.
- Children were encouraged and empowered to provide feedback of their experience through the child friendly feedback forms

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- Many patients who arrived in the ED were not seen by a clinician within 15 minutes of their arrival. This meant patients were at risk of deteriorating and experiencing poor outcomes
- Safeguarding training rates for medical staff were considerably lower than the trust's target in all modules.
- Mandatory safety training rates were lower than the trust's target for nursing staff in 12 out of the 14 modules and in 14 out of 14 modules for medical staff.
- The number of consultants within the adult's ED was lower than the recommended minimum of 12 as per national guidance.
- There were no hand cleaning gels situated at the entrance and exits to the departments.
- There was an upward trend in the monthly "black breaches" reported during the period January to December 2016.
- Waiting times for treatment were well above the England average.
- Review of emergency ambulance cases from time of arrival to initial assessment was worse than the overall England average.

However:

- Incidents were fully investigated and feedback and learning was evidenced.
- The environment was light, bright and fit for purpose and equipment checks were up to date.
- Medicines were stored appropriately.
- Patient records and assessments were well documented, written legibly, with clear and concise notes of treatment and care provided.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between January 2016 and December 2016, the trust reported no incidents which were classified as never events for Urgent and Emergency Care.
- There were 471 other incidents reported in the Emergency Department (ED) between November 2016 and February 2017.
- In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England between January 2016 and December 2016. Of these, the most common type of incident reported was sub-optimal care of the deteriorating patient meeting SI criteria; 38 % (3) of all incidents reported. The second most reported incident type was treatment delay meeting SI criteria; 25 % (2) of all incidents reported. Three of the seven serious incidents reported took place at University Hospital Lewisham.
- We saw evidence that senior staff had conducted appropriate investigations into the serious incidents and made suitable recommendations for improvement. We reviewed two serious investigation reports and each report was sufficiently detailed covering contributory factors, chronology, root cause, recommendations and lessons learnt.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. All serious incidents detailed above were subject to duty of candour.
- All staff we spoke with were able to show us how to report an incident. Incident reporting was very accessible on all desktop computers within the department.
- The two matrons completed and closed all incidents and provided feedback to staff involved and wider staff at morning meetings. We witnessed this during the inspection.
- Monthly mortality and morbidity meetings were held on a trust wide level. We saw that findings from these meetings were incorporated into teaching sessions with medical staff in the ED.

- Data from the Patient Safety Thermometer showed that the ED reported no new hospital acquired pressure ulcers, no falls with harm and no new catheter urinary tract infections between December 2015 and December 2016

Cleanliness, infection control and hygiene

- Staff wore the appropriate uniform and had their hair tied back.
- Personal protective equipment (PPE), including gloves and aprons was available to staff in all areas of the ED. This was in line with Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide.
- The majority of staff were observed to be bare below elbow, which enabled them to wash their hands before and after each patient contact. We observed regular hand washing in practice. However, we did observe two members of staff who did not observe the dress code with regard to having bare arms below their elbows. One was a member of the porter service and the other was mental health liaison nurse. We did not observe either of these people being challenged by staff regarding their long sleeves.
- Monthly hand hygiene audits were carried out. The ED achieved 94% hand hygiene compliance between January 2016 and February 2017 against the trust's target of 95%.
- We observed there were accessible clinical hand washbasins and instructions for good hand washing principles were displayed above these in all clinical areas. Staff were noted to adhere to these whilst we were present.
- Different types of waste were observed to be managed by staff in accordance with Department of Health (2013) HTM 07-01: Safe management of healthcare waste.
- We observed staff disposed of sharps, including needles and glass ampoules in accordance with safe practices outlined in the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Guidance for employers and employees.
- We saw cleaners present in the ED when we inspected. They undertook general cleaning of the department throughout their shift, with more thorough cleaning conducted when the department was less busy. We were shown a folder of guidance that the cleaners adhered to, which included the cleaning products they used and what their ingredients were.
- We observed staff of all grades cleaning the cubicles between patients. Gloves and aprons were worn for this, which was in line with best practice.
- Clinical areas at the point of care were visibly clean.
- Toilets were cleaned on an hourly basis within the department and we saw check sheets which confirmed this.
- Chairs within the main waiting area, adult's and children's EDs were metal and therefore were able to be cleaned regularly. There were chairs covered in wipe-able plastic fabric within the designated mental health cubicle and were in good condition with no visible tears.
- Equipment we observed within the department was visibly clean and some had 'I am clean' stickers attached, although use of these stickers was not consistent in all areas.
- The sluice areas within the department were clean and had no visible stains. There was a cleaning checklist which was updated regularly. The cleaners used colour coded cleaning equipment in line with national guidance. There were kits stored within the sluice room for the cleaning of spillages of blood or other bodily fluids.

Environment and equipment

- The adult and children's EDs were separated with respect to visibility, hearing of activities and conversations.
- The adult ED had a reception desk, large waiting area, urgent care centre (UCC), three triage rooms within the waiting area, majors' area, the resuscitation area, a clinical decision unit (CDU) and x-ray department.
- In the children's ED, there were two triage rooms off the waiting room. One visual desk area where admin staff worked was available to waiting parents and children for information. Clinical rooms and a four bedded assessment ward area.
- All areas of the department, including the resuscitation area, triage and UCC were suitably sized and fit for purpose. There was space in the cubicles for multiple staff to gather should they need to for resuscitation purposes. Private conversations could be had without fear of being overheard.
- The children's ED had an intercom entry system, which required staff within the department to open the door to

allow entry. Within the children's ED the clinical rooms were spacious, visibly clean and had evidence of green "I am clean stickers". Each clinical room had a locked drugs cupboard. All were found to be locked.

- There was a large play area in the children's ED with various items to engage children. Play co-ordinators worked four days per week from 10am to 6pm.
- The ambulance unloading area had a separate entrance, away from the main ambulatory entrance, which allowed a level of privacy for those patients when entering the department.
- The ED had a wide range of specialist equipment, which was visibly clean and had been maintained. Equipment checks in the unit were up to date. Equipment had maintenance stickers showing they had been serviced in the last year. Staff maintained a reliable and documented programme of safety checks. Staff maintained resuscitation equipment with daily documented checks. All emergency drugs and consumables in the resuscitation trollies were in date.
- The resuscitation area had five bays. This included a paediatric resuscitation bay, which had the appropriate specialised equipment to resuscitate children of all sizes. It could be used for adults if required. The resuscitation area was located by the door through which ambulance patients were admitted which allowed for easy access.
- The department had one psychiatric assessment room available. This room had two doors and panic alarm available within it and was visible from the nearby nursing station. The chairs within this were heavy and therefore would be unable to be lifted and used as a weapon.
- There were hand cleaning gel dispensers outside the cubicle area, however there were no hand cleaning gels available on any of the entrance or exit doors within the two EDs.
- We checked six cubicle curtains and observed that they had all been changed in March 2017.
- There were two cubicles within the majors area of the ED that had a solid door entrance. Neither of these doors had a 'do not enter' or 'knock before entering' sign displayed. There was no curtain behind the door which opened directly into the cubicle, which could compromise patient privacy and dignity.
- All patients we observed had a call bell within reach and we saw a patient being advised on how to use the call bell should it be required.

Medicines

- Medicine was stored appropriately and controlled drugs in resuscitation area were in a locked cupboard. We checked the logbook of the last three months and observed checks were carried out daily. The controlled drug (CD) cupboard was kept locked and when opened, we saw that the drugs inside were kept in an orderly fashion. Access to the drugs cupboard was via a keypad
- There were pre-filled syringes for emergency medicines, such as adrenaline and atropine stored on trolleys, which allowed nurses to access them quickly. These were stored in drawers on the trolley, out of reach of patients and their relatives. IV and oral drugs were stored separately. Prescription pads were stored in a locked safe. We randomly checked the stock control register and patient's own drugs register, all were correctly entered.
- Fridges were locked to ensure safety and security of medicines. Staff checked and recorded current fridge temperatures on check sheets, which we saw during the inspection.
- We saw that patient's allergy statuses were routinely recorded on medicines charts. Where applicable, appropriate antibiotics were prescribed and administered to patients, and the care records reviewed demonstrated this.
- There was a dedicated ED pharmacist who checked all patients' medicines. Medicines to take out (TTOS) were given to patients. Prescriptions provided in ED were required to be dispensed at the onsite Boots pharmacy only. The TTOS stock included broad spectrum antibiotics and pain relief (analgesia). The pharmacy technician was responsible for stock control.

Records

- We examined 22 sets of patients' notes, adults and children's, which included nursing assessments, medical assessments and prescription charts. Staff used paper records, which we found contained written entries that were legible, clear and concise. Staff had signed and dated the records we reviewed. In four cases, patients were referred for input from other specialities.
- Paper records were stored in a screened area that had an administrator located nearby at all times for security.
- Staff recorded observations carried out, national early warning scores (NEWS); paediatric early warning scores

(PEWS) and allergies. Care plans including pressure ulcer prevention care plans, body maps, falls prevention assessment and nutritional assessments were completed.
- We saw a mental health risk assessment completed for the patient attending with an acute mental health episode.

Safeguarding

- The trust set a target of 85% for completion of safeguarding training. University Hospital Lewisham had a safeguarding training completion rates for nursing staff, above the trust target for two and below target for two of the four safeguarding training module.
- Safeguarding training completion rates for medical and dental staff at University Hospital Lewisham were below the 85% target for all safeguarding modules. Safeguarding Adults Level 2 (Clinical) had the highest completion rate of 69% and Safeguarding Children & Young People Level 3 (Core) the lowest of 50%. This was not in line with the trust's adult safeguarding policy. Additional safeguarding training courses were planned for March 2017.
- There were appropriate systems and processes in place for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- Information about children attending the department who had a social worker or a child protection plan was passed onto the safeguarding team to inform them of their attendance in the ED. Additionally, we attended a meeting which was held weekly with staff from multiple agencies to discuss all children that had attended the department where there were concerns or where the child was known to social services, to ensure that information was shared appropriately. Referrals were made to the local multiagency safeguarding hubs (MASH) and drug and alcohol services.
- Nursing staff we spoke with were able to give examples of a safeguarding concern and were able to tell us how they would escalate safeguarding concerns to senior staff members and the trust safeguarding team.
- Staff also completed the prevent awareness training. PREVENT is a government scheme to safeguarding people and communities from the threat of terrorism. Completion rates for prevent training were lower than the trust's target of 85%. Forty-three per cent of nursing staff, 3% of medical staff and 71% of AHPs had completed the level three Workshop to Raise Awareness of Prevent (WRAP) training. We were told that additional PREVENT training courses were booked for April 2017.
- Staff we spoke with were aware of child sexual exploitation; grooming and female genital mutilation (FGM) and what procedures to follow should they have a concern regarding these issues. There was an alert system for female grooming and they were aware of specific children within the area that may be at risk.

Mandatory training

- The trust set a target of 85% for completion of mandatory safety training.
- University Hospital Lewisham had a mandatory training completion rate for nursing staff, above the trust target for two of the 14 mandatory training modules. The highest completion rates of 100% were for resuscitation, paediatric hospital life support (PHLS) and Equality and diversity (99%). Bullying and harassment training and Fire Safety Clinical had the lowest completion rate of 43% and 44% respectively.

Assessing and responding to patient risk

- All of the staff we spoke with told us the security staff were good; they responded immediately if the alarm was raised.
- All staff carried attack alarms, we saw evidence of this and they were tested each morning.
- The trust scored "about the same" as other trusts for four of the five A&E Survey questions relevant to safety. The trust scored worse than other trusts for the question "While you were in the A&E Department, did you feel threatened by other patients or visitors?"
- The pathway for children attending ED was very clear. The patient presented to the main reception, which registered their attendance and presented them with a yellow card. They were then directed straight through to the children's ED waiting room. If a child presented who was very unwell i.e. floppy, blue, not responding, they were directed immediately through to children's ED before registration.
- All paediatric patients were given a yellow card to hold, which identified them as not having been triaged yet.
- There was a policy which provided guidance for staff on what to do when triage time wait exceeded 30 mins.

Extra resources were provided to reduce the time back to 15 minutes as a safety net. This initiative was presented at a national conference by paediatric ED consultant and senior nurse

- At triage all jaundiced babies were bilirubin level tested, this was good practice as an early identification of serious illness could be ruled out.
- There was a metal detector for scanning to detect whether or not swallowed coins lodged in airways.
- The adults ED used National Early Warning Scores (NEWS) and the children's ED used Paediatric Early Warning Scores (PEWS), to identify deteriorating patients and vital sign observations were recorded in patients' notes. Staff had received training to carry out observations as part of their induction and refresher training had been also be offered to established staff members.
- The trust used the adult sepsis screening and action tool, which was applied to all non-pregnant adults and children over 12 who presented with fever symptoms or who were clearly unwell with any abnormal observations.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard over the 12 month period between October 2015 and September 2016
- Performance against this standard showed a fairly static trend. In September 2016 the median time to treatment was 85 minutes compared to the England average of 59 minutes. Performance over the 12 month period was consistently worse than the England average and the standard was not met throughout the period. Arrival to treatment times increased from October 2015 reaching the highest waits of 95 minutes in February 2016 and 100 minutes in March 2016.This could be due to winter pressure, the England average followed the same trend over this two month period though the England average waiting times of 65 and 69 minutes for the two months, were much lower than the trust average. Waiting times improved in April 2016 although with the exception of August (77 minutes) and October 2016 (75 minutes) remained between 81 and 87 minutes, higher than the England average and standard.
- The median time for emergency ambulance cases from arrival to initial assessment was worse than the overall England median over the 12 month period. In November 2016 the median time to initial assessment was 16 minutes compared to the England average of 6 minutes. Median time to initial assessment was longer than the England average for the entire 12 month period from November 2015 to October 2016. From January 2016 to March 2016 waiting times increased, with the longest wait of 19 minutes in March 2016. For the four months from May 2016 to August 2016 median time from arrival to treatment was 15 minutes although times increased again to 16 minutes in September and 18 minutes on October 2016.The overall England average for the 12 months was 6.5 minutes while the trust overall average was 16.16 minutes.
- Between January 2016 and December 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In January 2016, 54 % of ambulance journeys had a turnaround time over 30 minutes; in December 2016 the figure was 71%. From January to March 2016 times increased reaching the highest a high point of 73% in March 2016. In the period April to December 2016 percentages remained fairly stable between 66% and 71%.
- University Hospital Lewisham reported 2,163 "black breaches". Reporting 84 "black breaches" in January 2016 and 230 in December 2016. There was an upward trend in the monthly "black breaches" reported over the period. In the winter months from February to March 2016 the number of breaches increased month on month from 209 in February to 327 in March 2016. Performance improved from April 2016 to September 2016, with the exception of June 2016 when 228 breaches were reported, to between 125 and 146 breaches reported. The number of breaches increased once again in the winter months, from 194 in October to 230 in December 2016.

Nursing staffing

- Lewisham and Greenwich NHS Trust reported their staffing numbers as at December 2016. Most approaches to planning staffing relied on quantifying the volume of nursing care to be provided– on the basis of the size of population, mix of patients, and type of service – and relating it to the activities undertaken by different members of the team. The Accident and Emergency departments employed 13 fewer nursing

and midwifery staff and the trust employed 12% less nursing staff than what was determined by the trust to provide safe high quality care. University Hospital Lewisham had 12% fewer staff in place.

- As of December 2016, Lewisham and Greenwich NHS Trust reported nursing staff vacancy rate of 23% in Urgent and Emergency Care; at University Hospital Lewisham.
- In December 2016, Lewisham and Greenwich NHS Trust reported a nursing staff turnover rate of 14% in Urgent and Emergency Care; at University Hospital Lewisham.
- Sickness rates for nursing staff were at 3% in Urgent and Emergency Care; at University Hospital Lewisham in December 2016.
- Between April 2016 and November 2016, Lewisham and Greenwich NHS Trust reported a bank and agency staff usage rate of 26% in Urgent and Emergency Care; at University Hospital Lewisham.
- The Emergency Department at the University Hospital Lewisham had fill rates above 99% for registered nurses on day and night shifts for the period August 2016 to November 2016, reaching a high of 118% in October 2016. Fill rates for healthcare assistants on day and night shifts was below 90% for September 2016 however this was balanced by the increase in registered nurses.
- The Urgent Care Centre at the University Hospital Lewisham had fill rates below 80% for nursing and HCAs day staff for most months in the period August 2016 to November 2016. Fill rates for nursing and HCAs night staff was 100% throughout the four month period.
- E-roster was used to schedule staff within the emergency departments. Staff we spoke with were happy with their rota. The ED matron told us the support provided by e-roster was very good and was available during office hours.
- There was an Emergency nurse practitioner (ENP) working in the children's ED each day covering a 10am to 10pm shift.
- Staff handover meetings took place twice daily in the morning and evening. We attended a staff handover, which we found to be well organised, comprehensive and highlighted the patients most at risk within the department. The handover included a briefing by the sickle cell link nurse around care of sickle cell patients. The shift leader assessed the skill mix of the shift staff and assigned staff to the roles for the shift.
- All staff undertook an induction programme which was signed off by the practice development nurse.
- Experience nurses only worked in triage.
- Only paediatric trained nurses worked in the paediatric emergency unit. Senior staff confirmed they did not use agency staff for the paediatric ED except for registered mental health nurses (RMN). We observed only permanent staff on shift during the period of our inspection.

Medical staffing

- As at September 2016, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average. The ED had a lower proportion of middle career staff working at the trust; 4% compared to an England average of 12%. There were eight WTE consultants in the adult's ED. This was less than the recommended minimum of 12 in line with national guidelines. There were two WTE paediatric consultants in the children's ED.
- Figures provided up to December 2016, showed that Lewisham and Greenwich NHS Trust reported a vacancy rate for medical staff of 16% in Urgent and Emergency Care; at University Hospital Lewisham.
- As at December 2016, Lewisham and Greenwich NHS Trust reported a medical staff turnover rate of 2% in Urgent and Emergency Care; at University Hospital Lewisham.
- The ED at University Hospital Lewisham reported a sickness rate of 0.35% for the financial year 2015/16 for medical staff.
- Between April 2016 and November 2016, the ED reported a bank and locum medical staff usage rate of 11% in Urgent and Emergency Care.
- We observed a medical handover and found it to be structured, detailed and relevant. Medical staff discussed each patient in department. Medical staff were allocated to care for each patient in the ED and each medical staff received a handover from the night staff.
- Overnight cover in the ED was provided by a senior specialty doctor, trainee and middle grade doctor with support from additional specialty middle grade doctors.
- There was an out of hours cover schedule which the consultants had agreed to, to ensure there was on call availability between 11pm and 8am weekdays and 11pm and 9am on weekends. Doctors we interviewed told us medical cover was good with enough middle

grades doctors available at all times. Trainees told us, the consultants were fully involved in care delivery and were confident there were sufficient numbers of staff available.
- Nursing staff we spoke with told us they got the support they needed from consultants and had no difficulty accessing the on call consultant overnight and at weekends.

Major incident awareness and training

- The trust set a target of 85% for completion of major incident training (Emergency Planning). A breakdown of compliance for major incident training courses for the trust as at December 2016 for medical/dental staff was at 21.5% and nursing/midwifery staff at 89% completion.
- There were a major incident plan, with clear allocation of responsibilities and triggers for escalation, to deal with a major external incident and with internal incidents.
- In addition, the ED had an emergency department business continuity plan with action cards in place for dealing with internal and external major incidents. These included procedures for dealing with hazardous materials, incidents and chemical biological, radiological and nuclear defence (CBRN). It also included an evacuation risk assessment; a contact list and incident helpline; an escalation flow chart; lock down principles and evacuation flow chart; severe weather plan; and incident report forms
- All staff we spoke with were able to describe the process to follow in case of a major incident.
- The matron described the arrangements to deal with casualties contaminated with chemical or hazardous materials and items. We saw the equipment for major incidents was stored in a designated locked room. Emergency medicines stored within the major incident cupboard were within date.
- Security staff were available 24 hours a day, seven days a week. This meant ED staff had rapid access to security support if needed to help with violent or threatening patients. We saw security staff within the ED during our inspection. The majority of staff felt safe whilst working within the department and said security staff responded quickly when requested.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- Care was in line with relevant National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.
- Food was readily available for patient within the ED at all times.
- Facilities were available in the children's ED assessment ward area for parents to make snacks and drinks for their children.
- The child and adolescent mental health services (CAMHS) transformation has revolutionised the care with the majority of referral being seen on the same day (Monday to Friday).

However:

- In the consultant sign off audit summary from January 2017, the results showed that only 9% of patients were seen by a consultant.
- The department did not meet the seven day working standard requiring 16 hours consultant presence, seven days a week. Consultant presence in the ED was 15 hours a day Monday to Friday and 14 hours a day at weekends.

Evidence-based care and treatment

- The department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided and local policies were written in line with these. Clinical pathways followed included those for management of sepsis, and fractured neck of femur.
- Staff told us they use these guidelines regularly and showed us how they would access the local agreed guidelines on the trust's intranet. We looked at a range of policies and found that they were up to date. We saw the NICE guidelines for sepsis, recognition, diagnosis and early management displayed within the department.

- Staff used a variety of information technology within the department to enhance speed and access to patient care and treatment. This included internal electronic systems and systems used for digital imaging.
- The matrons within the ED were responsible for all reviewing and updating of policies. All policies were taken through the local governance committee for approval. We saw evidence of this in the minutes for that meeting.
- At the time of our inspection the ED operational policy was in the process of being updated.
- The department used recognised tool for sepsis management called 'sepsis six' and staff displayed good knowledge of treatment options when treating patients who had sepsis.
- We reviewed 22 sets of patient notes for people who had attended the ED, which showed patients had received care in line with relevant National Institute for Health and Care Excellence (NICE) guidance relating to sepsis screening, fractures and healthcare associated infections.
- There was a programme of local clinical audits based on the needs of the ED. These included pain relief, A&E assessing the management of patients, review of compliance of the London standards, fever in children audits, moderate and severe asthma, severe sepsis and septic shock audit, head injuries audit and fractured neck of femur audit.
- The National vital signs in children clinical audit 2015/16 resulted in the implementation of the rapid decision making tool, which was used to ensure that children's had a full set of vitals taken within 15 minutes of arrival within the children's ED. Paediatric early warning system (PEWS) was used within the ED.
- The procedural sedation clinical audit 2015/16 showed that the ED had met all of the six recommendations and training had been provided in August 2016.

Pain relief

- Nursing staff working from triage and clinical rooms were able to administer analgesia (pain relief) to patients, which saves time waiting for a doctor to prescribe it.
- In the Care Quality Commission's (CQC) Accident and Emergency (A&E) Survey, the trust scored 5.9/10 for the question "How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.
- The trust scored 7.3/10 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.
- We saw pain leaflets available in the children's A&E, which were in child friendly design, asking child to point to the face that best describes how they feel and scoring from zero(not hurt) to ten (hurts worst). There was information displayed for staff in line with RCEM standard for pain medication for children.
- We observed patients in all areas of the ED including children's ED, they were asked to indicate their pain level on a scale of one to ten with ten described as very severe pain and were then offered pain relief accordingly. We saw the documents used to triage patients for adult and children and both had a dedicated space to document pain score, which we saw had been completed in all the patient notes we observed. We reviewed the pain relief audit which was completed in November 2016. The data collection period was between August and October 2016. 64 patients were randomly selected. 75% had a pain score taken within 30 minutes of arrival within the department and 100% within 60 minutes of arrival.

Facilities

- There was a relative's room within the ED, which was comfortably furnished and provided an area of calm away from the ED setting. This room was also used for delivering bad news.
- Within the ED there was a room used for families and relatives to view patients who had passed away in the ED. This room was joined to the relative's room with a connecting door. This room was kept locked.
- Within the children's ED there was a separate breast feeding room which was visibly clean and had facilities conductive to comfort, privacy and dignity.
- There was a well-equipped play area in the children's ED waiting room. We saw children were playing happily and not distressed, despite being in the hospital setting. The hospital employs one play specialist who works four days per week from 10am to 6pm.

Nutrition and hydration

- Staff completed nutrition assessments and fluid balance charts on patient's admission to the clinical decision unit (CDU) or for patients with long stays in the ED. Within the records we reviewed we found that the

assessments and charts had been completed fully. Intravenous (IV) fluids were given to patients when required and for those patients we observed that a fluid balance chart was being used within their patient notes booklet.

Patient outcomes

- Patient journeys were improved because patients who were being admitted for short term assessment were able to stay within the unit in the four bedded ward area for up to 24 hours, this enabled continuity of care provided by the ED paediatric consultant. This also freed up ward space for sicker children. There were established relationships with the wards which enabled smooth transitions from ED to ward.
- From June 2016 child and adolescent mental health services (CAMHS) transformation had revolutionised the care for this patient groups within the area. Response times had improved with many patients being seen the same day by the CAMHS service. The service was provided in the children's ED five days per week.
- In the 2013 Royal College of Emergency Medicine (RCEM) audit for consultant sign-off, the University Hospital Lewisham was in the lower quartile compared to other trusts for three of the four measures and was in between the upper and lower quartiles for one of the four measures.
- The measures for which the trust performed in the lower quartile were: Consultant / associate specialist discussed the patient (2%). Specialist Trainee year 4 (ST4) or more senior doctor saw the patient (33%). ST4 or more senior doctor discussed the patient (10%).
- In the 2013/14 RCEM audit for asthma in children, the University Hospital Lewisham children's ED) was in upper quartile compared to other hospitals for six of the ten measures and was in the lower quartile for one of the ten measures.
- The measures for which the trust performed in the upper quartile were: Respiratory rate: Within 15 minutes (80%), Oxygen saturation: Within 15 minutes (80%), Pulse: Within 15 minutes (78%), GCS Score (or AVPU): Within 15 minutes (64%), Beta 2 agonist (+/- ipratropium) given by spacer or nebuliser as per CEM dosage within 10 minutes of arrival (14%), IV hydrocortisone or oral prednisone (90%).
- The measure for which the trust performed in the lower quartile was: Peak flow: Within 15 minutes (2%). Peak flow measures a person's maximum speed of expiration (breathing out).
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the University Hospital Lewisham was in the between the upper and lower quartiles compared to other hospitals for five of the six and was in the upper quartile for one of the four measures.
- The measures for which the hospital performed in the upper quartile were: communication of assessment findings with relevant services, carers and GP: admitted patients only was at 100%. They did not meet the fundamental standard of having an Early Warning Score documented.
- In the 2014/15 RCEM audit for initial management of the fitting child, children's ED was in the upper quartile compared to other hospitals for one of the five measures and was between the upper and lower quartiles quartile for four of the five measures. The children's ED met the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival.
- The measures for which children's ED performed in the upper quartile were: the proportion of discharged patients whose parents/carers were provided with written safety information for all audited patients was 48% and eye witness history recorded for all audited patients was 100%.
- In the 2014/15 RCEM audit for mental health in the ED, the University Hospital Lewisham was in the lower quartile compared to other hospitals for one of the eight measures and was in the upper quartile for one of the eight measures. The site was in the between the upper and lower quartiles for six of the eight measures.
- Of the two fundamental standards included in the audit, the hospital did not meet the fundamental standard of having a documented risk assessment taken. The site met the fundamental standard for having a dedicated assessment room for mental health patients.
- The measure for which the site performed in the upper quartile was: Risk assessment taken and recorded in the patient's clinical record (96%) and assessed by mental health professional within 1 hour (0%). The measure for which the site performed in the upper quartile was: details of any referral or follow-up arrangements documented (60%).

Urgent and emergency services

- Between November 2015 and October 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average. In the latest period, the trust performance was 10% compared to an England average of 8%. The re-attendance rate for the trust was consistently between 9% and 10% for the period compared to an England average of 7% to 8% over the same period.
- We reviewed the consultant sign off audit summary from January 2017. The audit reviewed 142 records between 30 December 2017 and 28 January 2017. Result of the audit showed that only 9% of patients were seen by a consultant, 16% were seen by middle grade doctors (ST4 or more senior doctor), 42% were seen by senior house officers or equivalent grade doctors, 11% were seen by ST1-2, 18% were seen by FY1-2 doctors and 3% were seen by non-medical practitioners.

Competent staff

- The practice development nurse (PDN) had worked within ED for 13 years and had progressed from band 5 to role of PDN. Student nurses were within the remit of the PDN, and PDN maintained direct links with the local universities. The PDN was responsible for student sign off and for the student paramedics.
- PDN is involved in the training for arterial blood gases, which give analysis on blood samples particularly lactate which is an early indicator for sepsis. Flood blood counts – determines anaemia. Ketones in blood – high levels can determine severity of illness in diabetic patents. Blood glucose – for diabetic testing. Pregnancy test in urine. All are signed off by the PDN for nursing staff when competent to test.
- New nurses undertook a two-week induction period with the PDN and received training and clinical supervision in all areas of the ED including triage, NEWS, incident reporting and safeguarding. Agency staff also undertook an induction before working in the department.
- The PDN worked alongside all new team members to ensure learning and proficiency.
- PDN worked with all nursing team members as a 'confirmer' for re-validation and was fully conversant with the process. All nursing staff had completed their revalidation when due.
- The PDN taught a modified Manchester triage (a process for determining the priority of patient's treatment based on the severity of their condition) and worked alongside new staff members until confidently able to sign off their practice.
- The PDN was involved in the training of staff for obtaining arterial blood gases, and other routine blood testing. Nursing staff were signed off as competent once assessed by the PDN.
- We observed clinical practice by both doctors and nurses was within accepted guidelines. Staff were competent and demonstrated a good level of knowledge and understanding of evidence based practice. They were aware of NICE and RCEM guidelines.
- Junior doctors told us they felt well supported, had access to training and there was good clinical supervision. There was protected time allocated for teaching and there was a well-structured induction programme.
- Staff in children's ED had SIM training which was a simulation of a real life cardiac arrest with a mannequin. We witnessed this training during our inspection. This was good practice because it gave very close to real life experience.
- Staff appraisals were customised to ED staff. The matrons acknowledge they were behind on completing appraisals; however, there was currently action plan in place to progress. Between April 2016 and August 2016, 57% of staff within Urgent and Emergency Care at the trust had received an appraisal. At the University Hospital Lewisham the appraisal rate improved from 50% to 64%.

Multidisciplinary working

- The ED paediatric nurse lead and ED adults nurse lead met daily to discuss any issues which may have had crossover for both services.
- We observed a morning hand over huddle with senior nurses and the sister in charge, they discussed each patient, which allowed staff to briefly observe patients as well.
- We attended a morning handover during our inspection. The handover focused on allocation of staff, bed capacity, number of patients within each area, number of breaches and waiting time. There was good leadership, consultant was present and staff were clear of their role. There was discussion regarding reported incidents or sharing of learning information.

Urgent and emergency services

- We observed four handovers from the ambulance service to the ED staff. These were well structured and ensured that all the relevant clinical information about the patients conveyed properly.
- We spoke with three ambulance paramedics and one emergency ambulance technician, waiting with non-priority patients to register with the receptionist in the ED. They told us staff were good and during peak periods staff had worked hard to book in patients as soon as they possibly could to ensure there was no immediate harm. They said that staff were caring.
- We attended a weekly children's safeguarding multiagency meeting. There was strong evidence or a mutually respected relationship between the attendees.
- A play specialist worked within the children's ED. Reports from staff were very positive and an example was given about a child who had been very distressed, had required treatment. With the support of the play specialist, the treatment was undertaken in a calm environment that meant the child was less distressed.
- We observed the relationship between the onsite mental health liaison nurse who was based within the ED in an office situated next door to the safe room and the ED team. Staff told us that having the mental health liaison nurse on site was very helpful. They felt supported and when they referred patients to the service they were seen within minutes.

Seven-day services

- The ED services for adults and children were open 24 hours a day, seven days a week. The UCC was also open 24 hours a day, seven days a week. The department had consultant presence from 8am to 11pm every weekday and 9 am to 11pm at weekends and on call overnight.
- The on-call consultant was accessible out of hours.
- There was appropriate imaging and pharmacy support available 24 hours a day, seven days a week.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours, 7 days a week.
- The child and adolescent mental health service (CAMHS) was available on site between 9am and 5pm Monday to Friday.

Access to information

- The department had a computer system that showed how long patients had been waiting and their location within the department. Our review of patient notes showed that all clinical staff recorded their care and treatment using the same document.
- Policies and guidelines were available on the trust intranet and were up to date. Information was cascaded to staff through daily meetings on the unit, notices on the information board in the staff rest room and emails.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that as at December 2016 Mental Capacity Act (MCA & Consent to Examination/treatment) training has been completed by 76 % of staff in Urgent and Emergency Care. Nursing staff had an average completion rate of 88% and Medical and Dental staff an average completion rate of 16%.
- Staff sought consent from patients prior to undertaking any treatment or procedures and documented this clearly in patient records where appropriate
- Staff told us consent was mainly obtained verbally for procedures such as receiving medicines and minor procedures. Clinical staff we spoke with showed understanding of the mental capacity, consent and decision making requirements of legislation and guidance and they understood the requirements of the Mental Capacity Act 2005.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- The ED staff were caring and compassionate. They treated patients with dignity and respect.
- The ED department was performing as well as other English trusts in the friends and family test and in the national Accident and Emergency (A&E) survey.
- Emotional support was provided by the chaplaincy or multi-faith services.
- Lullaby boxes were provided for families whose child had died in the department.

Compassionate care

Urgent and emergency services

- The Friends and Family Test (FFT) is a method used to gauge patients' perception of the care they had received. Patients who completed the survey reported whether they would be likely or very likely to recommend the ED to their friends and family. The results for December 2015 to November 2016 were above the England average with rates ranging from 92.7% to 97% of patients recommending the service.
- In the A&E survey in 2014 showed that the trust performed in line with other trusts for 24 of the 24 questions relevant to caring
- Patients told us staff introduced themselves, they were friendly and polite, food and drink was offered, and they felt safe in the department.
- We observed compassionate care delivered by nurses and doctors, to both adults and children. Staff engaged in an open and positive way with patients and their relatives. A patient told us "it has been very good; they got me sorted really quickly. They have been very kind." Another patient said "they are very good here; they know what they are doing".
- We spoke to 22 patients and relatives and they all provided positive feedback about their care. Patients said they were treated with dignity, respect and compassion, and had received good care. They said that staff were polite, courteous and professional and they were happy with their care. We were told by patients the staff always washed their hands before contact with them, they asked permission before touching them and explained clearly what they were about to do to them.

Understanding and involvement of patients and those close to them

- Patients told us they felt informed about the processes in A&E. They said once treatment had started, staff dealt promptly with their needs and most felt very confident about the explanations and care they received.
- During our observations, all staff routinely involved patients and their relatives in plans and decisions about their care and treatment. For example, one nurse explained to a patient the importance of taking regular painkillers when they were discharged home. In another observation, we saw a doctor explaining to a patient what tests they needed to perform in order to diagnose what was wrong with the patient. The doctor spoke clearly and answered any questions the patient had.
- Staff considered discharge planning as soon as a patient attended the ED. Staff discussed planning with patients and relatives to ensure appropriate arrangements were in place. This also reflected patient centred care and helped ensure that patients' individual needs were taken into consideration.
- Parents accompanying their children in the children's A&E were positive about the treatment their children received. They said the nurses and doctors understood them and were supportive. Parents commented positively on the knowledge of the staff treating their children.
- The results of the CQC A&E survey 2014 showed that the trust scored about the same as other trusts in 24 of the 24 questions relevant to caring.

Emotional support

- Chaplaincy service leaflets were available in both ED departments, staff gave these leaflets to patients and families who may want to have contact with the chaplaincy or multi-faith service. Emotional support was also provided by the multi-faith chaplain service within the trust and patients could access representatives from various faith groups.
- The A&E staff had a protocol on how to deal with relatives who experienced bereavement. They demonstrated compassion when talking about this area. There was a separate room where doctors or nurses would talk to the family if a relative had died. Family could stay in viewing room for as long as needed.
- There was a bereavement booklet with lots of useful information for relatives to inform them of where to obtain emotional support and information about registering the death.
- The children's ED staff undertook fundraising sporting events to raise funds to purchase 'lullaby boxes' which were memory boxes containing, hand print kit, photo frame, cuddly toy and other mementos for bereaved parents, whose child or baby had passed away in the hospital.
- There was a variety of specialist nurses available that provided support and advice for patients. Staff said usually there was a prompt response when they referred a patient to one of the specialist nurses.

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

Urgent and emergency services

Requires improvement

We rated responsive as requires improvement because:

- The trust did not meet the wait to treatment time of one hour during the 12 months from October 2015 to September 2016.
- The trust breached the target to admit or discharge within four hours of arrival each month between December 2015 and November 2016.
- Between November 2015 and October 2016 the trust's monthly median total time in A&E for admitted patients was consistently higher than the England average.
- The trust took significantly longer than their target to investigate and respond to complaints.

However:

- There was a play co-ordinator employed to provide activities and play with children waiting in the children's ED.
- There was a breastfeeding room within the children's ED.
- There was a family room equipped with kitchen facilities.
- Yellow card system used to identify children that had not yet been triaged so that they were not missed.
- There was access to translation services 24 hours a day seven day per week.

Service planning and delivery to meet the needs of local people

- The trust provided 24 hour accident and emergency and urgent care services for children and adults in the local boroughs.
- The ED saw 120,202 patients between April 2015 and March 2016 and approximately 18% of ED attendances resulted in admission.
- The urgent and emergency care department had its own x-ray department which was open 24 hours a day.
- The Royal College of Emergency Medicine recommends the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard over the 12 month period between October 2015 and September 2016. Average wait times from arrival to treatment ranged from 75 minutes to 100 minutes during this period. The England average ranged from 59 minutes to 69 minutes during the same period.
- Staff within the ED told us they would like to see a re-invigorated surgical assessment unit reopen. It had been closed due to capacity issues.

Meeting people's individual needs

- The trust provided a dedicated 24/7 children's emergency department and children were triaged in the children's ED. Suitably qualified children's nurses cared for all children. The environment of children's ED was child-friendly, the waiting room was bright and there were plenty of clean toys and books for children. The play co-ordinator provided activities for the children to do whilst they waited to be seen.
- The environment was good for patients with mental ill health. The secure room met the standards set out by the psychiatric liaison accreditation network, there were two doors to enter and exit.
- We looked at the relatives' room where people waited while their seriously ill relatives were being cared for, or where people were informed that a relative had passed away. We found the room was clean with suitable furniture. There was a separate viewing area/room where people could see their deceased relative within the A&E.
- Bereaved families were given an information booklet which provided help and advice in the first days following a death in hospital.
- Staff confirmed they had 24-hour access to telephone interpreting service or face to face interpreting service could be booked should it be required. All staff we spoke to were aware of the interpreting services and how they could access it if required
- Within the triage assessment documentation there were prompts for staff to identify patients with learning disabilities and dementia. This included cognitive assessments for patients living with dementia. There was a passport document used for patients with a learning disability. This document was completed by the patient, carer or family member and provided staff with information regarding the patient's needs.

- There were a variety of menus available for patients to choose from who were staying in the CDU. This included menus for specific dietary requirements, such as allergies and intolerances as well as vegan, halal, kosher and Asian vegetarian options.
- The children's ED had a room for breastfeeding mothers to feed their babies in comfort and private.
- There was a family room, which was equipped with kitchen facilities and an area for sensitive discussion and breaking bad news.
- Parent beds and recliner chairs were provided for parents to stay with their children on the ward area overnight. Security responded immediately if alarms were raised. There were close circuit television (CCTV) cameras throughout the department which were observed 24 hours a day at the security desk. Staff told us that they felt "safe" and "protected"
- There was a GP consultation room within the department that local GPs operate out of. When the UCC was busy the GPs would see patients waiting, to assist in reducing waiting times.
- Children and adolescent mental health liaison services were provided within the children's ED five days per week. This enabled swift referral in to the service for children and young people who presented to the ED with mental ill health.
- In the CQC A&E Survey, the trust scored 6.2/10 for the question "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as than other trusts.
- The department had its own well-equipped kitchen to provide food and drink to patients. During daytime there were a hostess responsible for ensuring that patients were offered hot or cold drinks, breakfast cereal and toast was available at breakfast time and a large selection of sandwiches, yogurts and fruit was available each evening to ensure that patients attending the ED overnight had food available to them. During evening and weekends, there were no ward hostess and food and drink was offered by nursing staff.
- There was a water cooler in the waiting areas, but there no vending machines in the main waiting room for relatives to use. We were informed that they had been removed and were being replaced with vending machines with healthier choices. The staff we spoke with were not aware of the date that the new vending machines would be installed by. There was water cooler in children's waiting area as well.
- All patients we spoke with told us they were offered food or drink while they were within the department.

Access and flow

- The introduction of the yellow card system to identify child that have not been triaged yet had helped ensure that no child be forgotten in the waiting room. .
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between December 2015 and November 2016. Between December 2015 and November 2016 performance against this metric showed a trend of decline. The trust performance was consistently below standard and the England average from January 2016 to November 2016. In December 2015 the trust performance was better than the England average by 1%. On average over the 12 month period 85% of patients were attended to within four hours compared to an England overall average of 90%.
- Between December 2015 and November 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average. Between January 2016 and November 2016 performance against this metric showed a trend of decline Trust performance was consistently worse than the England average throughout the 12 month period. The overall average for this period showed that 17% of patients waited between 4-12 hours before being admitted whereas the England overall average for the period was 12%. During the winter months from, January to March 2016, between 21% and 24% of patients waited between 4-12 hours before being admitted, while in the same period the England average was between 14% and 15%.Trust performance followed roughly the same trend as the England average, from April to September 2016 percentages decreased for both the trust and England, although in June 2016 trust percentages increased by 3% while the England averages remained stable. From October to November 2016 percentages increase for both the trust and the England average.
- Over the 12 months, December 2015 to November 2016, five patients waited more than 12 hours from the decision to admit until being admitted. One in March 2016 and four in November 2016.

Urgent and emergency services

- Between November 2015 and October 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was worse than to the England average. Trust performance followed roughly the same trend as the England averages; although the trust performed consistently worse than the England average. England averages were between 3% - 4% whereas the trust performance was between 4% - 7% over the period. Between October 2015 and September 2016 performance against this metric showed a trend of decline. During the winter months of January, February and March 2016, the percentage of patients leaving before being seen increased from 5% - 7%.
- Between November 2015 and October 2016 the trust's monthly median total time in A&E for admitted patients was consistently higher than the England average. Performance against this metric showed a trend of decline, between October 2015 and September 2016 the trust's performance followed roughly the same trend as the England averages. Time spend in ED at the trust increased from January to March 2016, reaching the longest waiting time in March 2016 of 216 minutes. The same trend can be seen for the England averages, although time spent in ED at the trust remained longer than the England average. The overall average waiting time at the trust was 3.3 hours while the overall average England waiting time was 2.5 hours.

Learning from complaints and concerns

- Between December 2015 and November 2016 there were 191 complaints about Urgent and Emergency Care services. The trust took an average of 71 days to investigate and response to complaints, this was not in line with the trust's complaints policy, which stated complaints should be responded to within 25 working days . Medical and surgical treatment accounted for 28% (53) of complaints received. Delays in patient being seen by a Doctor were responsible for 9% (18), missed diagnosis for a further 9% and nursing care for 8% of complaints received. On average 16 complaints were received per month. In June 2016 the highest numbers of 23 (12%) complaints were received. During the winter months of January, February and March 2016 between 18 and 20 complaints per month were received.
- Of the 191 complaints received by the trust, 42 complaints were in relation to the University Hospital Lewisham. The majority of those complaints received 29%, were in relation to medical and surgical treatment. Nursing staff attitude (11%), missed diagnosis (10%), delays in patients being seen by a doctor (9%) and nursing care (7%) accounted for a further 37% of complaints received.
- The matrons investigated and closed all incidents. Feedback was given to those involved and general feedback was given to the team during the morning briefings.
- Monthly governance meetings were held**,** with mixed team attendance including medical and nursing staff, feedback and learning from complaints was discussed. Consultants sent emails out to the medical staff regarding incidents and learning, which we observed and these were very informative.
- The matrons always tried to undertake a face to face meeting with complainants to resolve issues as quickly as possible. This had proven to be effective.
- Patient advice and liaison service (PALs), leaflets were freely available within both ED departments and the UCC.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There were insufficient systems in place to manage the fundamental issues of capacity and flow within the ED. ED performance was below the objectives set out in the delivery plan.
- Staff did not feel part of one trust. They did not support each other across sites when there was capacity to do so.
- The relationships between the ED and surgical and orthopaedic consultants were fragmented at times.

However:

- Staff felt well supported by local leadership and the local leadership felt supported by the executive, the departments were well managed.
- Children were encouraged and empowered to provide feedback of their experience though the child friendly feedback forms.

Leadership of service

- The systems in place were insufficient to manage the issues of capacity and flow within the ED. The ED performance was not meeting the objectives detailed within the service delivery plan.
- The departments were well managed on the days of the inspection. The staff spoke of the support they receive from medical and nursing leadership in the departments. Staff told us the leadership was visible and supportive. They said they saw the executive team from time to time. The managers within the departments said that executive level support was strong.
- The chief executive officer (CEO) provided regular 'blogs' and chaired monthly meetings at which complaints, action logs and learning were discussed. Staff said that the CEO was very personable.
- Nursing staff spoke highly of the matrons and professional development nurse (PDN). Staff said they were approachable and visible within the department. Doctors also said they were supported by the consultants within the ED. We observed consultant interactions with junior doctors and saw they provided leadership and direction when required. Black and minority ethnic (BME) staff confirmed they had equal opportunities in line with other staff.
- The deputy director of nursing attended a recent in house graduation ceremony to present the certificates to the nurses.
- We observed good leadership skills during handovers, consultants and senior nurses gave clear guidance and support to junior staff.
- The daily nurse's handover was used as a time where information could be shared from the leadership to the team.
- Staff told there was support available if required following a death in the department. This included a debrief on the day and then a follow up meeting with everyone who was involved.

Vision and strategy for this service

- The trust was working to deliver the Lewisham and Greenwich Emergency pathway redesign programme which was introduced in June 2016. The work streams include ED, Ambulatory, Acute Pathway, Frailty, Simple and Complex Discharge. Each work stream had a lead and clinical lead to drive forward the changes required. The emergency pathway redesign programme sits within the larger system wide programme. Staff that we spoke with were able to talk to us knowledgeably about the programme and the changes that were happening as a result of the work.
- Areas of focus within University Hospital Lewisham's ED were focussing on the non-admitted pathway. Establishing reporting mechanisms, weekly meeting and standard operating procedures. Progressing resilience schemes for ED triage and rapid assessment and treatment (RAT)
- The corporate objectives up to 2020 include, making improvements to quality and safety. Improving patient and staff experience. Deliver on the trust's financial target and ensure the work force is resourced and deployed effectively. We saw that the ED was trying to recruit the staff they required in the difficult London recruitment market.

Governance, risk management and quality measurement

- The two EDs sat under two different directorates. Adult's ED including the UCC and CDU were situated within the acute and emergency medicines (AEM) directorate and the children's ED was situated within the children and young people's directorate.
- Staff were able to articulate the department governance arrangements and which individuals had key lead roles and responsibilities within ED They were clear also of their own individual roles and responsibilities and commented on the considerable amount of governance information available to them.
- The divisional director, head of nursing, consultants, senior matrons and senior non-clinical staff attended a monthly divisional governance meeting. The leadership team discussed the AEM performance scorecard, staffing, serious incidents, complaints, finance and quality improvement projects. Action points were raised following each meeting.
- Within the quarterly clinical governance meetings in November 2016, there was discussion of the development of a new ED risk register. In the meantime the ED maintained a risk register and an issues register. There were three risks on the risk register and seven issues identified on the issues register. We saw evidence risks and issues were reviewed and mitigating plans

were in place. Senior staff routinely discussed risks and issues at clinical governance meetings and saw that the risks were identified in the AEM plan to improve the service.

Culture within the service

- Nurses said they felt valued and in terms of opportunity, promotion was available, they felt comfortable to report issues in an open and transparent manner. They felt supported to provide high quality care and to continually work to improve standards.
- The consultants attended nursing team teaching days and delivered sessions of training.
- The team work was described at good by the staff we spoke with, as were the relationships within the department and with the medical director. Relationship with surgical and orthopaedic consultants were fragmented at times.
- The department appeared well managed with staff working in calm and measured way. There was a strong team spirit from top to bottom within the department.
- A&E had good and visible clinical leadership. We observed good team working among nurses within the department. Shift leaders were very committed to patients and to supporting their staff; they feel their contribution was valued within the department.
- Junior doctors felt well supported for their training and supervision. Staff spoke highly of the A&E matrons.
- We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and provide advice.
- All staff we spoke with were passionate about providing empathetic care and it was a close knitted team. Several staff told us how they enjoyed working in the departments and had worked in the ED for many years, with two members of staff describing it as a "good place to work".
- Short term sickness levels were low in the department. However long term sickness was a bigger issue. We were told that human resources (HR) were very supportive with managing sickness. Regular staff support if colleague were off sick or they back fill with bank and regular agency staff within the department.

Public engagement and staff engagement

- The service had developed and was using a child friendly 'experience of the service' questionnaire, which was a single A5 piece of paper with cartoon faces representing happy to sad. This enabled children to feedback their satisfaction with the service. There was also a section for children or parents to write what the service could do to improve.
- The trust's Urgent and Emergency Care Friends and Family Test performance (% recommended) was better than the England average between December 2015 and November 2016. In the latest period, November 2016 the trust's performance was 94%. The percentage that would recommend the emergency department varied between 93% and 96% over the 12 month period. Recommendation rates reached high points of 96% in May 2016 and August 2016 then falling back between August and November 2016 from 96% to 94%.
- There were annual staff recognition awards, and staff could be nominated by each other.
- There was a departmental BBQ every summer. Staff felt that this social event was good for morale and to enjoy each other's company in a relaxed setting.
- Staff told us, they felt involved and that their contributions were valued within the University Hospital Lewisham, however, they still did not feel part of one trust with Queen Elizabeth Hospital. . They said that they were very separated from each other.
- There were leaflets in the ED for the local consumer champion for health and social care services, this organisation supports patients and service users to have a say about the care they receive and the services available to them in the local area.

Innovation, improvement and sustainability

- Within the children's ED there was a procedure which escalated up to when a triage time wait was about to exceeded 30 mins. Extra resources were provided to reduce the time back to 15 minutes as a safety net. This initiative was presented at a national conference by one of paediatric ED consultants and a senior nurse. Other hospitals had requested information on developing this practice.
- In a document title "Delivering the Plan" dated 30 September 2016, the trust's Acute and Emergency Medicine (AEM) divisional leads set out a strategic objective to deliver a 90% emergency care four- hour standard as an average for the year-end March 31, 2017. In other to achieve this, the division aimed to deliver 12 hours of rapid assessment treatment (RAT) per day, seven days a week and ensure patients were triaged within 15 minutes of their arrival. It also aimed to reduce

non-admitted breaches to 1% of total breaches and reduce the length of stay in the clinical decision unit to 24 hours or less. It aimed to ensure ambulance handover times were not more than15 minutes, discharge 40% of patients ahead of 1pm every day and reduce the trust bed occupancy to 95%. The trust was not yet meeting these objectives.

- The document identified risks to achieving the objectives, risk score and mitigation. Risks identified included capacity block in the ED caused by patients with decision to admit (DTAs) and the trust's bed occupancy rate. However, there were no other mitigating plans in place than those covered in the emergency redesign programme. This meant that there were no interim measures to address capacity and flow in the ED other than the use of escalation areas for patients when the ED reached full capacity.

Medical care (including older people's care)

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

Information about the service

Medical care services at University Hospital Lewisham include twelve inpatient wards, a coronary care unit, an endoscopy day unit, a discharge lounge and an ambulatory care unit. Patients have access to a range of specialties, including older people's medicine, stroke care, endocrinology, diabetes care, oncology, haematology, gastroenterology, respiratory, and HIV care. University Hospital Lewisham has 323 medical beds across the medical areas.

The hospital is part of Lewisham and Greenwich NHS Trust. Between March 2016 and February 2017, there were 11,289 spells of inpatient medical care. Between April 2016 and April 2017, there were 9,440 endoscopy procedures performed and the Alexis Clinic saw 854 registered patients.

In addition to our announced inspection between 7 March 2017 and 9 March 2017, we also conducted a weekend unannounced inspection on 18 March 2017. During the inspection, we visited every inpatient medical ward, the coronary care unit, discharge lounge, endoscopy day unit, and ambulatory care. During our inspection a team of inspectors visited the Alexis Clinic, which provides HIV services.

We spoke with 74 members of staff from a range of specialties and areas of responsibility, including the divisional director of medical services, heads of nursing for the service, the clinical lead, consultants, clinical fellows, health care assistants, junior doctors, and nurses. We spoke with 26 patients and 15 relatives.

We reviewed 34 patient records including risk assessments, prescription charts and care plans, observed ward rounds, board rounds and multidisciplinary meetings.

We last inspected the service in February 2014 and rated medical care services as requires improvement. There was a requires improvement rating for safety, caring, and responsiveness. This was because we found patients were not always treated with respect and dignity, there were problems with the flow of patients within the hospital, a lack of staffing for both medical and nursing staff and specialist medical input was not always provided. In addition, patients were not always seen by a specialist for their condition in a timely manner. We also found the hospital was not responsive, with a lack of bed capacity and failure to act on length of stay.

Medical care (including older people's care)

Summary of findings

Overall, we rated medical care services requires improvement. We rated medical care services requires improvement because:

- There was limited assurance about the safety of patients in particular in relation to the 'monitored bays' on the Medical Admissions Unit (MAU) and the Coronary Care Unit (CCU). Some but not all patients in these areas were level two patients but the hospital did not recognise these areas as level two areas. This meant patients did not receive the standard of care they would normally receive under the Faculty of Intensive Care Medical (FICM) guidance.
- Care on CCU and the monitored beds in MAU was not always provided by staff with the competence to care for acutely unwell patients requiring high levels of nursing interventions.
- Not all healthcare assistants (HCAs) had received appropriate appraisals and supervision. For example, some HCAs had not received supervision or an appraisal in the previous two years.
- Medicines management processes were not always in line with hospital policy or national guidance. For example, on our unannounced inspection, we found medicines that had expired on Hawthorne and Ash wards. In addition, staff did not always act when medicine fridge temperatures fell outside of the optimum range set by manufacturers. This meant medicines may not have been effective.
- Staff told us there was a lack of consultant radiologist out of hours and at the weekend for patients requiring chest x-rays following nasogastric (NG) tube insertion. Between December 2016 and March 2017, seven patients who had required a chest x-ray following NG insertion on Alder and Beech wards waited an average of 14 hours with three of the patients each waiting over 20 hours at weekends.
- Vacancies in medical care were high, in particular in relation to nursing staff and junior doctors. Five of the medical wards had nursing vacancy rates of between of 53% and 61% each as of March 2017.
- Some staff reported that high vacancy rates affected patient care and put patients at risk, in particular in relation to medicines being given late when wards were short staffed.
- Although the hospital was actively trying to recruit into nursing posts, there was limited evidence of success.
- There was a significant lack of venous thromboembolism (VTE) risk assessments in patient notes. VTE is the formation of blood clots in the vein. VTE assessments had not been completed in 15 of the 23 records we checked for completion of VTE assessments during the inspection. We checked both the electronic and paper records.
- Systems and processes around incident reporting did not always ensure staff reported all incidents or near misses or that staff received feedback on incidents and there was no evidence of learning from serious incidents, particularly in relation to VTE assessments.
- Staff on three medical wards told us they felt their wards were unsafe. On one ward, four staff said they would not recommend that their relative be treated there. We requested details of the friends and family test results for medical wards so we could compare the results from staff with our findings but the information provided by the service did not show the results from staff.
- There were no negative pressure rooms on the respiratory ward and staff expressed concerns that patients with tuberculosis were not always properly isolated as a result. Following the inspection, the service told us there were two negative pressure rooms on Cherry ward which were used for patients with multi resistant tuberculosis.
- The standard of infection control processes, including waste management and adherence to the control of substances hazardous to health guidance, was variable. Hazardous waste was not always managed in line with national and international best practice safety guidance, including in storage and access control.
- High nursing vacancy rates on some medical wards had resulted in health care assistants (HCAs) and junior nurses being left in charge of patients they were not competent to look after.

Medical care (including older people's care)

- Not all audits taking place had been reported and registered by staff leading those audits. This meant that it was not always possible to obtain an accurate reflection of the nature and extent of audit activity in the hospital in order to measure outcomes on a wider scale.
- While the majority of patients and relatives we spoke with told us they had positive experiences on the medical wards there were others who told us they had not been treated with dignity or respect.
- Referral to treatment (RTT) times were not met in rheumatology where 80% of patients were seen within the target of 18 weeks.
- Cancer treatment times did not meet the national two-week standard in relation to lung cancer. In November 2016, 61% of patients were seen within two weeks.
- The average occupancy rate in medical services between November 2015 and November 2016 was 99%. When occupancy runs above 85% there is an increased risk to patients.
- Complaints were not responded to in a timely manner. The average response time in medical services was 34 days, which was longer than the hospital's target of 25 days.
- There were low patient repatriation rates from the hyper acute stroke unit within 24 hours with compliance as low as 17% in October 2016, 33% in November 2016, and 11% in March 2017.
- Staff working on the wards had limited understanding of the trust's vision and strategy or local ward development plans.
- There were discrepancies between what staff on the wards said the risks in the service were and the understanding of risks in the leadership team.
- On some of the wards, staff said they were demoralised which they staff attributed to high vacancy rates, increased workloads, being constantly moved around to cover other wards, and a lack of support from matrons who staff thought should have been doing more to support them.
- Staff across medical wards reported a culture where they were not valued, or respected by matrons.

However:

- Even though elements of the vision and strategy were yet to be implemented, it was clear and credible.
- The hospital was responsive to the needs of patients living with dementia. There were various initiatives to increase awareness of dementia through the hospital's dementia strategy.
- Staff were knowledgeable about safeguarding.
- Although the hospital's overall grading in the Sentinel Stroke National Programme (SSNAP) had been downgraded from A to B in March 2017, a grading of B is above national average and demonstrates a good level of performance.
- The work of the transformation team had led to some improvements in processes and in the flow of patients within the hospital.
- The introduction of the flow coordinator in the MAU had resulted in an improvement in the flow of patients from the emergency department to the MAU and other medical wards.
- There had been an increase in consultant numbers in the Acute and Emergency Medicine division from six to ten between October 2016 and March 2017.
- The opening of the ambulatory care unit had helped reduce pressure on bed capacity.
- Daily multidisciplinary safety huddles and board rounds enabled staff to identify patients who were deteriorating, review patients with complex needs and plan for safe and effective discharges.
- The hospital demonstrated it was responsive to the needs of patients suffering from mental disorders.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated medical services as requires improvement for safety because:

- There was limited assurance about the safety of patients in particular in relation to the 'monitored bays' on the Medical Admissions Unit (MAU) and the Coronary Care Unit (CCU). Some but not all patients in these areas level two patients but the hospital did not recognise these areas as level two areas. This meant patients did not receive the standard of care they would normally receive under the Faculty of Intensive Care Medical (FICM) guidance.
- Care on CCU and the monitored beds in MAU was not always provided by staff with the competence to care for acutely unwell patients requiring high levels of nursing interventions.
- On our unannounced inspection, we found medicines that had expired on Hawthorne and Ash wards. This included controlled drugs.
- Vacancies in medical care were high in relation to nursing staff and junior doctors. Two wards each had a nursing vacancy rate of 50% at the time of our inspection.
- Some staff reported that high vacancy rates affected patient care and put patients at risk, in particular in relation to medicines being given late when wards were short staffed.
- The hospital was actively trying to recruit into nursing posts but there was limited evidence of success.
- There was a significant lack of patients' venous thromboembolism (VTE) assessments. VTE is the formation of blood clots in the vein. VTE assessments had not been completed in 15 of the 23 records we checked for completion of VTE assessments during the inspection. We checked both the electronic and paper records.
- Systems and processes around incident reporting did not always ensure staff reported all incidents or near misses or that staff received feedback on incidents and there was no evidence of learning from serious incidents, particularly in relation to VTE assessments.
- There was ad hoc testing and recording of patient blood sugar levels on Alder ward (the diabetes and endocrinology ward). Staff told us blood sugar should be tested every four hours but this was not reflected in the two of the three records we checked. There were concerns raised by some staff about blood sugar monitoring not being done for patients on this ward. This was not in line with best practice guidance for diabetic patients and put patient's safety at risk.
- Mandatory training completion rates frequently fell below the hospital's target of 85% for both medical and nursing staff. For medical staff, ten out of eleven mandatory training modules did not meet this target. For nursing staff, nine out of 15 mandatory training modules did not meet this target.
- There was room for improvement in cleaning standards, including on Beech ward where we found faeces/stools on the floor in the female patient toilet on the day of the unannounced visit
- Staff on three medical wards told us they felt their wards were unsafe. On one ward, four staff said they would not recommend that their relative be treated on that ward.
- The standard of infection control processes, including waste management and adherence to the control of substances hazardous to health guidance, were variable. Hazardous waste was not always managed in line with national and international best practice safety guidance, including in storage and access control.
- Staff did not always act when medicine fridge temperatures fell outside the optimum temperature of the manufacturer. This meant medicines may not have been effective.
- There were no negative pressure rooms on the respiratory ward and staff expressed concerns that patients with tuberculosis were not always properly isolated as a result. On the day of our unannounced inspection, there were two patients with tuberculosis on the respiratory ward. This meant there was a risk to other patients and staff.
- Complaints were not responded to in a timely manner. The average response time in medical services was 34 days, which was longer than the hospital's target of 25 days.

However:

Medical care (including older people's care)

- Staff demonstrated consistent infection control practices in relation to hand washing, decontamination, and the use of personal protective equipment and adherence to the bare below the elbow policy.
- There was consistent performance in hand hygiene audits across medical services with most wards meeting the hospital's 95% target.
- Nurses documented risk assessments for patients on admission, including for pressure sores and malnutrition. Processes were in place to monitor deteriorating patients, including use of the national early warning scores.
- Medical care services reported no never events between October 2015 and September 2016.
- There was secure storage of medicines on six of the seven wards we inspected.
- Across the medical wards, staff consistently and effectively used the national early warning scores to assess and respond to patient risk.
- There had been an increase in consultant numbers in the Acute and Emergency Medicine division from six to ten between October 2016 and March 2017.

Incidents

- Between December 2015 and November 2016, medical care services reported no never events. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers
- In accordance with the Serious Incident Framework 2015, medical care services at University Hospital Lewisham reported 10 serious incidents (SIs) that met the reporting criteria set by NHS England between December 2015 and November 2016. SIs included an outbreak of diarrhoea and vomiting in February 2016, failure to implement care and ongoing monitoring of an acutely unwell patient in July 2016 and missed venous thromboembolism (VTE) assessments and treatment resulting in probable pulmonary embolism and cardiac arrest in October 2016. In addition, in September 2016, a patient was discharged with another patient's medicine.
- We looked at four serious incident root cause analysis reports in the period February 2016 to October 2016. A senior matron, a consultant cardiologist, and the head of nursing had each led a root cause analysis for the four SIs. There had been a review of each patient's pathway through the hospital and appropriateness of their care and treatment. In each case the person investigating had identified factors that contributed to the SI, where staff had acted appropriately and where there was an opportunity for learning and arrangements for shared learning which included discussion of findings at monthly divisional governance meetings, sharing through the Acute and Emergency Medicine Newsletter, ward sisters' meetings, matron meetings and morbidity and mortality forums.
- Each report included evidence of compliance with the duty of candour, multidisciplinary communication and the effectiveness of the care pathways used.
- Between December 2015 and November 2016, staff in medical care services reported 3700 incidents. Of the incidents, 77% resulted in no harm to patients, 1.4% were near misses, 20% resulted in low-level harm to patients, 1.4% resulted in moderate harm to patients, 0.1% resulted in severe harm to a patient, and 0.1% related to the death of a patient. Of all incidents, 24% related to pressure ulcers and 23% related to slips, trips and falls. These were the highest category of all incidents reported.
- Staff submitted an incident report for each pressure ulcer either acquired on site or that deteriorated on site. The status of patient's pressure areas was part of staff handover. Information boards with leaflets and information on pressure ulcers were on display on the wards as part of a wider strategy to reduce pressure ulcer incidents.
- Staff were encouraged to report incidents and were able to describe the process of incident reporting via the hospital's intranet system. There was evidence most staff understood their responsibility to raise concerns and to record safety incidents and near misses.
- However, during our inspection, we received information from staff on two wards that some incidents were routinely not reported. On Alder ward, which is the diabetes and endocrinology ward, staff told us they did not report some incidents because of increased workloads and lack of time to complete the incidents. These incidents included insulin given at the wrong time, missed doses of antibiotics and antipsychotics, and treatment for patients with hypoglycaemia (low blood sugar level) not being given on time. There were concerns raised by some staff about blood sugar monitoring not being done for patients on this ward.

This was not in line with best practice guidance for diabetic patients and put patient's safety at risk. Alder ward reported 158 incidents between December 2016 and March 2017. Of these 18 (11%) related to medicines.

- On Maple ward one staff member told us incidents of verbal abuse of staff by patients or relatives were not reported. Following the inspection, we asked for data relating to incidents reported during the inspection. Incidents received from the hospital did not reflect an incident of verbal abuse to staff on Maple ward which occurred during our inspection which we would expect to have been recorded. Also, an incident where security staff were called to Alder ward on the day of our unannounced inspection had not been reported. A failure to report all incidents meant that the service was not always aware of patient safety incidents or the risk to staff and patients or trends in order to make necessary improvements.
- There were variable responses from staff about obtaining feedback following incident reporting. For example, some staff told us they did not get feedback after reporting an incident with most staff stating the only feedback was a request for more information to allow those investigating to complete their reports. This meant there was room for improvement in how senior staff ensured systems for staff learning from incidents were effective. In other areas staff reported practice development nurses (PDNs) had met with them to address areas of learning following an incident but this was not consistent across the medical wards.
- We saw evidence of learning following a root cause analysis of an SI. Following an incident where a patient was sent home with another patient's medicine in September 2016, the service implemented a new protocol where all to take out (TTO) medicines were checked by two trained nurses with the patient. The Acute and Emergency Medicine Newsletter for January 2017 reminded staff of the new protocol.
- However, there was also evidence the service did not always learn from serious incidents. In October 2016, a patient died following probable pulmonary embolism and cardiac arrest linked to missed VTE assessments and subsequent failure to treat VTE on Cherry ward. The SI investigation report found that staff had overridden the VTE electronic reminders by indicating on the electronic system that VTE assessments had been completed on paper when they had not. A review of records on the coronary care unit (CCU) considered part of and staffed by staff from Cherry ward during our inspection showed that five out of seven VTE assessments had not been completed electronically or on paper. This meant there was a risk of the SI happening again.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We found that staff had a good knowledge of duty of candour and senior staff were knowledgeable about their responsibilities in relation to this duty.
- We requested minutes of the service's mortality and morbidity meetings, which showed that the service used these meetings as a platform to discuss incidents. We also asked for information on an action plan for the SI involving an outbreak of norovirus in February 2016 to assess whether the service took action in response to the action plan. We found there had been an audit of stool charts on all medical wards, which was consistent with the SI action plan.
- Clinical staff from the Alexis Clinic provided medical care across the hospital for any patient admitted with HIV. This team submitted incident reports in relation to the specific area in which it took place and then followed up with the senior member of the team responsible for that area. For example, a nurse found one patient lying in soiled bed sheets. They estimated the patient had been lying in that condition for over four hours and submitted an incident report. They said the matron for that area attributed this to short staffing and did not feel that a solution was found. In another instance, a patient with a neck wound was found to develop an abscess over the weekend when staff had not cleaned the wound. A nurse from the Alexis Clinic cleaned the wound and then submitted an incident report.

Safety thermometer

- The NHS safety thermometer is used to record the prevalence of patient harm in wards and clinical areas and to provide immediate information and analysis to teams to monitor their performance in delivering harm free care.
- Each inpatient ward displayed a safety dashboard that tracked monthly safety thermometer events such as falls and pressure ulcers. Senior level staff such as ward managers and matrons were aware of this information

and were able to tell us how many safety thermometer events there had been on their wards. However, junior level staff were not always aware of the information even though this information was readily accessible.

- A falls practitioner worked with staff on the medical wards and staff were encouraged to refer all falls patients to the falls specialist nurse. We also found there were falls champions on the wards who were staff who had received additional education and mentoring on falls prevention strategies and raised awareness about the importance of preventing falls.
- Safety thermometer data was reviewed at various meetings such as the elderly care cluster meetings, Acute and Emergency Medicine governance meetings and matron meetings.

Cleanliness, infection control and hygiene

- Infection prevention and control link practitioners provided a number of preventative services in the hospital to support staff and protect patients from the risks associated with infection. Names of link practitioners were on display on the medical wards. The practitioners worked with staff around infection prevention and control alerts and were responsible for ensuring best practice and learning was shared with colleagues.
- Infection control boards were displayed on medical wards and information included reminders to staff about the World Health Organisation 'five moments for hand hygiene' standards as well as reminders to screen for MRSA on admission.
- Personal protective equipment (PPE) such as disposable gloves and antibacterial hand gel was readily available in most areas we visited. This included at the entrance to ward areas and in each bed space or private room. We observed staff consistently follow hand hygiene procedures including hand washing between patients or when leaving a private room used to look after a patient with an infectious condition. This was in line with best practice.
- The trust had a 'bare below the elbow' policy to prevent the risk of cross-infection between patients and wards. During all of our observations staff adhered to this.
- Disposable curtains separated bed spaces and were labelled with the first use date. Staff used this to ensure they were disposed of in line with the manufacturer's guidance.
- Staff used 'I am clean' labels to indicate when an item of equipment or furniture had been cleaned and decontaminated. We observed consistent use of this process by housekeeping staff, healthcare assistants (HCAs) and nurses.
- Medical areas were mostly visibly clean and tidy. However, on our announced inspection we found a female patient toilet on Beech ward had stools/faeces on the floor. We raised this with the nurse in charge and the toilet was cleaned immediately.
- Monthly hand hygiene audits took place in each clinical area or ward and the trust had a minimum compliance target of 95%. Between February 2016 and February 2017, average overall compliance was 94%. This reflected consistent levels of compliance with hospital policy that met or exceeded the minimum target, with the exception of hand hygiene before patient contact on Alder ward (87%) and Cherry ward including the CCU (88%). During this period the Alexis Clinic achieved 100% in hand hygiene, infection control and personal protective equipment audits.
- Staff reported one incident of methicillin-resistant staphylococcus aureus (MRSA) and three cases of clostridium difficile (C.Diff) in medical care services between April 2016 and August 2016. The trust identified the need for staff to follow the established protocol for processing analysis stool samples. In one case, a stool sample had not been taken and in the other cases samples had been sent for analysis late. The hospital also identified that staff needed to improve on medical documentation. This was identified as part of the serious incident investigations.
- MRSA screening was inconsistent across medical care services. An audit carried out in December 2016 showed screening rates ranged between 67% and 97%. One of the two stroke units (Beech ward) and the diabetes and endocrinology ward (Alder ward) demonstrated the highest rates of screening. Both Beech and Alder wards scored 97%. Oak ward (67 %) and Laurel ward (69%) showed the lowest number for screening on admission performing below the trust's target of 80%. Infection control notice boards reminded staff to screen patients for MRSA on admission but we did not see any other evidence of staff on Oak and Laurel wards acting to improve on the low screening rates from the MRSA audit.

- In January 2017, the hospital carried out a personal protective equipment (PPE) and isolation audit. Compliance rates ranged between 83% and 100% for both PPE and isolation against a target of 95%.
- An audit of C.Diff between February 2016 and February 2017 showed 97% compliance overall. The audit looked at correct hand hygiene, use of gloves and aprons, use of single rooms, and whether staff adhered to policies on antibiotics.
- There were no negative pressure rooms on the respiratory ward and staff expressed concerns that patients with tuberculosis (TB) were not always properly isolated as a result. On the day of the unannounced, there were two patients with TB on the respiratory ward. This meant there was a risk to other patients and staff.
- Housekeeping staff used a colour-coding scheme for mops and buckets, which was in line with infection prevention best practice.
- The decontamination of endoscopy equipment was carried out onsite.

Environment and equipment

- An audit of the decontamination of clinical equipment showed 92% overall compliance on the medical wards. The audit looked at whether equipment was decontaminated in the correct location, whether staff washed their hands before and after cleaning equipment and whether staff wore PPE and disposed of it correctly. The audit also checked whether cleaned and decontaminated equipment was stored away from cleaning areas. The lowest score overall was on Cherry ward (77%) and the highest was 100% on Aspen, Chestnut and Alder wards.
- Most ward areas and the endoscopy unit were visibly clean and tidy.
- Storage of chemicals was not always in line with the control of substances hazardous to health regulations (COSHH). On Alder ward, chlorine tablets were kept in an unlocked cupboard in an unlocked room and this was against COSHH regulations. These substances should have been stored in a locked facility.
- Waste management and storage did not always meet the requirements of the European Waste Framework Directive (2008/98/EC). For example, on Alder ward 12 sharps bins were stored in an unlocked sluice room despite there being a keypad on the door. On Ash ward, four closed sharps bins had been stored on the shelf in an unlocked dirty utility room. The storage of sharps bins in unlocked areas was against waste directive HTM 07/01 (2013). All used sharps bins and bags should be stored in a locked area awaiting collection.
- On Hawthorne ward, temporary closures on sharps bins were not always in place, which was against the EU Directive EU/2010/32 prevention from sharps injuries in hospitals.
- The service carried out an environmental audit on Oak, Ash, Elm, and Sapphire wards in June 2016.Results were variable but there was poor performance in relation to a comfortable level of lighting, access to a garden or outside space, and signage on toilet doors. The wards scored higher in the availability of social areas such as day rooms, cleanliness of ward areas, and availability of enough space and chairs for staff and carers to help with eating and drinking.
- Emergency equipment in the Alexis Clinic included an automatic defibrillator, emergency medicine, oxygen cylinders and masks for adults and children. All of the equipment was in working order and we found staff consistently documented daily safety checks.
- All items of electrical equipment we checked had an up to date portable appliance testing (PAT) 'pass' check for safety.
- On Ash ward, we found razors and hand gel that should have been locked in the clinical room were left in unlocked cupboards.
- The environment in the Alexis Clinic did not always keep staff safe from harm. For example, the reception desk was not equipped with a panic alarm or an immediate way of calling security. Although an intercom system was installed to control access, the trust had not provided CCTV. We spoke with staff about this who said they had raised this as a risk with the senior site team but there had not been a resolution to date. The service had banned patients who had physically assaulted staff but there was no immediate protection in the clinic. After our inspection the trust told us they could not provide CCTV in this area due to patient confidentiality and that no requests for CCTV had been received.

Medicines

- We visited the treatment rooms, storage rooms and medicine preparation areas on seven wards in the medical care services including the ambulatory care unit. We found medicines were stored securely on six of

the wards. However, we found an unlocked drug trolley on Hawthorne ward on the day of our unannounced inspection. Drug trolleys must be locked and secured to prevent unauthorised persons from accessing drugs.

- Registered nurses were responsible for the keys to the drug cupboards and lockers. On one day of our inspection a nurse on Cherry ward went on their lunch break with the medicine keys. This meant that if other staff on the ward needed to access medicines quickly they could not do so potentially putting patients at risk. When we had asked about this staff told us this had been an oversight and not a regular occurrence.
- Staff checked and recorded controlled drug stock daily. During the inspection, we found there was a good track record of practice. This was also reflected in the results of the matrons' two weekly quality rounds. Two nurses checked controlled drugs prior to administering to patients and this practice was consistent across the medical wards.
- Staff checked and recorded temperatures for fridges used to store medicine twice daily. On Ash and Laurel wards we found that staff did not always take action in relation to fridge temperatures that were outside the optimum range established by medicine manufacturers. Where staff recorded fridge temperatures outside the optimal temperatures, they had simply reset the fridge without taking action to check if medicines could have been affected, which meant some medicines may no longer have been effective.
- In all areas we visited, intravenous (IV) medicines and antibiotics were stored securely and in line with the medicines policy.
- On five of the seven wards we found that medicines were in date. However, on Hawthorne ward, we found five adrenaline syringes had expired in February 2017. On Ash ward we found three boxes of expired metoclopramide (commonly used to treat and prevent nausea and vomiting), which had expired in February 2017, and one lorazepam injection which had also expired in January 2017. We made the nurse in charge aware and these medicines were removed.
- Between December 2015 and November 2016 staff in medical care services submitted 274 incident reports relating to medicines. Overall, this represented 7% of all hospital incidents.
- PDNs provided support if it was deemed more learning or clinical supervision was required in safe medicines management and administration.
- Senior pharmacists conducted medicines safety walkabouts with practice development nurses to collect data on several medicines management indicators such as documentation, and storage and administration of medicines. For the month of February 2017, it showed there were satisfactory controlled drug balances and checks on the medical wards. However, the recording of the walkabout checks was not consistent. There was no data recorded for Chestnut and Mulberry wards for January 2017 and there was data for only three wards in December 2016.
- On Laurel ward, we asked a senior nurse if there was a critical medicine list on the ward and they were not able to locate it. However, they were able to explain what action they would take if a patient was prescribed a medicine on the critical list. Critical medicines are those where their omission or delay is likely to cause the most harm and timeliness of administration is crucial.
- Delays in giving TTO medicines to patients declared medically fit for discharge was described as the main reason for discharge delays. The transformation team had been working with pharmacy and ward staff to improve discharge processes including patients' medicines on discharge.
- The pharmacy department carried out quarterly audits of controlled drugs in medical and emergency services. The safe storage audit report for quarter two in 2016/17 showed 100% compliance with secure stock medicine, which was an improvement of 4% from the previous quarter. The audit identified an improvement of 7% in areas with secure drug fridges. However, only 39% of areas had the temperature of clinical rooms equal to or less than the target of 25°C. This was a decline from 61% in the previous quarter. Areas with fridge temperatures measured daily scored 70%, which was a decline of 18% compared to the previous quarter.
- The pharmacy controlled drug audit for quarter two in 2016/17 showed 100% compliance in relation to strong potassium IV fluids correctly stored as controlled drugs and in keys kept securely. These two figures were unchanged from the previous quarter where the division scored 100%.The lowest rate of compliance was 81% for unwanted or expired controlled drugs returned correctly. This was a decline from previous the previous quarter where this indicator scored 85%.
- The Alexis Clinic offered a home delivery service for antiretroviral medicine for known patients who were stable on their treatment.

- Clinical nurse specialists in the Alexis Clinic were nurse prescribers and prescribed medicine according to patient group directions that the lead consultant maintained. The pharmacist checked each prescription before it was dispensed.

Records

- Patient records were kept both electronically and on paper. During our inspection we reviewed records from both sources. We found patients' individual care records were not always completed in a way that kept patients safe. For example VTE assessments were not always completed by staff in line with trust policy and best practice. VTE is the formation of blood clots in the vein. During the inspection, we checked 23 patient records for completion of VTE assessments on Elm, Oak, Laurel, Beech and Alder wards. Of the 23 records, 15 did not have VTE assessments electronically or on paper. This amounted to 65% of the records. VTE assessments help professionals identify patients with an increased risk in order to put treatment plans in place to reduce the risk. Failure to record assessments meant that patients with the risk of developing VTE were not always identified.
- We also found that staff did not always record patients' visual infusion phlebitis (VIP) score. All patients with an IV access device in place must have the IV site checked at least daily for signs of inflammation of the vein. The findings are scored and make up the VIP score which forms the basis of how the IV site is managed ranging from monitoring it, changing it or initiating treatment. Results of the matron quality round audit for the end of February 2017 showed that staff on Ash, Aspen and Elm wards had not completed VIP scores for all patients. This meant that there was a risk of staff failing to escalate a high VIP score and as such putting a patient at risk.
- Compliance in the documentation audit across all medical wards between August 2016 and February 2017 ranged between 90% and 98%. The lowest scores across the wards were in relation to the patient's name not being printed on other pages of used documentation with some wards scoring 0% in that category.
- We found that nursing notes did not always expand on the issues raised during assessments For example, staff ticked boxes but did not expand on this in the patient's records. For example, there would be a fluid chart completed but no corresponding entries in the nursing notes to expand on the care/treatment plan.
- We observed staff maintained the security of patient records in line with information governance policies. This included using locked storage units and ensuring constant supervision when records were removed.
- We looked at 14 patient records and found 12 of them to have been completed legibly. However, we found the name and grade of the person completing the documentation was not always clearly documented.
- Hospital audit data from September 2016 to February 2016 showed high compliance rates for VTE completion across the medical wards. There was 100% completion in 12 out of the 13 medical wards audited. One ward had 99%. However, these results did not reflect our inspection findings in relation to the completion of VTE assessments.
- An electronic patient records system was being introduced in the Alexis Clinic and was due to be fully in place by September 2017. New patients were registered on the hospital's general records system so that if they were admitted as an inpatient, consultants had access to their most recent HIV-related data such as viral load.

Safeguarding

- The hospital had a safeguarding training completion target of 85% for medical and dental staff. As of January 2017, 100% of medical staff had up to date safeguarding children and young people level one training. Medical staff did not meet the minimum completion target in the remaining five safeguarding modules, including in the Mental Capacity Act (MCA) 2005.
- The completion target for safeguarding training for nursing and midwifery staff was also 85%. As of January 2017, the nursing team exceeded the target in all four modules. This included safeguarding children and young people level two (92%) and MCA training (92%).
- Staff accessed safeguarding policies electronically on the intranet and individuals we spoke with during the inspection could demonstrate how to access this policy.
- Staff were knowledgeable about the hospital's safeguarding policy and were able to give examples of what might constitute a safeguarding concern. Staff were also aware of their responsibilities in relation to safeguarding vulnerable adults.
- Safeguarding team noticeboards were visible on some of the wards, for example, Cherry ward. Photographs

and names of the safeguarding team were displayed. This meant that staff could easily contact the safeguarding team in the event of a safeguarding concern.

Mandatory training

- The trust target for rates of up to date mandatory training was 85% for medical staff. As of January 2017, medical staff had an 88% completion rate for equality & diversity. However, they did not meet the target in 10 out of 11 mandatory training modules. This included the adult and paediatric resuscitation training (45%) and the workshop to raise awareness of prevent (WRAP) training (30%).
- The trust had a mandatory training completion target of 85% for nursing & midwifery staff. The nursing team l achieved 100% completion rate for equality & diversity, non-clinical fire safety and non-clinical infection control training. The team met or exceeded the target in three other modules and did not meet it in nine out of 15 modules.
- We spoke with nurses and health care assistants (HCAs) about mandatory training. Most staff spoke positively about the training provision in relation to how it equipped them for their roles. However, some staff told us they did not have time to complete training during working hours due to the fact that wards were often short staffed. This meant that they completed training in their own time because they were not given protected time at work, which meant they were not paid for training.

Assessing and responding to patient risk

- In line with National Institute for Health and Care Excellence (NICE) guidance, staff used the national early warning score (NEWS) system to identify patients at risk of deterioration and trigger escalation to the patient's medical team or the critical care outreach team. The NEWS protocol was used to establish the frequency of patient observations. Stable patients had fewer observations and there was continual monitoring for acutely unwell patients. The use of the NEWS scores was consistent on the medical wards. We checked ten patients records for the recording of patient observations including NEWS scores during our inspection and found these were recorded in all ten records.
- Staff knowledge on the use of NEWS was also consistent across the wards. During our unannounced inspection two members of the outreach team were on call and had reviewed a patient on the respiratory ward.
- The use of NEWS across the trust was audited in 2015 and again in December 2016. The audit showed improvements in the recording, calculation, and escalation of patients by staff where the NEWS score indicated deterioration. The audit recommended the implementation of an electronic early warning score system. It also recommended that all vital signs be interpreted by a qualified member of staff and regular audits by practice development nurses. At the time of our inspection the recording of NEWS scores was still paper based.
- Daily safety huddles and 'board rounds' took place on each ward with multidisciplinary staff in attendance. Multidisciplinary staff teams used the safety huddle to review planned discharges, pressure sores, safeguarding concerns, any Deprivation of Liberty Safeguards (DoLS) applications, and any patients subject to the Mental Health Act. Staff also used safety huddles to discuss patient risk and corresponding treatment plans.
- In January 2016, the hospital introduced the sepsis care bundle, which was a new approach to the assessment of patients with sepsis. Staff also used the sepsis screening and management tool that followed the principles of the Sepsis Six protocol. This is national best practice guidance to identify risks in patients using predetermined criteria. Information on sepsis management was displayed on the wards.
- An enhanced care policy had recently been introduced and implemented on the medical wards. Patients presenting with the same risk were nursed together in 'cohort bays' where a member of staff was always present. For example, people presenting with a risk of falls were nursed in a cohort bay with a view to reducing patient falls. The same policy was also used for patients with cognition impairment.
- Some staff told us the hospital's new enhanced care policy did not always mean patients were safe. For example, if one HCA looked after a bay of four people all with a risk of falls or all with cognition impairment there was a danger they would be constantly moving from one patient to another. Others stated the policy failed to take into account the needs of patients. For example, looking after a patient with both dementia and risk of falls meant more than one HCA/nurse was required per

bay for the policy to be effective. Following the inspection, we requested information on whether the enhanced care policy had been successful in reducing falls and the information provided by the service showed there were 139 inpatient falls in December 2017, 144 in January 2017, 119 in February 2017 and 124 in March 2017.

- Staff were encouraged to monitor pressure areas early in order to prevent pressure ulcers. This included early monitoring and effective moving and handling of patients. Records showed staff carried out a risk assessment of pressure ulcers within six hours of admission. There was further monitoring of pressure ulcers throughout during the inpatient stay and regular updates during handovers.
- Staff had access to tissue viability nurses who attended the ward where patients were admitted with a grade two or above pressure ulcer.
- Shift handover documentation was detailed and included information on patients with specific risks, such as falls and pressure ulcers .The patient information board in each ward provided staff with a summary of the key risks on the ward, including patients with a DoLS authorisation in place, dementia or a safeguarding alert.
- Staff had access to a psychiatry liaison team and specialist mental health support. During our inspection we saw psychiatric liaison teams and registered mental health nurses on wards where patients had a history of mental disorder or had been detained under the Mental Health Act (MHA) (1983).
- The critical care outreach team could arrange for patients to be admitted to the high dependency unit or intensive care unit if their condition deteriorated or they needed life support.
- A security team was in place to respond to incidents of aggression by patients or incidents where a patient cared for with a Do LS authorisation attempted to leave the ward.
- Ambulatory care patients who deteriorated were transferred back to the accident and emergency department.
- There was ad hoc testing and recording of patient blood sugar levels on Alder ward (the diabetes and endocrinology ward). Staff told us blood sugar should be tested every four hours but this was not reflected in the two of the three records we checked. There were concerns raised by some staff about blood sugar monitoring not being completed for patients on this ward. This was not in line with hospital's policy and guidance for diabetic patients and put patient's safety at risk.
- An HIV consultant was available on-call 24-hours, seven days a week. An escalation protocol was in place overnight and at weekends and meant ward-based teams could obtain specialist input for patients who were deteriorating and also HIV positive.
- Where HIV positive patients refused to take antiretroviral medicine, clinical staff worked with the patients' GPs to develop a risk management plan.

Nursing staffing

- The trust used the safer nursing care tool (SNCT) to assess levels of acuity and dependency of inpatients and help determine and plan optimal nurse staffing levels. The trust also used an electronic system that allowed for the comparison of staffing levels and skill mix to the actual patient demand to support the identification and assurance that staffing levels and skill mix met patient need.
- During the inspection, we found that actual staffing levels mostly met the planned staffing levels albeit by use of bank and agency staff in some areas.
- Nurse vacancy rates were significant in medical services. For example, at the time of our inspection, senior staff reported a 50% vacancy rate on Alder and Mulberry wards. The medical admissions unit (MAU) had 20 nurse vacancies and Cherry ward had 10 nurse vacancies.
- There were on going plans to recruit nurses overseas to reduce the high vacancy rates in the service. Some senior staff told us the hospital had previously recruited nursing staff from oversees but this had failed to resolve staffing concerns due to poor retention. There was therefore a concern by these staff about whether overseas recruitment would address the service's recruitment and retention issue or whether a wider change was needed in the organisation in order to retain staff.
- Staffing levels on the 'monitored bays' on MAU and on the coronary care unit (CCU) did not meet Faculty of Intensive Care Medical (FICM) guidance which applies to all units capable of looking after level two or level three critically ill patients. This was because the service did not recognise these areas as level two areas despite level two (and level one) patients being admitted there.

Level two patients are defined by the Intensive Care Society Standards 2009 and include patients receiving basic respiratory support such as the use of a continuous positive airway pressure (CPAP) and bi-level positive airway pressure (non-invasive ventilation). During our inspection, there were patients requiring basic respiratory support on MAU and CCU. For example, on the day of the unannounced inspection, there were two level two patients on MAU, one on non-invasive ventilation and the other on high oxygen flow (optiflow). FICM guidance states that there should be a minimum nurse to patient ratio of 1:2 for level two patients but because the service did not recognise CCU and 'monitored bays' in MAU as level two areas level two patients admitted onto these areas did not get the 1:2 minimum staff to patient ratio set out in the FICM standards.

- The 'monitored bays' on MAU could take up to eight patients in two bays of four. CCU has capacity for up to five patients. Staff on MAU told us the staffing arrangements meant that one nurse sometimes provided care to four level two patients in one bay as staff shortages meant that nurses did not always have an HCA to assist them. On CCU, staffing had recently been reduced from two nurses and one HCA to one nurse and one HCA. Staff told us they regularly had more than two level two patients in CCU in addition to other level one patients.
- Staff on both MAU and Cherry ward told us they were concerned that staffing arrangements put patients' safety at risk. Following the inspection, we requested additional information on staff in MAU and CCU and we were told that the patients in CCU were not considered level two patients. This was not consistent with what we found during the inspection. Staff on Cherry ward were clear that level two patients were often cared for in CCU. This included patients on high oxygen flow, continuous positive airway pressure therapy (CPAP), bi-level positive airway pressure (BPAP), and non-invasive ventilation (NIV).
- Following the inspection, the hospital told us the service used the safer staffing care tool to ensure that where patients requiring a higher level of care were being nursed on MAU or CCU, there would be additional staff. However, this was not consistent with what staff told us during the inspection.
- A staff nurse and HCA led the discharge lounge and had access to more senior clinical staff in nearby medical wards if needed. The discharge lounge also had a porter working as part of the team.
- The hospital reported their staffing numbers for medical care below the established number as of January 2017 with an overall deficit of 95 whole time equivalent (WTE) for nursing staff. There should have been 455 WTE nurses but there were 360 WTE in post.
- Data received from the hospital prior to the inspection indicated a 24% vacancy rate in medical services.
- Data received from the hospital prior to the inspection indicated that the nurse turnover rate for medical services was 11%, which was similar to the overall hospital nurse turnover rate of 12%. Nurses in medical care had an average sickness rate of 5%, which was slightly lower than the hospital average of 7%.
- Medical services reported 11% use of bank and agency staff between April 2016 and November 2016.This was the same as the average for the hospital in that period. The hospital used bank and agency staff to cover gaps in the staffing levels but they were not always successful in obtaining cover. For example, on 22 March 2017 MAU, which should have been covered by 10 nurses, had only five nurses and HCAs. Senior nurses and ward managers had access to bank and agency staff and told us they prioritised staff who had previously worked on the ward for continuity.
- Sapphire ward, the community ward, was staffed entirely by agency staff. The ward manager was also from an agency. Senior staff also used bank and agency staff to cover gaps in staffing for the escalation ward Hawthorne. This was because this ward was only opened during times of high bed demand in the hospital in order to increase capacity. We did not find the fact that these wards had high rates of agency staff use affected patient care any differently in comparison with other wards.
- Staff raised staff shortages as a safety concern sighting risks such medication being given late, failure to fully complete patient assessments and care plans, and failure to report incidents. Following the inspection there was evidence of incidents which took place during our inspection which had not been reported.
- Two endoscopy nurses and an HCA were present for each procedure in the endoscopy unit.

Medical staffing

Medical care (including older people's care)

- The availability of consultants on the medical wards varied across the wards. MAU had more consultant presence in comparison to the rest of the medical wards.
- A clinical lead consultant, locum consultant and senior house officer led HIV care in the Alexis Clinic. GP trainees also rotated through the clinic. A specialist registrar was also on call to provide additional capacity and to review medical inpatients who were usually under the care of the Alexis Clinic.
- An HIV consultant, senior house officer, clinical nurse specialist and pharmacist conducted a weekly ward round across the hospital for every inpatient known to be HIV positive.
- Senior staff reported a shortage of junior doctors, which made it difficult for the hospital to provide a rota that covered all the wards fully. On some medical wards, nursing staff told us there were gaps in the junior doctor cover. As a result, the hospital was looking at alternatives such as the employment of physician associates and working with other hospitals. This had not come to fruition at the time of our inspection.
- The risk register for the hospital showed there were gaps in recruitment with 13 consultant vacancies and significant vacancies for junior doctors.
- Each speciality ward had a dedicated consultant allocated each month as part of a specialty team model of working. The consultant led ward rounds and provided supervision for the junior medical team during office hours. A dedicated consultant was based in the MAU between 8am and 8pm.There was a dedicated resident acute consultant on site 8am to 8pm every day including weekends, with on call cover between 8pm and 8am.
- Cover for medical wards overnight and at weekends was provided by a resident medical registrar, two resident senior house officers (SHOs) and two foundation year one junior doctors from 8am to 8pm on weekends and from 5pm to 9.30pm on weekdays.
- The ambulatory care unit had onsite consultant cover between 8am and 5pm Mondays to Fridays. There was also registrar support between 9am and 5pm Monday to Friday.
- Between April 2016 and November 2016, the vacancy rate for medical staff in medical services was 3.7%, which was better than the vacancy rate for the hospital (9.4%).The average turnover rate for medical staff for the hospital was 10% between April 2016 and November 2016. In medical services, the turnover rate was 12%, which was worse than the hospital average.
- Between April 2016 and November 2016, the hospital reported 9% use of bank and locum medical staff, of which 5% were in medicine. At the time of our inspection there was one locum doctor in care of the elderly services and two locum doctors in acute medicine.
- There was evidence patients were seen by specialists for their medical condition. For example, two consultants were available on the stroke wards, Beech and Maple. Diabetes consultants saw patients on Alder ward. However, staff reported that a consultant cardiologist did not always see cardiac patients on Cherry ward and CCU. We asked the service for information on how often a consultant cardiologist saw patients on Cherry and CCU but the service did not provide this information.
- Senior staff reported a shortage of junior doctors, which made it difficult for the hospital to provide a rota that covered all the wards fully.
- In October 2016, the hospital implemented changes to the working practices of medical and care of the elderly teams to improve the experience of patients and the workload of medical teams, particularly trainees. This involved the implementation of a separate care of the elderly and acute medicine rota with extended geriatrician cover on the care of the elderly ward and MAU. The geriatrician also covered the 18 frailty beds on MAU. Five consultant physicians were allocated to cover 20 acute admission beds on MAU, and the ambulatory care unit, which opened in November 2016.The consultant physicians provided overnight on-call cover between Mondays and Thursdays.
- There was cross-site working in cardiology in relation to gastroenterology staff. Staff could bleep a consultant on either hospital site to attend. However, consultant cardiologist cover was minimal and the plan was to have more cardiologists covering the hospital.

Major incident awareness and training

- There was a hospital wide major incident plan, which detailed what roles staff needed to take during an incident.
- The hospital's fire safety policy included the protocol staff should follow in the event of a fire. Training data received from the hospital indicated that 43% of

medical and dental staff had completed fire safety training. For nursing and midwifery staff 100% of non-clinical staff had completed fire safety training and 60% of clinical staff had completed fire safety training. The completion target for safeguarding training for nursing and midwifery staff was also 85%. As of January 2017, 87% of nursing staff had completed emergency planning training.

Are medical care services effective?

Good

We rated medical care services as good for effective because:

- There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation.
- Although the hospital's overall performance in the national Sentinel Stroke National Programme (SSNAP) audit had been downgraded from A to B in the most recent results (March 2017), a grading of B was still above the national average.
- Staff planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. The senior team monitored this to ensure consistency of practice.
- Staff used the malnutrition universal scoring tool (MUST) for each patient on admission to assess their nutrition and hydration needs. We found fully completed nutritional risk assessments in all 12 records we looked at during the inspection.
- When people received care from a range of different staff, teams or services, this was coordinated. Multidisciplinary staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.

However:

- Not all staff were qualified or had skills they needed to carry out their roles effectively and in line with best practice, including in the medical admissions unit (MAU) and coronary care unit (CCU). In addition, the learning needs of staff were not always identified and training put in place to meet those learning needs.
- Not all audits taking place had been reported and registered by staff leading those audits. This meant that it was not always possible to obtain an accurate reflection of the nature and extent of audit activity in the hospital in order to measure outcomes on a wider scale.
- Between March 2015 and February 2016, patients in medical services had a higher than expected risk of readmission for non-elective geriatric medicine admissions.
- Performance in the 2015 Heart Failure Audit was worse than the national average for eight of the 13 standards.
- The trust participated in the 2015 lung cancer audit and the proportion of patients seen by a cancer nurse specialist was 56%, which was worse than the audit minimum standard of 90%.
- In the national diabetes inpatient audit, the hospital performed significantly worse than the national average in relation to patients being seen by the multidisciplinary diabetic foot team within 24 hours. The latest available audit showed this rate was 33% lower than the national average.
- There was no seven-day provision of services in relation to the discharge lounge and ambulatory care which were only open on weekdays.

Evidence-based care and treatment

- The hospital used local and national audits to benchmark standards of care, treatment and practice in medical services against established guidance and best practice. In 2015/2016, the hospital took part in national audits such as the myocardial ischaemia national audit, the lung cancer audit and the national diabetes inpatient audit. However, not all audits taking place had been reported and registered by staff leading those audits. This meant that it was not always possible to obtain an accurate reflection of the nature and extent of audit activity in the hospital in order to measure outcomes on a wider scale
- Results from the 2015 national diabetes inpatient audit showed a need for improved foot risk assessments during stay and food timing. To improve standards in diabetes care staff had access to a diabetes specialist nurse, whose contact details were readily available.
- Staff submitted data to national audits such as the falls and fragility fractures programme for inpatient falls and for the national hip fracture database. This audit had concluded but results are pending. There was evidence clinical nurse specialists submitted data to national

databases such as the cystic fibrosis registry. This meant that the hospital could benchmark its standards against other hospitals submitting to the same audits and provide care in accordance with best practice.

- Staff provided care in line with the National Institute of Health and Care Excellence (NICE) clinical guidance 50 in relation to recognising and responding to deteriorating patients.
- The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) had accredited the endoscopy unit. This is formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the global rating scale (GRS) standards. The endoscopy unit at the hospital had held accreditation since 2012.
- Various patient pathways based on national guidance were used to guide treatment for patients with specific conditions. For example, the dementia pathway for cognitively impaired patients over 65 years old was based on the Healthcare for London Dementia services guide and best practice guidance from the Department of Health national dementia strategy 2009. This meant care was provided in accordance with best practice. The management algorithm for suspected deep vein thrombosis (DVT) in ambulatory care referenced NICE VTE clinical guideline 144 on the diagnosis and management of venous thromboembolic diseases in adults.
- The hospital's dementia clinical network group was part of the London Clinical Network for Dementia where different trusts undertook observational audits in each other's trust and provided feedback in order to encourage learning and improvements.

Pain relief

- Two pain nurse specialists were available via bleep between 9am and 5pm on Mondays to Fridays. Out of hours, the on call anaesthetic specialist registrar was available to attend to acute cases.
- As part of the matron-led quality rounds, which took place twice a month, matrons spoke with patients about how pain had been addressed by staff on the wards. The quality round carried out at the end of February 2017 showed that 100% of patients on medical wards said staff had addressed pain effectively.
- Two pain scoring systems were used in the hospital. A system was in place for patients who had the cognitive ability to tell staff about their pain. For those patients who did not

  have cognitive ability and as part of the dementia pathway, staff used the pain assessment in advanced dementia (PAINAD) tool .

  Staff used a pain assessment and management nursing care plan to establish pain and analgesia needs. The plan included five observational tools: breathing independent of vocalisation, negative vocalisation, facial expression, body language and consolability.

- Depending on the scores and on a scale of zero to ten staff were able to determine whether a patient was in no or severe pain. Staff used pain scores in the overall scoring system to identify patient deterioration.
- Patients we spoke with in all areas during our inspection confirmed their pain had been well managed and they were comfortable.
- On the oncology and haematology ward some staff expressed concerns that due to staff shortages, they were not always able to offer patients pain relief on time. They said that this meant that there were occasions when patients did not have pain relief on time. Staff told us pain relief was still given although late.

Nutrition and hydration

- Staff used the malnutrition universal scoring tool (MUST) for each patient on admission to assess their nutrition and hydration needs. This was updated weekly or more frequently if the patient was at increased risk. We found fully completed nutritional risk assessments in all 12 of the records we looked at during the inspection.
- Patients' view of the hospital food was varied. Most patients said the food was nutritious and there was a lot of choice but others felt the food was bland.
- In the national diabetes inpatient audit, 51% of patients rated their food choice as positive compared with the national average of 54%.
- In the trust's living our values survey, 89% of patients on care of the elderly wards agreed they had sufficient support and time to eat their meals.
- All patients spoken with in the matrons' quality rounds carried out at the end of February 2017 said they were happy with the food standards, temperature, choice,

and variety. Quality rounds involved matrons going onto the wards and speaking to staff and patients in order to assess the quality of the care being provided on those wards. Quality rounds took place twice a month.

- Staff told us staff shortages had affected their ability to feed patients food whilst still hot. Where one nurse or HCA was responsible for a bay of four patients requiring assistance with feeding, staff found that by the time they got to the second patient the food was cold. During the inspection, we observed three instances where only one member of staff was responsible for feeding four patients.
- The environmental audit carried out on the care of the elderly wards in June 2016 revealed that on all the wards, patients did not have independent access to snacks or finger foods. In response to this, the hospital had plans to pilot providing finger foods to patients on care of the elderly wards to encourage independence and cater for patients who preferred to eat small quantities at a time. Staff also attended the catering sub group and sampled different pureed meals, which would allow patients to eat the same amount of calories in smaller quantities.
- On one of the medical wards staff told us there was a lack of consultant radiologist out of hours and at the weekend. They said this had led to delays in patients requiring a chest x-rays following the insertion of a nasogastric tube (NG tube). An NG tube is placed through the nose into the stomach and is used for feeding and administering. Where there was such a delay a patient could only receive nutrition via intravenous fluids and staff reported delays of up to five days including weekends. This meant there was a risk of the patients' nutrition and hydration needs not being met. Following the inspection, we asked for information on the numbers of patients who had required an x-ray following NG insertion and how long they waited. Data provided by the service showed that between December 2016 and March 2017, seven patients had required a chest x-ray on Alder and Beech wards. The seven patients waited an average of 14 hours for a chest x-ray. The data showed the longest waits to be at the weekend where three of the seven patients waited over 20 hours for a chest x-ray.
- Staff referred patients requiring dietician input to the dietician and we saw from looking at records that referrals were acted on quickly.
- Meals were served by the catering department on red trays allowing for the easy identification of patients who required assistance to maintain their nutritional and hydration requirements. This initiative meant staff could identify patients who required assistance to eat and drink. Water jugs with red lids were also provided.

Patient outcomes

- Between March 2015 and February 2016, patients at the hospital had a lower than expected risk of readmission for the top three specialties for all elective admissions. For non-elective geriatric medicine admissions the risk of readmission was higher than expected, non-elective general medicine was similar to expected and clinical haematology admissions were lower than expected. Between March 2016 and February 2017, the hospital reported 1235 patients were readmitted onto medical wards with the highest numbers on MAU, Sapphire, and Alder wards.
- The hospital took part in the quarterly sentinel stroke national audit programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade A in the April 2016 to June 2016 audit. However, the latest SSNAP report (March 2017) relating to the period August 2016 to November 2016 showed that the hospital achieved an overall grade B, which represented a downgrade from the previous quarter. Within the latest audit standards of discharge, specialist assessments and multidisciplinary working decreased in rating. Standards of scanning, stroke unit, occupational, therapy, speech and language therapy, and discharge processes remained at the same grade as the previous period. An overall rating of B was still above the national average and demonstrated a good level of performance.
- The hospital submitted data to the national heart failure audit. Performance in the 2015 audit was worse than the national average for eight of the 13 standards and better than the national average in the remaining five standards.
- The hospital took part in the 2015 national diabetes inpatient audit. They scored better than the England average for three metrics and worse than the England average for 14 metrics. The indicator regarding patients being seen by the multidisciplinary diabetic foot team within 24 hours had the largest difference versus the England average, at 33% lower.
- In the myocardial ischaemia national audit project (MINAP), a national clinical audit of the management of

RTT, the hospital scored better than the England average for two metrics and worse than the England average for one metric. The indicator regarding non-ST-elevation myocardial infarction (NSTEMI) patients that were referred to or had an angiography after discharge had the largest difference versus the England average, at 19% lower. NSTEMI is a type of heart attack.

- The trust participated in the 2015 lung cancer audit and the proportion of patients seen by a cancer nurse specialist was 56%, which was worse than the audit minimum standard of 90%.
- The proportion of patients with histologically confirmed non-small cell lung cancer (NSCLC) receiving surgery was 50%. This was significantly better than the national (England, Scotland, Guernsey and Wales) level of 15%.
- The proportion of medically fit patients with advanced NSCLC receiving chemotherapy was 54%, which was similar to the national level of 52%.The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy was 52%, which was significantly lower than the national average of 77%.
- Following a review of excess deaths due to pneumonia between January and December 2015, all deaths in the trust were investigated. The expected mortality rate for pneumonia was 523 and there had been 534 deaths recorded within the trust. The review demonstrated that coding was overestimating pneumonia deaths. In response to this, the head of clinical coding and a coder attended the departmental teaching sessions to speak to staff about coding. Training was arranged for junior doctors on the completion of death certificates and a regular session in the acute and emergency medicine division junior doctors' induction programme was allocated to the coding team to increase competency in coding amongst junior doctors. The result was that between April 2015 and March 2016 staff recorded 502 pneumonia deaths against an expected rate of 503.
- There were clear pathways in place for medical patients who were HIV positive. For example, if a patient was admitted with a primary pathology related to HIV, an HIV consultant would review them alongside a medical consultant. If a patient of the Alexis Clinic was admitted as a medical inpatient, they would remain under the care of the HIV consultant with further specialist input from the consult in the related ward area. Patients newly diagnosed with HIV were also screened for latent tuberculosis.

Competent staff

- New staff attended a trust induction programme prior to commencing work in medical services. This consisted of a formal programme of introduction and orientation to the trust including the mandatory training requirement for all new staff on permanent, fixed-term or bank contracts. Following the trust induction staff underwent the local induction where they were orientated within their area of work including the reading of trust operations, policies and procedures relevant to their roles and locations. Local induction was undertaken by the individual and their manager, designated supervisor or mentor in the workplace.
- Consultants and specialty doctors were required to take part in the trust induction programme, which was organised jointly by medical staffing and medical education and was mandatory for all doctors who have not worked at the trust for at least twelve months. Foundation year one (FY1) junior doctors attended a mandatory five-day induction and shadowing programme, which included the corporate medical induction programme as well as mandatory training and cannulation training.
- Medical staff employed on locum contracts had to demonstrate compliance with mandatory and statutory training requirements before they were able to take up their post. The hospital maintained a record of this.
- Not all staff had the skills, knowledge, experience or competence to provide care to patients in the monitored bays on the MAU and the .Patients in these areas were recognised as acutely unwell patients requiring high levels of nursing interventions. These areas often admitted patients with level two needs including patients with non-invasive ventilation (NIV) and patients requiring high flow oxygen and gas directly into the nostrils. Monitored bays on MAU were made up of two bays of four patients each, one for males and the other for females.
- During our inspection, staff on MAU and Cherry ward told us patients were sometimes cared for by agency and permanent staff with no high dependency training, which would have equipped them to care for patients with level two needs. Following the inspection, we asked the hospital for information on the number of staff trained to look after level two patients on both these wards. The service told us that 46% of qualified staff on Cherry Ward (which includes CCU) had critical

care training and 30% of qualified staff on MAU had completed the acutely unwell adult course. The hospital also sent us a competency checklist used by PDNs to induct staff who had never worked in these clinical areas before.

- We found that HCAs and nursing staff were not always confident in caring for patients on the monitored bays and on the CCU. Staff told us newly qualified nurses were sometimes left in charge of these areas with no or little experience looking after level two patients or patients requiring high levels of nursing interventions. Staff also reported there were times HCAs were left in charge of CCU. Due to staff shortages, it was not always possible to get another nurse to replace the nurse in CCU if they needed to use the toilet. This meant that HCAs were left to care for seriously ill patients (up to a maximum of five) without the necessary competence albeit for short periods of time. There had been recent changes in the staffing levels for CCU. Due to staff shortages, nursing staffing was reduced from two nurses and one HCA to one nurse and one HCA in CCU.
- On MAU, staff reported that due to staff shortages, there were times HCAs were left to care for four and sometimes eight patients in the monitored bays while the other staff used the toilet. This meant that HCAs were left to care for seriously ill patients without the experience or competence to do so.
- Each ward had a PDN. The names and contact details for PDNs were displayed on ward notice boards. Senior staff worked with PDNs to identify and manage poor or variable staff performance. Senior staff referred staff they had concerns about to the PDNs. They also referred staff with good performance to prepare them for more challenging roles and positions. Staff across the medical wards valued the PDN role and said they were comfortable asking for help in areas they did not feel they were competent in.
- There was evidence staff received speciality training to improve their competence in their respective specialities. For example, on the two stroke wards, staff had undergone stroke related training including nasogastric intubation and speech and language therapy training. On the cardiac ward staff had undergone electrocardiogram (EEG) training. We found that a PDN had worked with staff on the respiratory ward to improve competencies such as caring for patients with chest drains. A cystic fibrosis nurse specialist had also trained nurses on the respiratory ward on the insertion of the portable catheter implantable venous access device used as a means of delivering medication to the body.
- Staff on care of the elderly and stroke wards had been trained in the care of patients with dementia. The dementia awareness training completion rate was 81% for nursing and midwifery staff and 65% for additional clinical services staff as of March 2017.
- Staff who were responsive for providing or monitoring intravenous (IV) fluid therapy had undergone appropriate competency training and assessment in relation to prescribing and administering IV fluids.
- Patients subject to the Mental Health Act 1983 were cared for by trained mental health registered nurses.
- Agency staff completed mandatory training through their nursing agency. To assure themselves that agency staff were competent, nurses in charge used a competency checklist to check what experience and knowledge agency staff had if it was their first time on the ward.
- Staff across the medical wards told us it was difficult to secure funding from the hospital to pay for any training in addition to mandatory training. Junior nurses told us mentorships were no longer available and this meant they could not develop professionally as quickly as they wanted. Most junior nurses we spoke with said they felt unsupported in their professional development and told us it was difficult to progress to higher bands. However, senior nursing staff told us they had been supported and felt there were opportunities to develop professionally in the service. There was limited evidence the trust had attempted to reconcile this gap in expectations and experiences.
- Following the inspection, the hospital told us the trust supported and funded mentorship, leadership and management courses for staff. However, this information was not consistent with what junior nurses told us during the inspection.
- Three HCAs on two separate wards had not been appraised or supervised in over two years. While they enjoyed working at the hospital they told us they felt senior staff did not care about their professional development. On Aspen ward, one nurse said they had not been appraised since 2015. As of April 2017, 77% of staff in the acute and emergency medicine division had up to date appraisals. The remaining 23% were due to have appraisals completed by April 2017.

- Teaching sessions took place in the medicine division every Wednesday at 2pm and staff could choose from a range of areas they wanted teaching on including diabetes.
- Foundation level doctors had protected time for training, research and audits. This helped to build core clinical competencies in medical staff.
- Weekly teaching meetings took place for HIV staff and included colleagues in other trust sites. Sessions included case studies and specific patient reviews to discuss care and treatment policies and practice. The teaching sessions were provided responsively in line with patient need. For example, following a leprosy diagnosis, the senior team provided training in this condition.
- Staff in the Alexis Clinic told us they had opportunities for professional development and we saw these were in line with patient needs. For example, a clinical nurse specialist had commenced a counselling course after a gradual increase in the complexity of patient needs and demand. This would help the service to provide a more structured emotional support service alongside clinical care.
- A nurse from the Alexis Clinic was taking part in a knowledge exchange programme with HIV service providers in Malawi and South Africa as part of a fellowship. This was intended to scope best practice guidance for nurse-led HIV services and the member of staff was due to share their findings shortly after our inspection.

Multidisciplinary working

- Nurses and specialists from a range of disciplines were readily available for ward staff. This included a falls nurse, a dementia nurse, district nurses, social workers, mental health liaison teams, a pain team, an older people's assessment liaison team, registered mental health nurses, dieticians, physiotherapists and psychiatrists.
- There was close working between the hospital and the mental health unit on the grounds of the hospital. This was in recognition of the fact that patients from the mental health unit were sometimes admitted to medical wards as well as the complex nature of care needed.
- National audits indicated staff facilitated multidisciplinary (MDT) specialist care for patients. For example, in the national diabetes inpatient audit, 35% of patients were visited by a specialist diabetes team. However, the national lung cancer audit report for 2015 showed that only 32% of patients were discussed at MDT.
- Staff reported good MDT working with specialist services such as tissue viability, infection prevention and control, safeguarding and the older people's assessment and liaison service (OPAL). Nursing staff were able to contact specialists for advice as needed and felt supported by them.
- A frailty specialist nurse worked with staff on MAU where 18 of the 46 beds were for frailty patients.
- Speech and language therapists saw patients on the stroke wards.
- Board rounds took place twice daily on both the care of the elderly and stroke wards. Senior staff reported this had helped with discharging patients from the wards. On the MAU, a multidisciplinary board round took place twice daily to review all patients. We attended a board round during our inspection, which had representation from multiple specialties and services including physiotherapists, staff grade doctors, social workers and occupational therapists. However, this meeting should have been consultant led was instead led by a ward sister, as there was no consultant in attendance. Staff told us the consultant's absence was not a regular occurrence.
- A multidisciplinary bed-meeting round took place at 8.30am daily. Consultants, wards managers and flow coordinator attended the bed meeting to discuss patients who were ready to be discharged and possible bed moves between the wards.
- On Cherry ward, a gastroenterology and cardiac ward, the gastroenterology team and the cardiology teams attended the ward at separate times to discuss patients. These meetings were speciality specific but multidisciplinary.
- On the respiratory ward, an MDT took place every Thursday for the cystic fibrosis team. Pharmacy, physiotherapists, dieticians, a cystic fibrosis nurse and consultants attended meetings.
- A stroke operational group met once a month to discuss stroke related issues and developments. There was multidisciplinary attendance at this group involving stroke consultants, matrons for the stroke units and psychologists. The minutes of the March 2017 meeting showed that stroke patient referrals to psychologists was one of the items discussed.

Medical care (including older people's care)

- In November 2016, medical services were below establishment for physiotherapists (1.27WTE), occupational therapy staff (4.1WTE), and speech and language therapists (1WTE).
- A dedicated HIV pharmacist was based in the Alexis Clinic Monday to Friday daytimes. Out of hours an HIV consultant was available to provide prescribing support for inpatient teams providing care to HIV positive patients.
- A weekly multidisciplinary meeting took place in the Alexis Clinic. This included HIV specialist doctors and nurses, a dietician and pharmacist and staff from other medical specialties. An HIV psychologist liaison attended the meeting every other week, or more frequently on request. The team used the meeting to review patients with complex needs, particularly those admitted as medical inpatients elsewhere in the hospital. For example, paediatricians, midwives and gynaecologists were involved in coordinating care for HIV positive pregnant patients.
- We saw evidence that services for patients in relation to HIV had improved following multidisciplinary working from staff in the Alexis Clinic. For example, following an 'HIV week' in the emergency department, clinical staff in that department now proactively offered HIV testing to at-risk patients. The Alexis Clinic team also provided training support to ward-based teams, who were able to recognise where an HIV test was appropriate and offer this with support from the HIV team. In addition, the team worked closely with social workers and community specialists to coordinate complex care, such as for patients who were HIV positive and pregnant.

Seven-day services

- The main trust pharmacy was open Monday to Friday 9.30am-5.15pm and between 10am and 1pm at the weekend and bank holidays. A clinical pharmacy service was provided Monday to Saturday. On Sundays, a clinical pharmacy service was provided at the Lewisham site to the acute admissions ward only. Out of hours, an on call pharmacist was available at all times.
- Medical wards were covered by a speciality team model. Each speciality ward had a dedicated consultant allocated to the ward each month, which undertook ward rounds and provided supervision for the junior medical team during office hours. A dedicated medical consultant was available on the MAU between 8am and 8pm. There was a dedicated resident acute consultant on site between 8am and 8pm every day including weekends, with on call cover between 8pm and 8am. A resident medical registrar, two senior house officers (SHOs) and two foundation year one doctors provided cover for the medical wards from 8am to 8pm on weekends and from 5pm to 9.30pm weekdays.
- Consultants reviewed patients twice daily on the MAU. This was in line with the NHS Services, seven days a week, priority standard eight. However, both medical and nursing staff across the medical wards reported that consultant cover on the coronary care unit was minimal and that patients were not seen and reviewed by a consultant twice daily as is required by the above standard. Our unannounced inspection was on a Saturday and on that day there was no consultant onsite but a consultant was on call for staff to contact if required.
- Physiotherapy and occupational therapy staff provided a seven-day service between 8am and 8pm on MAU. On the other medical wards, they provided cover between 8am and 4pm Mondays to Fridays with a 24 hour on call service for respiratory physiotherapy.
- Speech and Language Therapy (SALT) was available between 9am and 5pm Mondays to Fridays. There was no weekend cover.
- The endoscopy suite was open Mondays to Fridays only.
- There was no seven-day provision of services in relation to the discharge lounge and ambulatory care which were only open on week days.

Access to information

- The hospital held patient records both electronically and on paper. Staff working across networked services such as endoscopy could access patient records electronically.
- Patient GPs did not have remote access to records held by the hospital. However, discharge summaries were sent to patients' GPs and the patient retained a copy. Staff reported that discharge summaries were not always completed and some patients went home without them. This meant that patients sometimes went home without information on why they were in hospital and the names and contact details of professionals involved in their care.

Medical care (including older people's care)

- Folders with patient information such as hourly observations were on patient's bedsides and multi-disciplinary staff could easily access this information. All other records were located in locked trolleys in front of nurses' stations.
- Staff provided verbal and written handovers when patients transferred between wards. This meant that receiving teams had information about the patient to allow them to provide effective care.
- Patient investigation results, including blood tests and diagnostic imaging, were available electronically.
- Staff on Sapphire ward exchanged information with various social agencies and care homes in order to expedite discharge for patients declared medically fit for discharge.
- Policies and guidelines were available on the trust intranet and were up to date. Staff knew how to access the hospital's policies and procedures.
- We saw examples of effective sharing of information between teams to coordinate care for HIV positive patients. For example, staff in the Alexis Clinic provided GPs with clinical summaries when patients received a new diagnosis or when their condition changed. GP practice nurses also liaised with the clinic to coordinate advice and prescriptions for patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was variable understanding amongst clinical staff on the use of the Deprivation of Liberty Safeguards (DoLS). Senior staff such as matrons and heads of nursing had a good understanding of DoLS, how many patients on their wards were subject to them, and the process of extending them if required. However, junior staff lacked an understanding of how a DoLS authorisation changed how they should provide care. DoLS and the Mental Health Act are not the same even though they both deprive patients of their freedom. On the day of our unannounced inspection, security staff were called to Alder ward when a patient subject to a Mental Health Act order. When we asked staff why security had been called they said it was because a patient cared for under a mental health section had tried to leave the ward .A review of the documentation showed that this patient was subject to DoLS. This meant that staff did not always know what legal authority they relied on to stop patients from leaving the wards.
- As of January 2017, 58% of medical staff had up to date training on Mental Capacity Act (MCA) 2005 and consent to examination/treatment. In the same period, 92% of nursing staff had up to date MCA training.
- All DoLS applications were made and reported to the safeguarding team who were responsible for making the applications and extending them. They also kept a track on expiry dates and advised staff on the wards prior to DoLS expiring.
- Between March 2016 and February 2017, there were 97 DoLS applications across the medical wards. The highest number of DoLS was on Beech wardwith15 followed by care of the elderly wards Ash and Elm with11 DoLS each.
- The trust's Therapeutic Restraint Policy (Restrictive Interventions) of Adults under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and Procedure for DoLS Authorisation was accessible via the intranet.
- The hospital monitored incidents of violence and abuse, incidents where security staff were called to the wards and incidents of disorder and intimidation. Staff told us security staff did not restrain patients subject to DoLS. On the day of our unannounced inspection security staff had not restrained the patient but had blocked the ward exit.
- DoLS documentation for this patient had been appropriately completed including an assessment of patent's capacity and best interest assessment.

Are medical care services caring?

Requires improvement

We rated medical care services as requires improvement because:

- Not all patients had been treated with dignity and respect and some relatives described incidents where staff had failed to show compassion.
- While most patients we spoke with had a positive experience there was evidence that some patients albeit in the minority had received care that failed to respect their privacy and dignity.

- A lack of staff on some of the medical wards resulted in a reduction in the ability of staff to meet the personal needs of patients such as feeding them when their food was still reasonably hot.
- On one day of the inspection, staff left a patient in their bed in front of the nurse's station failing to respect their privacy.

However:

- Most staff spoke to patients with respect and in a manner that ensured their dignity.
- Staff in the Alexis Clinic provided patients with structured, individualised emotional support following an HIV diagnosis.
- Emotional support services were readily available for patients and their relatives. Staff demonstrated compassion and kindness in all of our observations, including when discussing difficult situations.
- Patients had access to chaplaincy and spiritual services.
- Relatives and carers of those with dementia were allowed to visit outside visiting hours including overnight as part of the hospital's dementia strategy.

Compassionate care

- We spoke with 26 patients on Laurel, Ash, Sapphire, Discharge Lounge, Mulberry, Aspen, Beech, Cherry, Chestnut (Medical Admissions Unit), Elm, and Maple wards. Most patients told us they had positive experiences on the ward. One patient said, "Staff listen to me and they respect my privacy". Another patient on Beech ward said "[Staff are] very nice and very patient". However, there was evidence that not all staff on the medical wards treated patients with compassion. We spoke with three relatives and one patient on the day of our unannounced inspection who all described poor patient care on Maple ward including an incident where patient dignity had not been respected. For example, staff did not respond to a patient's request for a bedpan for about 45 minutes and that patient had soiled themselves as a result. Other patients had become aware this had happened leaving this patient humiliated. The same patient also told us staff had ignored them during a period of prolonged vomiting.
- During the announced part of our inspection, another patient told us staff on Alder ward had mocked them after they had used a bedpan. The patient said "two nurses told me off for not being able to wait fifteen minutes for them to bring a commode". This had left them feeling shamed and humiliated. The patient told us, "A few nurses on Alder should not be working".
- On the unannounced inspection, three relatives said staff did not respond to them when they had asked for help. One of these relatives said they had asked an agency nurse for help moving their relative and they had been ignored. Another relative said staff were "horrible" and wanted their relative moved from Maple ward.
- The Friends and Family Test (FFT) response rate for medical care at trust level was 49%, which was better than the England average of 25% between December 2015 and November 2016. The FFT response rate at this hospital was 57%. The highest scoring ward at the hospital was Sapphire ward scoring 100% for 12 out of 12 months. The average response rate was 85%. Between March 2016 and March 2017, 99% of patients who completed the FFT in the Alexis Clinic said they would recommend the service.
- The patient survey results from the 'Living Our Values' audit showed that three out of 47 patients who responded in care of the elderly wards (6%) did not agree that staff had treated them with dignity and respect. However, 44 out of 47 (94%) said they had been treated with dignity and respect.
- During the inspection, we observed staff mostly maintaining patient dignity and privacy in their interactions with patients and during transfers and handovers. However, a patient on Beech ward had been left in front of the nursing station where anyone entering the ward could see them. The patient was covered but they had no privacy.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and relatives so they understood their care and treatment. In the discharge lounge, staff made contact with patients' carers, friends or relatives to arrange discharge prior to patients being sent home. This reduced the risk of the patient arriving home and not having access or support.
- In the discharge lounge we observed the nurse in charge explaining to each patient what their medicine was for and provided reassurance when they needed it. We spoke with patients across various medical wards and

most patients told us staff explained what medicine was for and explained what they were about to do before they did it, for example explaining that they were taking blood for blood tests.

- A relative on Sapphire ward told us staff had explained exactly what support would be required by their mother and said they felt reassured they would know how to support her following discharge.
- As part of the hospital's dementia strategy, the hospital signed up to John's campaign, an initiative that campaigns for the rights of relatives and carers to stay with their relatives while in hospital. The trust changed the visiting policy to allow family and carers to visit outside visiting hours including staying overnight.
- The dementia and cognition steering group had sessions where members observed the care of those living with dementia on the wards and could speak to patients and relatives about the care received and what could be improved.

Emotional support

- Patients had access to counsellors, psychologist and psychiatrists. During our inspection, we saw patients being supported by mental health liaison nurses when they became distressed.
- On Sapphire ward, a patient said, "I have been a bit stressed but staff are very caring". Another patient on Mulberry ward said, "Staff changed my clothes for me as I felt sick and they told me everything would be okay which was nice".
- Chaplaincy was available onsite 24 hours a day, seven days a week. Priests and other religious leaders attended the wards upon staff request. A Roman Catholic priest attended the wards every day to meet with patients.
- We saw social workers attending the wards to speak to staff about patients and packages in the community.
- Patient survey results for 2015 to 2016 received from the hospital showed that three out of five patients who responded said they had received sufficient emotional support for their needs. However the other two patients said they had not
- Clinical nurse specialists in the Alexis Clinic provided motivational interviewing and post-test counselling to patients who were recently diagnosed with HIV. This meant care and treatment planning was provided holistically in the clinic and ensured patients' emotional and psychological needs were also met.

Are medical care services responsive?

Requires improvement

We rated medical services requires improvement for responsive because:

- The service's risk register showed there had been a failure within medical services to treat patients with lung cancer within 62 days and failure to meet first appointment within two weeks. This meant there was a risk of deterioration in clinical condition whilst waiting and non-compliance with national standards.
- As of February 2017, the 18-week RTT standard was not met in rheumatology where 80% of patients were seen within the established RTT time against a hospital target of 92%.
- There was poor compliance with the cancer two week target for seeing patients for the first time following referral with 61% compliance in November 2016 against a target of 93%.
- The average occupancy rate in medical services between November 2015 and November 2016 was 99%, which was higher that the recommended average occupancy rate of 85% and higher than the hospital target of 95%.
- The complaints and senior teams did not always respond to complaints in a timely manner. The average response time in medical services was 34 days against a target of 25 days.
- Between April 2016 and March 2017, the average length of stay for medical elective patients was 15 days, which was higher than the England average of 4 days. The average length of stay for elective general medicine was 37 days longer than the England average.
- The number of overnight bed moves remained high and 50% of all patients experienced at least one bed move during their inpatient stay.
- There were low rates of compliance with the hospital's target for repatriation of patients from the hyper acute stroke unit within 24 hours of referral. The hospital's target was 90% but compliance was significantly lower at 17% in October 2016, 33% in November 2016, and 11% in March 2017.

However:

Medical care (including older people's care)

- The needs of different people were taken into account when planning and delivering services. In particular, there was a consistent focus on the needs of patients living with dementia.
- Patients had comprehensive assessments of their needs, which included considerations of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. Staff worked towards expected outcomes and regularly reviewed care and treatment.
- The service had been responsive to the problems we identified with the flow of patients within the hospital during our previous inspection in 2014. This included the work of the transformation team to improve flow processes and the opening of the ambulatory care unit in November 2016.
- In response to increased demand in the service, the hospital had temporarily opened up an escalation ward in October 2016 in order to manage capacity.
- The role of the patient flow coordinator in the medical admissions unit (MAU) and effective ward and board rounds had improved flow.
- Medical services used the hospital discharge lounge to support earlier discharge from the wards and this created bed capacity, which addressed the lack of capacity we found was a problem during our 2014 inspection.
- Staff and the trust senior team demonstrated an emphasis on raising dementia awareness amongst staff and volunteers.
- The hospital's enhanced care policy had been introduced to some inpatient ward areas in response to increased risks presented by some patient groups, for example, patients at increased risk of falls and patients with cognition impairment.
- As of February 2017, 96% of patients were seen within established referral to treatment (RTT) time for their speciality (18 weeks). This included 100% compliance with RTT times for general and stroke medicine, cardiology, neurology, haematology, and medical oncology. For general medicine, 92% of patients were seen within the 18 week RTT standard and 96% of endocrinology were seen within this time.
- A range of services were provided for HIV-positive patients. This included medicines and antiretroviral management and coordinated care between the HIV speciality team and other medical specialties. Where patients required complex, coordinated care, staff demonstrated they could provide this working with a range of other organisations to meet individual needs.

Service planning and delivery to meet the needs of local people

- The hospital had established working relationships with local social services. During our inspection, we saw social workers attending wards to speak to staff and patients to ensure effective discharge of patients and reduce discharge delays.
- The opening of the ambulatory care unit in November 2016 took pressure off the emergency department and medical wards and improved capacity, which we had found to be a problem at the time of the 2014 inspection. Ambulatory care pathways were in place to enable patients to avoid admission to the hospital where appropriate Ambulatory. The unit opened between 8am and 8pm Monday to Friday. Outside these hours patients attended the accident and emergency department before being admitted onto the medical wards.
- A new frailty pathway in the medical admissions unit (MAU) had been implemented to increase capacity for elderly patients in three hospital wards. Of the 46 beds in AMU, 18 beds were used to admit frailty patients with a predicted length of stay of less than 72 hours.
- As part of the national John's campaign, which the trust signed up to, the hospital revisited its visiting policy to allow open visiting at all times for immediate family or carers. The policy, which was launched in November 2016 also allowed one family member or carer to stay overnight.
- The needs of different people were taken into account when planning and delivering services. The dementia strategy included various initiatives to raise dementia awareness as well as provide services that addressed the nature of those patients. Staff at all levels demonstrated a focus on improving dementia awareness and getting staff involved in the dementia strategy.
- Between September 2016 and February 2017, 181 patients under the care of another speciality occupied a bed on medical wards. These patients are known as outliers. MAU and the escalation ward Hawthorne had the highest number of outliers. During the inspection, we found there were processes to monitor outliers on

the wards. This included marking patient's names in red on the whiteboard. This meant staff were always aware of the numbers of outliers they had on their ward and allowed them to ensure outlying patients received the care and input from nursing and medical staff relevant to their medical condition or specialty. The medical and multidisciplinary teams discussed outliers at board rounds.

- The hospital launched the enhanced care policy in January 2017 in response to increased falls on medical wards, in particular care of the elderly and stroke medicine wards. Patients at risk of falls and patients with cognitive impairment received specialised care in cohort bays where a healthcare assistant was present at all times. At the time of our inspection, the policy been rolled out on some of the wards such as Beech and Elm but not yet all the wards.

Access and flow

- We found that the hospital had taken action in response to our findings of poor flow within the hospital during our 2014 inspection. A transformation team worked with staff to improve processes and pathways within the hospital. For example, the team was involved in working with staff around their ability to take charge when coordinating shifts on the ward. The team was also involved in working with flow coordinators to maximise the effectiveness of their roles in improving flow within the hospital. A patient flow coordinator based in MAU worked with the flow coordinator in the accident an emergency department to monitor the flow of patients between the two departments. The flow coordinator in MAU also worked with the site bed team and discharge team to reduce delays in moving patients where beds became available. Flow coordinators attended bed meetings where a multidisciplinary team reviewed patients and discussed possible discharges.
- MAU had most beds in medical services with 46 beds including 18 frailty beds. Patients accessed MAU via the emergency department or from the sickle cell, cardiac or haematology clinics.
- The opening of the ambulatory care unit in November 2016 had improved access to services. The unit had four trolley bays, ten recliner chairs and three consulting rooms. Between November 2016 and March 2017, the ambulatory care unit saw 873 patients. The unit was also used for a deep vein thrombosis (DVT) and haematology clinics during which times ambulatory care staff assisted in providing care to patients. An older person acute care (OPAL) nurse was based in ambulatory care and sometimes saw patients who would normally have been seen by the district nurses.
- However, despite the work that had gone into addressing flow and capacity issues, the risk register for the division indicated that in November 2016, the occupancy and flow target of 95% was at 103% and this was due to inability to deliver on the emergency care pathway.
- In addition, there were challenges to operational patient flow due to lack of external capacity. For example, patients who were declared medically fit for discharge remained on the community ward Sapphire. The service was aware of this and there were plans to expand medical wards to include a residential nursing home, which would take pressure off the medical wards in relation to patients medically fit for discharge.
- The service met and exceeded its target (92%) for RTT times in eight out of nine specialities. Data received from the hospital following the inspection showed that as of February 2017, 96% of patients were seen within established referral to treatment (RTT) times for their speciality. This included 100% compliance with RTT times for general and stroke medicine, cardiology, neurology, haematology, and medical oncology. The figures for the remaining specialities were 96% in gastroenterology and 97% in dermatology. However, for rheumatology, 80% of patients were seen within the 18-week standard.
- There was poor compliance with the cancer two week target for seeing patients for the first time following referral with 61% compliance in November 2016 against a target of 93%.
- The service's risk register showed there had been a failure within medical services to treat patients with lung cancer within 62 days and failure to meet first appointment within two weeks. In November 2016, 0% of lung cancer patients were treated within 62days and in October 2016, 67% were treated within 62days. The hospital's target was 85%.This meant there was a risk of deterioration in clinical condition whilst waiting and non-compliance with national standard.
- Between March 2016 and February 2017, 1343 patients experienced a transfer from medical wards and 1290 patients experienced a transfer to medical wards between10pm and 5.59am. In addition, 50% of all patients experienced at least one bed move during their

inpatient stay. The highest number of moves from medical wards was from the MAU where patients seen in accident and emergency are admitted and assessed before being either discharged or admitted to another medical ward.

- Multidisciplinary board rounds took place twice daily on the medical wards. Board rounds were often but not always consultant led. The process was used to assess the needs of patients and to discuss treatment and discharge plans as well as tasks for completion as part of the treatment or discharge plan.
- The medical division used the hospital discharge lounge to support earlier discharge from the wards. Use of the discharge lounge improved capacity in the hospital. This was because medically fit patients could be safely discharged to the lounge whilst awaiting aspects of their discharge to be finalised allowing other patients to be admitted into that bed. The lounge was open from Monday to Friday between 8am and 8pm. The average length of stay in the discharge lounge between March 2016 and February 2016 was 3 hours. The number of patients seen in the discharge lounge was variable. For example, on 7 March 2017, the lounge saw 14 patients and on 21 February 2017, 30 patients were seen in the lounge. The discharge lounge saw 2435 patients between March 2016 and February 2017.
- In response to an increase in demand on the hospital's medical services, the hospital temporarily opened an escalation ward (Hawthorne ward). At the time of our inspection Hawthorne ward had been open since October 2016. The ward had both medical and surgical beds. The opening of an escalation ward meant the service minimised the amount of time patients had to wait to be admitted. Although this improved capacity and access to inpatient care, the service could not fully staff this ward, which resulted in regular movement of staff from other medical wards to cover medical patients on this ward.
- Between March 2016 and February 2017, the average length of stay for patients on the medical wards was 15 days, which was eight days longer than the England average of seven days.
- The service recognised the need to reduce the length of stay for stroke patients and improve repatriation times. The stroke operational group meeting discussed this in March 2017. There were low compliance rates, which failed to meet the hospital's 90% target for the timely repatriation of patients from the hyper acute stroke unit within 24 hours following referral. In October 2016, the compliance figure was significantly low with only 17% of patients being repatriated within this time. The figures increased in November 2016 (33%) and December 2016 (48%) but fell significantly in March 2017 (11%).However, repatriation compliance rates were higher within 72 hours of referral with 67% in February 2017 and 63% in March 2017.
- The average occupancy rate in medical services between November 2015 and November 2016 was 99%. This was above the recommended average occupancy rate of 85% and above the hospital target of 95%. When occupancy runs above 85% there is an increased risk of poor care to patients.
- We reviewed the reasons why ten patients on Sapphire ward were still in hospital even though they had been declared fit to be discharged. Four of the patients were waiting for residential homes to become available and two were waiting for an assessment for a residential home. We found that one patient was waiting for supported housing, one was waiting for sheltered housing, one was waiting to have the heating at their home fixed before they could be discharged, and one could not go home because there was no support as their carer was a patient on one of the care of the elderly wards. There was evidence of the involvement of social workers and community teams in discharge planning.
- On some of the medical wards, staff told us that delayed discharges often occurred due to late to take out (TTO) medicine prescribing. In the discharge lounge staff told us delays were usually as a result of delays getting medicines to patients from the wards as well as patients waiting for to transport.

Meeting people's individual needs

- In January 2017, the hospital launched the enhanced care policy, a policy supporting staff in providing patients with the appropriate care, supervision and observations as part of their individual therapeutic care plan. This policy was used to nurse patients presenting with similar risks in cohort bays, for example, patients with increased risk of falls or patients with cognition difficulties. A health care assistant (HCA) or nurse was required to be in that bay at all times.

Medical care (including older people's care)

- An older person's liaison service and a dementia team provided ad-hoc specialist support in wards on request. Named photographs of the dementia care team were displayed on the wards. Patients had access to the hospital's memory clinic.
- The hospital's visiting policy had been changed to allow relatives and carers to stay outside visiting hours including overnight.
- The hospital launched its dementia strategy in February 2017 with a focus on raising dementia awareness amongst staff and members of the public and providing effective and safe care for dementia patients. Staff and volunteers had been trained as dementia friends as part of this strategy. For example, 81% of nursing staff had been trained in dementia awareness and 65% of other staff had been trained. Security staff at the hospital had also been invited to training sessions and some had received the training. This meant that they would have an awareness of dementia when called onto the wards with patients living with dementia.
- The dementia and cognition steering group engaged the public to obtain views on the care offered to patients living with dementia as part of the hospital's involvement in the acute hospital working group. The group also sought carer's views on what they thought good care in nutrition and carer involvement looked like in order to inform best practice.
- The use of the dementia passport helped staff enhance the care and support given to a patient with dementia while the person is in an unfamiliar environment. The passport is a document that can be completed by the person with dementia and/or their carer providing professionals with information about the person with dementia as an individual.
- There had been a review of the inpatient pathway for dementia patients and this was subsequently modified to include the pain assessment tool called pain assessment in advanced dementia (PainAD).
- Patients subject to the Mental Health Act 1983 were cared for by a registered mental health nurse or a member of staff trained in mental health. Staff had access to psychiatric liaison nurses and psychiatrists from a mental health unit on the grounds of the hospital if it was felt a patient needed mental health input.
- Although staff told us they had access to patient information leaflets in other languages, when we asked to see the leaflets they were only available in English. This was the case on Beech, Cherry and Ash wards.
- During our inspection we observed ward rounds where we saw that staff demonstrated a detailed understanding of each patient, including of their social needs.
- Oak ward had a sensory room in place to help patients with sensory needs, such as dementia. There was a dementia corner on Ash ward which was an area used by the therapist for stimulation of patients with sensory aids and lighting.
- Staff in the Alexis Clinic had established links with an immigration non-profit organisation to provide targeted support to HIV positive patients who needed medicine but who were not UK citizens. This meant patients had access to critical treatment while being supported by other specialists relating to their social circumstances.
- An emergency department (ED) consultant from another NHS trust provided on-call mental health support for patients in the Alexis Clinic. Staff told us this worked well in practice. For example, when a patient in the clinic had disclosed suicide ideation, the doctor attended the unit from the ED within 10 minutes to support a crisis intervention.

Learning from complaints and concerns

- Between December 2015 and November 2016, there were 118 complaints in medical services. Of all complaints received 23% were in relation to nursing care, 10% about staff attitude, 9% about communication and information to and 8% of complaints received were about discharge arrangements. Data received from the hospital following the inspection showed that between March 2016 and February 2017, there were 53 complaints in medical services. The average response time was 34 days, which was nine days more than the hospital's target. The hospital's complaints policy stated that complaints were to be resolved within 25 days.
- The Patient Advice and Liaison Service (PALS) and the complaints manager had responsibility for handling formal complaints on behalf of the chief executive and ensuring a co-ordinated and effective system for reporting, investigating and monitoring of complaints.
- The complaints steering committee was responsible for overseeing the handling of complaints within the trust and monitoring achievement of the response times required by the NHS complaints procedure. It was the

role of the complaints steering committee to discuss any trends and learning in complaints, of which committee members should feed back to their associated teams.

- We reviewed complaints information and saw that for each complaint there was a documented subject, description of complaint, and the outcome the investigation .
- The monthly newsletter for the division addressed complaints and concerns as a way of encouraging learning from complaints. For example, in the January 2017 newsletter, the concerns and complaints section reminded staff to answer call bells quickly.
- In December 2016,the trust surveyed 43 patients over 13 questions. A total of 50% of the complainants said they were confident the trust had learnt lessons from their complaint. However, 26% of complainants were not confident or were unconvinced that the trust had learnt lessons from their complaint. The remainder of complainants (24%) answered neither.
- Staff in the Alexis Clinic demonstrated a proactive and multidisciplinary approach to resolving complaints and improving patient experience as a result. For example, the pharmacy provider had changed in the year leading to our inspection. Staff in the clinic had received complaints from regular patients that staff in the new pharmacy were not sensitive or discreet when dispensing HIV medicine. One patient said a pharmacist had announced their condition across the shop by stating, "Here's your HIV medication." In response the pharmacist in the Alexis Clinic visited the third party provider to discuss expectations of privacy and conduct. Following this the clinic received no further complaints.

Are medical care services well-led?

Requires improvement

We rated medical care services as requires improvement for well-led because:

- The leadership and culture in medical services did not always support the delivery of high quality person-centred care. On some of the wards, staff told us they were demoralised. This was against a reported background of high vacancy rates, increased workloads and a lack of support from the senior team who staff thought should have been doing more to support them.
- There was a discrepancy between what nursing staff on the wards said the risks in the service were and leadership's understanding of the risks, in particular in relation to the risk related to the admission of level two patients on the medical admissions unit (MAU) and on the coronary care unit (CCU).
- None of the staff (below matron level) we spoke with on medical wards had knowledge of the trust vision or strategy, either as a whole or for their individual service.
- Although senior staff told us there was on-going recruitment into nursing posts, the hospital had been unsuccessful in recruiting nurses and vacancies remained high with some wards reporting 50% vacancy rates for nursing staff at the time of our inspection.
- During the inspection, staff told us that senior staff routinely failed to effectively plan staffing requirements for the escalation ward (Hawthorne) resulting in staff being constantly moved around to provide cover for this ward.
- Some of the risks we found during the inspection were not reflected in the risk register for the service. For example, the risk related to patients of a level two nature in MAU and CCU.
- Staff were able to tell us the values of the trust but were unable to tell us the vision and strategy for the trust or for their units.

However:

- There was a clear vision and strategy for the organisation and for medical services, which was understood and enacted by senior level staff such as matrons and heads of nursing.
- There were areas of consistent leadership within the service, in particular, the drive for more dementia awareness by the dementia team and corresponding initiatives and strategies to put the plans into action.
- There was a clear and appropriate approach for supporting and managing staff when their performance was poor through the involvement of practice development nurses (PDNs).
- The transformation team worked with staff to improve flow and empower them to take charge when leading the wards. This had led to some improvements in the flow of patients within the service.

- Nursing staff reported good leadership and support from ward managers.
- Junior medical staff reported good leadership and support from consultants.

Leadership of the service

- A divisional director and a divisional manager had overall leadership of medical services. Additionally, there were three clinical directors in medical services (one for the emergency department, one for care of the elderly services and one for diabetes, respiratory and renal services).
- The head of nursing led a team of five matrons in medical services. At the time of our inspection, this was made up of one senior matron and three other matrons.
- One matron led elderly care wards Ash, Oak, Elm and Aspen, another led, Alder, Laurel and Mulberry wards and the third led the two stroke wards (Maple and Beech), Cherry ward (including the coronary care unit) and the community ward (Sapphire). All four matrons shared responsibility for the escalation ward Hawthorne. The senior matron had oversight of the ambulatory care unit, Medical Admissions Unit (MAU), and the discharge lounge.
- Ambulatory care was consultant led. A matron within the medicine division provided overall nursing leadership and a senior nurse oversaw the day-to-day running of the unit.
- We found that staff had an understanding of the duty of candour. We saw evidence of the use of the duty of candour in clinical governance meetings and serious incident investigation reports.
- There was a clear and appropriate approach for supporting and managing staff when their performance was poor through the involvement of practice development nurses (PDNs).
- During the inspection, staff told us that senior staff routinely failed to effectively plan staffing requirements for the escalation ward (Hawthorne). This resulted in staff on other medical wards being frequently moved around to provide cover for this ward. Staff told us they felt frustrated because they did not know what ward they would end up working on when they came to work each day. Following the inspection, we asked the service to provide information on how staffing arrangements for Hawthorne ward were determined and how far in advance this was done. The service responded by stating that the service allocated two nurses and one health care assistant (HCA) to cover 12 medical beds on Hawthorne. No information was provided on how long in advance staffing requirements were determined and planned.

Culture within the service

- On some of the wards, nursing staff told us they felt demoralised. They attributed this to high vacancy rates, increased workloads, being constantly moved around to cover other wards, and a lack of support from matrons who staff thought should have been doing more to support them. Staff on various medical wards also reported that they did not feel respected, valued or appreciated by matrons. On one ward, we spoke with five nurses who all said they felt demoralised, unvalued and unappreciated. None of them felt able to freely communicate with their matron and all described a culture of fear when the matron was on the ward. Staff described being shouted at in front of patients and being told to cope when they have raised issues of nursing shortages. Staff used words such as "horrible", and "terrible" when asked to describe their experience of working on that ward.
- The reported lack of support for nursing staff by matrons and senior matrons was expressed consistently across medical wards and not just on one ward. A consistent theme across the medical wards was that staff on the wards felt supported by ward managers and by colleagues but not by matrons or senior matrons.
- Across the medical wards, we had various responses about ward manager support by matrons. Some ward managers said they felt valued and supported by matrons and on other wards ward managers said they were unsupported, in particular in relation to the issues of staffing on their wards.
- Across the medical wards staff reported matrons were visible but staff consistently reported matrons were not approachable. Staff also reported they saw the heads of nursing on the wards, however some staff did not know anyone above head of nursing level.
- One out of five matrons told us they found the role overwhelming and thought changes were needed in the division by way of getting support from leadership above them.
- Junior doctors said they felt supported and respected by consultants.
- The clinical team in the Alexis Clinic described positive working relationships with colleagues elsewhere in the

hospital that contributed to improved patient outcomes and experience. For example, medical consultants and HIV consultants worked together to coordinate patient care wherever patients presented in the hospital. In addition the nursing team were able to visit patients in inpatient wards and provide targeted clinical support specific to HIV. All of the staff we spoke with said this worked well in practice and meant they felt well supported.

Vision and strategy for this service

- The vision and strategy for medical services was embedded in the trust's overall vision and strategy as set out in the two-year operating plan 2017/18 and 2018/19 and in the South East London: Sustainability and Transformation Plan of October 2016. The vision for medical services included improving referral to treatment times (RTT) and cancer treatment times, effective recruitment and retention of nursing staff and increasing

junior doctors' cover by substantively recruiting to posts covered by agency and locums through 2017/18. There was also a commitment to delivering services that met high quality standards, ensuring services remained sustainable, and supporting people to live independently.

- The hospital introduced a new frailty pathway in 2016 with establishment of an older people's assessment and liaison Service (OPAL) and frailty shorty stay model on the MAU. The service's vision was to build on, and embed, this throughout 2017/18 ensuring that the right patients were seen in the frailty short stay unit and that there was sufficient staffing to deliver the expected improvement in length of stay.
- The vision for the newly opened ambulatory care unit was to increase the proportion of the medical take that could be treated in an ambulatory pathway, improving patient experience and reducing bed occupancy. The service's vision was to increase consultant cover to support the new ambulatory service.
- The hospital recognised there were challenges with staff recruitment and retention and plans were put in place for new workforce initiatives such as the development of the role of nurse associates in partnership with a local university and local stakeholders. This would involve a two-year training programme with the individuals being recruited and paid for by the trust at band three for their period of training.
- To encourage retention the hospital plans included developing an internal staff transfer scheme, apprenticeship schemes, the employee loyalty programme, expansion of work placement schemes and foster relations with training institutes and education bodies to develop a pool of potential employees.
- Senior staff such as matrons and heads of nursing demonstrated a good understanding of the vision and strategy for the service including the corporate objectives. However, while staff on the wards were able to tell us their values in line with the Living Our Values project they were not aware of the vision or strategy for the service or for their units. Most staff said in response their ward's strategy was to provide the best care to patients.
- It was not clear whether the service's vision and strategy had been communicated to staff on the wards. The trust had established the Living our Values Project, which encouraged staff to describe what the trust values meant to them in the context of their roles. This aimed to empower staff in individual wards and services to establish their own service and quality charters and to establish what they wanted their objectives and commitments to be and be accountable for them.
- While staff understood how Living Our Values made a difference in their areas of work they were not aware of the vision or strategy for their units or what role they played overall in achieving that vision or strategy.

Governance, risk management and quality measurement

- Senior staff used risk registers and a monthly data quality 'dashboard' to measure trust performance, including time to treatment and staffing levels.
- There was a discrepancy between what nursing staff on the wards thought the risks were and the leadership team's understanding of the risks within the service. For example, there had been a recent change in staffing levels for CCU where senior staff reduced staffing from two nurses and one HCA to one nurse and one HCA. Staff told us this was a risk in relation to the ability of these staff to provide the care required by the nature of patients in CCU. In addition, during the inspection, staff on Cherry, CCU and MAU were clear that they cared for

patients with level two needs and as such needed more staff and experience to effectively provide risk free care to patients. However, the hospital did not recognise these areas as requiring additional staff support. .

- The quality and safety committee and the clinical quality review group fed into the integrated governance committee that met every two months. The committees were a way to risk assess and measure quality of care provided.
- Ward managers met with matrons once a month to discuss any concerns and issues on their wards. Each matron met with managers on their wards to discuss concerns. Meetings were ad hoc and informal.
- The service had representation at the monthly divisional governance board meetings, which were attended by heads of nursing and the senior matron. Agenda items included patient safety incidents including serious incidents, a review of the division's risk register, infection control, and mortality and morbidity and national and local audits and outcomes.
- The risk register for the service did not reflect the risks we found to be evident within the service. For example, the nurse and HCA provision in relation to CCU and MAU level two patients was not on the register. Staff on some of the medical wards reported feeling demoralised due to staff shortages and how senior staff managed this. One matron said they were aware of low staff morale on their ward but this risk was not indicated as a risk on the risk register.
- All matrons reported the top risk to be high vacancy rates and poor retention rates in the service. There was an ongoing programme of recruitment but limited evidence of success recruiting into the posts. There were plans to recruit from overseas but at the time of our inspection this remained a risk.

Public engagement

- Across most medical wards we saw 'you said, we did' boards on display. The boards allowed staff to demonstrate how patients, relatives and visitors were included in improvements to the service. For example, on Alder ward patients had said they wanted a daily paper and the ward responded by having volunteers bring in copies of a free daily newspaper onto the wards. On Maple ward, a welcome pack was created in response to patients requesting more information about their care. In the Alexis Clinic, staff had divided the waiting area into two sections following feedback from new patients that they found one large waiting area intimidating and impersonal.
- The hospital's dementia strategy included a training programme for volunteers. At the time of the inspection 35 volunteers had been trained to provide assistance of the care of the elderly wards.
- The hospital involved the public in the annual staff wards. The Healthcare Hero award was specifically for patients and local people to nominate staff in recognition of outstanding care.

Staff engagement

- The service carried out staff surveys in order to gather staff views and experiences. In the 2016 staff survey for the trust 75% of staff said they were able to contribute towards improvements at work. This was better than the 2016 national average (71%) for combined acute and community trusts.
- The staff survey carried out on elderly care wards for the period 2015 to 2016 showed that 76% (31 out of 41) either agreed or strongly agreed that the organisation would address a concern if they raised it. The remaining 24% of staff either disagreed or strongly disagreed. This accounted for 10 out of 41staff.
- As part of the hospital staff retention plan, there were plans to extend staff recognition schemes, introducing internal promotional opportunities and developing talent management within the trust. However, this had not come to fruition.
- The hospital participated in the trust's annual staff awards with staff being nominated for awards for commitment to quality of care, respect and dignity, improving lives, working together for patients, everyone counts, patient safety and compassion in care.
- Staff were actively engaged to play a role in defining the values of the organisation through the Living Our Values process. This encouraged staff to describe what the organisation's values meant to them in the context of the roles they performed in the organisation, and the organisation held people to account by them
- There was variable evidence that staff in the Alexis Clinic were engaged with and listened to by the trust senior team. For example, staff told us the trust had refused to provide them with a resuscitation trolley based on their perceived low level of clinical risk. However, when a patient had experienced a cardiac arrest, the

resuscitation team did not know where the clinic was and their response was delayed. Following this incident the trust provided emergency equipment. One member of staff said, "The trust shows no interest in us, no-one from the senior team ever visits." Another member of staff said, "I feel that we're quite isolated here, I don't think the trust knows what we do."

Innovation, improvement and sustainability

- The service had recently started to accept stroke patients with tracheotomy on the stroke ward. This meant that stroke patients requiring this procedure were not moved around different wards in the hospital but could be cared for on the stroke ward. This had been a matron-led initiative.
- As part of its dementia strategy, the trust signed up to the 'John's campaign', an initiative that campaigns for the rights of relatives and carers to stay with their relatives while in hospital. This resulted in changes in the service's visiting policy to allow carers and relatives open visiting including oversight stays.
- The physiotherapy team initiated and implemented the 'escape from knee pain' programme for those over 50. The programme focuses on enabling patients to self-manage and cope with pain through exercise. The programme commenced in 2014 and data received prior to the inspection indicated results had been positive with the majority of patients attending at least 70% of sessions.
- At the time of our inspection, the hospital had launched the enhanced care policy with a view to improving patient safety. This resulted in a reduction inpatient falls in the areas where it had been implemented.
- Since our inspection of the hospital in 2014, the hospital signed up for 'Sign up to Safety', an NHS England national initiative to help NHS organisations achieve patient safety aspirations and care for patients in the safest possible way.
- A 'transformation team' worked with staff across medical wards to improve processes around capacity and flow and empower ward managers to have more control and say on the wards.

Surgery

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

Information about the service

The surgery department at University Hospital Lewisham provides a seven day a week, 24 hour a day service, serving the communities of the London Boroughs of Lewisham, Bexley and the Royal London Borough of Greenwich.

The trust as a whole had 22,361 surgical admissions between April 2015 and March 2016. Emergency admissions accounted for 7,685 (34%), 11,911 (53%) were day case admissions, and the remaining 2,765 (12%) were elective.

The department is based primarily within the main building of the hospital. There are two theatre suites. One of these is the Ravensbourne theatres, with four adult operating theatres and two children's operating theatres. Elective surgery takes place in the Ravensbourne theatres between 8am and 5pm. Emergency or urgent surgery can be performed 24 hours per day, 365 days per year. The other theatre suite is the Riverside Treatment Centre, with four adult operating theatres (two of which are dedicated laminar flow orthopaedic theatres), three endoscopy rooms, a minor procedure treatment room, an admission area with consultation rooms, a patient waiting room and a day surgery discharge facility.

Each of the theatre suites had its own recovery areas, and there was a separate paediatric recovery area.

There were four surgical wards, Cedar, Juniper and Larch and Linden, located in the main building.

In addition, there was a pre-assessment unit, where patients were assessed in advance of surgery, and the Bell admissions unit, where patients were prepared and waited for surgery. There was also the There was also the Vanguard admissions unit, which was an additional theatre unit for urology patients.

We carried out an announced inspection between 7 and 9 March 2017 and then returned unannounced to the department on Tuesday 21 March 2017. We observed care and treatment, looked at 14 patient records, and spoke to 30 members of staff including nurses, doctors, consultants, administrative staff and domestic staff. We also spoke with 20 patients and four relatives who were using the service at the time of our inspection.

Surgery

Summary of findings

We rated this service as requires improvement because:

- There were significant issues with medication management within theatres. Including breaches of CQC regulations and The Misuse of Drugs Regulations 2001.
- Information governance practices were poor, with patient records being left unlocked and unattended in public areas throughout the hospital.
- We observed numerous breaches of Infection Prevention and Control (IPC) policy, potentially placing patients at significant risk of infection.
- There were significant vacancy levels within the service, and high staff turnover.
- The senior leadership team were unaware of the issues with medication within theatres.

However:

- Staff demonstrated a genuinely caring attitude towards patients and their families.
- Patients expressed a positive view of the care and treatment they received.
- Staff spoke highly of the teamwork within the department and of their local leadership.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- There was one never event in the reporting period.
- We identified significant breaches of regulations in respect of medication management, which placed patients at risk of harm.
- We observed poor adherence to the trust's infection prevention and control (IPC) policy, placing patients at significant risk of infection.
- We observed poor records management, with records being left unattended. Staff did not routinely lock computer screens when leaving them, leaving patient records open to public view.

However:

- There was a positive incident reporting culture within in the service. Learning from incidents and concerns was shared, including learning from incidents that had occurred at QEH.

Incidents

- Staff reported incidents on an electronic system. All the staff we spoke with during the inspection knew how to report an incident. Staff told us they received feedback and learning from incidents through emails, during handovers and at staff meetings. We saw evidence of this in the minutes of meetings.
- Staff we spoke with were also aware of incidents and learning from incidents that had occurred elsewhere in the trust at the Queen Elizabeth Hospital, Woolwich (QEH).
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. In the reporting period of January to December 2016, the hospital reported one never event related to surgery. This incident occurred in February 2016 and involved the wrong size component

being used during a knee replacement. The incident was subject to a root cause analysis (RCA) investigation, which included actions and recommendations to mitigate against the risk of reoccurrence.
- During the reporting period, there were 983 reported incidents. Of these, three were characterised as causing serious harm, 15 as causing moderate harm, 201 as causing low harm, 37 were near misses and 727 incidents were characterised as causing no harm.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Nursing and medical staff were familiar with the duty of candour and were able to explain what this meant in practice. They identified the need to be honest about mistakes made, offer an apology and provide support to an affected patient. We saw examples of this being demonstrated in written letters to patients and their relatives.
- Mortality and morbidity meetings were held on a trust wide level. We saw notes from these meetings, and other notes that indicated that outcomes of meetings were discussed at ward and theatre team meetings.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm free' care. We saw that safety thermometers were clearly displayed near the nursing station in the wards that we visited. They displayed data relating to performance in key safety areas such as patient falls, pressure ulcers, catheter acquired urinary tract infections and venous thromboembolism (VTE). These boards indicated how many days had passed since the last incident of each of these types. However, there was no safety thermometer data displayed on Hawthorne ward, which was an 'overflow' ward taking both medical and surgical patients, meaning that staff, patients and their families were not aware of themes and issues in respect of safety on the ward.
- There were three urinary tract infections (UTIs) in surgery across the trust in the reporting period.

Cleanliness, infection control and hygiene

- The environment in both theatres and the wards was clean and clutter free. We observed cleaning staff carrying out regular ward rounds and responding appropriately to a spillage in the course of one of these rounds.
- We observed poor adherence to trust hand hygiene policy and national guidance during our inspection. Staff did not routinely sanitise their hands between patients and on entering and leaving wards. Across the course of our inspection, we observed ten staff not adhering to hand hygiene policy on leaving and entering wards.
- Hand hygiene audits were carried out on the wards, and the results were displayed. On Cedar Ward, the January hand hygiene audit score showed 20% compliance with agreed standards. This fell short of the hospital target of 85% compliance. We raised this with the hospital infection prevention and control (IPC) lead, who told us that this audit had been carried out by a junior nurse, who may not have fully understood the audit process or how scores were calculated. However, this did not explain why the result was then displayed on the ward.
- A number of patients were in isolation to prevent the spread of infection. Staff should only enter an isolation room wearing advanced personal protective equipment (PPE), including a gown, gloves, cap and mask. During inspection, we observed a doctor leaving an isolation room while still wearing PPE to seek equipment that they had forgotten. A passing matron warned the doctor of the IPC risk this presented and asked them to change their PPE before returning to the patient's room.
- We observed anaesthetists and surgeons taking their outdoor bags and briefcases into the anaesthetic rooms and theatres on three occasions. This presented an infection risk. On each of these occasions, we raised the issue with the nurse in charge and the individual was spoken to.
- Yellow sharps boxes were in use throughout the service, and were appropriately signed and dated. However, on Larch ward, during our unannounced inspection, we observed a sharps box that had been wrapped in white paper, stating that it was solely for use on that ward. This obscured all of the yellow bin and the label.
- We saw minutes of a quarterly divisional infection prevention and control meeting for surgery and critical care, which took place at trust level. This meant that IPC learning could be shared across both hospital sites.

- Ward staff used "I am clean" labels to indicate that an item of equipment was clean and ready for use. We saw cleaning staff adhered to a colour coding procedure for cleaning the department and for the disposal of waste. Waste was disposed of in a secure area, with separate sections for clinical and domestic waste.
- The trust used an adult sepsis screening tool, for all non-pregnant adults with a fever, in order to recognise and treat sepsis as soon as possible.
- The department carried out monthly sepsis audits. In the most recent audit in December 2016, 100% of adults who met the criteria for sepsis screening were screened.

Environment and equipment

- All portable suction units and defibrillators we checked had been recently serviced and labelled to indicate the next review date.
- Resuscitation trolleys were available in all wards, theatres and the pre-assessment unit and Bell admissions Unit. Resuscitation equipment included portable suction units and defibrillators. However, there was inconsistency between the types of trolley used across the hospital as a resuscitation trolley. On the wards and in theatres, red trolleys were in use. However, a different type of trolley was used in the Bell Admissions Unit and the pre-assessment unit. This meant that resuscitation trolleys may not be easily identifiable in an emergency by unfamiliar staff.
- The resuscitation trolley on the Bell admissions unit contained a diary. Only relevant medication and equipment should be kept in a resuscitation trolley. In addition, the suction unit and defibrillator were not stored by the crash trolley, but on the opposite side of the nurses' station. This meant that a member of staff unfamiliar with the unit may have been unable to find the necessary equipment in an emergency.
- During our unannounced visit, we found cardiac arrest audit forms for patients stored in the resuscitation trolley on Juniper Ward. This again was an issue as only equipment essential to resuscitation should be stored in the trolley to prevent confusion in the event of an emergency.
- In the Bell admissions unit, we observed a surgeon who could not find a permanent marker to mark a patient prior to surgery. None of the staff on the unit were aware of where the markers were stored. This resulted in a delay of approximately ten minutes in getting the patient ready for surgery.
- Surgery packs were stored in the surgery equipment store, having been assembled at QEH. All equipment was sent to QEH for sterilisation. Theatre staff told us that equipment was previously sterilised outside the trust by a private company. They preferred the new arrangement as communication with the sterilisation team has improved. Staff said that surgical equipment was more readily available than it had been previously, as more surgery packs had been ordered. This followed requests to the senior management by the theatre users group.

Medicines

- We found significant medicines management issues in main theatres. In particular, in Theatre 2, we found a vial of Ketamine 50mg/ml (10ml vial) left on a shelf. Ketamine is a Controlled Drug (CD) and should be stored in a locked cupboard, accessible only to appropriately qualified staff.
- A nurse told us that an Anaesthetic Consultant had left it there. The anaesthetic consultant said they had used 1ml from this Ketamine vial for a patient in the morning and had left the remaining 9ml for use on another patient later in the day. The theatre nurse informed him that the vial should be for single patient use. The anaesthetic consultant immediately threw the vial of Ketamine (with contents intact) into the sharp bin.
- There was no record made of the volume destroyed, which is necessary in order to ensure the correct stock and whereabouts of CDs. Staff involved told us that this was the normal procedure. When we raised this with the hospital, we were told that this was not normal procedure and that the staff involved were agency staff.
- The hospital took action to rectify this incident. In addition, they assured us that the information and learning from this event had been shared with all theatre staff.
- There were incomplete entries and missing signatures in the CD register for Theatres 2 and 3. For example, the Ketamine referred to above had been signed for by a nurse at 8:30am, indicating they had witnessed the supply, administration and destruction, of the medication. In addition, the consultant responsible for using the CD had not signed the appropriate section of the register.

- The Misuse of Drugs Legislation (2001)CDs must always be signed for by two qualified staff members. Further, each stage of supply, administration and destruction of a CD should be signed for only at that stage of the process, not in advance.
- There were other missing signatures in the register, including for Morphine 10mg on 6 January 2017 and a Fentanyl injection on 30 January 2017. There was also a missing entry for Fentanyl on page sixteen of the CD register for Theatre 3.
- Whilst we were in the anaesthetic room of Theatre 2, an operating department practitioner (ODP) came into the room with the CD register from Theatre 3 and asked for the consultant to sign for the CDs issued in the morning because CQC inspectors were present in her theatre. We asked if this was the usual practice and were told that they had forgotten to sign for the CDs in the morning because the staff were rushing.
- The significant number of missing responsible person signatures we noted in the CD registers, including the incident we observed, demonstrated to us that staff were not following the trust's own policy on CD management.
- We raised the issue with the trust and were told that theatres had recently introduced new CD registers, which incorporated a significant change from previous documentation to support good practice. These new registers had only been in place for 12 weeks and new practice was still being embedded within the department at the time of our inspection. The trust told us that as a result of our findings, they were undertaking a widespread review of all theatres and all practices to ensure that the management of CDs was understood and adhered to.
- Fridge temperatures were usually recorded daily, with appropriate actions taken when these were not in range. However, in the anaesthetic room of theatre 2, temperatures were found to be out of normal range in January and February 2017, which could have had an impact on the effectiveness of medications.
- In the supply store in main theatres, sodium chloride irrigation solution, used during surgery for cleansing of tissues, body cavities, wounds or irrigation of catheters, was stored on the same unlabelled shelf alongside formaldehyde solution, which is used as a tissue fixative for biopsy samples. We raised this issue with theatre management at the time of the announced inspection. However, when we returned for the unannounced visit one week later, this issue had still not been resolved.
- In the clean utility room on Cedar Ward, there was a box for staff to use if a diabetic patient presented with hypoglycaemia. There were two opened bottles of an energy drink in the box. On the bottles, the manufacturer stated that bottles should be kept refrigerated once opened and used within four days.
- We saw that the allergy status of patients was routinely recorded on medicines charts.
- There was a hospital-wide pharmacy team. Ward and theatre staff we spoke with told us that they had a good working relationship with the pharmacy team and that additional medication stock requests were dealt with promptly.
- In-patient's take home medications were prescribed to them prior to discharge and provided by the on-site pharmacy. Nursing staff we spoke with said that turnaround for take home medications was good. This was not the case for day surgery patients, however, who were required to obtain their prescriptions from an independent pharmacy within the hospital.

Records

- Patient records were mainly paper based. Records were delivered to the admissions unit on the morning of a surgical list in a trolley and then taken by the ODP to theatres with the patient. Some staff said that there was rarely any issue with records not being present for a patient. However, other staff on the wards told us that due to the frequent movement of a number of outlying patients on non-surgical wards, and the frequent moving of patients throughout the hospital, there were sometimes issues in locating a patient's records.
- During our inspection we were able to enter the Vanguard admissions unit through an open door from the main corridor in the Riverside building. There was no one in the admissions centre at that time. However, the door to one of the consultation rooms was open, with the keys left in the door. The computer inside the office was logged on, with a nurse's access card in the computer and patient records on screen. This meant that unauthorised individuals could have accessed

confidential patient records. This issue was raised with the nurse concerned, as well as the manager of the unit. The Vanguard admissions suite and the consultation rooms were thereafter kept locked.

- Throughout our inspection on the wards, we saw a number of staff leaving their computers without first locking the screen, meaning that patients' confidential records remained on the screen.
- We observed patient records left in an unlocked, unattended trolley in the corridor in the Bell admissions unit.
- During our unannounced inspection, the printing and photocopying room on Juniper Ward was left open and unlocked, despite a sign on the door saying that it should be kept closed. There were completed patient request forms left on the photocopier which included patients' names, dates of birth, NHS numbers and conditions. We drew this to the attention of the nurse in charge, who told us that staff from other wards could print to a printer in that room, and therefore that the records did not necessarily relate to the Juniper Ward. Nonetheless, this presented a significant risk to patient confidentiality.
- On the same ward, we found cardiac arrest audit forms for patients stored in the resuscitation trolley. Two of these had been completed and contained detailed patient information, with one dated two days before the unannounced inspection. This presented a number of issues: relating to both patient confidentiality and safety. As well as the trolley not being kept locked, only relevant medication and equipment should be kept in a resuscitation trolley. The audit forms were also not being returned to the appropriate place for scrutiny.
- We checked 14 patient records. All of the records were complete, with signatures indicating that patients had consented to treatment. Medication prescription and administration records indicated that medicine was signed for as given, refused and destroyed.
  Pre-operative assessments had been completed for all of the patients whose records we checked and national early warning scores (NEWS), paediatric early warning scores (PEWS) and allergies had been checked and recorded. On the wards, care plans including pressure ulcer prevention care plans, body maps, falls prevention assessment and nutritional assessments had been clearly documented. Staff completed the sepsis screening tool in all the ward records reviewed.

Safeguarding

- Nursing staff exceeded the trust training completion target of 85% for both safeguarding adults level 2 training and safeguarding children level 2 training. However, surgery overall had an 84% safeguarding training completion rate, just below the trust target.
- Medical and dental staff had a training completion rate of 80%, below the completion target of 85%. Medical staff had a completion rate of 76% for safeguarding adults clinical level 2 and of 77% for safeguarding children and young people level 2 had a training completion rate below the trust target. Safeguarding Children & Young People Level 3
- There were systems and processes in place for safeguarding patients from abuse. Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children, including in respect of child sexual exploitation (CSE) and female genital mutilation (FGM). They understood safeguarding procedures and how to report concerns.
- There were signs in every ward identifying the hospital safeguarding lead.

Mandatory training

- Surgery nursing staff had a training completion rate exceeding the trust target of 85% for seven of the 13 mandatory training modules. However, training rates were low in some courses, for example, 'fire safety clinical and prevent level 3' had a completion rate below 50%.
- Nursing staff we spoke with told us that they were given paid, protected time to complete their mandatory training. Bank nursing staff we spoke with told us they were also given protected time to undertake mandatory training.
- Medical and dental staff had a 51% mandatory training completion rate, which was significantly below the trust target of 85%. The highest completion rates were in 'infection prevention and control' (74%) and 'management of resuscitation' (69%), whilst the lowest were 'prevent WRAP level 3'- training around the Prevent programme: (36%) and 'fire safety clinical' (39%).

Assessing and responding to patient risk

- In the 14 records we reviewed, we observed the use of Early Warning Scores (EWS) to identify patients who were deteriorating. Staff we spoke with told us that they

understood the necessity of recording vital signs regularly and knew how to escalate a deteriorating patient. They told us that ward doctors could be bleeped if required to provide medical assistance.

- We observed the World Health Organisation's (WHO) five steps to safer surgery in use in theatres. Use of the five steps was audited by the hospital. Each month, 20 observations of surgery were carried out by a matron as part of the audit. If there was less than 100% compliance, then the theatres were required to submit an exception report explaining where and why compliance was not achieved. In the last year, the lowest compliance rate was in July 2016, at 92.9% compliance. However, the compliance was mostly at 100%.
- We attended the daily, hospital-wide 'safety huddle' at which the headlines for the care of deteriorating patients could be discussed, and any risks or concerns identified by staff raised. This was attended by staff from all surgical wards, theatre staff, the hospital-wide service improvement team and the bed management team.

Nursing staffing

- There were 115.92 whole time equivalent (WTE) nurses within surgery. This number was 14% lower than the Trust's own recommendations regarding the number of WTE nursing staff required to ensure effective and safe care of patients.
- General surgery at had the highest vacancy rate of 26% followed by theatres (22%). The head of nursing told us that there had been efforts to recruit more surgical nursing staff. This included the development of a more attractive benefits package and advertising on buses at the time of our inspection.
- Surgery at University Hospital Lewisham had an average agency and bank use rate of 17%, higher than the trust average of 13%. Between January and December 2016, main theatres had the highest average usage of 30%, with rates ranging between 24% and 37%. General surgery's use of bank and agency ranged between 23% and 31%.
- Ward managers told us that when using bank staff, they tried to employ staff who worked elsewhere within the hospital, preferably within the surgery department.
- Agency and Bank staff told us that they had been given inductions into the wards they were working on, and temporary logins to computers on the wards.
- Anaesthetics had the highest turnover rate of 45% followed by theatres (19%). general surgery had a turnover rate of 2%.
- Anaesthetics had the highest sickness rate of 17% followed by general surgery with 8%.
- There were boards displayed prominently in each of the wards stating how many nurses and healthcare assistants (HCAs) were required on the ward and how many were working on it on that day. Throughout our inspection, all of the required staff were present on all of the wards we visited.
- Senior ward staff used an acuity tool to assess the number of staff required on a ward to provide safe care and treatment, depending on the number of patients and the complexity of the care they required.

Surgical staffing

- Between September 2015 and September 2016, the proportion of consultant staff working at the trust as a whole was lower than the England average by 6% and the proportion of junior (foundation year 1-2) staff was the same as the England average.
- Within general surgery there was a vacancy rate of 33%, resulting in the unit having 9.1 less WTE surgical staff in place than recommended by the trust. For example, ear nose and throat (ENT) reported a vacancy rate of 18% (4.2 WTE), while anaesthetics had a vacancy rate of 11% (7.03 WTE).
- Anaesthetics reported the highest turnover rate of 7%. ENT reported a turnover rate of 2%. General surgery reported a 0% turnover.
- The urology department reported a high overall bank and locum use of medical staff, with rates of between 48% (November 2016) and 70% (August 2016). General surgery reported high usages in May (18%), June (17%) and August 2016 (17%). For the remaining four months, rates of between 5% and 8% were reported consistently.
- We observed a handover of a patient between ward doctors. The handover was clear and detailed.
- Consultant care was available 24 hours a day, seven days a week. All of the consultants were within 30 minutes of the Hospital and there was an on-call rota to ensure their availability. Staff we spoke with said that issues with consultant availability were very rare.

Major incident awareness and training

- There was a hospital-wide major incident plan, which detailed what roles staff needed to take during an

incident. In addition, the surgery department had a business continuity plan with action cards in place for dealing with internal and external major incidents. These included procedures for dealing with hazardous materials incidents and chemical biological, radiological and nuclear defence (CBRN). It also included an evacuation risk assessment, a contact list and incident helpline, an escalation flow chart, lock down principles and evacuation flow chart, a severe weather plan and incident reporting forms.

- A hard copy of the major incident and business continuity plans was available in the nurses' stations. Staff could also access the policies on the trust's intranet.
- Staff we spoke with said that they had major incident training and were aware of what their role and responsibilities would be in the event of such an incident.
- There were protocols in place to prioritise unscheduled emergency procedures. In addition, at all times, one theatre and surgical team were working solely on unscheduled emergency procedures.

Are surgery services effective?

Good

We rated effective as good because:

- Pain relief for patients was proactively managed.
- The service participated with national audits. In the majority of cases, patient outcomes were within the expected range.
- We observed good multi-disciplinary team (MDT) working during a ward round, which included a surgical consultant, registrar, junior doctors, nurses and physiotherapists.

However:

- A number of staff said that whilst local leadership supported them in their continuing professional development, there was limited funding for additional training or courses. Staff felt that this impacted on their ability to progress within their careers and some said that this would lead them to seek work elsewhere.

Evidence-based care and treatment

- Policies and procedures were developed in line with national guidance and best practice evidence from professional bodies, such as the Royal College of Surgeons (RCS) and the National Institute for Health and Care Excellence (NICE).
- Guidelines were easily accessible on the trust intranet page and were up to date. Staff were able to demonstrate how to access relevant policies and information online. Staff could also access hard copies of the guidelines in the event of a system failure. Bank and agency staff were also provided with access to online policies.
- Policies had been independently ratified and reviewed in line with specified review dates.
- The department carried a number of local audits to monitor adherence to policies and procedures. These included audits of the use of the pain assessment tool, formal handover time in theatres and use of the trust's pathway for emergency patients.
- We saw evidence from both governance meeting minutes and local ward and theatre team minutes that showed learning and improvement from audits was shared with staff throughout the department.

Pain relief

- Patients that we spoke with on the wards told us that they received pain relief when required.
- The department implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- There were a number of different pain assessment tools available to staff, including the Wong-Baker faces scale, verbal rating scale or numerical rating scale (in this scale, zero meant no pain and 10 was extreme pain). We saw that these scores had been documented in patient's notes.
- Pre-assessment records indicated that the pre-assessment team undertook pre-operative assessments for post-operative pain relief, including taking account of any allergies a patient might have. We observed a patient being referred to a doctor for a further assessment for appropriate pain relief.
- We observed the use of patient controlled analgesia (PCA) on the wards, whereby patients could administer pain relief themselves, controlled by a button. We saw completed prescriptions for PCA and notes indicating how much PCA had been used, to allow the medical team to monitor its use and efficacy.

- There was a dedicated pain team at the hospital, who visited each of the surgical wards daily.

Nutrition and hydration

- Nurses monitored patient's hydration using fluid balance charts.
- Ward patients chose their meal preferences from a menu at the beginning of each day.
- There were water coolers in patient waiting areas. In addition we observed nursing and HCA staff providing fresh water to patients.
- There were protected mealtimes on each of the wards, during which visiting was restricted. We observed protected mealtimes signs in use.
- We saw that dietary plans were included in patient care plans.
- We observed 'nil by mouth' signs in use on patient bays. Nil by mouth patients were provided with nutrition via intravenous fluids. There was a nil by mouth protocol for patients to ensure that they were nil by mouth for the correct amount of time and that patients whose operations were postponed were not kept without food unnecessarily.
- There were dieticians and speech and language therapists working within the hospital to whom patients could be referred for tailored nutrition plans or swallow assessments.

Patient outcomes

- The Trust participated in the National Bowel Cancer Audit. In the 2015 Audit, 79% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national average, and had risen from 69% in 2014.
- The risk-adjusted 90-day post-operative mortality rate was 6.1, which was within the expected range. The risk-adjusted 2-year post-operative mortality rate was 17.7%, which also fell within the expected range. The risk-adjusted 90-day unplanned readmission rate was 17.9%, which also fell within the expected range. The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 47%, which again fell within the expected range.
- In addition, 79% of bowel cancer patients undergoing a major resection had a post-operative length of stay greater than five days. This was above the national average of 69%. The case ascertainment rate of 103% was better than the national average of 94%, which indicates good quality of audit participation.
- In surgery across the trust, the Patient Reporting Outcomes Measures (PROMS) indicators, from April 2015 to March 2016, showed fewer patients' health improving and more patients' health worsening, than the England averages.
- In the 2016 National Emergency Laparotomy Audit (NELA), the hospital achieved a green (>70%) rating for the proportion of cases who had a documented risk of death. This was based on 60 cases. This indicator shows that the quality of clinical review for emergency general surgical patients in the pre-operative period was good, scoring 92% against the national average of 64%.
- The hospital also achieved a green (>80%) rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 90 cases, with an average of 90% against 82% nationally. The hospital achieved a green (>80%) rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 33 cases. This demonstrated that the adequacies of critical care support and capacity for high-risk emergency general surgery patients was good, with the hospital scoring 85% against a national average of 74%.
- The hospital achieved a green (>80%) rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 23 cases. The risk-adjusted 30-day mortality was also shown to be within expected range, based on 60 cases.
- The hospital participated in the national Hip Fracture Audit. In the 2016 audit, the risk-adjusted 30-day mortality rate was 7.1%, falling within the expected range. This had risen slightly from 2015, where the figure was 6.9%.
- The proportion of hip fracture patients having surgery on the day of or day after admission was 54.7% (falling from 75% in 2015). This did not meet the national standard of 85% and placed the site in the bottom 25% of hospitals nationally.
- The perioperative surgical assessment rate for hip fracture patients was 93% (falling from 94.7% in 2015), which was below the national standard of 100%.

- The proportion of hip fracture patients not developing pressure ulcers was 96.5%, which falls in the middle 50% of trusts.
- The length of stay for hip fracture patients was 23.9 days, which falls in the best 25% of trusts.
- The Hospital adhered to the Royal College of Surgeon's (RCS) standards for unscheduled care. For example, by ensuring that there was a theatre dedicated to emergency surgery and the implementation of a protocol for deferring elective work to prioritise urgent care.
- Between October 2015 and September 2016, the average length of stay for surgical elective patients at University hospital Lewisham was 3.6 days, compared to 3.3 days on average nationally. For surgical non-elective patients, the average length of stay was 5.1 days, which was the same as the England average.
- Trauma and Orthopaedic elective patients had a stay of 4.4 days, which was longer than the England average of 3.4 days. Elective patients in general surgery stayed 3.8 days, compared to an England average of 3.3 days. Non-elective trauma and orthopaedic patients had an average stay of 10.2 days, which was also longer than the England average of 8.8 days.
- Between September 2015 and August 2016, patients at the hospital had a slightly higher than expected risk of readmission for non-elective admissions. Trauma and orthopaedics had the largest relative risk of readmission.
- In the same time period, elective patients had a lower than expected risk of readmission.

Competent staff

- There was a 55% appraisal completion rate across the surgical division between April and August 2016. HCAs had the highest appraisal rate of 68% Additional professional scientific and technical staff, for example operating department practitioners (ODPs) had the lowest appraisal rate of 39%. We were not provided with a hospital or trust-wide target for appraisal rates.
- A number of staff said that whilst local leadership supported them in their continuing professional development, there was limited funding for additional training or courses. Staff felt that this impacted on their ability to progress within their careers and some said that this would lead them to seek work elsewhere.
- The department offered a number of continuous professional development (CPD) sessions that staff could attend. However, staff told us that opportunities for additional training and development had become increasingly rare over time.
- A number of nursing and HCA staff in the day surgery unit (DSU) said that there was limited opportunity to progress within the unit or to undertake further training.

Multidisciplinary working

- We observed good multi-disciplinary team (MDT) working during a ward round, which included a surgical consultant, registrar, junior doctors, nurses and physiotherapists.
- We spoke with two ward-based physiotherapists. They told us that there was good MDT working throughout surgery. They said that they were included in handovers and clinic decision making and felt like part of the wider surgery team.
- The majority of allied health professionals' contracts required them to work at both this hospital and QEH. Some allied health professionals that we spoke to told us that this meant they had a good understanding of the challenges facing each site. This therefore improved communication, especially in relation to transfers between sites.
- Theatres and wards held regular multi-disciplinary team meetings.

Seven-day services

- Out of hours medical cover consultant surgeons were on call, rather than resident within the hospital. Nursing staff we spoke with said they were able to contact consultants if they needed to.
- The hospital pharmacy was only open Monday to Friday. However, pharmacy services were available out of hours. However, this was not the case for the day surgery unit, where the allocated pharmacy for take home medications closed at 7pm, whereas patients were discharged up until 9pm. This meant patients discharged after the pharmacy closed would have to return to the hospital pharmacy the next working day to collect their take-home medications.
- The theatre designated for emergency patients operated and was fully staffed 24 hours a day, 7 days a week.

- Ward-based allied health professionals, for example physiotherapists and speech and language therapists had out-of-hours cover for weekends.

Access to information

- Policies and guidelines were available on the trust intranet and were up to date. Agency and bank staff were given temporary logins to allow them to access this information. There were computers on trolleys in corridors and at nursing stations. Staff told us that they had no issue in finding a computer when needed.
- There was an out-of-date British National Formulary in the nurses' station in the Bell admissions unit. Staff said that there was an in-date copy in the doctors' room.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- As of December 2016, Mental Capacity Act (MCA) and Consent to Examination/Treatment training had been completed by 27%% of medical and dental staff within surgery. This was a low rate of completion for medical and dental staff. In comparison, nursing staff had a completion rate of 84%. The trust completion target was 85%. All staff we spoke with had a clear understanding of the MCA.
- Staff had a clear understanding of the importance of consent to treatment, and the right of the patient to refuse treatment. We observed a number of patients being asked for consent prior to undergoing surgical procedures, and signing the relevant consent forms.
- All of the surgical records we checked had been signed by the consenting patient. One record had also been signed by a translator. Staff understood that only an independent translator could undertake the consent process with non-English speaking patients, not a family member or friend.

Are surgery services caring?

Good

We rated caring for surgery as good because:

- Staff we spoke with demonstrated care and compassion for patients and their families.
- All of the patients we spoke with spoke highly of the care they received and said that they had been kept informed about their care and treatment options.
- Completed friends and family tests indicated a high recommendation rate for the service.
- There were clinical nurse specialists to provide care, support and advice to patients with specific care needs.

However:

- The friends and family test response rate was below the national average.

Compassionate care

- In discussions between staff, we observed genuine care and compassion and an interest in the patients' wellbeing.
- We spoke with 10 patients. All were positive about the caring attitude of staff. One patient told us, "no one wants to come to hospital, but if you have to, this is the place to be. Everyone's got a smile on their face". Another patient told us, "I thank God for this hospital, staff are accommodating and kind. They are at ease, and that puts you at ease".
- The Friends and Family Test (FFT) response rate for surgery at the Hospital was 18% for the period between December 2015 to November 2016. This fell below the England average of 29%. The FFT recommendation score for the surgical wards mostly fell between 88% and 100% in this period. Larch Ward had the highest response rate of 64%, and with the exception of February 2016 (86%), recommendation rates (both recommend or highly recommend) rates ranged between 89% and 98%.
- During our unannounced inspection, we saw that a paediatric patient's underwear had been left in a clear plastic bad on a trolley in the corridor outside the theatre where they were undergoing surgery. This impacted on the privacy and dignity of the patient.

Understanding and involvement of patients and those close to them

- All of the patients we spoke with said that they had been kept informed about their care and their options for care. They said that, where appropriate, family members had been kept informed.
- Patients we spoke to in the day surgery unit told us they felt their concerns had been listened to, appreciated, and allayed by the staff.

Emotional support

- There were a number of clinical nurse specialists within the hospital with links to the surgical wards. For example pain and, diabetic specialist nurses who offered specialist advice and support.
- There was a multi-faith chaplaincy service in the hospital who offered spiritual and emotional support to patients.

Are surgery services responsive?

Requires improvement

We rated responsive in surgery as requires improvement because:

- Due to limited bed capacity, surgical patients were distributed throughout the wards. Similarly, there were medical patients in surgical wards. This had the potential to create logistical problems for staff providing treatment.
- The day surgery unit discharged patients until 9pm. However, day surgery patients were required to use the on-site pharmacy, which closed at 7pm. This meant that patients discharged after 7pm would have to return to the hospital the next working day after their surgery, delaying the time from which they started their medication.
- The service took significantly longer than its stated target of 25 working days to respond to complaints.

However:

- Staff had access to translation services both for verbal and written translation, and we saw that these were used appropriately.
- Patients could have their pre-assessments and operations carried out at the two different sites within the trust, at their convenience.

Service planning and delivery to meet the needs of local people

- The trust had 22,361 surgical admissions between April 2015 and March 2016. Emergency admissions accounted for 34% (7,685), 11,911 (53%) were day case admissions, and the remaining 2,765 (12%) were elective.
- One theatre in the main theatres was allocated solely for emergency patients.
- Senior staff told us that the hospital undertook more elective and day surgery than the QEH site. A number of patients we spoke with had been referred and pre-operatively assessed through QEH, but offered surgery at the hospital, in order to ensure they received their surgery in a timely manner. Patients we spoke with, for whom this was the case, told us that this had been very convenient for them.
- The hospital had a computer programme that allowed information leaflets to be translated for non-English speaking patients.

Access and flow

- The department audited the referral to treatment time for patients within different surgical disciplines. In general surgery, the trust performed better than the England average with 83.1% of patients treated within 18 weeks of referral (compared with the average of 75.9%). However, it performed worse than the England average in other areas, including ear, nose and throat (34% against 69.6%), ophthalmology (16.7% against 78.2%)
- Throughout the surgical wards, there were outlying patients from other core services, as well as surgical patients outlying in other wards. Patients were placed and tracked through daily bed meetings.
- There were numerous outlying surgical patients in the medical wards as well as non-gynaecological surgery patients in the gynaecological ward. We observed outlying patients being visited on surgical ward rounds. Junior doctors told us that the number of outlying patients meant that they were used to visiting different wards throughout the hospital to assess their patients. They told us, however, that the frequency with which outlying patients moved was frustrating and presented challenges in attending patients in a timely manner.
- We attended a bed meeting. The meeting was constructive and nursing and MDT staff had the opportunity to challenge decisions.
- We observed a patient being admitted for surgery through the Bell admissions unit. The patient had their observations taken by a nurse from the unit and had a final discussion about their surgery with their consultant.
- There was a hospital-wide complex discharge team. We spoke with a member of the team who said that the primary challenge in discharging patients in a timely manner was ensuring suitable care packages were in

place, in liaison with the local authorities. They told us that the hospital had more effective working relationships with some of the surrounding boroughs than others.

- Staff in the day surgery unit described some of the challenges they faced when discharging patients. In particular, they told us that patients' medication prescriptions were handled through the on-site commercial pharmacy. This meant that patients (who were not exempt from doing so) had to pay for their prescriptions. This was an issue as many patients arrived at the hospital without any money or bank cards, as per instructions ordinarily given to DSU patients at the hospital.
- Further, this meant that all patients had to go the pharmacy upon their discharge. However, the pharmacy closed at 7pm, whereas the last discharge from day surgery could be as late as 9.30pm. These patients therefore had to return the next day to obtain their prescription medications, presenting an inconvenience for patients, and a delay in them beginning the course of medication prescribed for them.
- Staff explained to us that prescriptions were restricted to the on-site pharmacist, meaning that they could not collect prescriptions at their local pharmacy.
- For the period between quarter three of 2014/15 and quarter two of 2016/17, Lewisham and Greenwich NHS Trust cancelled 653 surgeries. Of these 653 cancellations, 4% weren't treated within 28 days.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital, or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. From November 2015 to November 2016, the hospital failed to meet its own target of 50% for fractured neck of femur patients seen within 24 hours every month with the exception of December 2015 and January 2016.
- We had sight of the trust-wide out-of-hours discharge policy, which had been reviewed in line with review dates.

Meeting people's individual needs

- There were information boards clearly displayed in all wards. Healthcare related leaflets were available in all waiting areas. For example, patient information regarding stopping smoking was widely available.
- The paediatric surgical recovery area was appropriate for children, brightly painted, with pictures on the walls. The heating in the paediatric recovery was kept at a high temperature, as children are more susceptible to cold when recovering from surgery.
- We observed a member of staff arranging for a translator in order to obtain consent for a procedure. They recognised that when obtaining consent for treatment, it was not sufficient to rely on a family member for translation. Where a face-to-face translator was not available, for example out of hours, staff had access to a telephone translation service.
- In one of the sets of surgery notes we looked at, we saw the signature of a translator appropriately recorded on the consent forms.
- There was a trust-wide dementia working group, which met monthly. We saw minutes of meetings, at which members of the group discussed ways in which to improve care for patients with dementia across the trust. There were also hospital wide dementia specialist nurse, from whom staff could seek advice on care for patients with dementia.
- Patients on the wards were provided with a daily menu from which they could select their meals. Religious, vegetarian and other dietary requirements were catered for.
- However, one of the patients we spoke with said that gluten-free meal options were limited, meaning that during their stay they had, on occasion, gone without breakfast.

Learning from complaints and concerns

- Throughout the wards we saw posters and leaflets explaining to patients and their families how to complain and how their complaint would be dealt with.
- Between December 2015 and November 2016, there were 46 complaints relating to surgical care across at the hospital. The trust took an average of 65 days to investigate and close complaints. This was not in line with their complaints policy, which stated complaints should be responded to within 25 working days.
- Of the 46 complaints, the most common theme was medical and surgical treatment, which accounted for 24% of all complaints received. Discharge arrangements

and communication/information to patients were responsible for 12% and 10% of complaints respectively. Surgical outpatients was the most complained about department, who received 22% of complaints. Theatres (adult) accounted for 14% of complaints, along with Cedar Ward with12% of complaints.

Are surgery services well-led?

Requires improvement

We rated well-led for surgery as requires improvement because:

- The service's leadership were not aware of the safety issues we identified, in particular in respect of medications management and infection prevention and control.
- There was a lack of integration between surgery across site. This was exemplified in concerns expressed by staff and also in the continued use of forms which used former names for the hospital and trust.
- Whilst staff spoke highly of immediate local leadership, staff and local leadership felt that there was a disconnect between their concerns and those of the senior leadership team.

However:

- Staff spoke highly of their immediate local leadership.
- The senior team recognised the cultural divide that many staff felt with regards to working in partnership with QEH.

Leadership and culture of service

- Surgical services were led by the divisional director, with two assistant with two general managers, one responsible for theatres, anaesthetics and critical care, the other responsible for surgical specialities. Leadership was provided across site. In addition, there are two site based Heads of Nursing.
- There was also a trust-wide director and associate director for quality and safety for surgery. During our inspection, we identified a number of safety breaches which had not been addressed.
- Staff at all levels acknowledged that there was a cultural divide between the two sites which the leadership had failed to address.
- A number of staff that we spoke with expressed concern that the partnership with QEH was impacting negatively on the finances of the service. They told us that since the partnership, funding had been less readily available at the hospital. Further, they were of the view that issues at QEH were a priority for senior, cross-site staff and issues within surgery and at the hospital were not being dealt with as a result.
- Throughout the department we saw forms in use that referred to historic names for trusts within which the hospital had operated. This impacted on the overall culture within the department, in particular in respect of promoting cross-site teamwork. This issue was still to be addressed by the leadership.
- The majority of staff we spoke to spoke highly of their local leadership, however, they had less confidence in the executive management level. Junior staff we spoke with felt that the executive management did not have an understanding of the challenges they faced within the department. Some senior, non-executive staff reflected these concerns. They told us that they felt that the executive team did not always listen to or act on concerns they raised.
- A number of senior staff within the department had resigned, but remained employed at the Trust on temporary contracts as no one had been recruited to fill their post. This meant that the leadership of certain key aspects of the department was based on the goodwill of those staff members.
- A number of staff told us that they were fearful of being involved in a reported incident as they believed this may result in disciplinary proceedings against them.
- A number of staff were concerned at a perceived lack of opportunity for progression, training and development.
- However, staff said they were encouraged to raise concerns with senior staff.
- A new member of staff in main theatres told us that the staff had been highly supportive in helping them to get to know the unit.
- Senior theatre and ward staff were visible throughout the inspection, including during the unannounced inspections.

Vision and strategy for this service

- Since the trust was formed in 2013, the division of surgery, theatres, anaesthetics and critical care developed a joint vision to: "provide safe and caring surgical services across our two sites to our population

by one , cohesive well led multi-disciplinary team that are responsive to our patients and populations needs yet effective through utilising our facilities and workforce across both site, producing positive outcomes and value for money".

- Staff we spoke with were not aware of the vision and strategy for the service.
- At the time of inspection, the hospital was implementing a building improvement plan for theatres to modernise the theatre suite. This had an initial start date of April 2017, but had been postponed due to the volume of work that theatres had been experiencing.

Governance, risk management and quality measurement

- We had sight of the risk register for the department. This identified risks, whether the risk affected just one sight or both and action plans to mitigate the risks. The risk register was up-to-date and clear. However, it did not highlight the same risks as those identified during our inspection, for example in respect of CD management or infection prevention and control.
- There were cross-site monthly clinical governance meetings within surgery. These included staff from both sites and were held alternately at each site. We were provided with minutes of the meetings. They were well attended. The meetings discussed patient experience; clinical effectiveness and policies, protocols and information exchange. Learning and outcomes from the meetings were then shared at a local level.
- In addition, there were monthly governance meetings for each of the surgical specialities, for example general surgery, or ear, nose and throat (ENT) surgery and for ward managers. We had sight of these minutes. Issues raised at these meetings could be escalated to the trust-wide surgery governance meetings.
- There were monthly theatre users' meetings for both theatre suites.
- Executive staff identified recruiting junior doctors as their number one risk within surgery. They said that this risk was mitigated against by the use of locum staff and that there was currently a recruitment drive.
- The department produced a monthly trust-wide surgery scorecard in respect of various criteria under the headings: safe, effective, responsive, caring and well-led.
- The trust had introduced a document audit for surgery for 2016/2017, conducted by the hospital-wide risk and patient safety team. This was in response to concerns identified on the risk register in respect of poor medical records for surgical patients on wards. The conclusion from the audit was that: "The findings of this audit demonstrate that the standard of record keeping at a Trust and hospital site level in the majority of areas is at the minimum level required to ensure that the clinical record can support direct patient care by acting as an aide memoir for individual clinicians, supporting clinical decision making and providing an important means of communication."
- However, despite the statement above, during our inspection, we found significant issues with the recording and documentation of medicines.
- The trust completed a monthly standardised mortality review report, which identified any concerns relating to patient mortality, for example contributory factors, to be discussed at mortality and morbidity meetings.

Public and staff engagement

- Patients and their family and friends were invited to feedback on their care through the friends and family test and through the Trust's patient advice and liaison services (PALS).
- As part of a project, junior doctors and senior nurses had taken over responsibility for bed management, in order to give them insight into the work of the bed management team.

Innovation, improvement and sustainability

- There was a yearly update of the innovations for surgery across the Trust. At the time of our inspection, there were nine recorded innovations, for example the introduction of complex abdominal wall reconstructions. There were also three that were awaiting approval to be adopted. All innovations were monitored through outcome audits and overseen by the clinical effectiveness team leader.

Critical care

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

Information about the service

The critical care service at Lewisham and Greenwich NHS Trust is provided at University Hospital

Lewisham (UHL), and Queen Elizabeth Hospital, Greenwich. Critical care includes areas where patients receive more intense monitoring and treatment for life threatening conditions. These areas are described as high dependency unit (HDU) (level two), intensive care unit (ICU) (level three), or by the umbrella term, critical care unit (CCU).

The CCU at UHL provides both specialist and general critical care support for the local population. Ten beds are provided in HDU for patients requiring level two care (more detailed observation and higher levels of care such as those requiring basic respiratory support or those with single organ failure). Eight beds are allocated in an intensive care unit for patients requiring level three care (advanced respiratory support). Patients requiring level three care have one to one nursing, and those requiring level two care have a ratio of one nurse to two patients. All patients are nursed in fully equipped single bedded bays or side rooms. A 24 hour critical care outreach team (CCOT) supports doctors and nurses in the rest of the hospital in caring for acutely ill patients who are at risk of clinical deterioration.

Our inspection team included a CQC inspector and pharmacy inspector, and two specialist professional advisors. During our inspection we visited the high dependency unit and the intensive care unit at UHL. We spoke with 26 members of staff including the leadership team, medical staff, registered nurses, support workers, administrative staff, and allied health professionals. We also spoke with five patients and three relatives. We reviewed 10 sets of patient records, and an additional 14 patient medicines administration records.

Critical care

Summary of findings

We rated this service as good because:

- There was a positive incident reporting culture, and learning from incident investigations was generally shared with staff in a timely manner.
- The environment was clean, infection rates were low and staff complied with infection prevention and control practices. Nursing staffing levels met national standards.
- Systems were in place to ensure the safe supply and administration of medicines.
- Records were safely secured and contained documentation in accordance with national and local standards.
- Care and treatment was delivered in line with national guidelines and best practice guidance.
- There was an ongoing programme of clinical audit which included measurements of patient outcomes.
- Patients were cared for by appropriately trained staff who achieved specific competencies, and who were supported by a practice development nurse.
- There was access to a multi professional health care team who worked collaboratively to understand and meet the range and complexity of people's needs.
- Physiotherapy was available seven days a week and patients had appropriate access to rehabilitation.
- Interactions between staff and patients were individualised, caring and compassionate. Patients and their relatives felt they were treated with dignity and respect.
- Staff involved patients and their relatives in the delivery of care and treatment where appropriate and tailored their help to meet the needs of the patient.
- Staff said there was a positive organisational culture, and they worked well together as a team.
- Staff were happy with the support they received from managers, and reported an open door policy.
- Research and development within the service was supported and was reflected in publications.

However:

- There was no documented strategy for the critical care service, and there were concerns around the medical leadership and governance arrangements.
- There were higher than national average numbers of delayed discharges due to problems with access and flow within the hospital. Bed occupancy was also higher than the national average which could limit the service's ability to provide a bed in the event of an emergency.
- The 24 hour critical care outreach service was not managed by the critical care service and the operational policy was past its review date.
- There was no clinical ownership of the unit risk register, which sat within the surgical directorate.
- There were no scheduled multidisciplinary meetings for the team to review patient care and goals of treatment in a unified way. Frequency of ward rounds used for this purpose did not meet Faculty of Intensive Care Medicine (FICM) core standards.
- There was limited patient satisfaction data in the reporting period which meant we were unable to fully assess where patients perceived improvements may be needed.

Critical care

Are critical care services safe?

Good

We rated safe as good because:

- There was evidence of a positive incident reporting culture, and learning from incident investigations was shared with staff in a timely fashion.
- Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would act on any concerns.
- Staff, patients and relatives were happy with the cleanliness of the environment and infection rates were low.
- Nursing staffing levels consistently met national standards.
- There were systems in place to ensure the safe supply and administration of medicines.
- Records were safely secured and contained notes which were maintained in accordance with national and local policy.

However:

- Morbidity and mortality (M and M) meetings were not held on a regular basis.
- There was insecure storage of intravenous infusion medicines and no ambient temperature recording of medicines storage cupboards.
- The ICU/HDU safety thermometer from May 2016 to March 2017 showed two months where venous thromboembolism (VTE) data was not collected or reported.

Incidents

- Staff reported incidents using the trust electronic reporting system. Incidents were then categorised, investigated and then discussed with staff at all levels at handovers and staff meetings. Between April 2016 and December 2016 there were 57 reported incidents. 52 of these were identified as community acquired pressure ulcers.
- The trust reported to the Strategic Executive Information System (STEIS) which records serious incidents and never events. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between January 2016 and December 2016 the trust reported three Never Events; one of which occurred in the critical care unit at Lewisham Hospital in July 2016.
- The never event met the serious incident criteria. It involved a controlled drug prescribed and prepared for nasogastric administration which was administered via a central line, in error.
- Managers investigated the error and concluded following a root cause analysis that it was caused by a failure of nursing staff to follow the trust medicines administration policy and lack of available feeding syringes. Following the investigation all nursing staff in critical care at both hospital sites were supported to complete a reflective exercise. This was used to identify factors which contributed to the mistake and consider how a similar event could be avoided in future. All staff we spoke with viewed this as positive learning.
- Incident reporting and learning about safety issues was shared at handover meetings attended by members of the multi-disciplinary team, by email, and at staff meetings.
- Mortality and morbidity meetings were set to take place monthly, in order to review patient deaths in a timely manner. We saw that these meetings had not occurred on a regular basis. Managers told us the purpose of the meetings was to review unexpected deaths in the service. These deaths represented only a small proportion of the overall mortality. At the time of our inspection senior leaders told us there were plans to ensure monthly meetings took place in future. We saw dates for meetings were set and publicised.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with had a good knowledge of duty of candour and, senior staff were clear about the requirement of this. Staff demonstrated how candour had been applied in relation to the never event through an apology to the patient.

Safety thermometer

- The critical care unit (CCU) participated in the NHS safety thermometer scheme. The safety thermometer is a national tool used to measure, monitor and analyse patient harm such as hospital acquired infections, new pressure ulcers, falls with harm, catheter urinary tract infections and venous thromboembolism.
- This information was clearly displayed at the entrance to the ITU and HDU. However, the ICU/HDU safety thermometer from May 2016 to March 2017 showed two months where venous thromboembolism (VTE) data was not collected or reported.
- The trust reported, no hospital acquired (new) pressure ulcers, no falls with harm and no new catheter urinary tract infections.
- NICE guidance QS3 statement recommends all patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool. We looked at 14 medicines administration records and saw that 4 out of 14 were not completed.

Cleanliness, infection control and hygiene

- The service had established procedures in place for infection prevention and control. These were based on the department of health code of practice on the prevention and control of infections. They included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of spillage of body fluids.
- All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet. There had been no reported incidents of health acquired methicillin resistance staphylococcus aureus (MRSA) or Clostridium Difficile (C.Diff) in the reporting period, or six months prior to our inspection.
- All areas we inspected were visibly clean and tidy including the treatment and waiting areas. Clinical waste, including sharp objects, was disposed of safely. There was clear segregation of clean and dirty equipment.
- NICE guidance QS61 requires that people receive healthcare from health care workers who decontaminate their hands immediately before and after every episode of direct contact or care. We saw that staff consistently used hand sanitisers, were bare below the elbow and washed their hands in accordance with national and local policy. We also saw visitors to the unit consistently used hand sanitisers and wore personal protective equipment.
- Compliance with procedures such as hand hygiene and bare below the elbow was audited monthly. The average compliance rate for hand hygiene between January 2016 and December 2016 was 89% with 88% by doctors, 91% nurses and 100% phlebotomists in CCU. Audit data showed all staff groups were consistently 100% compliant with the bare below the elbow policy. Bed space curtains were labelled with the date to show when they were last changed.
- All patients were screened for MRSA on admission, so that necessary precautions could be taken.
- The unit audited antimicrobial prescribing on a monthly basis. For four out of the previous six months the compliance rate was 100%, for the remaining two months this was 89% and 90%.
- During our visit we saw two patients with a known infection. In both cases, best practice guidance on isolation procedures was being followed. We reviewed both patients' records and saw clear instructions for infection prevention and control precautions, antibiotics were prescribed in accordance with the trust policy, and there was daily input by the microbiologist.

Environment and equipment

- There was an electronic swipe card entry system for authorised personnel only to gain access to the main entrances of ITU and HDU and utility rooms.
- Resuscitation trollies were located at appropriate intervals throughout the CCU. There was also instant access to a difficult airway trolley which enabled staff to intubate patients with challenging airways.
- Staff knew how to locate all emergency equipment. Staff maintained a register of checks which showed equipment was checked on at least a daily basis and the required equipment was in place and in date.
- There was clear segregation and correct storage of clean and dirty equipment and clinical waste.
- Staff told us they were satisfied they had the equipment they needed to carry out their responsibilities and deliver effective patient care.

Medicines

- There were systems in place to ensure the safe supply and administration of medicines in accordance with NICE NG5 Medicines optimisation: the safe and effective use of medicines.
- We saw the main supply of intravenous fluids in ITU was not stored securely in accordance with best practice. The fluids were kept in a store room and were not visible from the corridor; however, there was unlimited access to the store room. The risk of the fluids being tampered with was raised by three members of staff during our inspection who told us this had been a long standing problem since the unit opened. This was first recorded on the risk register two weeks prior to our inspection and remained unresolved. We brought this to the attention of managers who told us a request for swiped access by staff had previously been made but had not yet been actioned. Staff told us this was due to a delayed response by the estates department.
- The FICM core standards state clinical pharmacy services should be ideally available 7 days per week. As a minimum the service should be provided 5 days a week (Monday-Friday). The hospital pharmacy was open during core hours between Monday and Friday, and on Saturday and Sunday mornings. Access to the pharmacy during opening hours was by designated pharmacy staff only. In addition, there were specific procedures for other named staff to gain emergency access out of hours, meaning that unauthorised access was not possible.
- All medicines were supplied and administered against an individual prescription by a doctor. All the individual medicines administration records we reviewed were documented in accordance with local and national guidance, and we saw all medicines were given as prescribed.
- There was a checking system that ensured the accuracy of the prescription and dispensing of medicines. This meant only one prescription was prepared at a time to minimise the risk of error.
- There was a regular medicine stock top up service provided by pharmacist staff. Staff we spoke with were positive about the service and told us it was very rare to run out of any medicines stock. Measures were in place to arrange for emergency supplies where needed.
- With the exception of the intravenous infusion fluids, we saw all medicines were stored securely in locked cupboards or, where applicable, in a refrigerator. Fridge temperatures were monitored and recorded at least daily to ensure medicines were kept in optimal conditions. All the temperatures were within the required range. However, the ambient room temperature of medicines' storage areas was not monitored, and we saw that medicines fridges were not always locked. We brought this to the attention of the critical care pharmacist who told us corrective action would be taken. Room temperature was not on the services risk register.
- Controlled drugs (CDs) are medicines which require additional security. CDs were stored in locked cupboards with restricted access which were bolted to the wall. We saw that CDs were checked by two appropriately qualified members of staff and at the time of our inspection all stock levels we looked at were correct.
- We looked at 14 medicine administration records and noted that no prescribed medicines had been missed or omitted. NICE guidance QS61 recommends that people are prescribed antibiotics in accordance with local antibiotic formularies. The service had a clear policy, process and guidelines for managing the administration of preventive and therapeutic antibiotics.
- There was evidence of medicines audits being carried out. Staff told us medicines errors would be picked up as part of the wider incident reporting system and we saw where this happened.
- Pharmacists visited the critical care unit at least daily. They checked each patient's medicines administration record to ensure safe and effective use of medicines, and organised medicines to be given to patients on discharge from the unit. However, they told us that whilst they attended the unit daily they were only able to attend the daily multidisciplinary ward round two to three times a week because of their workload. This did not meet the FICM core standard of daily MDT attendance.

Records

- Individual care records were managed in a way that kept people safe. The hospital had a clear policy which described how records should be completed and stored. There was clear guidance on how information should be recorded and which areas of the records had to be filled in, for example, hospital numbers and discharge details.

- Staff predominantly used a paper record system because full electronic records were not available. We reviewed 10 sets of patient notes. In all of the notes we looked at we found that records were completed in full, were legible and signed.
- CCU conducted a monthly documentation audit where performance was rated either green (100%), amber (85% to 99%) or red (less than 84%). Between January 2016 and July 2016 the service achieved green and amber in all areas which were audited including recording of patient identification, nursing assessment and evaluation, drug delays or omission. The service had only started auditing nutrition screening, clinical risk assessment and NEWS scores in January 2017 and showed 100% for January February 2017.
- We saw care pathways for critical care patients incorporated risk assessments such as a nationally used pressure ulcer risk assessment (Braden) and risk of falls. Those we saw were fully completed alongside documentation of allergies. Where appropriate, there were records of involvement by the multi-disciplinary team (MDT), for example, the dietician, physiotherapists, tracheostomy team, pain team and specialist nurses.

Safeguarding

- Staff we spoke with were aware of how to identify signs of abuse, how to seek further specialist advice, and how to report safeguarding concerns. Information on how to raise concerns was clearly displayed.
- None of the staff we spoke with could recall reporting any safeguarding concerns in the critical care service. Records we looked at confirmed there had been no reported concerns in the past 18 months.
- All staff were required to complete mandatory training in safeguarding children and adults to level one and two.
- The trust set a target of 85% for completion of safeguarding training. Data showed nursing staff at UHL reached and exceeded the trust target of 85% completion for all but one of the seven safeguarding modules. Completion rates for safeguarding training at level two for adults by medical staff were 80% which was below the trust target. Safeguarding children and young people level three specialists had a training completion rate of 41% which was well below the trust target.
- Medical and dental staff had exceeded the training completion rate in four out of seven safeguarding modules. They had the lowest training completion rates for safeguarding adults clinical level two, safeguarding children and young people level two, and safeguarding children and young people level three.
- The trust set a target of 85% for completion of safeguarding training.

Mandatory training

- All staff were required to complete mandatory training in 14 modules either through participatory (face to face) learning or on line. There were systems in place to monitor attendance and remind staff of their responsibility to attend. All staff we spoke with told us they were up to date with their required training.
- The trust set a target of 85% for completion of mandatory training for all staff groups.
- Nursing staff at UHL had an average mandatory training completion rate of 81% between January 2016 and December 2016. Fire Safety, Prevent Wrap, Equality and diversity, Infection prevention and control, conflict resolution, safeguarding level one and two and life support at all levels met and exceeded the trust target of 85%. The lowest completion rates which were all below target were in the following topics: bullying and harassment (50%), information governance (63%) and health and safety (75%).
- Medical and dental staff at UHL had an average mandatory training completion rate of 57%. Between January 2016 and December 2016 doctors had not met the Trust target in any of the 14 modules. Lowest completion rates were for Mental Capacity Act (40%) and Fire safety training (40%).
- Other staff such as allied health professionals and non-clinical staff in HDU were meeting the trust targets for mandatory training in all modules.

Assessing and responding to patient risk

- There was a critical care outreach team (CCOT) available 24 hours a day, seven days a week. This was led by two critical care nurses and a critical care consultant. The CCOT followed up patients in HDU after discharge from the ITU and supported staff in other wards and departments in managing on-going clinical issues and in maintaining continuity of patient care. We saw there was good communication between the ITU consultant and the CCOT at the ITU morning handover and throughout our inspection.

- Staff told us that the majority of readmissions to the unit from other wards and departments in the hospital were as a result of the CCOT effectively identifying patients who were at risk of deteriorating. We saw an example of this during our inspection.
- Staff in wards and other departments in the hospital used the National Early Warning Scores (NEWS) system to identify and monitor patients who were deteriorating.
- ITU and HDU staff conducted safety huddles twice daily, using the safety, background, assessment and recommendations (SBAR) tool. This enabled them to share information and act on risks in a timely way.
- Staff showed us the sepsis pathway which enabled them to diagnose sepsis at an early stage and a clear treatment process to follow when a patient was deteriorating. This incorporated the sepsis six which are six nationally recognised steps staff should take with patients who are at risk.
- NICE QS3 statement recommends all patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool. We looked at 14 medicines administration records and saw that 4 out of 14 were not completed. There was no data available about the incidence of VTE in the CCU.

Nursing staffing

- Teams of senior sisters and deputy sisters led critical care nursing supported by more junior nurses and support workers. There was always a supernumerary nurse in charge of each shift in HDU and ICU. Nurse handovers took place at least twice daily on each unit. The senior nurse in charge used the handover to allocate staff to patients based on nursing skill mix and competencies.
- There were 78 whole time equivalent (WTE) nursing staff. Data provided by the service stated there were 10 WTE vacancies: seven less in place than what was determined by the trust to provide safe and effective care. UHL reported an average vacancy rate for nursing staff in critical care of 14%, which was lower than the average vacancy rate for the hospital of 20%.However staff could not provide any examples of when this had negatively impacted on patient care.
- Nurse staffing levels met the requirements of the Royal College of Nursing (RCN) and the Faculty of Intensive Care Medicine (FICM) through the use of bank or agency staff when required. UHL reported an average agency and bank usage rate higher than the trust average of 13%. There was a 25% usage rate for three consecutive months from April to June 2016. From July to October 2016 usage decreased from 18% to 14% although rates increased to 16% in November 2016.
- The nurse to patient ratio in the ITU was consistently maintained at 1:1 and in the HDU; the nurse to patient ratio was always 1:2.
- There was a practice development nurse responsible for coordinating education; training and continuing professional development. In addition there was a full time research nurse who worked with staff to enable a dynamic programme of research and innovation.
- UHL reported a turnover of 12%. 8 nursing staff had left the trust within the reporting period.
- The trust reported a sickness rate of 4% for critical care at UHL, which was lower than the trust average of 6%.

Medical staffing

- At UHL there were six critical care consultants. Only one consultant was full time in ICU. Due to consultant vacancies at Queen Elizabeth Hospital consultants working at UHL were required to cover shifts at QEH. During our inspection we saw this happened on a daily basis. The consultants were supported by a team of specialist medical registrars and junior doctors.
- Medical staff were scheduled to work a maximum of a 12 hour shift and had sufficient rest periods between each shift. We saw that this happened.
- Out of hours doctors remained on site and were easily accessible. The ITU trainee was supported by an anaesthetic specialist registrar (SpR) out of hours. Medical staff gave a formal handover at every shift change; this included the presence of a consultant at the morning handover.
- The trust medical staff bank and locum use was 11%. In the critical care service at UHL this was 9%.
- At the time of our inspection the service was recruiting four new consultants to work at Queen Elizabeth hospital and UHL. We were told this would ensure the service met the FICM guidelines around consultant cover at both sites. We looked online at the consultant advertisements and saw they were for locum posts. These posts were for six months and therefore we were not assured the trust had put together a long term solution to resolve this issue.
- There was a vacancy rate of 4% of medical staff in critical care which was lower than the 12% overall

vacancy rate for the trust. Between January 2016 and December 2016 the turnover rate for medical staff in critical care was reported to be 0%. The sickness rate was also reported to be 0%.

- Consultant cover was not always in line with the Faculty of Intensive Care Medical Core Standards for Intensive Care Units recommendations that the consultant to patient ratio was between 1:8 and 1:15. During the day, CCU had two consultants but at night there was only one consultant. In order to meet the recommended level for the number of patients the unit would require two consultants 24 hours a day.
- There were nine junior doctors working on the CCU plus one foundation year doctor. During the day three to four junior doctors were allocated to work, and this was reduced to two for the night.
- Medical staff performed ward rounds twice daily, meeting the Intensive Care Society Standards.
- The trust average turnover rate for medical staff at UHL was 7.6%. In the critical care service at UHL this was 9.7%.
- We saw a surgical consultant and an orthopaedic geriatrician consultant conduct ward rounds for their patients in CCU. There appeared to be open communication and a good working relationship between the specialists and the critical care team.

Major incident awareness and training

- There was a hospital wide major incident plan, which detailed the roles staff needed to take during an incident.
- A target of 85 % was set for compliance with major incident training provided by the Trust.
- At March 2017 the trust reported 77% compliance amongst registered nurses and 68% amongst medical staff. Staff we spoke with described where to locate the major incident and fire safety policies, and their specific responsibilities in accordance with the policy.

Are critical care services effective?

Good

We rated effective as good because:

- Patients were provided with care and treatment based on a range of best practice guidance.
- There was a programme of clinical audit which included measurements of patient outcomes.
- Patients were cared for by staff that had completed an induction to the unit and achieved specific competencies before being able to care for patients independently.
- Staff were supported to complete continuing professional development and we found examples of courses being funded by the trust.
- There was good access to dieticians, speech and language, microbiology, pharmacy and physiotherapy services. Physiotherapy was available seven days a week and patients had appropriate access to rehabilitation.
- Pain scores were consistently assessed and pain was effectively managed.
- Staff had a good understanding of consent and capacity and systems were in place to ensure compliance with Deprivation of Liberty Safeguards.

However:

- Multidisciplinary meetings were not planned on a regular basis.

Evidence-based care and treatment

- Staff we spoke with provided evidence of policies based on national best practice guidance from all professional disciplines. For example policies based on The National Institute for Health and Health Care Excellence (NICE) and Royal College of Anaesthetists and FICM guidelines. All staff had access to policies and procedures on the intranet.
- Patients undergoing rehabilitation received regular sessions of physiotherapy which met the Faculty of Intensive Care Medicine Core Standards for Intensive Care Medicine: a minimum of 45 minutes of each active therapy, for a minimum of five days a week.
- The hospital used a sepsis screening tool and sepsis care pathway based on the 'sepsis six', which is a national screening tool for sepsis. However, this was not audited.
- Patients were not daily assessed for their level of delirium as recommended by the Intensive Care Society Standards and NICE guidelines.
- The CCU was part of the South London Adult Critical Care Operational Delivery Network (SLACCODN). This is an NHS operational delivery network provides clinical advice and expertise through clinical collaboration. It helps identify any gaps or issues in service provision.

The CCU at Queen Elizabeth Hospital had recently participated in a peer review process. Although this had not taken place at UHL, the findings from the report had been shared with the leadership team at UHL and where any action points applied to both sites there were improvement plans in place. In particular: consultant staffing levels, clinical governance, managing delayed discharges and clinical ownership of the critical care risk register.

Pain relief

- We saw pain assessed on an hourly basis as part of clinical observations using a formal patient reported scoring system. Patients were asked to score their pain on a scale of one to 10. If a patient was unconscious, staff used a measurement to assess pain in those unable to communicate. Staff told us they would look for signs of pain such as grimacing and restlessness.
- Some patients had Patient Controlled Analgesia (PCA) devices, which is a method of pain control that allows the patient to control the administration of pain relieving medicines. One patient we spoke with told us this was very effective and had lessened her anxiety about potential pain.
- We saw staff ask patients about their pain on a regular basis. All patients we spoke with were satisfied with their access to pain relief medicines and said their pain was managed well. Records we looked at confirmed this.
- Support for patients with pain issues could be obtained from the hospital's acute pain team who were available via a bleep system. The pain team were available from 9am to 5pm Monday to Friday; outside of these hours an on-call service operated. We saw nurses and anaesthetists on the pain team carry out a daily ward round and documented interventions and advice in patient notes at the time. The pain team felt that pain was well managed by the ITU team.

Nutrition and hydration

- There was one whole time equivalent (WTE) dietician working in the critical care service at UHL. The trust reported that because this was at the lower end of the recommended level within the FICM core standards for intensive care it limited the potential to carry out audit and developmental work. However staff and patients we spoke with told us they were satisfied with the service they received from the dietician.
- Where possible the dietician attended the MDT ward round daily to assess and manage the nutritional needs of patients. However, staff told us this was on average two to three times a week.
- All patient records we looked at provided evidence of patients' weight being recorded and comprehensive fluid balance monitoring on the daily care charts.
- The CCU had an enteral feeding protocol in place for initiating enteral nutrition out of hours. This incorporated guidance for identifying and managing patients at risk of refeeding syndrome. The nurses implemented the feeding protocol when patients were admitted to the unit. Enteral feeding refers to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach.
- Parenteral nutrition (PN) was started upon agreement of the CCU medical team. PN could be started out of hours or at weekends by suitably qualified critical care staff. Parenteral nutrition (PN) is the feeding of a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formulae that contain nutrients such as glucose, salts, amino acids, lipids and added vitamins and dietary minerals. The dietician was not available over the weekend; if a patient was admitted they would be seen by the dietician and hospital PN team at the earliest opportunity.
- Patients told us they were happy with the food and drink choices available on the unit. We observed patients were enabled to eat independently and drinks were placed within their reach. When required, nurses or family members assisted patients with eating and drinking.

Patient outcomes

- The critical care service contributed data to the UK Intensive Care National Audit Research Centre (ICNARC) database. This meant care delivered and patient outcomes were benchmarked against similar units across the UK. We reviewed data from the 2016 Annual report.
- The CCU at University Hospital Lewisham had a risk adjusted hospital mortality ratio of 2%.This was within the expected range. There were 5,840 available bed days in the CCU at UHL between January 2016 and December 2016. The percentage of bed days occupied by patients

with discharge delayed more than 8 hours was 11.51%. This compared to the national aggregate of 5.16%. This was not in the worst 5% of units nationally. The figure in the 2015 annual report was not available.
- There were 756 admissions, of which less than 1% had required a non-clinical transfer out of the CCU at UHL. Compared with other units this was within the expected range. The figure in the 2015 annual report was 0.39%.1% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, UHL was within the expected range. The figure in the 2015 annual report was 1.54%.
- ICNARC data demonstrated the service was about the same (1.4) as other similar units (1.2) in terms of unplanned readmissions within 48 hours.

Competent staff

- The FICM Core Standards for Intensive Care Units (2013) recommend that a minimum of 50% of registered nurses should be in possession of a post registration qualification in critical care. At the time of our inspection 72% of the staff at UHL met this standard, and others were working towards it. Staff spoke positively of the education provider for this programme.
- Agency nurses undertook an orientation prior to working in critical care. They were also given training and access to the electronic patient record system so they could work more safely with patients.
- There was a practice development nurse that supported staff and facilitated a continuing professional development programme. A spacious training room adjacent to the unit provided a suitable room for learning and learning resources.
- Newly appointed staff attended the trust induction programme, where they received an organisational and local induction and were allocated to a mentor. Staff were supernumerary for a period of up to six weeks while their competencies were reviewed and signed off as appropriate. Staff told us they found this beneficial as it allowed them time to settle into the unit and get to know ways of working before looking after patients independently.
- Once nursing staff completed the induction programme, they progressed to the National Competency Framework for Critical Care Nurses – Step one. This is a competency-based programme for staff to develop core skills in caring for critically ill patients under supervision from a mentor or practice development nurse. Staff were very positive about the learning and level of support they received during this.
- Self-assessment competency documents were in use for certain items of specialist equipment, for example the cardiac output monitors and specific types of ventilators and nasogastric feeding pumps.
- All staff we spoke with told us they had an up to date job description and there was good access to training for professional development. Staff could access charitable funds from within the organisation to help fund courses. For example, one nurse was studying for a masters' degree and had received charitable funding from the organ donation team.
- Appraisals had been completed within the previous 12 months for 94% of nursing staff.
- The Critical Care Outreach Service (CCOS) were not part of the same directorate as critical care. The nurses who were part of CCOS were separate from the nursing team on the CCU. Nurses from CCU were not able to rotate onto the outreach service which limited developmental opportunities. Junior doctors felt well supported by consultants and described their training as well organised, even though there was no training schedule or calendar in place. The training largely took place in practice, for example as part of the ward round(s), and ad hoc teaching sessions were often held for the trainees when time allowed.

Multidisciplinary working

- The critical care outreach team (CCOT) was responsible for reviewing patients in other areas of the hospital to determine their need for admission to the CCU. Staff spoke positively of their role and accessibility.
- There was a clinical lead and specialist nurse responsible for organ donation. However, as the hospital was not a trauma centre there were very few potential donors.
- There had been four organ donors across the trust in the previous year: none of these were in the past six months.
- A multi-professional organ donation committee met every quarter, chaired by the hospital chaplain.
- There were no formal multidisciplinary meetings or 'rehabilitation group' to review patients admitted to the CCU. This group should be attended by consultants, follow up nurses, critical care liaison nurses and other members of the multidisciplinary team, such as

physiotherapists. This gives staff the opportunity to discuss short-term or long-term goal setting. The CCU was not compliant with NICE clinical guideline 83 in this instance. Staff recognised the need to set up a formal MDT meeting for patients with longer term complex needs.

- There was a recently established hospital wide tracheostomy group which involved the CCU consultant, outreach team and physiotherapists. We saw them visit patients and document interventions in their notes.
- All staff we spoke with said there was good MDT working between nursing, doctors and therapists. We witnessed several examples of interdisciplinary discussions about patients on ITU and HDU.
- Therapists worked closely with ward staff to implement rehabilitation plans for each patient and we saw nursing staff and therapists working together to complete patient tasks and rehabilitation during the inspection.
- The CCU was funded for 0.5 WTE Speech and Language Therapist (SALT). Recommendations from the Faculty of Intensive Care Medicine (FICM) state that patients should have access to SALT staff with critical care experience; therefore the recommendation was being met.

Seven-day services

- Consultants completed twice daily ward rounds, including at weekends, which was in line with recommendations from the Guidelines for the Provision of Intensive Care Services. However, pharmacy staff, dieticians and physiotherapy staff were unable to attend ward rounds on a daily basis due to workload pressures, which was not in line with recommendations.
- Physiotherapy staff worked across seven days and the unit could access emergency respiratory physiotherapy support 24 hours a day, seven days per week.
- SALT was available five days a week (Monday to Friday) and also for a morning service on Sundays. This was to help pick up patients who had been admitted Friday evening.
- Direct access to an ICU trained dietician was available five days a week.
- Access to an ICU trained pharmacist was available five days per week. Non-specialist pharmaceutical support could be obtained over the weekend, unless an ICU trained staff member was working.
- Patients could access investigations such as blood tests, x-rays and CT scans 24 hours per day, seven days per week. Staff reported there was no difficulties for accessing this type of support services and told us urgent investigations for critical care patients were prioritised.
- At the time of our inspection patients would be transferred to other hospitals if they were ventilated and required an MRI scan. The leadership team told us a new MRI scanner had been ordered which would be enable scans for ventilated patients and would be available soon.

Access to information

- Staff accessed most of their information via the hospital's intranet and shared drive. This included policies and procedures, mandatory training, safety alerts, and emails from colleagues. Computer terminals were available in patient bed space, which allowed instant access.
- When patients were admitted to CCU, a verbal handover was provided to the medical and nursing staff as well as written information in the patient records.
- Patient investigation results, including blood tests and diagnostic imaging, were available electronically and were instantly available to relevant staff on the shared drive.
- Discharge summaries were sent to general practitioners (GPs) when patients were discharged from the unit. All of the discharge summaries we looked at were detailed and contained all key information. The CCU and CCOS used different computer systems and were unable to access each other's.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with understood the need to obtain consent from patients before performing care, investigations, and giving medicines. Where staff could not obtain consent, for example unconscious patients, staff explained they provided care in the patients best interests.
- We observed staff seeking consent from patients throughout CCU, including explaining the rationale behind each procedure being performed. We also observed staff provided clear explanations to unconscious patients.
- Staff completed Mental Capacity Assessments for people who they believed may lack the capacity to consent. Key information about mental capacity

protocols and Deprivation of Liberty Safeguards (DoLS) was available on the shared drive. There was also information about DoLS displayed on a notice board in the staff room.
- Staff knowledge of deprivation of liberty standards (DoLS) was good. Staff explained the principles behind DoLS and were clear how this was applicable in a critical care setting.
- Staff were aware when a patient might need to use independent mental capacity advocates (IMCAs) and told us they would seek support from the matrons and mental health team.

Are critical care services caring?

Good

We rated caring as good because:

- We observed a caring, kind and compassionate service, which involved patients and their relatives in their care.
- Staff at all levels demonstrated dignity and respect when speaking with patients, their relatives and visitors and colleagues,
- Patients and relatives consistently told us they felt involved in the treatment decision making process.
- Staff provided good emotional support to patients and there was access to a chaplaincy service.

However:

- The service had not participated in the NHS Friends and Family Test which is used to enable patients to give feedback about the service provided. However, UHL had been running the International family satisfaction survey annually since 2012. There was a recently introduced local survey, as part of the trust quality review, however the data only covered a four week period so we were unable to fully assess how satisfied patients were with the service.

Compassionate care

- Patients we spoke with were consistently positive about the care and treatment they received.
- We saw that staff maintained privacy and dignity in all of their interactions with patients and relatives.
- We observed medical staff communicating with patients and their visitors during ward rounds. On one round we saw little interaction with the patient or their families or with other members of the multidisciplinary team. However this was a 'one off' as we saw all other teams conduct ward rounds where all staff, patients and family members were fully involved in discussions with doctors.
- We saw many thank you cards expressing gratitude and compliments from previous patient and relatives about the care received.
- One patient on HDU told us "I like listening to the respectful way staff speak with each other".

Understanding and involvement of patients and those close to them

- The service had not participated in the NHS Friends and Family Test which is used to enable patients to give feedback about the service provided. However, UHL had been running the International family satisfaction survey annually since 2012. There was a recently introduced local survey, as part of the trust quality review, however the data only covered a four week period so we were unable to fully assess how satisfied patients were with the service.
- Patients and relatives told us they were kept informed of treatment plans and staff explained tests and procedures they were due to have. One relative told us: 'They've been spot on explaining everything to us and calming our anxiety whatever the time of day. We feel very at ease with the staff here'.
- We observed doctors on ward rounds offering patients and relatives the opportunity to ask questions and to clarify anything they were unsure of. Patients said they were given opportunities to ask questions and these were answered by staff. Patients and relatives told us staff would always explain things in a language they could understand.
- We observed staff interacting with patients and involving them in decisions about their care, for example one patient discussed dietary requirements. Another patient discussed the plan to start mobilising in HDU.
- When patients were thought to have brain stem death or if there was a plan to withdraw life-sustaining treatment, the possibility of organ donation was discussed with the patient's next of kin and documented. The CCU and the specialist nurse for organ donation did this collaboratively where possible.

- Photographs of some of the nursing and therapy team were displayed at the entrance of the unit. This directed patients and relatives on which staff they could contact for support.

Emotional support

- Patients told us they felt supported emotionally and that staff were always happy to listen to them. We saw patients and family members' emotional needs were documented in individual care plans and acted upon.
- A multi faith chaplaincy team was available on-call 24-hours, seven days a week. There was a chaplaincy rota with contact details.
- Feedback from patients and relatives we spoke with was positive. They consistently told us staff were supportive and had been reassuring and comforting during difficult times.
- There was no access to a clinical psychologist on the unit. Staff told us if a patient required psychological support they would refer the patient to the psychiatric liaison team.
- Staff could not tell us about any external support organisations that they would signpost people to for emotional support.
- There was no bereavement protocol or service in place. Staff told us these were previously in place and were unclear why this had stopped.

Are critical care services responsive?

Good

We rated responsive as good because:

- Services were tailored to meet the needs of individual people and there was flexibility in the provision of care.
- Staff demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met their needs and promoted equality.
- Complaints were investigated and changes were implemented as a result.
- There was a range of methods to communicate with patients including visual aids and alphabet boards. Staff sought and gained specialist advice to enable effective communication with people with a learning disability for example.
- Detailed discharge summaries were sent to patients local doctors (GPs).
- Overnight accommodation, confidential conversation rooms and waiting areas were available for visitors and were used for their intended purpose only.

However:

- The numbers of delayed discharges were higher than the national average due to problems with access and flow within the hospital.
- Bed occupancy was also higher than the national average which might limit the service's ability to provide a bed in the event of an emergency.

Service planning and delivery to meet the needs of local people

- The critical care unit (CCU) admitted patients after elective or emergency operations or after they become medically unwell either in the community or on the hospital wards.
- Between February 2016 and February 2017 there were no cancellations of elective surgery due to CCU bed unavailability.
- The critical care service at UHL did not provide follow up consultations for patients following discharge from the CCU. Patients would be followed up by the consultant from the other clinical specialties that had necessitated their admission to the service, for example, the medical or surgical team.
- Unplanned admissions to CCU were referred to the consultant on duty during working hours.
- There was a confidential conversation room available for visitors to meet clinical staff. There was also a relatives' room for relatives to use which had sofas and access to refreshments.
- HBN 04-02 recommends services should provide access to overnight accommodation or have arrangements with a nearby hotel. We saw two spacious rooms which provided overnight accommodation and bathroom facilities in use at the time of our visit. Staff told us that this met people's needs.

Meeting people's individual needs

- People's individual needs were documented in care plans which were reviewed on at least a daily basis.
- We saw a patient with a learning disability who could not speak because of a tracheostomy. We saw they communicated with staff through written

documentation and visual aids and that expert advice was sought from the trust learning disability specialist nurse as required. Staff could also access agency carers for additional support. If interpreter services were required staff could book both either telephone or face-to-face consultations in a range of different languages.

- Relatives and patients had access to a multi-faith chaplaincy service and we saw information on how to access this was displayed.
- We saw staff used a range of aids to communicate with those who could not express their needs verbally. This included a written and pictorial guide for a patient with a learning disability to express their needs. We communicated with this patient who expressed her positive satisfaction with the service and the way all staff understood their needs.
- Staff told us if they suspected a patient of living with dementia they would contact the consultant or dementia nurse within the hospital for specialist advice. We saw where an orthopaedic geriatrician advised staff about managing a patient living with dementia and provided clear written instructions in the patient's notes.
- All patients were reviewed by a critical care consultant within 12 hours of admission. This met the FICM guidance.
- Food menus offered a range of options including healthy option, softer choices, and vegetarian, kosher, halal. If a patients had any specialist dietary requirements staff would record this.
- There was no counselling or psychological team available on the unit. Staff told us if they identified a patient with mental health needs they would refer the patient to the psychiatric liaison team. Staff could also access agency mental health nurses for additional support.
- Visiting hours were set at 10.00 until 12.00 and 15.30 to 19.45 hours as a result of feedback from patients. However, staff were flexible with this and made reasonable adjustments on request.
- Patients and visitors had also given feedback to HDU staff regarding noise in the unit from equipment and call bells. To address this staff provided ear plugs to patients to support a better quality of sleep.

Access and flow

- The maximum physical capacity for level three care in the intensive care unit (ICU) was nine patients; however, the nursing establishment typically allowed a maximum of eight patients.
- Admission of patients to the intensive care unit had to be agreed by the ICU consultant and nursing shift leader, who were jointly responsible for deciding when maximum capacity was reached.
- The Royal College of Anaesthetists recommend an occupancy rate of 70 % critical care occupancy. Between January 2016 and December 2016 bed occupancy ranged at UHL from between 72% and 100% with an average occupancy of 91% compared to the England overall average rate of 83%. The percentage of bed days occupied with patients with discharge delayed more than 8 hours was 11%.
- On a regular basis patients were ready for discharge but a lack of access to medical beds meant discharge was delayed. We were told that patients were discharged from the CCU to home on. This issue was highlighted by a range of different staff including the leadership team.
- From September 2016 to December 2016 occupancy rates were consistently higher than the England average, although occupancy rates decreased from a high of 15% above the England average in October to 1% above in December 2016. The higher than average occupancy rates combined with high vacancy rates, bank and agency and locum use could have an influence on the quality of care provided.
- There were 5,840 available bed days for the critical care unit at UHL. Between January 2016 and December 2016 the percentage of bed days occupied by patients with discharge delayed more than 8 hours was 18%. There were 98 discharges (37%) delayed more than four hours, and 131 (49%) discharges delayed by more than 24 hours. This meant that the delayed discharges were higher than the national average; however the service was not in the worst 5% of units nationally. The figure in the 2015 report was not available.
- Faculty of Intensive Care medicine core standards for ICU recommend that patients should not be transferred to other units for non-clinical reasons. ICNARC data showed less than 1% of admissions to the critical care unit at UHL required a non-clinical transfer out of the unit which was within the expected range.

Learning from complaints and concerns

Critical care

- The trust had received eight formal complaints for the critical care service between January 2016 and December 2016. Site specific data for the two hospitals was not provided. Four of the eight complaints related to communication: two with family, and two with patients.
- Staff we spoke with were aware of the complaints through staff communication and told us that local resolution was encouraged and supported.
- The average rate to investigate and close complaints within the trust was 44 days, which did not comply with the trust policy of 25 working days.

Are critical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Senior critical care staff, including the clinical director were responsible for overseeing risk management, including the maintenance of the risk register. There was no clinical ownership of the unit risk register, which sat within the surgical directorate risk register. There was no documentary evidence it was regularly reviewed and updated.
- The service did not have a long term vision and strategy in place at the time of our inspection. There had been no review or development of a formal critical care strategy by the leadership team.
- There was irregular occurrence and attendance at clinical governance meetings and morbidity and mortality meetings. Due to staffing vacancies these meetings were not held on a regular basis and the service did not formally review all patient deaths. We saw there were plans in place to change this, however, at the time of our inspection these had not yet come into effect.
- The leadership team had not demonstrated appropriate responses to risks identified until very recently. For example long standing concerns about the insecure storage of intravenous fluids.

However:

- There was an established programme of research and development and safe innovation in place, which was reflected in publications and national and international conference presentations.
- Patients and relatives told us the staff worked collaboratively and spoke to each other with respect.
- Nursing leadership consistently promoted the delivery of high quality care.
- The matron was commended in a staff award scheme for leading by example in patient safety.
- Staff were positive about the levels of support they received from the matron, ward sisters, and each other.
- The culture within the service was described as open and staff told us they felt comfortable approaching their line managers and colleagues with any concerns or ideas.
- Engagement with nursing staff was continuous and they were able to develop their leadership skills through professional and clinical development.
- A research nurse worked with medical staff to enable a comprehensive programme of research and development and safe innovation was in place which was reflected in publications.

Leadership of service

- Clinical leadership was the responsibility of the divisional director and directorate clinical lead (cross-site) who worked closely with the lead nurse and matrons for critical care that were site specific. Critical care was part of the surgical directorate within the trust. Several members of staff said they felt the service would be better managed by critical care.
- The medical leadership team was undergoing a period of change at the time of our inspection. Consultants to work across both hospitals were being recruited.
- The CCOS was not part of the critical care directorate. This limited joint working and developmental opportunities for nursing staff as there was no rotation available. Staff and senior leaders felt the CCOS should be part of the critical care directorate and not separate. Nurses do not rotate from outreach and could become deskilled eventually.
- All staff spoke positively about the critical care matron at UHL, reporting a supportive attitude and open approach to management. We were told the matron was readily available and approachable and fully involved in the unit both clinically and managerially. We saw examples of this throughout our inspection.
- Staff at all levels, and from all professional disciplines, told us their roles were valued and the management team cared about them and their well-being. They provided us with personal examples of this.

- Lines of nursing accountability and responsibility in the unit were clear. Staff understood their roles and how to escalate problems. Nurses told us the matron kept them up to date with any incidents and safety alerts and fed back the results and learning to the team.
- Junior doctors told us they received good access to supervision, however, a previous rota for teaching sessions had not worked out due to levels of work and emergency cases. There was no protected time for training medical staff were satisfied with the arrangements.

Vision and strategy for this service

- Managers we spoke with told us as a result of the peer review by the South London Adult Critical Care Operational Delivery Network (SLACCODN) at Queen Elizabeth Hospital the vision for the critical care service at both hospital sites was currently under review in order to prioritise the suggested improvements. The trust had developed an action plan to address the issues highlighted and described this as work in progress.
- We were told the trust had placed advertisements for five consultant posts to cover critical care at both hospital sites in order to improve cross site working.
- We looked on the NHS jobs website and saw there were four consultant posts advertised at the time of our inspection, and these were not for full time posts. The posts advertised were for locum doctors for six months, with the possibility of an extension.
- At the time of our inspection, the leadership team told us there was no formal documented strategy for the service. We were told once the consultants were in post it was anticipated that a strategy would be developed.
- Access and flow of patients was a key challenge for the service. However, we found no plan or strategy in place detailing how the service was going to mitigate this. One manager told us this happened in roughly one third of patients during November 2016.

Governance, risk management and quality measurement

- The critical care leadership team, including the clinical director were responsible for overseeing risk management and the maintenance of a shared cross site (two hospitals) risk register. There was no clinical ownership within CCU of the CCU risk register, which sat within the surgical directorate risk register. There was no documentary evidence it was regularly reviewed.
- We saw there were different versions of the risk register available to different staff and that this could cause confusion. It was not a dynamic system.
- There were no regular meetings where all consultants discussed the care of patients, strategy regarding the bed base, patient case load, recruitment and standards or guidelines.
- The service fed into the surgical division governance meeting which took place on a monthly basis. Once every quarter the meeting focused on critical care. The matrons from both hospitals critical care units prepared a joint report of performance for this meeting.
- Every eight weeks there was a site-specific governance meeting which involved the unit's matron and band seven nurses. The band seven nurses also held their own meeting every six to eight weeks to discuss any key challenges on the unit. We reviewed the most recent two sets of minutes for these and saw evidence that a variety of quality, risk and safety topics were discussed. Senior staff told us key information from these meetings was disseminated to ward staff via handovers and in the communication book and we saw this happened.
- There was no evidence of regular meetings where all consultants discussed the care of patients, strategy regarding the bed base, patient case load, recruitment and standards or guidelines.
- Despite the cross-site clinical governance meeting, feedback from staff suggested there was still work to do on harmonising the two hospitals' ways of working. There were many examples of practice being different at the two sites including the timing of parental nutrition (PN) infusion resting time and nursing intensive care charts.
- The critical care outreach service (CCOS) was not part of the surgical directorate and therefore not part of the critical care unit. At the time of the inspection, the senior leaders of critical care could not access the CCOS information system and had no oversight of the CCOS risk register or incidents records and vice versa. This limited sharing and learning between the two teams.

Culture within the service

- Staff consistently spoke of an open door culture and told us they felt comfortable raising any issues with the matron or their line manager.
- Staff commented there was a culture of 'no blame' should things go wrong. Staff told us they were encouraged to learn from incidents that occurred within CCU and across the trust.
- Nursing staff described good levels of support and opportunities to develop. There were established arrangements for mentoring and staff training. We saw staff were keen to share their knowledge with each other and observed staff asking questions and seeking guidance from relevant colleagues.
- Junior doctors reported that it was a friendly and supportive unit to work in and those trainees asked to work there.
- Staff at all levels told us they were proud to work in the service and had good working relationships. They described staff morale as good. We observed staff work together to complete tasks and ensure suitable patient care took place. Staff told us they participated in social events together outside work.
- Staff understood the important of being open and honest when things went wrong and understood the principles of duty of candour. Staff we spoke with consistently told us there was a learning culture, and that staff treated each other with a 'healthy respect'. Staff also spoke of a culture of challenge and questioning where appropriate.

Staff and patient engagement

- There were regular team development days held on the unit to develop staff skills and knowledge and improve teamwork.
- The CCU encouraged patients and relatives to give feedback and there were feedback forms available on the unit for them to complete. There was a 'you said, we did' board on the unit which gave details of any changes made because of feedback.
- Staff told us the trust held staff awards every year to celebrate good practice. Staff who won awards were given vouchers. The matron of critical care at UHL had recently been commended in the staff awards for driving patient safety.
- A weekly newsletter called 'Spotlight' was shared with staff throughout the unit via noticeboards and a staff communication book.
- Other than the recent introduction of feedback questionnaires, we did not see evidence of engagement with patients or their relatives in terms of developing services to meet patient needs.
- In the NHS Staff Survey 2015 the trust performed higher than the England average of other trusts in reporting good communication between senior management and staff. In the previous 12 months, the trust performed below the England average for staff satisfaction in areas including resourcing and support, completion of appraisal, percentage of staff working extra hours, suffering work related stress in last 12 months, organisation and management, interest in and action on health and wellbeing, recent experience of violence, harassment bullying or abuse.
- We saw evidence of monthly Matron's meetings, sister's meetings and nursing staff meetings. Staff described these as useful and informative and we saw they were generally well attended.

Innovation, improvement and sustainability

- There was a dynamic programme of research and development enabled by the full time appointment of a research nurse working with doctors including consultants. Examples of research studies completed in the past year included a study exploring the relationship between family satisfaction and patient length of stay, and a pilot study looking at the improved physiotherapy outcome measure by the use of cycle ergometry in critical care patients. The trust recognised only a small sample size was used for each study. There was also participation in national audits and research programmes.
- The critical care Matron had been highly commended in the trust staff safety awards in October 2016.

Maternity and gynaecology

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

Information about the service

Lewisham and Greenwich NHS Trust have 123 maternity beds across two sites. Of these beds, 64 are located within four wards at University Hospital Lewisham. Between February 2016 and January 2017, there were 3866 births at the hospital.

We visited University Hospital Lewisham as part of our announced inspection on 7 March 2017. We visited the antenatal, labour and postnatal ward, the early pregnancy unit, birthing centre and the day assessment unit. We spoke with 27 members of staff including maternity support workers, midwives, matrons, sonographers, trainee doctors, consultants, allied health professionals, senior staff and domestic staff. We spoke with thirteen patients and six relatives. We reviewed nine care records. We observed staff interactions with women and those close to them. During and following the inspection, we requested a large amount of data in relation to the service which we also reviewed and considered when making our judgements.

In addition to the maternity and gynaecology service, we have included information about sexual health, genitourinary medicine and HIV services, which are within the women's and sexual health division. Only the maternity and gynaecology service contributes to the ratings. During our inspection a team of inspectors visited the Alexis Clinic, which provides HIV services.

Summary of findings

The ratings contained in this report are linked to maternity and gynaecology rather than sexual health. We rated maternity and gynaecology as requires improvement because:

- We found the cleanliness of the environment and some equipment to be of a poor standard, even where green 'I am clean' stickers had been used to show that surface areas and equipment had been cleaned that day.
- We observed that a number of key items of equipment were out of date for safety testing, such as CTG (cardiotocography) and BP (blood pressure) machines, incubators and resuscitaires.
- We found that local leadership at the hospital had overlooked the basic issues of poor cleanliness and out of date equipment checks and the potential clinical, infection control and patient safety risks they posed.
- While the service said that it had enough Dopplers to assess babies' health, these did not appear to the inspection team to be readily available.
- IV (intravenous) fluids were unsecured in all ward areas, such as delivery rooms and emergency trolleys.
- Mandatory training levels were below the trust's benchmark of 85% compliance across a number of subject areas.

Maternity and gynaecology

- There was a risk to clinical outcomes and patient safety due to maternity guidelines not being merged across the Lewisham and Greenwich sites and some guidelines also being out of date.
- Bed occupancy levels for Maternity were generally higher than the England average with the trust having 90% occupancy in Quarter 2 2016/17 compared to the England average of 61%.
- The maternity dashboard showed that between February 2016 and January 2017, the percentage of pregnant women accessing antenatal care who were seen before 12 weeks and 6 days gestation was only 83.5% which was below the 90% target.
- Trust wide risks existed relating to community midwives being unable to access the patient records system and maternity guidelines still not being merged across the trust.
- Some BME members of staff that we spoke with felt opportunities for staff development, promotion, training and support wasn't always afforded to them in the same way that it was given to their Caucasian counterparts.

However:

- Teardrop stickers from a stillbirth and neonatal death charity were being used on the front of women's notes to indicate a woman having experienced a past loss of a child.
- The maternity dashboard showed that in March 2016 and May 2016, women received one to one care from a midwife whilst in established labour.
- A wide range of pain relief options were available to women.
- We observed good examples of multidisciplinary team (MDT) working between staff groups in clinical areas. The atmosphere on the labour ward was positive and friendly.
- Feedback from women and those close to them was generally positive. We observed women were treated with kindness and respect throughout our visit.
- Staff ensured women's privacy and dignity was maintained.
- Women were involved and encouraged to be partners in their care and were supported in making decisions.
- Partners said they felt welcome and involved in their partners' pregnancy at all stages.
- Women spoke highly of the staff in gynaecology and the Early Pregnancy Unit.
- A bereavement midwife and a bereavement counsellor provided sensitive support for women and families who had suffered a pregnancy loss.
- Since the merger of University Hospital Lewisham Hospital with Queen Elizabeth Hospital, there had been increased working between sites to ensure care plans for women were fulfilled.
- There was good support from The Kaleidoscope Team which worked with vulnerable women and those with mental health needs.
- There was a dedicated maternity helpline to provide women and their families as well as GPs and other health care professionals with direct and easy access to maternity-related information.
- Good post-natal information was provided to patients.
- Staff understood the vision and strategy for the service.
- A number of public engagement initiatives were being explored to seek feedback from users of the service to drive improvement such as a 'maternity open forum' which was held by the senior managers in the head of midwifery's office.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- We found the cleanliness of the environment and some equipment to be of a poor standard, even where green 'I am clean' stickers had been used to show that surface areas and equipment had been cleaned that day.
- We observed that a number of key items of equipment were out of date for safety testing, such as CTG and BP machines, incubators and resuscitaires.
- While the service said that it had enough Dopplers to assess babies' health and heartbeat, these did not appear to the inspection team to be readily available.
- IV fluids were unsecured in all ward areas, such as in delivery rooms and on emergency trolleys.
- Mandatory training levels were below the trust's benchmark of 85% compliance across a number of subject areas.

However:

- SANDS teardrop stickers were being used on the front of women's notes to indicate a woman having experienced a past loss of a child;
- The maternity dashboard showed that in March 2016 and May 2016, women received one to one care from a midwife whilst in established labour.
- Between February 2016 and August 2016 University Hospital Lewisham had 81 hours per month of medical cover on the labour wards. Between September 2016 and January 2017, the hospital had 87.5 hours per month of medical cover on the labour wards.

Incidents

- Between December 2015 and November 2016, the trust did not report any incidents which were classified as Never Events for maternity and gynaecology.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the hospital reported five serious incidents (SIs) in maternity and gynaecology, which met the reporting criteria, set by NHS England between 2015 and November 2016. Of these, the most common type of incident reported was maternity/obstetric incidents.
- We looked at the investigation report for one of the SIs that occurred, relating to an intrapartum stillbirth whilst undertaking an induction of labour. We found the SI to have been investigated appropriately, with subsequent recommendations and an action plan made. Arrangements were made to share the learning from this event in a number of ways, such as through a unit newsletter, at divisional audit afternoons and at team meetings both for staff members who worked at the hospital and in the community.
- All staff that we spoke with were aware of how to report incidents using the electronic trust wide incident reporting system. Staff were encouraged to report incidents and felt supported by their line managers when they did. Staff told us they received feedback from incidents reported across the trust in the form of lessons and action plans shared with them via email and in daily ward huddles, handovers, 'Take 5' briefings and one-to-one meetings.
- We spoke to a matron on the postnatal ward who told us she encouraged staff to raise and fill out incident forms and would always email investigation outcomes to her staff. The matron also told us that a patient safety midwife would come to the ward and speak to staff about incident forms, providing support in investigating and closing them.
- We spoke with four midwives who had all submitted incident forms within the preceding six months of our inspection.
- Perinatal meetings were taking place monthly and a mortality committee, comprising of local and external clinicians reviewed neonatal and maternal deaths.

Safety thermometer

- The maternity safety thermometer measures harm from p**erineal and/or abdominal trauma, post-partum haemorrhage, infection, mother's separation from baby** and **psychological safety.**
- The service was participating in the national maternity safety thermometer, though evidence of this was not seen for all parameters. Each ward area published quarterly information on MRSA Bacterium

(Methicillin-resistant Staphylococcus aureus), emergency caesarean section and normal births. However, the information seen only included 3 months up to November 2016.

Cleanliness, infection control and hygiene

- We observed the cleanliness of the environment and some equipment to be of a poor standard, even where green 'I am clean' stickers had been used to show that surface areas and equipment had been cleaned that day.
- Emergency trolleys were all dusty and generally not clean, even though 'I am clean' stickers were in use. The instrumental trolley on the postnatal ward was generally unclean and dusty even though a dated 'I am clean' sticker was in use.
- In Delivery Room 2 on the labour ward, the computer on wheels had an 'I am clean' sticker dated 8/3/17 but it was visibly dusty and there were sticky tape marks on the console above the bed.
- A shared en-suite bathroom located between a delivery room and observation ward had been used but not cleaned and staff were not aware of when it was last used. We observed hair in the sink, the toilet had not been flushed and a dirty and scratched bowl on the floor that staff reported would be used for post caesarean section women.
- The sluice room opposite Delivery Room 9 on the labour ward was not secure even though it had a keypad lock. This meant that people and members of the public were able to gain free access. We noted blood spillage in the sluice area however immediate cleaning was arranged when we brought it to the attention of the ward matron.
- We found that the antenatal and postnatal wards were cleaned to a much higher standard than the labour ward.
- The utility room for dirty linen was unlocked on the labour ward. Not all rooms were secure, for example the sluice room. Those with key pads were sometimes not secure.
- We saw a sample of equipment, all of which had been cleaned daily and were all visibly clean. This included 11 BP cuffs – seven of these were seen on the postnatal ward and four on the labour ward.
- We spoke to a housekeeper who was responsible for the cleaning on the antenatal and postnatal wards. She told us that she was responsible for cleaning clinical rooms, checking call bells, cleaning surfaces and equipment, checking temperature logs for fridges, restocking hand sanitising gel and checking the expiry dates for blood sampling bottles. We did not observe guidance available to domestic staff on the frequency of cleaning. There was no signage or cleaning schedules in key areas such as toilets/showers to show that cleaning had taken place or informing patients what to do if levels of cleaning were not acceptable to them.
- Domestic staff worked six days a week. We were told that on the day where domestic staff did not work, MSWs (maternity support workers) would be responsible for checking temperature logs for fridges, cleaning surface areas, checking and cleaning call bells and restocking hand-sanitising gel.
- The maternity service had no cases of MRSA between February 2016 and January 2017.
- Results from decontamination audits undertaken on instrumental trolleys within the gynaecology department showed 100% compliance for the months of October 2016, December 2016 and January 2017. Results were not collected for November 2016. Hand hygiene audits completed within the gynaecology department also showed 100% compliance for the months of October 2016, December 2016 and January 2017. Hand hygiene results were also not collected for November 2016. We were not provided with hand hygiene audits for the maternity wards.
- Sharps bins located on the postnatal ward were appropriately labelled and not filled above the lines marking the limit up to which to fill.
- Hand hygiene practices amongst staff were carried out correctly and staff use of hand gel was good. However, there was no signage to encourage women and visitors to use hand gel. On entry to the ward, no one spoke to mothers to ask them to use gel throughout the duration of their time on the ward.
- There was a link midwife for infection prevention and control (IPC) for the antenatal and postnatal wards and then a separate link midwife for the labour ward. Infection control policies and guidance were available to staff on the intranet.
- We were told that there was a uniform policy, which specified non-wearing of jewellery except wedding rings that was audited monthly. However, we saw multiple staff wearing jewellery.
- Single rooms were used when needed if a patient needed to be isolated from other patients.

Maternity and gynaecology

Environment and equipment

- There were many areas on all wards including the labour ward, where walls and paintwork were in poor repair. Plaster was exposed and woodwork was chipped meaning these areas could not be cleaned thoroughly and were an infection risk.
- While the service said it had enough Dopplers to assess babies' health, these did not appear to the inspection team to be readily available. The hospital acknowledged that these had to be moved around according to need. We witnessed one member of staff searching for a Doppler for twenty minutes before obtaining one.
- Equipment safety testing was significantly out of date. Whilst some had been checked in the last year, many items of key equipment were not in date for safety testing. Staff informed us that they had raised this in September 2016 with the EBME (electro-biomedical engineering) department but they had responded saying that there was a backlog. This had not been chased up, nor had it been entered on the risk register, so staff could not be assured that the equipment they were using was safe. We witnessed one member of staff taking at least 20 minutes to search for a Doppler to listen to a foetal heart. She reported a lack of these and the matron said they had a particular problem with these going missing. Attempts had been made to secure them onto trolleys, but they had been unscrewed. Staff reported trying new strategies but even though an additional six had been ordered, there were still not enough.
- We observed that a number of key items of equipment were out of date for safety testing. On the labour ward, a CTG machine's safety testing had expired in May 2016.
- On the antenatal ward, we looked at two BP machines; the safety testing for one had expired in November 2016 and the other had no date recorded at all. Safety testing for scales was in date and we were told that these were checked by an external company.
- On the postnatal ward, an ophthalmoscope and otoscope that we checked were out of date for safety testing by 15 months. A resuscitaire was out of date for safety testing and its safety test was due in May 2016. Eight blood pressure machines were seen and two were without a date and barcode, two were due for safety testing in January 2017 and another three had been due for safety testing in November 2016. Only one blood pressure machine was in date for safety testing. Three incubators were checked and all were out of date for safety testing, having been due for testing in November and December 2016.
- Four phototherapy units that were on the postnatal ward were also checked. One was in date for safety testing and the other three were due for safety testing in November 2015. There were also bold signs on the phototherapy units informing staff to contact EBME when a certain number of hours of use had been achieved with each unit. We checked three units and one label on a phototherapy unit said to inform EBME when 6291 hours were reached. The actual hours used for this machine was 10188.8. On the second phototherapy unit that we checked, the label said to inform EBME when 1680.7 hours had been reached. The actual hours used were 1680.7. The third unit that we checked said to inform EBME when 5332 hours had been reached. The actual hours used were 9475.
- We spoke with an EBME technician who was on one of the wards repairing an item of equipment. He was unaware that so many key items of equipment were out of date for testing and whether there was a regular testing programme. He confirmed that there were only three members of staff working in EBME covering the whole trust.
- In excess of 50 heparin blood bottles on the labour ward were out of date with an expiry date of July 2016 and virology swabs had an expiry date of 2001. Bottles and swabs were immediately removed from the clinical area when we highlighted our findings to staff. Though neither of these were used often, relevant checks had not been undertaken.
- One suction catheter had fallen out of the bag that it was contained in and was loose in a drawer, so it was not clean and ready to use. We found the equipment checking form to be ambiguous and staff had interpreted opened items to be 'clean'. However, senior staff believed it was best practice to leave a sterile suction catheter adjacent for use. No clear guidance was available.
- Overall we observed good compliance for checking and acting on fridge temperatures. On the labour ward there was a problem with the location of a fridge switch which sometimes accidently got turned off. Practices had been changed to reduce the risk of this happening which had improved compliance.

- We saw a completed risk assessment for a fridge in the treatment room on the labour ward to evidence why the fridge did not need to be locked. The rationale was that "the main door to the treatment room was digilocked at all times and only accessible to authorised staff, so risk of inappropriate access to treatment room is low".
- A senior sister on the postnatal ward informed us that a fridge in the treatment room was not working. She confirmed that a new fridge had been ordered and delivered but could not be used as there had been issues with the temperature gauge so further to that, a subsequent ordered for another fridge had been placed. We were told that medicines were currently being held in a fridge on the antenatal ward (the antenatal and postnatal wards were co-located).
- There was only one room available to check on the birthing centre at the time of our inspection. The room was spotlessly clean, well-stocked and all checks were up to date.
- We found the early pregnancy unit (EPU) to be clean and tidy.
- The matron on the postnatal ward told us that the ward was in the process of acquiring new waste bins as women had identified that the closing of bin lids especially during the evening was very loud and alarming to them and their babies.

Medicines

- We observed good compliance for the checking of CDs (controlled drugs) on the antenatal and postnatal wards. However, on the labour ward there were eight occasions over a two-month period where epidural drugs had not been countersigned.
- We were told that the midwife in charge held the keys to the controlled drugs cupboard. Digilocks were on the rest of the cupboards where all other drugs were kept. All staff had access to the door combination to get into the medicines room on the labour ward and postnatal ward.
- The senior sister on the postnatal ward told us that two midwives would check the controlled drugs cupboard on a daily basis, both in the morning and night. Ward pharmacists were reported to routinely check the stock balance of drugs and would carry out monthly medicines audits.
- IV fluids were unsecured in all ward areas, such as in unlocked cupboards, within unsecured emergency trolleys and in all delivery rooms. We found the drug Lidocaine (a topical jelly or ointment used on different parts of the body to cause numbness or loss of feeling for patients having certain medical procedures), unsecured in a delivery room. Drugs within the adult and neonatal resuscitation trolleys were unsecure. Although the trolleys were shut, they were not locked, making them unsecure and at risk of tampering with. We also found iodine unsecured in a ward cupboard. The bottle did not have a lid and should have been discarded as it was at risk of spillage and contamination.
- The senior staff nurse in the EPU showed good awareness of drugs that could impact on a woman's pregnancy such as epilepsy medications and told us that she would alert an on-call doctor who would liaise with a GP about what steps to take.
- The maternity scorecard, which detailed information about medicines management, showed that the percentage of women that had an allergy status documented in April and June 2016 was 97% and 92% respectively, against a target of 100%. In May, August 2016, October and November 2016 the hospital was 100% compliant. No data was collected for September 2016.
- Data regarding the percentage of intended doses given to women in the preceding 24 hours or reasons documented for the omission and/or delay exceeded the 90% trust target in April 2016, August 2016, October 2016 and November 2016. No data was collected for September 2016.
- We came across a number of drugs and infusions that all had an expiry date of February 2017: Diazemuls (Diazepam) EP 0.5% w/v emulsion for intravenous injection; Adrenaline (Epinephrine) Injection 1:10,000 and x6 Cefuroxime 1.5g (powder solution for injections or infusions). They were immediately removed from the cupboards when we informed a member of staff.

Records

- Maternity records consisted of a combination of hand written and electronic documents. In the antenatal and labour episodes, hand written notes were used. All birthing information and postnatal care was recorded electronically.
- Labour ward notes were stored in a trolley behind the desk of the main nurses' station in the middle of the

ward. The trolley was not locked but did have a locking facility. (At the time, there was no one in the nurse's station but there was a receptionist in the same area. However, the trolley was not in their line of sight).
- One patient that we spoke with said that her baby's notes had not been looked at carefully which delayed her baby receiving a scan.
- Nine sets of antenatal records we examined showed good compliance to legible signature and evidence of care planning. VTE (venous thromboelism) compliance was good in antenatal episodes we looked at. We were unable to check postnatal episodes as they had been recorded electronically. Notes reflected assessment tools for Sepsis 6. Fluid balances were undertaken and completed appropriately and records also showed compliance to Maternity Early Obstetric Warning Score (MEOWS) where appropriate.
- We observed SANDS teardrop stickers used on the front of notes of women to indicate a woman having experienced a past loss of a child.
- Records for antenatal checks, scans and screening tests were in patient folders. We saw evidence of a letter that was sent to a woman with the results of her screening test for Down's Syndrome and also saw a postnatal discharge summary in the notes of this woman.
- Red books were now being given to women and we were told that this had been in force for more than a year.

Safeguarding

- There was a safeguarding midwife located at UHL (University Hospital Lewisham) who worked Monday to Friday from 8am to 4pm. Staff were aware of who she was and understood what her role was.
- We were told that the safeguarding midwife was "very approachable" and would always give "good levels of support and guidance". A member of staff working in the antenatal clinic reported being able to take any concerns to the safeguarding midwife who would assist her in gathering the correct information needed to liaise with social services and move individual cases forward.
- We were told that there was an out of hours safeguarding team that could be accessed by calling the hospital's switchboard.
- Safeguarding meetings were held weekly on a Friday morning and were attended by young mums midwives, Kaleidoscope midwives (a team of midwives working with vulnerable women), health visitors and social workers. Minutes of the meetings were circulated via email to those staff members who could not attend.
- University Hospital Lewisham had a safeguarding training completion target of 85% for nursing and midwifery staff. Both Safeguarding Children and Young People Level 3 core and specialist training had a 100% completion rate. The remaining four modules did not meet the trust completion target. The lowest scoring module was Emergency Planning with 68% completion.
- University Hospital Lewisham had a safeguarding training completion target of 85% for medical staff. Safeguarding Children and Young People Level 3 had a 100% completion rate. The remaining four modules did not meet the trust completion target. The lowest scoring module was Mental Capacity Act & Consent to Examination/Treatment with 34% completion.
- We saw an action log from September 2016 from a Safeguarding Assurance Group meeting which raised that if a member of staff was non-compliant in their safeguarding training their annual appraisal would not be signed off and doctors would not be revalidated.
- The trust had a child abduction policy, which was ratified in September 2016 and was to be reviewed again in September 2017.

Mandatory training

- Data submitted to us by the trust showed that mandatory training levels were below the trust's benchmark of 85% compliance across a number of subject areas. These were subject areas the trust deemed as a basic requirement to ensure safe working practice.
- Amongst nursing and midwifery staff, 73% completed medicines management; 71% completed infection control and only 67% had completed health & safety training as of 28 February 2017. 100% of nursing and midwifery staff had completed Adult and Paediatric Basic Life Support.
- Of medical staff, 78% had completed infection control training; 68% Equality & Diversity, 61% had completed Manual Handling; 58% had completed Adult & Paediatric Basic Life Support; 39% had completed Health & Safety and 0% had completed Non-patient Manual Handling training as of 28 February 2017.
- However, we spoke to three midwives who reported good compliance with mandatory training on their part.

All three midwives had completed all of their mandatory training with the exception of one midwife having an e-learning module outstanding and the other midwife who was due to complete one module before it expired at the end of the month.

- We were told that trust training was a combination of classroom based and e-learning. Midwifery specific mandatory training was completed over a four day block period, which was all classroom based but included some practical sessions such as adult life support and new-born life support. Medicines management training was offered as a classroom based session or as an e-learning module.

Assessing and responding to patient risk

- Regular risk assessments throughout women's pregnancy took place to ensure they could get access to the optimum place of birth based on their clinical needs. The birthing centre was available for low risk women and a consultant led labour ward was available for women who required medical surveillance.
- Each day a capacity document was completed on each site to record activity, clinical acuity and staff on duty. This was emailed to matrons and managers so decisions could be made on clinical workload and adequate staffing across both sites.
- The MEOWS system was used to support the recognition of deteriorating patients and their timely escalation. The MEOWS system has been in use in maternity areas throughout the acute sites of Lewisham & Greenwich NHS Trust since April 2015. A baseline audit was performed in July 2015 and a re-audit took place in October 2016.
- Results from the re-audit showed overall good compliance, with improvements being made in a number of standards following the baseline audit. In the standard 'are observations timed', there was 96% compliance against a target of 90%. In the standards 'is temperature recorded' and 'is heart rate recorded', there was compliance of 95% and 99% respectively. However, there was a fall in compliance for the standard 'are observations dated'. Results were 79%, down from 85% compliance in the 2015 audit. Results for the standard 'are EWS correctly calculated' showed 79% compliance. In the records that we looked at, it showed that MEOWS had been recorded and scored properly.
- A security threat to mothers and babies had been identified on the risk register in October 2013. This was due to the number of entrances and exits that linked the antenatal, day assessment unit and postnatal ward. We were told that this had allowed for visitor (those authorised and those wrongful) tailgating in and out of the ward areas, which could not be prevented. We were shown a business case and building elevations for a new security block feature, with the day assessment unit being relocated to the postnatal ward and the existing sister's and planning coordinator's office being converted into two baby examination rooms. Work was due to start in April 2017 and we were told that there would be no disruption to the services provided and the areas would be well signposted.

Midwifery staffing

- Birthrate plus were engaged 2 years ago when services first merged. Staffing levels were set for each clinical area but there was flexibility and contingency built in to ensure staff were available at times of heightened activity. For the financial year 2016/17 the birth to midwife ratio was funded to be 1:29, with a 90/10 split between qualified midwives and maternity support workers. The maternity dashboard showed that between April 2016 and January 2017 a ratio of one midwife to 29 births had been achieved.
- Staff were moved between clinical areas and at times between the two hospital sites. We were given an example of where an agency midwife was transferred from University Hospital Lewisham to Queen Elizabeth Hospital (QEH) on a staff bus, as QEH's need was greater.
- Maternity wards displayed staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels to cover the day and night shifts. This meant that people who used the services were aware of the numbers of staff available that day and whether this met the planned requirement.
- The maternity dashboard showed that in March 2016 and May 2016, 100% of women received one to one care from a midwife whilst in established labour. Between June 2016 and January 2017, one to one care that women received from a midwife ranged from between 95.2% and 99%.
- A manager working a day shift once a month at the weekends had recently been introduced to offer support and managerial oversight. We were told that this had improved care given to women as midwives were able

to focus on their clinical roles rather than on operational issues. Staff in specialist roles and managers would help clinically when needed and staff working on the wards corroborated this.

- In data provided to us by the trust, it showed that there was a vacancy rate amongst midwifery staff of 7.3% and a turnover rate of 10.7%. We were told that lots of staff were on maternity leave which had presented a challenge in terms of turnover of staff at times.
- A dedicated role for a Staff Planning Coordinator had been filled in October 2016 and was reported to have greatly improved staff rostering across the maternity service. Band 7 and Band 8 midwives previously completed staff rostering and we were told that previously if there had been high activity occurring on the wards, the Band 7 and 8s would have to assist clinically. However, this subsequently meant that rotas would not then always be completed in a timely manner. Rota rules were also now being adhered to such as a midwife not working more than two consecutive night shifts.
- We were told by the Staff Planning Coordinator that there was not a heavy reliance on using agency staff. Where agency staff were used, it was primarily due to unpredictable activity on the wards. We were given an example where there had been five caesarean sections in one day and this had constituted the need to bring in agency midwives.

Nursing staffing

- Three clinical nurse specialists in HIV and sexual health, supported by a healthcare assistant, provided nursing care in the Alexis Clinic.

Medical staffing

- Between February 2016 and August 2016 UHL had 81 hours per month of medical cover on the labour wards. Between September 2016 and January 2017, the hospital had 87.5 hours per month of medical cover on the labour wards.
- We were told that rosters were arranged so that medical cover was achieved for the day unit and the antenatal ward separately to the on-call team. This ensured that women were reviewed in a timely way and decision-making and care planning was streamlined. We were told that this had improved patient flow through the day assessment unit and reduced delays for women.
- As of January 2017, the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1 – 2) staff was higher.
- There were 12 consultants working in the service, one of which was a locum. 11 of the 12 consultants provided on-call cover on a 1:11 rota basis. Consultant labour ward presence existed Monday to Sunday between the hours of 8am and 8:30pm. Consultants were on-call outside of these hours.
- As of the end of February 2017, there was one vacant consultant post and three vacant junior doctor posts.
- We spoke with a junior doctor who had requested to work at Lewisham Hospital due to its good reputation for training opportunities. They reported that consultants were “friendly” and “supportive”.

Major incident awareness and training

- There was an escalation plan and staff working in non-clinical roles such as managers and specialist midwives would work clinically to assist the ward and labour ward teams when needed.
- A table top exercise on the baby abduction policy had taken place recently with all staff groups. We were told that babies were never left alone. A companion/relative could stay with a baby on the ward if the mother for instance needed to go to the toilet. Where there was no companion or relative available, a midwife would stay with the baby at the patient’s bedside.
- We spoke with a midwife who stated that there was a policy available on the intranet in relation to major incidents but that they hadn’t personally received any training.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- A wide range of pain relief options were available to women;
- As well as a teaching audit programme that took place in January 2017, the service was participating in a number of local audits;

- The service had a breastfeeding team and the hospital was being assessed for UNICEF Baby Friendly Initiative Level 3 in April 2017;
- We observed good examples of MDT (multidisciplinary team) working between staff groups in clinical areas. The atmosphere on the labour ward was positive and friendly.

However:

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

Evidence-based care and treatment

- There was a foetal wellbeing midwife who worked at the hospital, with the recruitment underway for another. The foetal wellbeing midwife supported midwives in providing safe care for women, particularly around CTG interpretation. The roles had been funded for two years with money from the "sign up to safety" initiative.
- The risk register identified that there was a risk to clinical outcomes and patient safety due to maternity guidelines not being merged across the Lewisham and Greenwich sites and some guidelines also being out of date. Work to ensure that all guidelines were merged across the two sites was due to be completed by the end of March 2017.
- We reviewed information related to various audits, including shoulder dystocia and electronic foetal monitoring audits which were completed in November 2016. In the obesity audit carried out between November and December 2016, recommendations were made around a women's BMI (body mass index) being recorded early on in their antenatal care. If a BMI score greater than 30 was recorded then a referral should be made to an obstetrician. If a score was greater than 40, then a woman should receive an anaesthetic review and documented anaesthetic plan. Recommendations made from a perineal trauma audit were that doctors repairing third degree tears were to prescribe antibiotics, analgesia and laxatives themselves.
- We were told of an audit teaching programme that took place in January 2017 which was well attended by the multidisciplinary team. Various audits were discussed, a research update was given about pre-eclampsia toxaemia prevention and physiotherapists gave a presentation about incontinence.
- Staff in the Alexis Clinic used a domestic and sexual violence risk referral pathway to obtain rapid support to patients at risk of abuse.
- Care in the Alexis Clinic was delivered in line with British Association for Sexual Health and HIV and British HIV Association (BHIVA) guidance. This included BHIVA guidance on vaccinations for HIV positive patients.

Pain relief

- A wide range of pain relief options were available to women such as aromatherapy in the birthing centre, pethidine and mobile epidurals.
- Patient controlled analgesia was available for women who had a foetal loss or termination of pregnancy.
- Post-delivery pain relief was prescribed on an individual basis. The most common times for prescribed pain relief to be administered were during the following times: 8am, 12pm, 2pm, 6pm and 10pm.
- Women on the labour ward reported pain relief to be administered in a timely manner. However, two patients on the postnatal ward reported that their epidurals were delayed, with one woman waiting over an hour. One partner felt that they were being discouraged to have an epidural because staff seemed busy.
- We were told that if a mother returned back to the hospital after a caesarean section with pain, there was a 24/7 outreach pain team they could access.

Nutrition and hydration

- The trust collected data on the percentage of women who breastfed after delivering their babies. The results of this data collection exercise were 83.3% of women in quarter one (April to June 2016), 82.9% of women in quarter two (July to September 2016, 84.3% of women in quarter three (October to December 2016) and 82.7% of women in quarter four (January to March 2017).
- The trust did not collect data on the percentage of women who were breastfeeding at the time of discharge from the hospital. The trust also did not collect data on the percentage of women who were breastfeeding on discharge from maternity care.
- We sat in on a breastfeeding class that was being run by an Infant Feeding Support Worker. The class was attended by five mothers, with two of their partners also being present.
- The service had a Breastfeeding Team comprising of a Band 7 Lead; a Band 4 Infant Feeding Support Worker

(which was currently filled by a bank member of staff while the position was being advertised), and a Band 3 Infant Feeding Support Worker. A matron told us that three to four volunteers also worked within the team.

- Parents were encouraged to have meals and beverages together on the postnatal ward, with a variety of food choices, including options for a range of dietary and religious needs. Breakfast was served between 8am and 9am, lunch was between12:30pm and 1pm and dinner at 5pm on both the labour and postnatal wards. Tea and coffee facilities were available 24/7. Snacks such as biscuits were always available with cakes available in the evening.
- The service had achieved Level 2 in the UNICEF Baby Friendly Initiative accreditation in 2015. The service was being assessed for Level 3 in April 2017 and we were told that a new infant feeding co-ordinator was in post to lead on this.
- Expressed milk was kept in a lockable fridge and temperature logs showed that temperatures were all within range. Temperature logs were completed everyday but we noted that it had not been completed for the 14 February 2017.

Patient outcomes

- Between April 2016 and January 2017 the overall caesarean section rate was 30%, higher than the England rate of 27.3%. The emergency caesarean section rate was notably higher than the England average (20.7% compared to 15.4%). The elective caesarean section rate was lower than the England average (9.3% compared to 11.9%)
- Operative vaginal deliveries using ventouse or forceps had a target of equal to or less than 10%. In April and December 2016, results indicated 7.7% and 9.1% respectively. However, between May and October 2016, results ranged from 10.5% to 11.6%.
- The maternity dashboard showed that the percentage of women who experienced third and fourth degree tears during vaginal births as 2.8% between February 2016 and January 2017. This was against the hospital's target to achieve less than 3% and no more than 6%.
- The hospital did not set itself a target for an appropriate level of maternal readmissions within 42 days. Between February 2016 and September 2016 no data was collected on the number of maternal readmissions that took place. In October, November and December 2016, the percentage of maternal readmissions that took place was 3.8%, 3% and 3.9% respectively. In January 2017 there were 5.2% maternal readmissions took place.
- The numbers of stillbirths at 24 weeks of gestation or more were 41 across the trust between April 2015 and May 2016.
- The trust was participating in a number of national audits such as: Diabetes in Pregnancy and Each Baby Counts. In the 2015 National Neonatal Audit Programme, University Hospital Lewisham was below the NNAPP standard for four standards and met the NNAP standard/benchmark for one standard.
- However there was a lack of clinical outcomes for gynaecology at Lewisham. A joint Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG) report published in early 2017 stated that 'clinical indicators for gynaecology need to be developed at an individual, site and trust level combining activity, admissions, conversion rates from outpatient to inpatient, clinical outcomes at surgeon and patient level (i.e. length of stay, new/follow up ratios/readmission rates after surgery/reoperation rates within 2 years/return to theatre within 72 hours/ inadvertent damage to viscus and patient satisfaction)'.
- The same joint RCM/RCOG report highlighted a lack of common pathways for gynaecology and recommended that these be devised and implemented as soon as possible and within 6 months.
- There were clear pathways in place for medical patients who were HIV positive. For example, if a patient was admitted with a primary pathology related to HIV, an HIV consultant would review them alongside a medical consultant. If a patient of the Alexis Clinic was admitted as a medical inpatient, they would remain under the care of the HIV consultant with further specialist input from the consult in the related ward area. Patients newly diagnosed with HIV were also screened for latent tuberculosis.
- In March 2017, HIV consultants conducted a 'grand round' in the hospital to encourage staff to offer HIV testing more frequently to patients, in line with national standards. This included NICE national guidance 60, in relation to national best practice in improving uptake of HIV testing to reduce the prevalence of undiagnosed HIV.
- Staff in the Alexis Clinic demonstrated significant effort in ensuring patients who were 'lost to follow up' were

traced. 'Lost to follow up' means the patient did not turn up for a booked appointment and subsequently placed their health, and that of their sexual partner(s), at risk. For example, when one patient who was newly diagnosed with HIV did not attend a booked appointment to consider starting antiretroviral therapy, clinic staff prepared a tracing strategy in the weekly multidisciplinary team meeting. As a result community clinical nurse specialists were contacted who identified that they knew this patient. A nurse conducted a house call and successfully engaged with the patient to begin their treatment.

Competent staff

- Data submitted by the trust showed that from April 2015 to March 2016, 75% of nursing and midwifery staff working within the division of women's and sexual health had received an appraisal. We spoke with five members of staff who had all received an appraisal with the last 12 months. For midwives, this appraisal was linked in with revalidation and was seen as a meaningful experience with clear personal & service goals being identified.
- Staff that we spoke with confirmed of having regular one to ones with their managers. A matron that we spoke to told us that the Head of Midwifery was a "very good listener", sharing an occasion when the Head of Midwifery sat and listened to her for two hours.
- We spoke with a screening coordinator in the antenatal clinic who told us that the trust had supported her in her request to take up a genetic counselling course. We also spoke with a senior staff nurse working in the early pregnancy unit who spoke enthusiastically about a recent training opportunity to qualify as a sonographer.
- One third year student midwife that we spoke with said she had been well supported in her role and that she loved her training at Lewisham Hospital. She was hopeful that she would get a job at the hospital.
- There was an IT system that enabled agency staff to access the intranet for guidelines and policies. All agency midwives were checked by Supervisor of Midwives to ensure that they were on the midwifery register and that they had an intention to practice.
- The independent role of the Supervisor of Midwives is due to end nationally at the end of March 2017 and we were told that once supervision had ended, the trust would employ one FTE midwife to perform this role. We were shown no evidence of how this would materialise or work in practice.
- The Local Supervising Authority (LSA) annual report to the Nursing and Midwifery Council (NMC) for 2015/16 indicated that 91.3% of midwifery staff had a supervisory review during the period 2015/16. The maternity service had 15 Supervisor of Midwives (SOMs), with an average number of supervisees of 1:15. The report also commended SOMs for their excellent evidence of women-focussed supervision. We saw evidence of many testimonials from women about SOMs.

Multidisciplinary working

- We observed good examples of MDT working between staff groups in clinical areas. The atmosphere on the labour ward was positive and friendly.
- Midwives, doctors, paediatricians and anaesthetists reported good working relationships with one another and there were no staff members who voiced any concerns either voluntarily or when prompted.
- We attended a multidisciplinary handover on the labour ward, which was attended by midwives, anaesthetists and obstetricians from the day and night shift. All staff who were available attended and the handover started promptly at 8am, though there were two latecomer doctors (anaesthetists). The handover was concise and well organised and based on the SBAR methodology (Situation, Background, Assessment, Recommendation). The handover discussed all relevant women on the unit and elsewhere in the trust. Joint discussions took place between midwives and doctors with plans made for care.

Seven-day services

- The antenatal assessment unit was open Monday to Friday between 8am and 8pm. On Saturday and Sunday, they were open from 9am to 5pm.
- The examination of new-born babies was conducted by midwives with support from paediatricians. Two neonatal clinics were run every day between 9am and 5pm and the other in the afternoon between 12:30pm and 5pm.

- Ward based pharmacists worked in the maternity service Monday to Friday between 10:30am and 12:30pm. The hospital pharmacy department was open Monday to Friday between 9am to 7pm. On Saturday and Sunday, the service was open 10am to 1pm.
- We saw that there was a provision for out of hours medical cover on the labour ward from a senior and junior registrar 24 hours a day. Consultants were on-call between 8:30pm and 8am Monday to Sunday.

Access to information

- All staff appeared to have access to information at handovers, on staff noticeboards and also had access to IT systems. Even for temporary and agency staff, they could access IT systems which gave them temporary access.
- There was a hospital wide electronic patient record system that was used. However, we were told that Queen Elizabeth Hospital had one version and Lewisham another version. A merger of the systems was to take place later in the year to iron out some of the issues that existed such as guidelines not being merged and community midwives not being able to access the electronic patient record system This had been highlighted on the risk register in October 2016 and to address this, a work stream had been set up led by the head of midwifery, the community matron and the medical records lead to find and implement solutions.
- The matron on the labour ward told us that there may occasionally be issues with IT but generally it was very good. We were told that an electronic patient record administrator was available to help staff rectify issues such as information entered incorrectly. The administrator worked Monday to Fridays and he was reported to resolve issues very quickly.
- Student midwives had some access to the intranet. They could not order blood tests, which we were told could only be done through the intranet but they could access guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that it was the responsibility of community midwives to get consent for screening tests and that verbal consent was only needed for antenatal & new-born screening programmes and would be documented in women's handheld notes. For operations there would be formalised consent forms.
- The matron on the labour ward gave us an example of a recent scenario which showed awareness of DoLS. The incident involved a patient who needed an emergency caesarean and an interpreter was not available and the question arose as to whether she should have been DoLS assessed. Following on from this, the matron reported using the opportunity to send staff on a MCA DoLS refresher to update their knowledge in the subject.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Feedback from women and those close to them was generally positive. We observed women were treated with kindness and respect throughout our visit;
- Staff ensured women's privacy and dignity was maintained;
- Women were involved and encouraged to be partners in their care and were supported in making decisions. All women using maternity and gynaecology services reported that they felt well informed about their care and treatment;
- Partners said they felt welcome and involved in their partners' pregnancy at all stages and were able to stay with their partner during labour and on the postnatal ward;
- Women spoke highly of the staff in gynaecology and the Early Pregnancy Unit. They said that staff were professional and always understood their needs;
- A bereavement midwife and a bereavement counsellor provided sensitive support for women and families who had suffered a pregnancy loss.

Compassionate care

- We spoke with six mothers post-delivery, one woman attending an antenatal clinic, two women on the antenatal ward, three gynaecology patients, five partners and one visiting relative. Feedback from women and their partners was generally positive. Patients and partners in all areas of maternity and gynaecology described staff as "friendly and helpful."
- The CQC maternity survey of December 2015 surveyed women who gave birth in February 2015. A total of 104

women returned a completed questionnaire for University Hospital Lewisham (UHL). Results showed that the hospital performed about the same as other trusts in all questions. The hospital scored better than other trusts on the measure: 'women were given a choice about where antenatal check-ups would take place'.

- The maternity NHS Friends and Family Test (FFT) results for February 2017 for antenatal care at UHL had a response rate of 16.3% with 98.5% of women who recommended the service. 94.4% of women from a response rate of 63.6% recommended birthing care at UHL. The postnatal ward had a response rate of 74% with 91.2% of women who recommended the service, which was below the England average of 94%.
- The gynaecology FFT results for February 2017 showed that 86.4% of the 38 women who responded recommended the service. 80% of 20 respondents recommended the Early Pregnancy Unit.
- The Colposcopy Patient Survey 2016 showed positive results with 99% of the 81 respondents answering that they found staff friendly and welcoming on arrival.
- We observed all staff respecting the privacy and dignity of women. We observed staff knocking on doors, politely asking before opening curtains and waiting to be invited into rooms and cubicles. We saw many positive interactions by staff who were kind and caring to both patients and their families.
- Staff demonstrated an understanding of women's personal and social needs. One woman's partner said: "our midwife was empathetic to our social situation" and was pleased to have been able to have their baby at the hospital of their choice. One woman on the antenatal ward said: "individual members of staff are fantastic" and described how she appreciated the attention to detail she received when one nurse helped her to dress.
- On the antenatal ward, women commented on how regular staff would introduce themselves and address them by their names.
- A woman visiting an antenatal clinic commented on the caring nature of her specialist midwife. She described how supportive and encouraging the midwife was in helping her manage her own care. She said she could call or email her midwife at any time for advice.
- A gynaecology patient said: "staff know my medical history well and I feel well supported." We observed a staff member demonstrate sensitivity and compassion to ensure the patient was seen as quickly as possible.
- We observed a receptionist booking a woman into the labour ward, liaising with a midwife in a sensitive manner and ensuring that confidential information could not be overheard.
- We observed thank you cards displayed on the labour ward walls commending the friendliness, supportiveness and professionalism of staff.

Understanding and involvement of patients and those close to them

- Women said they felt supported to make informed decisions about their care. We observed good rapport and clear explanations in a specialist antenatal clinic consultation. The expectant mother commented that the midwife always explained in a way she could understand. One woman who had chosen to give birth at the birth centre and was moved to the labour ward due to complications said she felt she was supported by the staff and everything was explained clearly to her and her partner. However, some women on the labour and postnatal wards felt when the ward was busy, midwives' answers to their questions "felt rushed and could have been clearer."
- One woman commented on how she appreciated the practical support and advice she and her partner received from the breastfeeding midwife who also took the time to go through the new mother starter pack leaflets with them.
- Partners said they felt involved in the care and treatment of their partner and felt able to ask questions. A partner of a woman commented: "in discussions about the pregnancy, midwives and consultants would make eye contact with me as well." A mother explained how she had regular check-ups throughout her pregnancy and confirmed how her partner was always involved in conversations at her consultations.
- A woman on the antenatal ward described how staff were understanding and friendly with her relatives and acted on all of her partner's requests. She commented that "it has been a very positive experience for all of us."
- Staff in gynaecology and the EPU recognised the individual needs of women. Women commented that they always felt able to approach staff with questions. A woman said that "the care I have received reflected my

needs." Another patient said she felt comfortable discussing her mental health needs with staff. She said: "staff reassured me, gave me the facts and I felt comfortable bringing my partner in."

Emotional support

- A bereavement midwife and bereavement counsellor sensitively supported bereaved women and their partners. The bereavement midwife would follow up the care of every woman with a telephone call to ensure she had the right support arranged in the community.
- Staff showed us patient notes marked with a teardrop sticker to indicate women who had experienced loss. They explained how the sticker reminded staff to show extra sensitivity towards the woman and her family.
- A midwife said staff valued the support they received from the bereavement counsellor after a maternal death in 2015.
- Women in labour and in postnatal care could have their partners stay overnight to give them further support.
- We observed a specialist midwife reassuring her patient by taking into consideration the impact on the expectant mother's wellbeing and social situation.
- We observed staff offering to make tea for women and their partners on the labour ward. On the labour ward, a woman described how her midwife was particularly supportive and reassuring because she was aware of her anxieties about having her first baby. A woman on the antenatal ward said: "when I looked tearful, the midwife noticed and came over to talk to me."
- The Kaleidoscope midwifery team which, which consisted of specialist midwives supported women with learning disabilities and mental health needs. Staff said that the team's involvement would be made clear on the notes of women so all staff would be aware and sensitive to the patient's needs.
- Women and those close to them had access to the multi faith chaplaincy service which provided spiritual care and religious support. Staff also commented that they would often see chaplains on the ward and they would take the time to speak to staff members as well.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Since the merger of University Hospital Lewisham with Queen Elizabeth Hospital, there had been increased working between sites to ensure care plans for women were fulfilled. Staff felt encouraged with service planning and were able to suggest improvements in women's care.
- The Kaleidoscope Team which worked with vulnerable women and those with mental health needs worked closely with a neighbouring NHS trust.
- The Day Assessment Unit ran from 9am to 8pm Monday to Friday and 9am to 5pm Saturday and Sunday.
- A dedicated maternity helpline had been developed in 2015 to provide women and their families as well as GPs and other health care professionals with direct and easy access to maternity-related information.
- The matron and the ward sister on the postnatal ward were part of a catering subgroup, where they would meet monthly and talk about dietary menu options for women, also taking issues to the group that women complained about. The matron and the ward sister also took part in tasting sessions every six months and this was done in conjunction with the patient experience team;
- Women were given a postnatal information pack on arrival to the postnatal ward, which was an amalgamation of a number of leaflets brought together into one information pack. The pack included information about car seat safety, breastfeeding, jaundice in a baby, postnatal bleeding, perineal care and instructions on how to perform pelvic floor exercises.
- A range of services were provided for HIV-positive patients. This included medicines and antiretroviral management and coordinated care between the HIV speciality team and other medical specialties. Where patients required complex, coordinated care, staff demonstrated they could provide this working with a range of other organisations to meet individual needs.

However:

- Bed occupancy levels for Maternity were generally higher than the England average, with the trust having 90% occupancy in Quarter 2 2016/17 compared to the England average of 61%.
- The maternity dashboard showed that between February 2016 and January 2017, the percentage of pregnant women accessing antenatal care who were seen before 12 weeks and 6 days gestation was only 83.5% which was below the 90% target.
- The environment for gynaecology was cramped and not conducive to meeting patients' needs.

Service planning and delivery to meet the needs of local people

- The number of births that the maternity service delivered from February 2016 to January 2017 was 3866. The service was funded to deliver 3879 babies in that period.
- Since the merger of University Hospital Lewisham with Queen Elizabeth Hospital, there had been increased working between sites to ensure care plans for women were fulfilled. Staff felt encouraged with service planning and were able to suggest improvements in women's care.
- At times of capacity pressures, women were offered care at an alternative trust. We were told that whilst this was not always taken up, with good forward planning and preparation, women were accepting of this.
- Maternity services served women across the boroughs of Lewisham and Greenwich. Twenty-two percent of the women served were of Asian and Black Afro-Caribbean descent.
- Community midwifery was provided across the boroughs for antenatal and postnatal care in community settings such as family planning centres and PCTs (primary care trusts). We were advised that there were six teams of community midwives each having between six and seven midwives. Two on-call midwives worked Monday to Sunday.
- The Kaleidoscope Team which worked with vulnerable women and those suffering with mental health, worked closely with a neighbouring NHS trust.
- In addition to the core HIV specialty, the Alexis Clinic also offered sexual health screening, family planning and contraception.
- The specialist HIV team recognised that there was a significant number of people in the local population who presented with undiagnosed HIV. Where late diagnosis was identified, an HIV consultant visited the patient daily wherever they had been admitted in the hospital.
- A senior house officer in the Alexis Clinic offered a post-exposure prophylaxis (PEP) clinic. PEP is a course of antiretroviral medicine that can prevent a person from becoming HIV positive following an exposure risk, such as through unprotected sex with an HIV positive person. This was a walk-in, on-demand service and included appropriate emotional support and clinical risk assessment. In addition, the clinical team had established a PEP pathway with the emergency department that enabled staff there to identify risk and begin this course of treatment themselves.
- The clinical team in the Alexis Clinic had worked to expand the provision of psychological support available for patients in response to significant changes in the local population. For example, in response to an increase in the number of patients experiencing psychosis related to advanced-stage HIV, the service expanded the working relationship already in place with an HIV specialist psychologist as well as the provision to refer patients rapidly to crisis intervention teams.
- The Alexis Clinic provided ongoing support for new mothers who were HIV positive. This included providing weekly baby formula directly from the clinic.

Access and flow

- Between Q1 2015/16 and Q2 2016/17 the bed occupancy levels for Maternity were generally higher than the England average, with the trust having 90% occupancy in Quarter 2 2016/17 compared to the England average of 61%.
- The post-natal ward had 31 beds, including seven single rooms and five four bedded bays.
- Between March 2016 and February 2017, 704 women were admitted to the labour ward who did not give birth during their admission.
- Between March 2016 and February 2017, the average length of stay for non-elective cases in maternity services was 2.1days. The average length of stay for elective cases in the same period was 2.2 days.
- The maternity dashboard showed that between February 2016 and January 2017, the percentage of pregnant women accessing antenatal care who were seen before 12 weeks and 6 days gestation was only 83.5% which was below the 90% target. The

contributing factors to this were due to women presenting to their GP late and women being transferred into Lewisham maternity services after 12 weeks and 6 days gestation, though they may have previously been booked elsewhere.

- Women could attend emergency scan clinics at the EPU clinic, which ran from 8.30am to 5pm, Monday to Friday excluding bank holidays. The clinics accepted walk-in referrals up until 12pm from the emergency department and up until 11am from primary care and community clinics. Women who need to return were seen in the afternoon. We were told that the criteria for women to be referred to the EPU were a positive pregnancy test with pain and/or bleeding, a previous ectopic pregnancy, a previous molar pregnancy and recurrent miscarriages. The EPU were planning to run a Saturday clinic due to commence on 15 April 2017. Staff in the EPU reported close working with a designated nurse for pregnancy loss in the emergency department.
- The Day Assessment Unit ran from 9am to 8pm Monday to Friday and 9am to 5pm Saturday & Sunday. Staff told us that up to forty women were seen a day.
- A dedicated maternity helpline had been developed in 2015 to provide women and their families as well as GPs and other health care professionals with direct and easy access to maternity-related information. The helpline which was run across the two sites was coordinated and set up by a senior midwife. We were told that the helpline relieved pressure and reduced workloads on busy maternity wards by providing a dedicated senior midwife to answer any maternity related questions where previously women would have contacted the labour ward or other wards for advice.
- A senior sister on the postnatal ward told us that there was a discharge midwife allocated to the ward every day. Discharges over the weekend were reported to not be as speedy as discharges during the weekday. We were told that sometimes there could be a lack of doctor to carry out baby reviews. To address this, some midwives had been trained in the examination of new-borns and worked a bank shift on a weekly basis to carry out this role.
- The matron for the postnatal ward told us that there was no cut off time to facilitate discharges. If a baby was on IV antibiotics, the midwives would liaise with the neonatal team to have the baby receive their IV antibiotics earlier so that mothers could go home earlier.
- The Alexis Clinic provided a mix of pre-bookable appointments and a walk-in service. A senior house officer led the walk-in service and provided triage for HIV positive patients or those who had an infection risk. The service had opening hours that had been modified over time in accordance with patient feedback and demand on the walk-in service. For example, the service opened at 8am on Mondays and closed at 8pm on Mondays and Tuesdays. This improved access for patients who could not easily take time off work to attend. The clinical team in the clinic could admit patients directly to a medical ward. This took place according to an established process including clerking led by the senior house officer and coordination with the bed manager.
- The Alexis Clinic team offered an e-mail contact option that allowed patients to check on the wait time for walk-in appointments before travelling to the clinic.
- Patients did not need a clinical appointment to obtain contraception in the Alexis Clinic, which provided free condoms and sexual health promotion printed information to anyone who visited the unit.

Meeting people's individual needs

- There was an infant feeding room furnished with a television and DVD player available to women who wanted to breastfeed their babies and network with other mums. For those women who were not so mobile, for reasons such as having a caesarean section, we were told that women could have a DVD player brought to their bedsides and breastfeed there.
- Partners and companions of women could visit twenty-four hours a day but for all other visitors, visiting times were restricted to 3:30pm to 8pm.
- There was no specific clinic for women who may have experienced Female Genital Mutilation (FGM). However, we were told that women suspected of experiencing FGM would be referred to a consultant and the safeguarding team.
- The Kaleidoscope Team had midwives to support young mothers and vulnerable women such as those with mental health issues. We were told that where appropriate, the Kaleidoscope Team would link in with a mental health nurse and psychiatrists at the neighbouring Ladywell Unit. Postnatal discharges could be extended for women but this was dependent on women's mental health needs.

Maternity and gynaecology

- A number of specialist clinics were available for women. A pre-operative assessment clinic ran for women who were choosing to have an elective caesarean. A specialist diabetes clinic took place and a clinic for mums to come in and check their babies for jaundice was run by a maternity support worker Monday to Fridays. Women with a high BMI could attend a Pregnancy Plus clinic and could also have an appointment with a consultant and anaesthetist depending on their needs.
- Bright orange recliner chairs were at the bedsides for women and their partners. We were told by the matron on the postnatal ward that they were being replaced due to colour staining.
- The matron and the ward sister on the postnatal ward were part of a catering subgroup, where they would meet monthly and talk about dietary menu options for women, also taking issues to the group that women complained about. The matron and the ward sister also took part in tasting sessions every six months and this was done in conjunction with the patient experience team. Pictorial menus were used for women who could not speak or read English.
- Women were given a postnatal information pack on arrival to the postnatal ward, which was an amalgamation of a number of leaflets brought together into one information pack. The pack included information about car seat safety, breastfeeding, jaundice in a baby, postnatal bleeding, perineal care and instructions on how to perform pelvic floor exercises. We saw evidence of the welcome pack placed on a bed, which a midwife was expected to go through the pack with a woman on her arrival to the ward.
- Leaflets for screening were in different languages. Formally, Language Line was the service used for interpretation requirements; however, we were told that midwives who spoke other languages could be used to communicate with patients where appropriate. Staff reported being able to use an interpreter over the phone but also booking an interpreter in advance to attend a woman's booking appointment.
- A bereavement room was available to women on the labour ward, which was not soundproofed. There were cold cots available in the room and there was a butterfly symbol attached to the door to signify that it was a bereavement room. The room adjacent to the bereavement room was primarily used for women in labour but we were told that use of this room would be avoided. The décor of the room was non-clinical, calming and was furnished with a sofa and a patterned bedspread, and we were told that patients were able to stay in the bereavement room for as long as they needed. There was a 0.8 WTE bereavement midwife who helped mothers with practical arrangements such as burial and cremation choices.
- Ambulatory facilities, bereavement and clinic rooms were cramped and squeezed into an inadequate facility. The waiting areas for patients were poor with adverse impact from a patient perspective. In addition both Early Pregnancy Assessment Units (EPAU) facilities lacked adequate room for privacy, counselling and potentially grieving parents in such a busy environment.
- A 0.6 WTE counsellor provided a service for women who had experienced loss at 16 weeks or more of pregnancy or at stillbirth. The counsellor attended a pelvic pain clinic and provided sessions for women whose pain may have had a psychological effect on them e.g. past abuse. The counsellor also ran a clinic with a consultant to give women post-mortem and test results following miscarriage and stillbirths. The clinic also included advice about future risks to pregnancies. The counsellor described close links with other services such as IAPT (Improving Access to Psychological Therapies) and Safeguarding Health Visitors.
- We saw visual aids that were used for patients living with a LD (learning disability). A senior nurse in the EPU told us that those patients living with LD would be shown prior to their procedure, the equipment that would be used.
- There were a total of six community teams for Lewisham Hospital including the Kaleidoscope Team. The composition of four of the six teams were: one Band 7 team leader, 5.5 WTE Band 6's, one Band 3 MSW and one Band 2 administrator. The composition of the fifth team was similar to the other four with exception to having 5 WTE Band 6's.
- A 'centring' project was being developed for vulnerable women and for women whose English was not their first language. The aim of the project was to provide antenatal care in a group like setting and to build on existing initiatives where women with a raised BMI could meet with other similar women, receive their antenatal care but also receive education around exercise, healthy eating and portion sizes.

Maternity and gynaecology

Learning from complaints and concerns

- Complaints were monitored via the maternity dashboard. Between February 2016 and January 2017, 42 formal complaints were received. The most common themes of complaints were attitude of staff, lack of communication and information, and medical & surgical treatment.
- A matron told us about a complaint she was currently dealing with in relation to alleged lack of consultant involvement. The matron also told us that she would always call the complainant to acknowledge their complaints and would offer them an opportunity to meet with her to discuss their concerns.
- Information on how to make a complaint was provided in a postnatal information pack that was given to women on admission to the postnatal ward. It provided a contact number and email address for the PALS (Patient Advice and Liaison Service).
- We reviewed two complaints that the service received from October 2016 and February 2017. We saw evidence of appropriate departmental investigation by a labour ward matron for one of the complaints and the divisional director for women's and sexual health for the other complaint. As a result of one of the complaints, the maternity service was developing a leaflet explaining the benefits of skin to skin contact between mother and baby following delivery. Both complaints were responded to in a timely manner and we were told that complaints were never left outstanding.
- Since September 2014, four complaints had been referred to the PHSO (Parliamentary Health Services Ombudsman). This meant that these complainants had felt that their complaints had not been dealt with appropriately by the hospital.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

- We found that local leadership at the hospital had overlooked the basic issues of poor cleanliness and out of date equipment checks and the potential clinical, infection control and patient safety risks they posed.
- Trust wide risks existed relating to community midwives being unable to gain IT access to maternity guidelines which were still not merged as uniform across the trust;
- Some BME members of staff that we spoke with felt opportunities for staff development, promotion, training and support wasn't always afforded to them in the same way that it was given to their Caucasian counterparts.

However:

- Staff understood the vision and strategy for the service.
- The head of midwifery, deputies and managers all appeared to be a cohesive team that worked well together.
- Staff felt valued in their work and contributions and felt that Lewisham Hospital was a good place to work.

Leadership of service

- All staff that we spoke with were positive about the managers and head of midwifery in particular. Staff reported that the senior team were accessible, had an open door policy and were very supportive.
- We were told by a member of staff on the postnatal ward that the deputy head of midwifery would come up to the ward at least three times a day and we observed his attendance at a morning huddle.
- Despite this our observation was that the leadership of the service had overlooked and failed to rectify the risks posed by poor cleanliness and out of date equipment checks.
- The Alexis clinic was consultant-led and was part of the sexual health and HIV directorate. This unit was part of a broad sexual health and HIV service that included the Trafalgar Clinic at the Queen Elizabeth Hospital in Woolwich and several community clinics.

Vision and strategy for this service

- There were banners around the service, created by staff highlighting key values such as communication, teamwork, language, celebrating success, and sharing learning.
- The midwifery strategy prescribed to 10 objectives, which included visible midwifery leadership; health promotion; education, training and development and having the right staff in the right place at the right time. The service's commitment to the objective 'work in partnership with our women' was to encourage engagement with local women and their families to

ensure that the service was woman-focussed. To build on that work, the service had started to ensure that women and their families' voices were heard when service developments were planned.
- The senior team, including the head of midwifery, deputies and managers all demonstrated a similar vision for the service. They appeared to be a cohesive team that worked well together.
- The labour ward matron was able to tell us what the eight trust corporate objectives were. She demonstrated understanding around patient safety, and explained that patients were to have an improved experience but that also staff were to have an improved experience too. The matron was aware of the trust's objective to meet its financial target and gave two examples of ways in which she had helped the trust to save money and reduce its deficit.
- Sexual health, HIV and genitourinary medicine services staff had established their own set of values, which were prominently displayed in a public area. This demonstrated the service standards patients could expect and the values staff worked to.

Governance, risk management and quality measurement

- Trust wide risks relating to community midwives being unable to gain IT access and retrieve historic clinical information for patients, as well as maternity guidelines still not being merged across the trust had been added to the divisional risk register. Risks were graded according to likelihood and severity. Both the maternity and WaSH (Women's and Sexual Health) divisions had up-to-date risk registers that included mitigation and action plans. Issues on the risk registers were aligned to the concerns that staff identified to us on inspection.
- There were several groups which aimed to improve governance and risk management across the service. The WaSH governance board discussed topics such as: policies, clinical and national audits, serious incidents, and NICE compliance, all of which were standing items on the agenda. The MSLC (Maternity Service Liaison Committees) focussed on topics such as perinatal mental health, breastfeeding and safer sleeping to prevent sudden infant death syndrome. The risk committee met every third Tuesday of the month and was attended by the clinical director, head of midwifery, consultant obstetrician & gynaecologist, ward matrons, clinical governance manager and a pharmacy lead. Within these meetings, topics such as the maternity statistics, complaints, medicines safety, safeguarding and training were discussed.
- There were also regular senior staff meetings as well as ward meetings where risk and governance issues were discussed with a wider staff group. The frequency of these meetings varied across the division, with the labour and postnatal wards meeting monthly, and the senior staff team meetings occurring every one to two months. Senior staff were able to tell us how their ward's performance was monitored and how performance boards were used to display current information about the staffing levels and risk factors for each ward.
- HIV specialist services staff met quarterly across all trust sites to discuss anti-viral strategies and work. This formed part of a multi-site clinical governance strategy to incorporate all of the service's key functions as well as community sexual health services. In addition, a monthly divisional meeting included reviews of new practice guidance.

Culture within the service

- Staff unanimously reported a positive culture at Lewisham Hospital. The care and culture within Lewisham was reported to have improved since the merger with QEH.
- All staff that we spoke with stated that they felt valued and that Lewisham was a good place to work. The community matron shared with us that it was a "lovely unit to work in" and that the hospital had a "family feel" to it.
- Each clinical area had involved their staff to agree to sign up to a charter of how to move the service forward.

Equalities and Diversity – including Workforce Race Equality Standard

- We spoke to two BME members of staff who felt that opportunities for staff development, promotion, training and support wasn't always afforded in the same way that it was given to their Caucasian counterparts.

Public engagement

- Pregnancy evenings were taking place every third Wednesday of the month. Expectant mothers and partners could attend and learn about birthing preferences, bra fitting as it relates to breastfeeding, the socialisation of dogs with new babies, smoking

cessation, and the benefits of using real nappies to reduce their carbon footprint. A representative from a dogs' welfare charity would attend these pregnancy evenings, as well as health visitors, breastfeeding advisors and a smoking cessation midwife.
- The community midwife matron told us that the pregnancy evenings were attended by up to 200 women and their partners' and the evening was also a forum for women to give feedback, with positive feedback being given about community midwives and the birthing centre.
- Senior maternity managers were holding a 'maternity open forum' every first and last Tuesday morning of the month in the Head of Midwifery's office. This forum allowed women, their partners and healthcare professionals to feedback with their experience, compliments and concerns of and about the maternity service.
- A Maternity Services Liaison Committee, which is a group of parents, volunteers and health professionals, would meet every three months to make sure that the services that were being provided to pregnant and new parents are what they want and need.

Staff engagement

- All staff were aware of Take 5 briefings, safety huddles and service meetings. Staff that we spoke to on the postnatal expressed feeling valued and reported that at the daily huddles, there was an opportunity to hear positive issues about the service and individuals.
- Staff wellbeing sessions were being run for staff in the service at the request of the head of midwifery and the midwifery team. Volunteers would come into the unit from the community to provide head, neck & back massages for staff and these would be run as drop in sessions for staff.
- Service users as well as staff were actively encouraged to nominate a 'star of the month' for an award. Those staff who received two or more nominations would receive a 'gold star' and a voucher for their work. Staff that we spoke with said that this was a good initiative and a positive way of acknowledging their hard work.
- We saw posters on a wall advertising a 'staff open forum' which started in December 2016. However, the reported turnout to this forum was low.

Innovation, improvement and sustainability

- A specialist midwife told us that the head of midwifery would approach relevant staff with information of funds available from public charities that would benefit in the work that they did. The head of midwifery was reported to also help them gain the funding.
- The trust received charitable funding for new fathers, which provided specific antenatal preparation for fathers-to-be and new dads.
- A senior sister on the postnatal ward told us that the ward had implemented a number of positive changes such as improving the patient experience by refurbishing the single rooms, having huddles every day in the morning to openly discuss complaints, incidents as well as positive aspects. Quality ward rounds took place and any issues identified from women would then then be fed back to the midwives.
- We were told by the matron on the postnatal ward that the practice of holding a team 'huddle' to discuss daily issues had first started in maternity services in 2014 and had since been replicated across the hospital.
- A bid had been put in with a charitable fund and the service was nearing the completion stages of creating a cross site DVD version of the post-natal information pack. We were told that this DVD was being created primarily for women who did not speak English, which they would be able to watch at their bedside or online.
- Staff in the Alexis clinic were encouraged to participate in research as part of their professional development. Two band seven nurses and a band six nurse were formally involved in this and in the previous 12 months the unit had participated in the first commercial clinical trial to take place on site. In the two years to our inspection, sexual health and HIV services recruited up to 50% of the participants for the trust's whole clinical trial and research portfolio. This resulted from a policy of proactive and early-adoption participation. At the time of our inspection three research trials were live. This included clinical research with HIV positive women who were experiencing the menopause, a national study on the efficacy of certain antiretroviral medicine and a qualitative study on the experiences of people living with HIV.
- In response to patient demand and research with another NHS hospital, the Alexis Clinic team was planning to introduce a postnatal contraception service. This was based on research that suggested when women returned for a postnatal check at six weeks, there was a 50% increase in contraception uptake. The

team involved with this were due to present the work at a national conference prior to final implementation. This represented a broad and consistent approach to service improvement, development and innovation.

Services for children and young people

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Lewisham and Greenwich NHS Trust provide services for children and young people at two acute hospitals. University Hospital Lewisham, within this report and Queen Elizabeth Hospital, Greenwich, which has a separate report.

Some of the data that we have is data that includes both hospitals and, where this is the case we have referred to it as trust data.

Lewisham and Greenwich NHS Trust provide services for a population of over 150000 children and young people aged 0-17 living in Lewisham, Greenwich and North Bexley. The catchment population comes from two of the most deprived boroughs in England, many of whom are vulnerable with significant health needs.

The services for children and young people include diagnostic, treatment and care facilities for children and young people from birth to 16 years of age. The needs of young people aged 16 to 18 years of age are considered on an individual basis with most being admitted to adult facilities within the hospital. Where a young person has particular needs, such as a learning disability or a life limiting condition may be admitted to the children's unit if more appropriate.

Between April 2015 and March 2016, there were 17,841 admissions to the children and young people services at the trust.

Children's and young people's services at Lewisham University Hospital consist of an inpatient ward, a level two neonatal intensive care unit. The hospital is a specialist centre for children with cystic fibrosis on a shared pathway with another acute hospital.

There is a dedicated children's outpatient centre providing outpatient support for children and young people and a dedicated day case surgical unit.

The children's emergency department at Lewisham is managed as part of the children's services division however this was inspected and reported on as part of the emergency and urgent care core service.

The service was last inspected in 2014. We rated 'effective', 'caring', 'responsive', and 'well led' on our previous inspection as good, however we rated 'safe' as requires improvement. This gave the service an overall rating of Good. On our previous inspection we rated safe as requires improvement because not all staff grades could report incidents, there was a lack of joint working across the two hospital sites, there were staff shortages impacting on the quality of care and there was a shortage of some equipment.

During our inspection, we visited all clinical areas including theatres, ward areas, the neonatal unit, and the outpatient centre. We also visited the children's emergency department to understand how patients could access services. We spoke with three parents, two young people, and 20 members of staff, which consisted of a clinical director, doctors, nursing staff, a non-clinical support worker, and administrators.

Services for children and young people

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits provided by the trust and observed handovers between the paediatric nursing and medical staff. We inspected nine sets of medical records, eight prescription charts and the environment and equipment.

Summary of findings

At our previous inspection in 2014, we rated the services for children and young people overall as good. On this inspection, we have maintained the overall rating as good, as the overall standard and quality of care has been maintained.

We rated this service as good because:

- There was strong evidence of good learning from incidents including sharing of methods cross-site to reduce errors across both sites.
- All areas we saw were clean and regular audits supported this process. Good hand hygiene was maintained rigorously including the introduction of specialist hand gel door dispensers in the neonatal unit to prevent infection.
- There were clear business continuity plans for each department and scenario testing was carried out, which meant when staff had needed to react to extend capacity significantly due to an incident at the other site this had been achieved successfully.
- A comprehensive audit schedule supported the use of national guidance within policies and guidelines. Peer reviews were used to identify improvements to services.
- The hospital participated in national audits and reviews for assessing patient outcomes.
- Babies receiving mother's milk exclusively, or as part of their feeding at the time of their discharge from NNU was significantly above the national average.
- A rotational program for new nurses through each department meant that they developed a wide range of knowledge and skills.
- Patients and parents were positive about the compassionate care that they received and we observed kind and respectful care during the inspection.
- Parents and patients were informed about the plan for their care in a compassionate and appropriate manner.
- There were facilities provided for parents to stay with their children while they were receiving care. Improvements had been made to these facilities following feedback.

Services for children and young people

- Changes had been made to patient pathways, such as the introduction of ward reviews, and referrals to the hospital at home team which had decreased length of stay.
- Additional training had been arranged for staff following recognition that there had been an increase in the admission rates of children with mental health concerns due to the unavailability of beds elsewhere.
- There were a low number of formal complaints made about the service and response rates to complaints received were within the agreed timescales.
- Since the last inspection there had been clear progress in developing cross-site governance structures, risk management and learning.
- Staff spoke positively about the leadership team and felt involved in improving services.
- Patient feedback was encouraged within all departments with innovative ways of involving children and young people.

However:

- The neonatal unit did not have sufficient levels of Qualified in Speciality (QIS) nurses to meet national guidance levels.
- The consultant cover provided was just below the level recommended by national guidance.
- Medications were not locked within cupboards, which was not in line with best practice, however the room medications were stored in had restricted access.
- Some medications were not stored in their original packaging, which meant that there was a risk of staff unknowingly administering out of date medications.
- Action had not been taken appropriately by staff when fridge temperatures had been recorded as being outside of the required ranges.
- There was no play specialist available for the outpatient department or at weekends and holiday cover in the inpatient ward.
- No outpatient clinics were run at evenings or weekend which reduced the accessibility of services for patients.
- Parents and patient were not involved in the weekly 'grand round' held on the inpatient ward.
- The Do Not Attend (DNA) rates for both the outpatient department and surgery were higher than the trust targets.
- Compliance to issuing electronic discharge summaries within 24 hours of discharge were substantially below the trust target.
- There were low levels of attendance at governance and safety boards which reduced opportunities for sharing of information to the appropriate people.

Services for children and young people

Are services for children and young people safe?

Good

We rated safe as good because:

- There was strong evidence of good learning from incidents including sharing of methods cross-site to reduce errors across both sites.
- All areas we saw were clean and regular audits supported this process. Good hand hygiene was maintained rigorously including the introduction of specialist hand gel door dispensers in the neonatal unit to prevent infection.
- Appropriate levels of safeguarding supervision occurred to ensure that staff maintained their knowledge of how to keep children safe.
- Pre-assessment clinics ensured that risks could be identified prior to the day of surgery and appropriate advice provided to parents and patients.
- Vacancies were low for the children's inpatient ward and as a result, there was a lower use of bank and agency staff as well as actual staff levels exceeding planned requirements.
- There were clear business continuity plans for each department and scenario testing was carried out, which meant when staff had needed to react to extend capacity significantly due to an incident at the other site this had been achieved successfully.

However:

- The neonatal unit did not have sufficient levels of Qualified in Speciality (QIS) nurses to meet national guidance levels.
- Nursery nurses provided care for babies in the special care unit with minimal supervision from a registered nurse which is not compliant with national guidelines.
- The consultant cover provided was just below the level recommended by national guidance.
- There had been difficulties accessing advanced life support training for nurses and so there were not enough staff trained to ensure that one staff member per shift had the required training. However there was planned training to rectify this within six months.
- Not all staff on the neonatal unit were confident in the actions that they would take in the event of child abduction.
- Medications were not locked within cupboards, which was not in line with best practice, however the room medications were stored in had restricted access.
- Some medications were not stored in their original packaging, which meant that there was a risk of staff unknowingly administering out of date medications.
- Action had not been taken appropriately by staff when fridge temperatures had been recorded as being outside of the required ranges.

Incidents

- There were no never events reported from December 2015 to November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in children's services which met the reporting criteria set by NHS England between December 2015 and November 2016. (Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response).
- Lewisham hospital children's services reported 123 incidents in the year December 2015 to November 2016. Of these, one was graded as moderate harm, 31 as low harm, 90 as no harm and one as a near miss. There were no incidents causing death or serious harm.
- Consent, communication, confidentiality accounted for the majority of incidents reported 19% compared to a trust average of 4%
- Medication incidents were responsible for 16% of incidents reported. This was over twice as high as the trust average of 7%. In data of incidents reviewed between August 2016 and January 2017 the rate of medication incidents reported remained high at 20%. The majority of these (11 out of 17) had caused no harm to the patients and the remainder were graded as low harm.

- As a result of the higher level of medication incidents a medications errors group had met in May 2016 and an action log had been set up to reduce medicine errors. One action had been the production of large posters displaying age appropriate doses of common medications such as paracetamol and ibuprofen. This had seen the number of incorrect dose incidents fall. These posters had also been provided for the Queen Elizabeth Hospital site which demonstrated that learning from incidents was shared cross-site. In addition the introduction of only a single person signing for medications within the last two months had reduced the number of incidents. Pre-labelled ward based dispensing had been introduced which had aided safety and also the speed of discharge. A decision tree matrix had also been introduced and was now used across the trust. There was a consistency in management of medication incidents across all grades of staff which encouraged learning and sharing of knowledge and this had led to a more open culture. We saw information boards within the staffroom of the inpatient ward that highlighted learning from medication errors for staff to view. Staff told us of a teaching session that had been run following an error identified by the pharmacy team.
- Documentation (including electronic & paper records, identification and drug charts) incidents (11%) were much higher than the trust average of 4%. In data of incidents reviewed between August 2016 and January 2017 five incidents were reported in this category. There were no themes relating these incidents and the levels of harm reported were three for no harm and two for low harm.
- Infrastructure (including staffing, facilities, and environment) amounted to 14% of incidents reported compared to a trust average of 7%. In data of incidents reviewed between August 2016 and January 2017 all 12 of this category of incidents were related to staffing levels, primarily within the neonatal unit and where planned agency staff did not attend. The incidents reported no injury or harm caused to patients as bed and cot numbers had been reviewed and reduced to ensure safe staffing.
- At the last inspection, not all grades of staff had access to the electronic reporting system, which meant they were unable to report incidents independently. However the incident reporting system had been changed and was accessed with an open system on the computers so that all staff, including those on bank and agency were able to report incidents. We spoke with a range of medical and allied health professionals and nursing staff and they were able to describe the incident reporting system. Staff members were able to explain their roles and responsibilities related to incident reporting. Staff explained recent incidents and provided examples of how lessons learnt were shared.
- The divisional lead nurse and matron monitored the electronic reporting system closely. They discussed incidents with staff members and shared information during shifts and at ward meetings. Nurses on the inpatient ward reported that they had monthly team meetings which were led by the ward manager. We were told by staff who attended these meetings significant events, errors and near misses were discussed. Learning outcomes were also shared and good practice was discussed. All nurses were expected to attend if they are not on duty and meeting minutes were emailed to all staff.
- A weekly email was sent to all the doctors from the clinical lead that contained learning from incidents that had taken place.
- Staff we spoke with described recent examples of incidents, actions taken and how they had received feedback. We saw in the minutes from the clinical governance meetings that incidents were discussed as a standard agenda item.
- Perinatal morbidity and mortality meetings were held in this service on a weekly basis. The meetings were well attended by staff. In addition a trust mortality and morbidity meeting was held monthly that discussed case reviews of all transfers. This included outcomes of cases where children had died at other hospitals, following transfer. We saw presentations from three meetings and saw that these included information on outcomes and also clear learning points following the case review.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. We saw records of five incidents occurring within the trust children's services where duty of candour actions had been undertaken and patients and their families had been told when they were affected by an event where something unexpected or unintentional had happened.

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections between December 2015 and November 2016.

Cleanliness, infection control and hygiene

- All areas of the wards and departments we visited appeared to be visibly clean and we saw cleaning being undertaken during our inspection. Dedicated support staff were allocated to the neonatal unit that were specialised in cleaning incubators.
- Between February 2016 and February 2017, there had been no Methicillin Resistant Staphylococcus aureus (MRSA) blood stream infections, within children and young people's services at the trust. MRSA is a type of bacterial infection, is resistant to many antibiotics, and has the capability of causing harm to patients.
- Between February 2016 and February 2017, there were no cases of Clostridium difficile (C.diff) within children and young person's services at the trust. C.diff is a type of bacteria, which can infect the bowel and cause diarrhoea.
- Babies on the neonatal unit (NNU) were screened on admission for MRSA and then on a weekly basis if they remained in hospital. However, between August 2016 and January 2017 out of 54 admissions, 10 did not have specimens recorded which risked an infection not being identified.
- There were sufficient handwashing sinks and alcohol hand sanitising gel within the wards and departments we visited. The Neonatal Unit had a large sink for handwashing at the entrance to the unit.
- Uniquely designed door handles had been installed on the doors to the neonatal unit that automatically delivered the required dose of sanitising hand rub, when somebody pulled open the door. These handles have been shown to significantly increase hand hygiene in patients, staff and visitors. In addition these hand gel delivery systems have been found to be significantly cleaner than a standard door handle.
- We observed that staff cleaned their hands in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene', and posters on hand washing technique were displayed above sinks. We observed all staff in the wards and departments we visited were 'bare below the elbow'.
- Hand hygiene audits were completed on a monthly basis as one of the 'Saving Lives' audit measures. Results between February 2016 and February 2017 were all above the trust target of 95%. We saw audit scores displayed prominently on the entrance wards and departments. For example, we saw on the entrance to the inpatient ward that their most recent hand hygiene compliance was 100%.
- Infection control training was mandatory for all staff groups, and was undertaken yearly. Data provided showed that 78% of paediatric medical staff, 91% of paediatric nursing staff, 88% of allied health professionals and 82% of additional clinical services had completed their mandatory infection control training. Not all staff groups had met the trust target of 85%.
- If children or young people were found to have an infectious condition or had a poor immune system, single side rooms were used to reduce the risk of cross infection. We saw signs available to be placed on the doors informing staff and visitors to see the nurse in charge before entering the room.
- Staff used personal protective equipment (PPE), such as gloves and aprons when caring for patients. We observed a doctors ward round in the neonatal unit. The doctors involved used PPE appropriately by changing gloves and aprons as well as washing hands in between seeing patients.
- Equipment was identified as being clean by using 'I am clean' labels, which included the date of cleaning. All equipment we checked was found all to be clean and labelled up to date.
- Spare equipment within the NNU was stored within a dedicated room. There was a clear flow procedure from the adjoining cleaning room so that dirty equipment would not be placed amongst clean.
- Regular cleaning of toys took place. We saw the play specialists cleaning toys that had been used. The play specialists confirmed they regularly checked the toys, to ensure they were intact and safe to use.
- All waste bins we saw were foot-operated and clean, waste was separated in different colour bags to signify

different categories of waste. This was in accordance with the HTM 07-01, control of substances hazardous to health (COSHH) and health can safety at work regulations.

- Monthly audits were conducted to assess the standards of cleanliness for each area. Different standards were applied which depended on the risk of infection to patients. In audits that we viewed for September, October and November 2016 the cleaning company provider met their all their targets for the NICU, children's medical ward, children's day care and Children's Outpatients Departments.
- There were multiple information leaflets provided for parents, patients and visitors throughout the departments we visited advising on the importance of good hand hygiene and hand washing technique. The NNU also provided a visiting and handling guide for parents which explained why handling the baby was restricted to specific people. Clear information, including some designed specifically to be understandable to children was also available on the website.
- Hand hygiene had been identified by parents on the day-case unit as an area for improvement and so the unit had introduced a system called 'WIPE'. This stood for 'Wash, Introduce, Permission and Privacy and Examine and Evaluate.' This was displayed on posters prominently throughout the unit. This had reduced the number of negative feedbacks that they received for these areas.
- In the CQC children's survey 2014, the trust scored 8.24 out of ten for cleanliness for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Environment and equipment

- The inpatient ward, day-case unit and neonatal unit we visited had controlled access on both external doors and to treatment or utility areas. There were signs in place to warn parents and staff when entering the secure area of tailgating, and to make sure they did not let people onto the ward. The CQC team were asked to provide identification on arrival at the ward. We saw one incident where staff from a neighbouring office let visitors in without confirming their identity. The visitors were seen by nursing staff at the desk before they went further onto the ward. During the rest of our inspection we did not see anyone allowing people onto the wards without permission from the nursing staff. This ensured the safety of children and young people and their visitors.
- The children's inpatient ward had a regular capacity of 16 beds, which could be increased during escalation to 26 and included three large bays and five side rooms, two of which had en-suite facilities. Incorporated within this was a four bed High Dependency Unit (HDU) for patients requiring additional monitoring and care. Patient bedrooms and bays were well equipped with either beds or cots, seating and bedside lockers for personal belongings. It was reported that the lack of individual cubicles sometimes meant that patients had to be transferred to other hospitals as there was not suitable accommodation for them.
- There was a separate playroom on the inpatient ward with a range of toys and activities available. Although this would not always be left open during evenings and weekends when there was no play specialist in attendance, a range of toys would be left out within the ward. There was a sensory room with specialist equipment available for children with special needs. The minor procedure room also had a mobile, sensory projector that could be used for distraction for children if they required blood tests or other assessments.
- Staff we spoke with in all areas felt there was always enough equipment when required. However some staff within the paediatric theatre and recovery areas told us that they felt some equipment needed updating although no further details were given and they did not tell us if they had raised their concerns with senior managers.
- There was no outdoor play area for inpatients. Senior staff told us that this was an area that they were hoping to identify a suitable location and build one in the next year as they recognised it could have benefits for the children cared for.
- The children's outpatient department had 11 consulting rooms, some with specialised equipment, such as for ophthalmology (treatment of eye disorders); three rooms where weight and height of children could be measured and two accessible toilets that also contained baby changing facilities. One of the consulting rooms had a two way observation window which could be used with consent if students needed to observe consultations without crowding the patient.

- The children's day care unit had capacity for 15 children accommodated within three bays of four beds each, and three separate cubicles, one shared the bathroom facilities that they told us they would generally keep allocated for teenagers attending the unit.
- There was a separate theatre for paediatric surgical cases. This was used for adult patients as well but they were recovered separately. There was a four bed separate recovery area specifically for paediatrics facility.
- The trust's electronics and medical engineering (EME) department serviced equipment. Maintenance was generally undertaken using two methods: planned preventative maintenance (PPM) or reactive maintenance. PPM was undertaken on a regular programme (weekly, monthly, quarterly, yearly) to meet statutory requirements, legislation, manufacturer's guidance, and industry good practice. Reactive maintenance was undertaken on an as required basis to address damage, breakdowns, or failure. Staff on the neonatal unit reported a good relationship with EME.
- There had been a severe problem with ventilators within the neonatal unit, however three new ones had been purchased a year ago which had improved the reliability of these.
- During our inspection, we randomly selected five pieces of equipment to check in the inpatients and neonatal ward. All were safety checked and in service date.
- The NNU had four intensive care, four high dependency and 12 special care cots, split into two bays of six.
- In the CQC children's survey 2014, the trust scored 8.59 out of ten for the question 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Medicines

- The lead paediatric pharmacist covered both sites and was based at Queen Elizabeth Hospital. A member of the pharmacy team could attend the inpatient ward twice a day.
- The trust set a target of 85% for completion of medicines management training for nursing staff. The current compliance levels for these in January 2017 were 82%, just below the target.
- Medications on the inpatient ward were stored in the treatment room. This was accessed with a staff swipe card and meant that access to the room was tracked for security of medications.
- However all medicines cabinets were unlocked and could be pulled open. In total there were 14 medicines cupboard doors unlocked.
- Some medicines, such as ibuprofen and prednisolone (an oral steroid) soluble tablets were left in blister packs out in the cupboard shelves and not in original packages. These did not have expiry dates on the blister strips and therefore we could not be sure, when the medicines expired. This meant staff would also not know the expiry dates. We saw that there was Azithromycin (an antibiotic) and three sterilised water bottles left out on the work bench which was inappropriate medicine management. We asked staff why these had been left out but they were unsure.
- The fridge for medicine storage was kept in the same room. There was no room temperature monitoring or log and the room felt very warm. The lack of room temperature monitoring meant that staff may not be aware if it exceeded 25 degrees which can affect the stability of some medicines.
- We saw medicine and milk fridges in the inpatient ward and NNU. All temperature logs viewed showed a large number of days over the last few months when the fridge readings were outside of the required ranges. If temperatures fluctuate throughout the day it could mean that the stability of the medicines or milk stored in the fridge cannot be guaranteed. We reported these incidents to the matron and one fridge was removed from service and the manufacturer contacted. Later in the inspection we were told the error was likely to be due to incorrect guidance for re-setting of the temperatures correctly each day and this was confirmed by the manufacturer after they had been checked. However, before our intervention, no action had been documented by staff after the recording of these temperatures out of range and this could mean that a future malfunctioning fridge would not be identified quickly.
- Within the NNU the medicine fridge was locked and secured appropriately however the fridge for fluids was not locked.
- We checked the controlled drug (CD) cabinet and found that it was locked and secured appropriately. There was a CD register and we saw daily checks were carried out.

We saw that the pharmacy teams were doing quarterly audits and this was logged in the CD registers. However, we saw that other items were being stored in the CD cabinet inappropriately, including glasses, nurses' time sheets and spare keys.

- We reviewed four sets of prescription charts within the inpatient ward. Allergy boxes had been completed and the identity of the nurse administering the doses was clear on each record.
- We reviewed four sets of prescription charts within the neonatal unit. All prescriptions and dosage records were legible and had been signed for. Allergy boxes had been completed and the identity of the nurse administering the does was clear on each one.
- Medicines management audits were completed monthly for the quality scorecard. These included allergy status documentation, missed does and no harm incident reporting, controlled drugs compliance, daily fridge monitoring and safe and secure storage. In most areas results had improved over the last 12 months and most recently in February 2017 all but one above the trust target levels with many at 100% compliance. The area showing the lowest compliance rates were for fridge monitoring requirements and documentation, which reflected our findings regarding fridge temperatures.

Records

- Staff managed patients' records in accordance with the Data Protection Act 1998. Records within children's services were a predominantly paper based and kept confidentially on the wards in lockable trolleys next to the nurses' station. We did not see any unattended notes during our inspection.
- Records for children attending outpatient appointments were prepared before appointments by the medical records department. Staff reported a low number of times when a record was unavailable and a temporary record had to be compiled.
- Patients were identified on white boards by the nurse's station on the inpatient ward, showing first name only. This meant patient confidentiality was maintained. The board was colour co-ordinated according to the acuity score of the patient. Within the day-case unit children were identified by first name and surname which could mean a breach in patient confidentiality as the board was visible to all those within the ward. We asked the senior nurse about this and were told that this had been done as there were often children attending with the same first name and therefore, following a risk assessment the decision had been made to put the full name of the child on.
- There were specific templates available for care plans for different conditions. For example we saw a care plan for patients admitted following self-harm.
- We reviewed four sets of medical records on the neonatal unit. All of these had the relevant information recorded such as patient details communication and management plan. Records were legible and were dated and signed by those completing them.
- Data indicated that only 63% of paediatric medical staff, 80% of paediatric nursing staff, 82%of allied health professionals, 73% of administrative and clerical staff and 75% of additional clinical services had completed their information governance training. No staff groups had met the trust target of 85% which meant that the trust could not be confident all staff members were aware of their roles and responsibilities to keep patient information safe.
- Senior staff told us that children's services wards completed a documentation audit monthly, however we did not see results of these audits and they did not feature on the division quality scorecard. In addition we were told about local audits that had taken place on the inpatients ward, for example name band audit and care record audit. We were told that results of these would be followed up with individuals. However the results were not kept or shared more widely.
- Work had taken place over the last year to change the records systems and documentation so that it was consistent across the two sites. This had been completed, with one exception, the fluid charts. When a fire at the Queen Elizabeth site meant that patients were transferred to the Lewisham site to be cared for, the consistency in paperwork had been helpful as it meant that it was easier for both sets of staff working together.
- An administration clerk supported the inpatient ward between 8.30am and 4.30pm Monday to Friday and 10am to 3pm on weekends.

Safeguarding

- The trust had a safeguarding children policy and we saw dedicated noticeboards in all departments we visited with information about safeguarding children which

could be viewed by both staff and members of the public. These boards contained contact details for the teams, where to find them and about the service, they provided.

- Staff we spoke with knew who the nursing safeguarding leads for the trust were, and could explain the actions they would take if they had any concerns.
- The safeguarding team would come directly to the ward if they were contacted to provide support and if urgent there was a contact available from the safeguarding team 24 hours a day, seven days per week. A member of the safeguarding team was also present at the medical handover we observed.
- There was a dedicated safeguarding link nurse for the inpatient children's ward. The play specialist on the children's ward also had a special interest in safeguarding. Link nurses are members of the department, with an expressed interest in a specialty; they act as a link between their own clinical area and the safeguarding team. Their role is to increase awareness of safeguarding issues in their department and to motivate staff to improve practice.
- The number of referrals made to children's social care by the trust was between 45 and 144 per month between February 2016 and February 2017. In addition the trust had been involved in ten serious case reviews in that time.
- An electronic flagging system was used within children's outpatients department to identify children with safeguarding concerns. This was checked against the national Child Protection Information System (CPIS) to ensure that children subject to a child protection plan were highlighted when accessing outpatient services.
- The trust audited it's attendance at case conference for children with a child protection plan. Data provided to us showed that the trust target was met in the majority of months between February 2016 and February 2017 for both initial and review case conferences. For all months where it was not met, attendance was over 90%.
- The trust set a target of 85% for completion of safeguarding training for all groups of staff.
- Most medical & dental staff were required to complete safeguarding adult's level two and Safeguarding Children and Young Adults Level 3 specialist. The current compliance levels for these in January 2017 were 76% and 75% respectively which was below the trust target. Compliance was at 100% for the two medical and dental staff required to complete safeguarding children and young people level 4 and three staff requiring level 3 core.
- All nursing and allied health professional (AHP) staff were required to complete safeguarding adult's level two and Safeguarding Children and Young Adults Level 3 specialist. The current compliance levels for nurses in January 2017 were 89% and 86% respectively which was above the trust target. Four nursing staff had also completed safeguarding children and young people level 4. AHP staff were above the trust target for safeguarding adults with a level of 86% but slightly below for safeguarding children with compliance at 80%.
- All other staff groups including administrative staff completed a range of safeguarding training for both adults and children depending on their requirement for their job. All but two of the modules for these groups had compliance over the trust target of 85%. The two that fell below were both for additional clinical service staff where Safeguarding children and young people level 3 was below at 79% and safeguarding adult's level 2 was at 82%.
- Staff we spoke with had a good understanding of female genital mutilation (FGM). All staff we spoke with knew how to raise FGM as a safeguarding concern.
- The safeguarding lead nurse conducted safeguarding supervision of senior nursing staff. Staff were able to access reflective learning forums held by the safeguarding children team and records provided to us showed that five sessions had taken place at the hospital between May 2016 and February 2017. Subjects included reflective practice on recent cases and topics such as child sexual exploitation.
- In the CQC children's survey 2014, the trust scored 9.51 out of ten for the question 'Did you feel safe on the hospital ward?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Mandatory training

- Mandatory training for all staff groups was comprehensive. The training was a mixture of face-to-face and on line learning system. Mandatory

training modules included equality and diversity, information governance, fire training, infection control and manual handling. Other training was role specific for example, new-born or paediatric life support.
- Staff were alerted individually when their training was due for renewal by an automatic email sent to them to remind them to book a session.
- The trust set a target of 85% for completion of mandatory training. Children's Services audited overall compliance with mandatory training as part of its quality scorecard. The most recent numbers recorded were 83% compliance.
- Medical and dental staff had 10 modules of mandatory training to complete, in addition to safeguarding training referred to previously, mental capacity act and emergency planning training. Data provided by the trust showed as of January 2017, the trust target was only reached in one module - the basic life support training which achieved an 88% completion rate. Nine modules did not meet the trust target; with the lowest scoring module being Fire Safety Clinical with 58%.
- Nursing and midwifery staff had 16 modules of mandatory training to complete, in addition to safeguarding training referred to previously, mental capacity act and emergency planning training. Eight modules exceeded the trust completion target with two achieving 100%. Eight out of 16 modules did not meet the completion target; the lowest scoring module was Paediatric Hospital Life Support with 63%.
- Paediatric life support training was mandatory for all staff groups, and was undertaken yearly. Data indicated that 88% of medical staff had completed paediatric basic life support, above the trust target of 85%. However only 78% had completed advanced paediatric life support which was below the trust target. All required modules for nursing staff were below the trust target of 85%. Paediatric basic life support was at 83%, new-born life support at 73% and paediatric hospital life support at 63%. This meant the trust could not be confident enough staff members within the children and young people service had the necessary up-to-date training to keep patients safe.
- The three children's nurses working in paediatric recovery had completed paediatric life support training.
- We were told that there had been issues in accessing training for advanced paediatric life support so only two nurses were in date for this training. This meant that they currently could not ensure that at least one member of the team was qualified for each duty. However the remaining nurses had been planned for this training to be held within the next six months.

Assessing and responding to patient risk

- The Paediatric Early Warning Score (PEWS) system was used on both observation charts and as part of the ward round. Details of the escalation required, depending on the scores, were in place on each PEWS chart. Four different PEWS charts were used for different children of different age ranges. Each chart recorded the necessary observations such as pulse, temperature, and respirations. We saw five records that included PEWS on the inpatient ward, and all were completed fully. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. We saw the Paediatric Early Warning Score (PEWS) system also recorded pain scores.
- Neonatal unit nurses used New-born Early Warning Trigger Scores (NEWTS) on the unit to assist in identifying deterioration of patients. This was entered into an electronic system.
- As we found at our previous inspection, there remained a process in place for referring children who were deteriorating via the South Thames Retrieval Service (STRS), which specialises in the inter-hospital transfer of critically ill children in South London. The paediatric resuscitation team from the emergency department would be contacted and would include an anaesthetic response. The team would generally care for children requiring intensive care management within the high dependency bay on the inpatient ward or within the operating theatres prior to retrieval. The neonatal unit was able to provide care for babies requiring an enhanced level of neonatal intensive care prior to transfer.
- Pre-assessment clinics for day-case patients were conducted six to seven weeks before the procedure. These were usually face to face unless the patient lived a substantial distance away when they would be conducted on the telephone. In addition clinical observations were conducted on the day of the procedure.

- The World Health Organisation (WHO) checklist is a process that involves a number of safety checks before, during and after a procedure. We observed a surgical procedure and all of the elements of these checks were completed during this.
- When patients from the ward required diagnostic tests such as an x-ray their escort would depend on their acuity. For instance, if the child was stable then parents or a nursing student would accompany them, otherwise, for a more unwell child a nurse would attend to monitor them.
- Patients admitted to the ward following a self-harm incident had a specific care plan that included a reminder to staff to remove items within their bed area that might pose a risk to them.
- Resuscitation trolleys in all areas we visited had completed daily and monthly checklists. Checklists we saw were completed, dated, and signed. All equipment against the checklists was in date and available on the trollies. We saw child-sized equipment was available on the trolleys.
- There was a trust abduction policy which we saw that had been reviewed in September 2016. Staff completed training on potential abduction from the ward as part of the induction program on their arrival within the hospital and staff on the inpatient ward were able to confidently describe the actions that they would follow in the event of a potential abduction. However, staff we spoke with in the neonatal unit had not read all the policy and stated that they had not carried out abduction drills. This meant there was a risk that staff may be unfamiliar with the actions to take in the event of an attempted abduction.

Nursing staffing

- Paediatric nursing staffing was based on a 1:4 ratio on the inpatient ward with an allocated nurse-in-charge, reflecting the Royal College of Nurses safe staffing levels for children's nursing which had adjusted aims dependent on the age of the children admitted and smaller ratios were used if children's acuity required one to one care. There were additional staff planned with supernumerary status on every shift as additional cover. A safer staffing review led by the chief nurse was carried out twice a year to review the skill mix in each area.
- The nursing staffing establishment for the children's services was 102.99 whole time equivalent (WTE), with 92 WTE in post as of January 2017. This meant the nursing staffing level was at 89% of the WTE establishment. On our inspection we were told there were no vacancies within the children's inpatient ward and only one recent vacancy on the day-case unit.
- A safe staffing and escalation policy ensured staff were able to escalate to senior managers any cases where staffing or skill mix deficiencies were unacceptable against the standards. Bank and agency staff were used to cover sickness and holiday absences. There had been a reduction in the amount of agency and bank staff usage within the eight months from 17% in April 2016 to 11% in November 2016.
- Planned staffing against actual staffing levels provided to us showed that for the inpatient ward registered nurse levels were at 104% which means more staff were provided than were planned.
- Senior nursing staff provision on the children's inpatient ward consisted of six band six nurses. This meant that there were not currently enough to ensure that there was always a senior nurse on that shift. However, on Monday to Friday day shifts a senior ward sister who would provide senior nursing advice. Out of hours and at weekends, the nurses were able to contact a senior children's nurse in the emergency department or the clinical site manager if they required senior nursing advice.
- Nursing staff provision on the day-case unit was four children's nurses that undertook long days Monday to Friday as well as one HCA who worked between 10:30am to 4.30pm. If lists ran on a weekend then it was usually covered by permanent staff on overtime.
- Nursing staff levels within the outpatients department for each day were two band six nurses, three band five nurses and a healthcare assistant.
- Nursing staff on the inpatient ward had a handover at the beginning of each shift. We attended one of these handovers and found that comprehensive information was discussed for each patient meaning that there was clear understanding of the progress and plan was shared. Nurses were allocated to patients to care for during that shift.
- If a registered mental health nurse was required for a patient then this was arranged through an agency. We were told that there had never been any difficulty arranging this.
- There were three paediatric nurses who worked within the recovery area of paediatric theatres. We were told there was a high use of agency staff within the theatres

and staff we spoke with said it was difficult to recruit and retain staff for these areas so there was a high level of agency use. Efforts were made to use the same agency staff so that they were familiar with the department.

- The Neonatal Unit (NNU) had a lack of Qualified in Speciality (QIS) nurses. The recommendation was that 70% of staff were QIS however the department had 60%. This was listed on the divisional issues log which stated that there was an ongoing recruitment plan as well as specialist training of internal staff in order to improve the levels. This meant the unit did not meet the British Association of Perinatal Medicine (BAPM) staffing standards for units providing neonatal intensive care.
- The BAPM standards were for 1:1 QIS nursing ratios in Neonatal Intensive Care (NICU) areas, 1:2 QIS nursing ratios in High Dependency Areas (HDU) and 1:4 nursing rations for Special Care. Although we were provided with information following the inspection that said the unit met this criteria we were given different information on the inspection. Staff we spoke with told us that the ratios for nursing care in the neonatal ward were two nurses to four babies within the ITU and one nurse, supported by one HCA to three babies within the special care bays.
- We also saw that the special care unit for was generally staffed by two nursery nurses. Nursery nurses are unregistered staff who support registered nurses and need to have adequate supervision for the unit staffing to comply with BAPM guidelines.
- Funding had been agreed to achieve full BAPM compliance. Managers told us there had been a 38% absence rate on the neonatal unit due to vacancies, sickness and other absences. However there had been improvements to the absence rate with recent reductions in the number of staff on long term sickness, four new nurses appointed, one already started and the others due to start soon. They told us senior managers had agreed to over recruit to mitigate the effects of high turnover particularly amongst recently qualified staff. Agency staff were used to cover gaps in nursing provision and we were told that these were staff that were familiar with the unit and they did not accept staff with no neonatal experience. Rates of agency and bank staff had decreased in the eight months from 19% in April 2016 to 7% in November 2016.

Medical staffing

- Across the trust children's services medical staffing included 32% consultants, 52% registrars, 5% middle career and 7% juniors. Information provided by the trust before our inspection showed that as of February 2017, the vacancy rate for medical staff across children and young people services was 17%, which equated to 10 whole time equivalent doctors. Use of locums between the eight months from April to November 2016 averaged 6%.
- The consultant medical staffing establishment for the hospital was 14.23 whole time equivalent (WTE), with 13.96 WTE in post as of January 2017. This meant the consultant staffing level was at 98% of the WTE establishment which showed a very low level of consultant vacancies. However, as of January 2017 the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1-2) staff was about the same as the England average. This may meant that there may sometimes be insufficient numbers of doctors with the qualifications, skills and experience to meet the need of children and their families who used the service, thereby placing patients at risk.
- The 14 consultants all had a speciality, for example there were paediatric consultant specialists for sickle cell and diabetes. Five of the consultants were dedicated neonate specialists and had their own rota covering the unit.
- There were well-structured medical handovers, which made sure important information was passed onto each other, including all known risks, and any incidents that may have occurred.
- We observed one handover on the inpatient ward and noted it to be a wide ranging discussion around the pharmacy needs, dietetics, safeguarding, psychosocial and parental education needs. Other professionals such as a member of the safeguarding team and a community nurse from the hospital at home team also joined the handover. Consultants were present at least one of the handovers; this was in line with the Royal College of Paediatrics and Child Health (RCPCH) guidelines. The consultant of the week undertook two daily rounds on the ward. We observed that following the ward round the team was updated on any decisions made in that time.
- The RCPCH standard three (2015) states that every child that is admitted to a paediatric ward should be seen by

a paediatric consultant within 14 hours of admission. Data provided to us from an audit undertaken in September 2016 showed that the trust compliance for paediatric medicine speciality against this standard was 70%. Although the trust was not yet meeting this standard the levels were in line with national levels of compliance.

- We observed a ward round on the neonatal unit and saw that the nurses caring for the babies joined these with the medical staff and were able to contribute to the discussion as well as be informed of any changes.
- Consultants provided cover between 8.30am and 10pm on weekdays. However due to current staffing levels this was only available until 10pm on only three to four days per week and until 7pm for the NICU. This did not meet the RCPCH standard one which states that a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week. Outside of these times two consultants of the week (one dedicated to NICU and the inpatient ward) would be non-resident on call for emergencies.
- Middle-grade doctors worked a shift system which included resident on-call cover to all areas.
- Adult surgeons would operate on children and young people above the age of 13 only. Otherwise paediatric surgery was provided by specialist paediatric surgeons. A paediatric anaesthetist was available including on call out of hours between 8pm and 6am.

Major incident awareness and training

- There were separate comprehensive paediatric business continuity plans for each department, which included clear instructions on what to do in the event of key identified risks such as loss of staff, information technology failure, loss of utilities or severe weather. As the plans were specific to the relevant area they contained pertinent information to each department. The plans included action cards that staff could grab and use to remind themselves of the appropriate actions and were reviewed on an annual basis.
- Scenario based training was held jointly with across sites for each type of service which ensured staff responded appropriately to emergencies. For example the inpatient wards from both hospitals and the day-case unit had undertaken a joint table top session in August 2016 to exercise the scenario in the event of a sudden loss of power. Trust-wide events had also been attended by representatives from the children's service with regard to testing responses in the event of examples such as heatwave and pandemic flu.
- All groups of staff were above the trust target of 85% for completion of emergency planning training except for paediatric medical and dental staff where compliance was lower at 66%.
- The hospital had four escalation beds within the inpatient services that were used for increase in provision during winter and other times by exception. The hospital had opened up these beds over the last winter and increased nursing staffing by employing agency staff to manage the increase in demand of services over this period.
- There had been a fire recently within the Queen Elizabeth Hospital children's inpatient ward and, as a result of this, children receiving treatment had been transferred to Lewisham Hospital. The ward had used escalation beds and increased the ward to a 32 bedded unit to accommodate the extra children. Practices had been adapted to accommodate nursing staff and for the care of additional patients. For example, the registrar would not usually stay on the ward, but during this period they stayed to ensure that there was always suitable medical cover. In addition, the handover time was extended rather than split so that all staff on the ward had an awareness of all patients.

Are services for children and young people effective?

Good

We rated effective as good because:

- A comprehensive audit schedule supported the use of national guidance within policies and guidelines.
- The hospital participated in national audits and reviews for assessing patient outcomes.
- Peer reviews were used to identify improvements to services.
- Babies receiving mother's milk exclusively, or as part of their feeding at the time of their discharge from NNU was significantly above the national average.
- There were a number of clinical nurse specialists appointed.

- A rotational program for new nurses through each department meant that they developed a wide range of knowledge and skills.
- Multi-disciplinary working was well-embedded in all departments that we visited.

However:

- There was no play specialist available for the outpatient department or for weekends and holiday cover in the inpatient ward, although there was assistance from trained volunteers.
- No outpatient clinics were run at evenings or weekend which reduced the accessibility of services for patients.
- Limited follow up of babies had been completed as part of a national audit. This reduced the hospital's ability to assess longer term outcomes of babies that had been treated.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. Most of these policies were shared across both sites to enable consistent practice. Examples of this included the guidelines for neonatal jaundice and early onset infection.
- The hospital had undertaken a number of external peer reviews over the last 12 months to identify improvements to services. This included one on inpatient services in July 2016, and another on neonatal care in April 2016.
- The physiotherapy staff used the Alberta Infant Motor Scale to assess gross motor functions of children less than 18 months of age. This is a developmental criteria-referenced assessment tool that measures items related to posture, movement, and weight bearing in different positions.
- A comprehensive audit programme was run by the hospital children's services. The audit plan was devised based on audits required nationally as well as to assess compliance with NICE about paediatrics and neonatology, governance and risk audits as well as local priority audits identified through complaints and incidents.
- We saw the results of an audit conducted on the NNU for administration time of antibiotics for babies with presumed neonatal sepsis, which should be within 60 minutes of decision. This audit highlighted areas of improvement for both the maternity department and NNU and made recommendations for both departments to improve the response, including good practice shared from other hospital trusts.
- A review had been undertaken in June 2016 that was based on the recommendations of the National Paediatric Diabetes Audit of 2014/15. It found that the hospital had met all of the recommendations except for one which was partially met.
- The neonatal unit was working towards accreditation of the BLISS family friendly accreditation scheme. This followed the BLISS baby charter principles which are a framework for neonatal units to self-assess the quality of family-centred care they deliver against a set of seven core principles which are social, developmental and emotional needs, decision making, specialist services and staff, benchmarking, unit information and support, feeding and discharge.
- The trust used the Paediatric Early Warning Score (PEWS) system as recommended by NICE. The trust had completed an audit across both sites in October 2016 which found that compliance to the standards had improved in all but one area since a baseline audit in July 2015. In six out of 10 standards the results were greater than 90% compliance which was the target. The remaining four standards were between 70% and 83% compliance. Actions identified included use of electronic recording, training for healthcare support workers and regular local audits by practice development nurses.
- The pharmacy team carried out medication audits. Including a monthly medicines safety walk about on the ward and had recently started an antibiotic audit. A teaching session had recently been run in response to a recent error that the pharmacy team had identified from carrying out audits on the drug charts.

Pain relief

- Children received adequate pain relief and there were appropriate systems for assessing pain in children used.
- A variety of assessment tools were used to assess pain depending on the age of the child. Staff assessed pain using recognised methods based on FLACC observation (the FLACC scale is based on observation of a child's

face, legs, activity, crying, and consolability) or children's own reporting of pain, for example, the Wong Baker FACES pain rating scale. Staff used the visual analogue pain score, where zero meant no pain and 10 meant severe pain for older children. Levels of pain were documented within PEWS charts and we heard pain levels discussed during nursing handovers.
- Children and their parents received clear explanations regarding medication and analgesia and parents and children we spoke with were happy with the levels of analgesia that they had received.
- Analgesia and topical anaesthetics were available to children who required them in the ward and outpatients department.

Nutrition and hydration

- An acute paediatric dietetic service covered both hospital sites. At Lewisham hospital there were two specialist paediatric dieticians for the children's services. One for cystic fibrosis and the other for diabetes.
- The dieticians were part of outpatient clinics which included specialist allergy and gastroenterology.
- The inpatient ward used STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) to assess children for malnutrition. This is a simple five step validated nutrition screening tool for use in hospitalised children aged 2-16 years.
- The hospital gave children and young people a choice of meals on the inpatient ward. Hot food was available at lunchtime and in the evening.
- Admitted children who were enterally fed (where a tube is used to deliver nutrition directly to the stomach) were supported by the community enteral feeding team.
- Information on fasting prior to surgery was provided within the pre-assessment appointment for children and young people having elective surgery. For most children food could be given up to six hours beforehand and water two hours before. Following surgery, sandwich packs were provided for children to eat.
- Data provided to us showed that 93% of babies received mother's milk exclusively, or as part of their feeding at the time of their discharge from the NNU. This was significantly above the national average of 58%.
- A new breastfeeding nurse specialist role had been created in order to provide senior nursing support to breastfeeding mothers. This role had not yet been recruited to so improvements as a result of this introduction were not yet known.
- A better breastfeeding care bundle had been introduced 18 months ago that included a colostrum pack in order to increase the rates of exclusive breast feeding and support given to mothers.
- We saw breast pumps in the expressing room, which allowed easy accessibility and could potentially encourage mothers who may not have wanted to breastfeed. Advice leaflets were provided for parents on breast feeding that also gave information about safe storage times for expressed milk and contact numbers for support. A mother told us 'Breastfeeding information [is] available and I have been shown breastfeeding videos.'
- A nutrition round was conducted each week within the neonatal unit that included the community dieticians.

Patient outcomes

- National audits participated in by the children's service for 2016/17 included the National Paediatric Diabetes Audit (NPDA) and the NPDA patient reported experience measures, Inflammatory bowel disease registry, neonatal intensive and special care (NNAP), Paediatric pneumonia audit and the cystic fibrosis registry.
- The hospital also contributed to the National Confidential Enquires into Patient Outcome and Death (NCEPOD) review for chronic neuro-disability.
- The "Mothers and babies: reducing risk through audit and confidential enquiries" (MBRACE) showed the trust was up to 10% lower than average for neonatal mortality in the country.
- The NNU staff participated in the National Neonatal Audit Programme (NNAP), which was implemented to assess whether babies admitted to neonatal units in England, receive consistent care in relation to key criteria. The hospital was above the national average for documented consultation within 24 hours with 99% of babies compared to 88% nationally. It was equal to the national average for babies having their temperature checked within an hour of birth. However it was below the national average for screening for retinopathy of prematurity (a disease that can cause blindness in

premature babies) and number of babies within the target temperature ranges. Retinopathy screening was 87% compared to 93% and target temperatures only 45% compared to 62%.

- The NNAP audited data on two year follow up of babies admitted to the NNU. The hospital had 51 babies eligible for this follow up however had no data entered for 33 (65%) of the babies. This limited the hospital's ability to assess longer term outcomes of babies that had been treated in the unit. Of those who were followed up, 11 babies had some level of impairment compared to seven with no impairment or where it was unknown.
- The number of under one year olds readmitted following an elective admission of children between September 2015 and August 2016 was too low to be compared to the England average.
- There were 22 readmissions within two days of discharge following an elective admission of children aged one to 17, between September 2015 and August 2016. The readmission rate for paediatric medical oncology of 2.7% was slightly worse than the England national average readmission rate of 2.4%, for this age group however the general paediatric readmission rate of 0.9% was better than the England average of 1% for this age group.
- Between October 2015 and September 2016 there were too few admissions to measure the trust performance for the percentage of patients under the age of one who had multiple admissions for asthma, diabetes, and epilepsy.
- The rate of multiple (two or more) emergency admissions within 12 months among children aged one to 17 with asthma was 14.7% between October 2015 and September 2016, which was better than the England average multiple admission rate of 15.9% for this age group.
- The rate of multiple (two or more) emergency admissions within 12 months among children aged one to 17 with epilepsy was 33.3% between October 2015 and September 2016, which was worse than the England average multiple admission rate of 27.5% for this age group.
- The rate of multiple (two or more) emergency admissions within 12 months among children aged one to 17 with diabetes was 13.1% between October 2015 and September 2016, which was the same as the England average for this age group.
- The National Paediatric Diabetes Audit 2014/15 found the hospital performed similarly to the England average of 22% for the measurement related to HbA1c monitoring. This meant the trust in line with national levels for having an HbA1c value of less than 58 mmol/mol. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)".

Competent staff

- All nurses employed were children trained and additional courses were offered by the trust for care of children with high dependency. Healthcare assistants and play specialists complimented paediatric nurses on the children's ward and day surgery unit. Play specialists are an important part of the ward and department teams, as they work with children to make sure the hospital environment is welcoming and fun.
- For the last 18 months new nurses to the service had worked on a nine month rotation program within each of the areas of the inpatient ward, neonatal ward and children's emergency department. This was reported to not only help in learning new skills but also to establish good working relationships and understanding of each of the areas challenges and practices.
- On the neonatal unit, nursery nurses who were specifically trained to care for this group of babies supported nurses.
- The trust currently had two vacancies for practice development nurses (PDNs) in both the neonatal and inpatient ward. However cover had been provided for the inpatient nurses by one of the emergency nurses acting up into this position so that the vacancy did not disrupt ongoing education and development of staff while recruitment took place.
- Half of the nursing team working on the inpatient ward had an additional qualification in specialty for looking after children and young people within the high dependency unit (HDU). There was an expectation set by the ward sister that all new staff would complete the HDU training and mentoring within three months of joining the ward.
- The trust target for completion of staff appraisals was 90%. Between April 2015 and March 2016, the trust

reported a staff appraisal completion rate for children and young people's services of 88%, although this figure excluded healthcare scientists where data showed that the completion rate was 0%. Data provided by the trust for the progress between April 2016 and August 2016 showed the appraisal rate was 84%. There were consistent levels of over 80% for all staff groups except for healthcare scientists where the figure was 0%.

- Nurses were encouraged and supported to develop areas of interest and act as a source of advice and training for the team. For example, there were clinical nurse specialists for sickle cell, diabetes, respiratory, epilepsy and allergies. In addition there were link nurses for adolescents, bereavement, nutrition and milk kitchen, orthopaedics, safeguarding, and ear, nose and throat (ENT).
- Within the last 12 months there had been joint training set up to include paediatric staff for both hospital sites. This had been focussed on care of a child with complex medical needs and had included tracheostomy (where there is surgical opening made in the neck to assist with breathing) training.
- The day surgery unit was nurse-led and there had been training delivered over the last two years in upskilling staff working there to have an extended role, such as in phlebotomy. Nurses were encouraged to join the advanced nurse practice modules.
- Within the outpatients department one of the healthcare assistants and two nurses were trained in breastfeeding support and they worked at the tongue tie clinic providing support to mothers. (Tongue tie is a malformation of the tongue which may cause a baby to have difficulty in breastfeeding).
- At the weekly multidisciplinary review of patients was consultant led and all levels of staff were invited to attend. This provided a teaching opportunity for those attendees.
- Bereavement care training was provided for administrators as well as nurses who undertook HDU modules. Additional in-house study days were provided that discussed communication and bereavement support.
- The induction program for new nursing staff was tailored to meet the individual need. For example if a new nurse had undertaken student placements at the hospital then their induction would be different to a new nurse that had never worked there. All new staff completed a trust induction of two days and then they would complete a role based induction in different departments of the hospital as well as attending teaching sessions. The new nurse would then undertake shifts shadowing a member of staff. The length of time that this would last for would be dependent on the previous experience of the nurse joining the department.
- During our inspection a number of new junior doctors had recently joined the service. We observed an education session on sepsis being run for them as part of their induction by one of the consultants.
- Senior pharmacists conducted teaching and training sessions for nurses and doctors on the inpatient ward. For example a recent session of training was provided on gentamicin (an antibiotic) in response to a recent error that the pharmacy team had identified from carrying out audits on the drug charts.
- The hospital provided student nurse placements within children's services. We saw a notice board on the ward dedicated to student nurses that provided clear guidance on what levels of care could be provided by student nurses relevant to their year of study. We spoke with student nurses who told us that they had two allocated mentors to support them during their placement. In addition they enjoyed their placement and felt that it was a supportive environment for them to learn.
- The trust revalidation team commenced a rolling programme in December 2015 and all nurses within the hospital submitted revalidation on time. Workshops were run by senior facilitators to ensure that have education was provide to nurses about the process.

Multidisciplinary working

- Our review of records and interviews with staff, patients and parents confirmed there were effective multidisciplinary working practices, which involved nurses, doctors, allied health professionals, and pharmacy. Staff told us they felt supported and that their contribution to overall patient care was valued.
- We observed that staff worked well together during our visits to the various wards and departments. They also worked well with multidisciplinary teams (MDT) within the hospital and with other outside services in order to provide the best care possible for children and young people. We observed comprehensive handovers between staff, for example one in the recovery area

between an anaesthetist and recovery nurses. Following the handover the anaesthetist returned 10 minutes later to check if any additional information or support was required.

- A multidisciplinary meeting called the 'grand round' was conducted each week on the children's inpatient ward. This would consist of doctors, nurses and allied health professionals from both in patient and community services that would discuss each patient on the ward to ensure a MDT approach to their care plans. We observed part of this meeting and noted that it was a good communication forum with lots of interaction and general discussion. As well as discussion of the clinical needs of patients, time was given to discuss the practicalities of an inpatient attending an outside event.
- A weekly MDT round was held on the neonatal unit. This included a pharmacist, microbiologist, health visitor, consultants, trainees and the nurse in charge.
- In the CQC children's survey 2014 the trust scored 8.62 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts. This was the most recent data available at the time of inspection.
- The hospital inpatient team reported excellent links with the community children's services. As these services were within the same division for the hospital it helped to have more interacted working.
- There were two full time play specialists who worked on the children's inpatient ward and day-case unit respectively. Staff used play specialists in providing distraction techniques when a child required a procedure that may be painful or upsetting. However there was no play specialist provision at the weekends or when they were on leave, although we were told that volunteers would assist with play on the weekend and in the outpatient department.
- It was recognised by the senior managers at the hospital that there were gaps in the provision of play specialists, such as the outpatient department and lack of play specialist provision at the weekends. They told us that they were considering other potential options for providing support for this such as further use of volunteers and medical students as a development option.
- The hospital had good links between children and young people's services and the child and adolescent mental health service (CAMHS). Staff told us they this was a good service, however it was only offered Monday to Friday. The ward had access to advice from a CAMHS psychiatrist by telephone. If children or young people with mental health conditions were required to be admitted as patients on the ward then a registered mental health nurse could be requested through an agency for one to one care.
- There were a number of MDT clinics offered within the children's outpatients department. For example the diabetes and cystic fibrosis clinics included a psychologist.
- The neonatal ward round included a handover from the postnatal ward daily and consultants attended the post-natal ward round which improved consistency. In addition a weekly 'huddle' with maternity was in its third week and was viewed as a positive communication method by the matron and consultant who attended.
- The neonatal unit reported good working within the neonatal network of other hospitals providing enhanced level three services such as daily contact phone calls. The matron attended local network meetings and also the national network meeting which meant that they had regular interaction and updated knowledge from these meetings.
- Physiotherapy outpatient appointments were provided for children from birth. In addition there was physiotherapy support for the inpatient ward. Nurses told us that team working with physiotherapists was good across the children's services and they felt supported by their colleagues in the MDT.

Seven-day services

- The inpatient ward and the neonatal unit provided seven-days services for children and young people at the trust.
- Outpatient appointments were scheduled Monday to Friday between 9am and 5pm, with no clinics run at the evenings or weekends. This meant that children and young people and their parents or carers could not always access outpatient appointments at times that suited them. This resulted in children having time out from school and parents or carers taking time off from work in order to attend appointments.
- The children's day-case unit provided services for children Monday to Friday from 7.30am until 8.30pm although occasionally a Saturday paediatric theatre list

would be scheduled and the day-case unit used. The paediatric theatre and recovery area closed at 6pm however the adult theatres could be used for paediatrics in an emergency.
- There was a facility to provide high dependency care for children and young people at the hospital. However if any children required intensive care management and ventilation, they would be stabilised within the inpatient high dependency unit before being transferred to the anaesthetic department of the operating theatres prior to retrieval by either the South Thames Retrieval Service (STRS).
- A single paediatric pharmacist provided specialist cover to the service Monday to Friday. Out of hours an on-call pharmacist was available so there was always access to medication if required urgently.

Access to information

- Staff told us they could access most information they needed to deliver effective care and treatment in a timely and accessible way. For example, they said that there were no delays to access blood tests or imaging requirements and results and other investigations such as x-ray and scan results were available as soon as they were ready and on the system.
- There was no phlebotomy (taking of blood samples) or audiology clinic service provided within the children's outpatients department. Children and young people requiring this had to attend the main phlebotomy services where the environment was not as child friendly.
- Policies, protocols, and procedures were kept on the trust's intranet and staff were familiar with how to access them. There were enough computers available to allow staff to have quick access to trust policies and guidance.
- Patients and families were provided with a copy of the discharge summary prior to leaving the inpatient ward and neonatal unit. This would also be sent electronically to the GP. In the case of patients who required further support from services after their discharge then a telephone call to discuss needs would occur with the community team, and we were told, for complex patients a full planning meeting with all relevant services would be arranged. Outpatient appointments were usually arranged prior to discharge so that parents and patients would know when their next follow up appointment was.
- The service used the 'personal child health record' (PCHR), referred to as the "red book", to record the height and weight of children attending an outpatient appointment and encouraged parents to bring these to hospital if their child attended an appointment or received treatment.
- We saw a sickle cell information folder on the inpatient ward. This contained useful information for staff to access for children on admission and also contact links with the community nurse specialist.

Consent

- Staff obtained consent from patients and parents appropriately in relation to care and treatment. Staff were able to explain how consent was sought and how they involved both the child and the person with parental responsibility in obtaining consent where appropriate. When appropriate teenagers were able to discuss their care and treatment without their parents present.
- Staff described the process of giving consent. Consent forms and care plans shown to us incorporated areas for both parent and children, where appropriate to sign their written consent.
- Staff used the principles of the Gillick guidelines, when making decisions about the ability of a young person to consent to procedures. 'Gillick Competence' refers to any child who is under the age of 16 who can consent, if he or she has reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision.
- Audits of consent prior to surgery for both the trauma and orthopaedic speciality and ear nose and throat speciality had been carried out and these had included paediatric patients within the data sampled. Clear recommendations in response to the findings had been made in order to target improvements identified.

Are services for children and young people caring?

Good

We rated caring as good because:

- Patients and parents were positive about the compassionate care that they received and we observed kind and respectful care during the inspection.
- There were good support available for parents within the neonatal unit and parents were encouraged to be involved in ward rounds.
- Parents and patients were informed about the plan for their care in a compassionate and appropriate manner.
- Over 95% of respondents to the friends and family test recommended the service.

However:

- Parents and patient were not involved in the weekly 'grand round' held on the inpatient ward.
- There was a low response rate to the inpatient friends and family test.

Compassionate care

- All staff we spoke with were passionate about their roles and were dedicated to making sure children and young people received the best patient-centred care possible.
- We saw and heard staff delivering kind and compassionate care to the children and young people in their care. Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) QS15.
- Children and young people, their families and carers told us they felt well supported by staff. We saw young people being treated with dignity and respect, and observed staff providing child centred, compassionate care. Parents, children, and young people told us that they were kept up to date with plans about their care verbally.
- Staff protected the privacy and dignity of patients by using children specific bays and we saw curtains were used to screen children from other patients when needed.
- Staff were confident in describing the process and of chaperone provision.
- Staff were skilled in communicating with children and young people; we observed this on every ward and department we visited. Most staff introduced themselves with "my name is". Additionally, all staff wore a yellow badge that clearly stated their first name.
- We spoke with three parents and two young people on the wards and departments we visited. All parents and patients we spoke with were very positive about their care. One patient told us "It's all fine, the nurses come when called". Another said 'I feel that my baby is safe…. Really happy with the service. I have seen the same staff throughout and I can come and talk to them.'
- The children's outpatient response for the January 2017 friends and family test (FFT) had been 83 responses. Of these, 77 (93%) had been extremely likely or likely to recommend the department with only two responses being unlikely or extremely unlikely to recommend it.
- The children's inpatient response for the FFT was a low rate of between 10% and 21% against the trust target of 30%. However of those responses over 95% of patients recommended the service.
- The inpatient ward completed patient satisfaction interviews. The score for the last two weeks of December 2016 had been 86%, below the target of 90%. Areas highlighted as being an issue were cleanliness of the bathroom floors, unaware of safety knowledge and disturbance at night.
- In the 2014 CQC children's survey for all 14 questions relating to care were about the same as other trusts. This was the most recent data available at the time of inspection.

Understanding and involvement of patients and those close to them

- We found staff interacted with children and their parents in a polite and friendly manner. Children, young people and their families were given the opportunity to speak with staff, to ask questions and were kept informed of what was happening.
- We observed staff explaining to families the care their child was receiving and the purpose of the equipment helping them to do this. Staff did this in a compassionate way, allowing families to ask questions.
- We observed members of staff talking with children and young people. We heard them using language appropriate to their age and level of understanding.
- Older children we spoke with felt they were kept updated about their care by staff and could be involved in making decisions as appropriate.
- On each ward and department, it was clear which nurse was looking after each child or young person. The children and young people we spoke with all knew who was looking after them.
- We saw that support mechanisms were in place for parents of babies in the neonatal unit. This included a

weekly parent group where clinical staff could join parents for an informal discussion about the developmental care of new-born babies. In addition a library was available for parents to borrow books that contained information about care of their new-born. In addition a parent folder was being designed for parents on the unit to improve communication and involve parents in the care of their babies. Parents were also invited to join the ward round when their child was being discussed and this was seen as a positive engagement opportunity by staff.

- We saw thank you cards from parents in appreciation of the support given on every ward we visited.
- A multi-disciplinary team meeting held each Friday called the 'grand round' did not include parents or children or young people which meant that their views could not be shared.
- The pre-assessment clinic provided an opportunity for information to be given to parents and patients about their planned operation and for them to ask any questions. It also offered the chance for the child to see the day-case unit where they would be cared for so that they were familiar with the environment.
- In the CQC children's survey 2014 the trust scored 8.92 out of ten for the question 'Did a member of staff agree a plan for your child's care with you?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Emotional support

- Parents told us they felt able to leave the ward or area in which their child was being cared for and felt their child would be safe.
- We observed a young child being given a general anaesthetic prior to surgery. All staff involved provided reassurance to the child and to the parent accompanying the child. The parent was accompanied back to the ward by one of the day-case unit nurses for additional support.
- The child and adolescent mental health services provided by another NHS trust supported children with mental health problems.
- Play therapy services included preparation for operations and other procedures, distraction therapy, emotional support, and pain management. There was a specialist play worker available on the day-case unit, including the pre-assessment clinics and the inpatient ward.
- The inpatient ward had links with a national children's charity that provided a performer called a 'Giggle Doctor' on a fortnightly basis to the ward to provide entertainment to the children receiving treatment at the ward. These specially trained performers would visit every child that wanted to see them and provide fun activities for them to enjoy that were appropriate to the child's needs.
- A 'wall of hope' on the neonatal ward had stories of babies that had been cared for on the unit and had been discharged. This provided parents with positive stories to support them.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- There were facilities provided for parents to stay with their children while they were receiving care. Improvements had been made to these facilities following feedback.
- Changes had been made to patient pathways, such as the introduction of ward reviews, which had decreased length of stay.
- Additional training had been arranged for staff following recognition that there had been an increase in the admission rates of children with mental health concerns due to the unavailability of beds elsewhere.
- The hospital had recognised that the local borough had a high prevalence of children and young people diagnosed with autism spectrum disorders (ASD) and adapted practices on an individual basis to improve care provision for patients with ASD.
- There were a low number of formal complaints made about the service and response rates to complaints received were within the agreed timescales.
- The inpatient ward referred a large number of patients to the hospital at home team, which significantly reduced the amount of bed days that were required which reduced length of stay.

However:

- There was no policy for transition services.

- The Do Not Attend (DNA) rates for both the outpatient department and surgery were higher than the trust targets.
- Compliance to issuing electronic discharge summaries within 24 hours of discharge were substantially below the trust target.

Service planning and delivery to meet the needs of local people

- The trust treated large case-load of children and young people for sickle-cell disease. At Lewisham Hospital they had over 150 children and young people on the case load. As a result a clinical nurse specialist for sickle cell had been appointed and worked across both sites to support provision of care to this group of patients.
- There was no policy for transition services. However collaboration was being undertaken with other organisations to consider transition services. Transition processes were in place for children moving to adult services who had conditions such as Diabetes Mellitus or Cystic Fibrosis. The processes were variable dependent on speciality and would generally involve a staggered handover of care from children's to adult services. These discussions started when the child was 12 years old and included engagement and interviews with parents. For patients with sickle cell disease transition clinics were held twice a year and attended after an initial transition meeting. Rheumatology transition clinics were held at the trust in partnership with adult medical colleagues.
- The hospital had a dedicated paediatric operating theatre and recovery area which was in line with The Royal College of Surgeons, "Standards for children's surgery" (2013) recommendations that children and young people should not be cared for alongside adults in recovery areas and parents should be allowed to visit their child in recovery.
- Fourteen dedicated paediatric surgery lists were planned across the trust each week and at Lewisham hospital all day-case patients were cared for pre and post operatively within the day-care unit. Children or young person were initially been recovered from surgery, in a separate recovery area and nurses from the day-case unit would accompany the parents to collect children following surgery and take them back to the unit.
- There was no facility within the hospital for patients to be sedated for a magnetic resonance imaging (MRI) scan. Patients requiring this would need to be transferred to another hospital. This had been highlighted within a peer review conducted in July 2016 of the service however there had not yet been any actions taken to consider changing this.
- Antibiotics for babies cared for on the post-natal ward were administered on the NNU. This was listed on the divisional risk register as an issue due to infection concerns, staff capacity issues and a poor experience for mothers and babies recovering after birth. To mitigate the effect of this the unit provided time slots for one baby at a time. We were told the future plan was for midwives to be trained to administer the medications on the post-natal ward. An audit of babies on antibiotics to assess both midwives and parents views had been completed. Results showed that parents were happy with the service overall however views of midwives were mixed. Some reported that moving the service to the post-natal ward would be positive for parents but others were concerned about the additional workload.
- There were facilities for parents to stay overnight with their children on the inpatient ward and NNU. On NNU three bedrooms with en-suite facilities were designed for parents to stay prior to discharge and care for their baby in a less clinical environment but with nursing support if required. On the inpatient ward, folding beds were available for parents who wished to sleep next to their child. Only one parent was generally allowed to stay at one time, however staff told us that this could be adapted if required. Parents had access to shower facilities on the ward.
- A parent's lounge had been introduced in the children's inpatient ward after parent feedback. There was access to cooking facilities and hot water, which allowed parents to prepare food and drinks for themselves. This room was locked with a key code, provide to parents to prevent unaccompanied children from entering.
- The inpatient ward had a dedicated school room adjoining the ward which had a full time teacher and teaching assistant available during weekday term times. If patients were not able to mobilise to the room then worksheets or a laptop could be provided to the patient's bed. The school room had been inspected by Ofsted in May 2016 as part of an inspection with another education location and the report had been rated as 'Good'.

Services for children and young people

- A snack bar selling food and drinks as well as toys and books was run by volunteers within the children's outpatients department. This provided an option for parents and children to have refreshments without having to leave the department.
- In the CQC children's survey 2014, the trust scored 6.9 out of ten for the question 'for parents and carers who stayed overnight saying facilities were good?' This was about the same as other trusts. This was the most recent data available at the time of inspection.
- In the CQC children's survey 2014, the trust scored 8.3 out of ten for the question 'for parents and carers being able to access hot drinks when in hospital?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Access and flow

- There had been 17,841 children and young people admissions to the trust between April 2015 and March 2016. For children aged one and under the most common diagnosis was jaundice (22%). This was above the England national average of 7.4%. The most common diagnosis for children aged one to 17 was viral infection, (15%), which was below the England average of 12%.
- The majority of children and young people were admitted to the inpatient ward through the children's emergency department (70-80%). Others were admitted via a planned admission process. Neonates were admitted via maternity as a planned or emergency admission or as a transfer from other hospitals.
- Children and young people attended pre-assessment clinics before being admitted for surgery. During the clinic, staff explained the procedure to children and their parents and consent forms would be signed. Staff we spoke with told us if the treatment needed to be cancelled or delayed, they would contact the parents or carers to explain. A new appointment would then be arranged.
- The day-case clinic offered extra capacity for specific clinics. For example; children and young people requiring regular blood transfusions as part of their sickle cell and thalassaemia treatment plan or for selected allergy clinics. The day-case unit tried to allocate the same bay for these patients so that there was continuity of location.
- An electronic referral system operated for patients referred to outpatient appointments. Staff we spoke with said that they aimed to keep referral waiting times for the outpatient clinic appointment below 13 weeks. We were told that due to staff changes there had been an increase in ophthalmology waits to 15 weeks and due to more referrals waits had increased for the allergy clinic to 19 weeks.
- There had been a change since our last inspection and the NNU no longer accepted babies born before 27 weeks gestation. This had been changed in November 2016. Since then the network guideline had been changed. Babies born that were below the acceptance criteria were transferred to a level three unit or the mother would be transferred before delivery.
- There had been occasions when additional babies were admitted to the NNU above the cot numbers. Incidents reported between August 2016 to January 2017 showed four times when this had occurred. One incident reported two additional babies and the other three were when one extra baby was admitted.
- There were regular telephone discussions across sites on a daily basis about bed numbers to improve patient flow.
- The average length of stay for the hospital's inpatient ward was 2.1 days. For the neonatal unit it was 12.5 days. The average occupancy rates had been above the trust maximum target level of 85% for all but two of the months within the last year.
- A Hospital at Home Team had been introduced within the community Children's service and this team worked with the inpatient ward as well as the Emergency Department to reduce admissions to, and length of stay on, the ward. Data provided to us showed that between February 2016 to January 2017 269 referrals had been made to this team by the inpatient ward which had meant an estimated 726 bed days saved.
- Ward reviews were arranged for some children in order to reduce their length of stay. For example children requiring intravenous antibiotics could be discharged home and return when required to the ward for their medication.
- Pathway changes for patients suffering from paediatric haemoglobinopathy requiring regular blood transfusions had resulted in a decrease of admission time from eight to just over five hours. (Haemoglobinopathy is a genetic defect that results in abnormal structures of haemoglobin molecules).

- A discharge nurse worked within the neonatal unit to support discharge planning and all parents were provided with a copy of the discharge summary.
- In the last year April 2015 to March 2016 29.7% of discharges were before 1pm below the trust target of 40%. We were told by nursing staff that sometimes if a patient was ready to be discharged in the morning discharge medicines may not be ready for them to take home until the afternoon, and caused a delay. These times had not been reported as incidents.
- The trust's target was 95% for electronic discharge summaries to be completed within 24 hours of discharge. In the last 12 months this target had not been met by the hospital and average rates for compliance were at 75% across the period. This was listed as an issue on the division risk register.
- Do not attend (DNA) rates for the paediatric outpatients department between March 2016 to February 2017 were 22% higher than the trust target of below 14%. Staff told us that they were aware of a high rate of DNAs within the outpatients department and said that parents often changed phone numbers which caused an issue for follow up. A texting reminder system could not be introduced as the hospital was awaiting a merger on a computer system. We were told that where possible, for specialist clinics, the nurses would telephone the patients to remind them of the appointment.
- The DNA rates between March 2016 and February 2017 for paediatric surgery were 15% which was slightly higher than the trust target of below 12.4%. In three of the last 12 months, including the most recent the rates had been lower than the target.

Meeting people's individual needs

- The hospital was level two UNICEF Baby Friendly accredited and were working towards level three accreditation. The Baby Friendly initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- Breastfeeding was supported in the hospital with a designated feeding room available in outpatients and providing meals to mothers' breastfeeding. One mother reported she had felt supported to breastfeed and equipment including breast feeding pumps was provided.
- Inpatient ward staff explained that children would be generally be accommodated according to age groups, however children and parents would be asked for their preferences before admission. There were multiple bathrooms available on the ward. However, it was difficult to designate a toilet to either male or female.
- The hospital had separate menus for children that were appropriate to their age and also reflected the nationalities of the local community. Staff we spoke with told us that the catering service provided specific dietary requirements such as halal or kosher food. Food quality was a common theme of negative feedback from children and young people and the hospital had established representation on the catering committee in order to work to continually improve food within the children's service.
- A sensory room was available on the inpatient ward. This was used for calming anxious children and access was provided for patients supervised by parents or carers by the nursing staff.
- The hospital offered face-to-face, telephone and written translation services, as well as sign language using an outsourced company. The doctors and nurses we spoke with were able to fully describe how to organise translation services for families. We did not observe any interpreters being used during our inspection.
- We saw a range of information leaflets to help inform families about care, clinics and support services available to them. An example of this was for the 'paediatric sickle cell and thalassaemia service. The service had produced a comprehensive leaflet about the ward routine and facilities. These leaflets, given to all in-patients were also available in other languages.
- The discharge nurse on the neonatal unit provided resuscitation training for parents prior to discharge. They also could offer a 'safe sleeping' guidance card, which was available in different languages.
- We saw all areas visited had noticeboards displaying current and relevant information. This included information on childhood illnesses and vaccinations, safeguarding information and a 'Meet the Team' board which had a photo of every member of staff and what their role was. We also found a suitable range of information leaflets were readily available for families and children; these were easily accessible.
- Children and young people admitted with mental health concerns had increased over the last two years with 106 admissions due to unavailability of mental health beds

over the 12 months before our inspection. Staff had received additional training through the Simulation Workshop at the Mental-Physical Interface: Children and Young People (SWAMPI-CYP) provider. A review of skills was being undertaken to reduce reliance on agency mental health nurses by identifying different professionals for care or developing the skills of internal staff

- A high number of children and young people diagnosed with Autism Spectrum Disorders (ASD) live in Lewisham borough. ASD is a term used to describe a group of pervasive developmental disorders that can be identified with differences and impairments in social interaction and communication. Staff adapted care provided to this group on an individual basis. Nurses described how one child got upset seeing many different people and so they made an effort to keep this to a minimum. In the day-case unit the order of the operating lists could be adjusted so children were not waiting so long.
- A two bed adolescent bay had been created in the inpatient ward. It had a sofa, small fridge and microwave for patient use as well as books suitable for teenagers. We were told by nursing staff that this space was often allocated to patients attending with cystic fibrosis for more space and privacy during long stays. However a peer review conducted in 2016 had identified that this bay not being in line of sight from the nurses' station could present a risk.
- A number of clinics were held within the outpatient department which children and young people with learning difficulties or additional needs attended on a regular basis. Lead nurses within this area told us that longer appointments would be offered in some clinics such as the epilepsy clinic in order to provide extra support for these children.
- An adolescent clinic had been introduced on a monthly basis for any speciality. This had been started in order to reduce the non-attendance rates and reduce the time spent out of school for patients of this age group. In addition early evening clinics for adolescent diabetes and epilepsy clinics had been introduced within the trust since the last inspection to reduce the time spent out of school for these children.
- The hospital had clear specific guidance for principles of care for dying patients. This was not children and young people specific, however we were told that there was limited requirement for this at the hospital and that support could be provide from the trust palliative care team. Staff were able to explain how they would support bereaved parents. We saw a pack they provided that contained useful information about next steps and where to access support and a named contact given.

Learning from complaints and concerns

- Between January and November 2016, there were six complaints about children and young people's services at the hospital. Between February 2016 and February 2017, in all but one month the service was above the trust target of 70% of responses within 18 days. There had been a 100% response rate within 18 days for complaints received in the last six months. Between June 2016 and February 2017 100% of complaints had been resolved within the agreed timescales.
- We saw information was displayed in wards and departments explaining how parents, children, and young people could raise their concerns or complaints.
- Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process.
- The hospital gathered information on informal complaints from children on the inpatient ward and day-case unit about services using 'Tops and Pants'. Children were asked to colour in either a pair of pants (trousers) or a top and to write a message about their hospital experience. 'Pants' identified a negative experience and 'tops' a positive experience. All the tops and pants were displayed on the ward and action was then taken where appropriate to improve their experience. One such example was the introduction of the parents lounge within the inpatients ward.
- We saw the display of tops and pants feedback on the ward. Common complaints received on 'pants' were about the food, noise, beds and needles. Positive comments on 'tops' were about caring staff. On some of the complaints, for example where there had been a delay to a procedure, we saw a written feedback response on the board next to it.
- The children's services governance lead attended the trust wide patient experience meeting. They would share a patient story and provide feedback about complaints or concerns raised within the children's services as well as learning from feedback from other departments.

Services for children and young people

Are services for children and young people well-led?

Good

We rated well-led as good because:

- Since the last inspection there had been clear progress in developing cross-site governance structures, risk management and learning.
- Staff spoke positively about the leadership team and felt involved in improving services.
- Patient feedback was encouraged within all departments with innovative ways of involving children and young people.
- A positive culture meant that all staff engaged with the service visions and values.

However:

- There were low levels of attendance at quality and safety boards which reduced opportunities for sharing of information to the appropriate people.
- The issue of additional babies being cared for in the NNU was not listed on the risk register and therefore may not have been be effectively mitigated against.

Leadership of service

- The divisional leads, including director, general manager and a head nurse led both sites and this included spending time at each of the hospital sites.
- There was a clear framework for nursing leadership within the hospital. The lead nurse for children's services worked at both sites and held a monthly senior nurses meeting that was attended by the matrons from each hospital as well as the community.
- Staff reported that they regularly saw the senior staff and divisional leads visiting children's service areas. Senior staff reported that they found the executive management open so that they could raise issues if required. The Chief Executive had attended consultant meetings in the past and also had come to the inpatient ward to respond to a complaint.
- The trust had been a pilot site for a peer review of children's services that had been conducted in July 2016. The review had observed that the paediatric clinical and leadership teams functioned very well and observed support and commitment to the review by the Board and the Executive team.
- There had been an away day for children's services staff of all levels held in the last year and been viewed extremely positively with around 90 people attending. There were plans for another away day to be held in April.

Vision and strategy for this service

- The divisional strategy was to provide consistently safe, high quality services and improved outcomes for their children; which included create a sustainable, well governed division, which is clinically-led; strengthening and extending relationships with their partners; promoting a caring, high performing workforce through good quality leadership; and ensuring the division was in a strong financial position. We saw staff embraced the vision and strategy in the provision of neonatal intensive care, acute care and day care provisions, and outpatients and community paediatric services.
- Staff spoke about how they continued to work towards the same goals when caring for children and young people.
- The last away day had included the creation of 10 divisional aspirations that were compiled by all the staff in attendance.

Governance, risk management and quality measurement

- At the last inspection we found that there was a lack of joint working between the two hospital sites and this included sharing of learning from incidents. On this inspection, we saw that improved arrangements were in place for cross-site governance, risk management, and quality measurement associated with the care of children and infants across the trust. We found the arrangements enabled the service to measure their performance and quality. Meeting locations, such as the quality and safety meeting alternated between sites to encourage attendance and tele-conferencing facilities would also be used where possible.
- Divisional board meetings were held monthly and included senior managers, clinical directors and nurses from both sites and also the community services. Additionally representatives from human resources and communications also attended. Exception reports from

each directorate were presented for discussion at this meeting as well as topics such as incidents, complaints and workforce. In all the minutes that we reviewed it showed these meetings were well-attended providing a useful forum for learning and sharing information.

- Divisional Quality and Safety boards were held on a monthly basis and had attendance from both sites. Exception reports from each children's' area were presented for discussion at this meeting as well as topics such as incidents, risks, patient experience, audits and policies and highlighted where cascade of information was required for staff. All of the meeting minutes that we reviewed had significant (over 50% of total invitees) apologies which may have meant that there were reduced opportunities for sharing information. We were told that the new video conference system was planned to improve attendance as it meant a reduction in travel if the meeting was on the site where attendees worked.
- Neonatal governance meetings were held monthly and alternated the location at each site. Topics such as incidents, infection control, staffing, risks, audits, referrals, policies, complaints, guidelines and research were considered. Actions showed where learning needed to be cascaded. These meetings were intended to provide MDT feedback, however two sets out of three meeting minutes that we reviewed showed poor attendance and this therefore limited the MDT input.
- Minutes of governance meetings were circulated to ward sisters, although we were told that they were also welcome to attend. It was cascaded to staff on the inpatient ward by monthly team meetings which were led by the ward manager. All nurses were expected to attend if they are not on duty and meeting minutes were emailed to all staff. In addition a governance newsletter was circulated to staff that included points of interest. For example the one for January 2017 had information and learning on incidents.
- Analysis of the children's risk and issue register provided by the trust prior to this inspection generally showed risks that we identified on the inspection. We saw that the risks and issues were being reviewed and updated regularly. Each area could submit a form if they had identified a risk or issue for consideration to be added to the register. Risks for the Lewisham site were qualified staff for the neonatal unit and the fact that babies from the post-natal ward needed to attend the neonatal unit for intravenous antibiotics. A new issue that had been added recently for both sites that there were an increasing number of children with mental health conditions admitted to the ward and nursing staff did not have some competencies to care for them effectively. Staff were updated on the division top five risks through the governance newsletter. However the risk register did not include the issue of additional babies being cared for the NNU which meant it may not have been effectively mitigated against.

Culture within the service

- Within each area of the children's services that we visited there was a large poster detailing the charter of the ward and how they would work with other colleagues. For example there was a charter between the inpatient children's ward and the children's emergency department. This charter had been developed by staff from each of the departments meeting in early 2016 to discuss some of the issue that they had and from this a charter was developed about how they could support each other. This had helped each team understand the problems that others faced and improved working relationships.
- Staff talked positively about the service they provided: they enjoyed working at the hospital. Some members of staff had worked there for many years. They felt part of the team and felt staff worked well together and supported each other. Morale appeared good.
- The 2016 peer review identified that paediatric staff had a mutual respect of each other.
- The average sickness rate for children and young people services was monitored on the quality scorecard. This showed that between February 2016 and February 2017, the sickness rate within nursing staff working in children's services had declined to 2.8%, better than the trust target of 3.5% to 5.6%. Changes had been made to sickness management including assessing whether reasonable adjustments could be made to support staff to return to work sooner.
- The inpatient ward had an 'employee of the month' award. Nominations could be submitted by any member of staff and details of the winner were put on a board within the staff room.
- Staff within the neonatal unit spoke of the team ethos and how patients being cared for could be followed up

by any of the consultants. They stated that patients were 'our patients' and not 'my patients'. Consultants also covered for nights when there were shortages of doctors.

Public engagement

- Feedback was received from children and young people using 'mouse mail'. This was a colourful feedback sheet with three simple questions which children could complete to inform staff about children's perception on the ward. This was attached to the friends and family feedback sheet that parents could complete.
- The 'Tops and Pants' scheme meant that informal feedback could be gathered from children using the service. All the tops and pants were displayed and action taken where appropriate to improve experiences. One such example was the introduction of the parents lounge within the inpatients ward.
- We saw a number of examples of changes that had been made following patient feedback. 'You said, we did' posters were displayed in each department we visited. For example, the introduction of a mobile, sensory projector within the procedure room used to distract children while having a test or procedure.
- The neonatal unit had an ideas board where parents could suggest improvements that could be considered for the ward.
- The outpatients department had engaged with schools across the borough and were planning on supporting work placements for students within the department. This had been identified as a key demographic for engagement as one in four people within the borough of Lewisham was under the age of 25.
- A quality ward round had been introduced throughout the hospital five months before the inspection and was carried out on a fortnightly basis. This centred on patient experience and the environment and included the views of patients and parent within it.

Staff engagement

- Staff were encouraged and supported to develop areas of interest and act as a source of advice and training for the team, such as becoming a link nurse for a specialist subject, for example in bereavement.
- The 2016 staff survey results found that out of 29 responses at the hospital the vast majority (85%) stated they were always or often enthusiastic about their job which was higher than the national response of 76%.
- In three questions on the 2016 staff survey which asked whether respondents were involved in deciding, suggestions or making improvements to the service or department the majority of respondents agreed or strongly agreed. These scored an average of 65% across the three questions which were in line with the national average across the same three questions of 63%.

Innovation, improvement and sustainability

- The trust held an annual 'Healthcare Heroes Awards' to celebrate staff achievements and dedication. Some staff we spoke with told us that this was a good way of recognising staff that went the extra mile to improve patients' experience.
- The 'tops and pants' scheme for receiving feedback from children and young people using the service was due to be rolled out to Queen Elizabeth Hospital as it had been identified as good practice.
- The quality ward round which had been introduced throughout the hospital five months before the inspection was identified as a key way of senior staff engaging with patients, parents and staff on a 'back to the floor' level and driving improvement.
- The trust had introduced a 'Hot topics' poster that included a 'QR' code that staff could scan on their phone for more details. A 'QR' code is a quick response code, consisting of a matrix barcode that stores information capable of being read by the camera of a smartphone. An example of a hot topics poster produced for children's services was about extravasation (when drugs or fluid leak into surrounding tissue) and the QR code linked to information about the Visual Infusion Phlebitis score tool used for monitoring sites.

End of life care

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

555 referrals were made to the SPC between December 2015 and November 2016, of which 65% were cancer related and 35% were non-cancer related and included heart failure, stroke and chronic respiratory disease. The team saw 59.8% of patients within 24 hours of referral.

We previously inspected end of life care services in May 2014, which resulted in a rating of requires improvement. This rating reflected the fact there were no clear guidelines on when and how to involve the palliative care team for people who were reaching the end of their life. 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. This meant 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. There was mixed recording of information on patient's care plans, one of the consequences of which meant we could not be sure that all patients were receiving adequate reviews of their medication.

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

End of life care

Summary of findings

We rated this service as requires improvement because:

- End of Life Care (EoLC) did not appear to have a high profile at trust board level.
- The trust performed poorly in the End of life care Audit: Dying in Hospital 2016 and most staff whom we spoke with were unaware of the trust's performance in this.
- Utilisation of end of life care plans was not fully embedded.
- There was poor recognition of when a patient was at end of life.
- Responsibility for end of life care appeared to rest with the Specialist Palliative Care team, rather than being seen as a hospital wide responsibility.

However:

- Staff were confident in their ability to safeguard patients.
- Staff closely monitored patient's pain and discomfort levels.
- Verbal feedback from people who used the service and those who were close to them was positive about the way staff treated patients and their relatives.

Are end of life care services safe?

Requires improvement

We rated safe as requires improvement because:

- End of life care was not included as part of mandatory training
- Some staff told us they did not always get feedback about incidents they had raised.
- There was inconsistent hand hygiene on some wards.
- A recent trust board report evidenced that just 11% of patient records had a copy of the Principles of Care for Dying Patients in the notes and 15% of patient records had an end of life care plan (Care Plan 8) completed in the nursing notes.
- Patient notes were not always contemporaneous, dated or timed.
- We looked at six completed DNACPR forms and noted that five forms had no record of review date.
- There was one palliative care consultant for the hospital which meant there was not always consistent on-site clinical oversight of end of life care patients.

However:

- Staff were clear about their responsibility to report incidents.
- Syringe driver refresher training was being rolled out to all staff.
- Staff demonstrated a good level of understanding of how to safeguard patients.
- Medicines were safely stored.
- There were good levels of hygiene in the mortuary.
- Staff were fully compliant with mandatory training.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. No never events or serious incidents were reported between December 2015 and November 2016.
- The staff on the wards and in the specialist palliative care team (SPCT) told us there was an expectation that incidents were recorded.

- However, whilst staff reported incidents and were confident with the process, they said they seldom received feedback about the outcome. We saw one ward had a board which had incident, investigation, learning points and actions written on it. The ward sister told us they started each morning team meeting by talking through an incident in this manner.
- The SPC team gave examples of when they reported incidents, such as when a patient's syringe driver battery ran out one hour prior to discharge from the ward. Whilst the patient was given alternative pain relief, the battery should have been replaced on the ward.
- The majority of mortuary incident reports were about patient identification. The incident reporting system recorded action taken, such as further discussion with the ward manager and suggestion of an information giving session to reinforce the importance of attention to detail when recording the deceased's name.
- Staff we spoke with were aware of the requirements of duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- There had been no serious incidents or never events reported by the mortuary team or the SPC team in 2015 – 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Cleanliness, infection control and hygiene (only include if there is a palliative care ward)

- Infection prevention and control was part of mandatory training for all staff.
- We found the mortuary area to be clean during our inspection. We saw there were regular audits to check compliance with the infection protection and control processes.
- Staff told us that all leakages were wiped up immediately and trays with bodies on were cleaned once the body was removed. A fogger machine was used to assist with more intense cleaning of the fridges.
- Ward staff identified deceased patients who had an infectious disease. Porters placed these in a body bag and they were stored separately in the fridge. Porters, mortuary staff, and undertakers were provided with personal protective equipment such as gloves or aprons.
- We did observe inconsistent hand washing on some wards, for example, some staff did not wash their hands when moving from patient to patient.

Environment and equipment (only include if there is a palliative care ward)

- The syringe drivers for delivering measured doses of pain medication conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia.
- Ward staff obtained syringe drivers from the equipment library. They told us there was no shortage of equipment and syringe drivers were usually delivered to the ward within 30 minutes of the request being made.
- The syringe drivers had annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations.
- The mortuary had sufficient numbers of fridges and a range of sizes for storing bodies. This included specialist fridges for bariatric and super bariatric bodies.
- There was an additional temporary storage facility on standby in the mortuary in the event of the number of bodies exceeding the availability of permanent storage. This could be brought to temperature within 20 minutes of requirement. There were arrangements with local undertakers in case of emergencies, who would store additional bodies.
- There was an automated temperature measurement system on each fridge, which facilitated regular checks automatically. An alarm rang if there was a fluctuation in temperature. This went to the security desk, as well as a member of the mortuary staff. They oversaw that appropriate checks were made to ensure that the fridges were working properly. We were told that this same automated temperature measurement system was soon to be installed on the temporary fridge.

Medicines

- Drugs were stored safely, including controlled drugs. Prescriptions were checked by the pharmacist and controlled drug prescription were checked twice and countersigned
- The development of non-medical prescribing within the health service enables suitably trained healthcare

professionals to enhance their roles and effectively use their skills and competencies to improve patient care in a range of settings involving. Whilst the trust had a non-medical prescribing policy for nurses, pharmacists and allied health professionals, there were no non-medical prescribers at the time of our inspection; prescribing was the sole remit of the doctors.
- There was a fixed set of anticipatory medicines on the electronic system with guidance for usage. Doctors told us it made prescribing the appropriate medicines much safer and easier.
- Medicine administration records were completed accurately in the records we reviewed. However, we noted on one patient's record that a decision taken earlier in the day by the doctor to discontinue medication had not been relayed to nursing staff. Nurses had continued to administer the patient's medication until a member of the inspection team drew it to the matron's attention, at which point it was discontinued immediately.

Records

- End of life care plans had been introduced since the last inspection. The SPC consultant told us they were designed not to be tick boxes, and staff had to document in free hand writing in order to ensure person centred recording.
- However, in a report presented to the trust board in September 2016 by the Associate Director of Nursing, it was evidenced that just 11% of patient records had a copy of the Principles of Care for Dying Patients in the notes and 15% of patient records had an end of life care plan (Care Plan 8) completed in the nursing notes.
- We found this to be the case in the seven sets of patient notes we reviewed. On one record we looked at, there was no evidence of an end of life care plan in the medical notes and there were no notes in the EoLC part of the nursing notes (care plan 8).
- Patient notes were recorded in paper records, with separate records for medical staff and nursing/allied health professional staff. They contained a record of patients' needs and care plans, medical decision-making and review, and risk assessments.
- The SPC team recorded on an electronic system, printed off their consultation and then lodged it into the medical record. We noted that on some records, these patient notes were not filed in date order which made it difficult to track what the most recent assessment had been and could negatively impact on the patient's care.
- This was noted as an issue at the last CQC inspection in February 2014.
- We reviewed nursing notes and saw that whilst there was good evaluation of the patient, this was not always linked with the end of life care plan, and recording of notes was not always contemporaneous, dated or timed. This was also noted in the last inspection.
- An end of life care plan was initiated when it was thought the patient was close to death. This was in paper form and we noted that on some, the hand writing was poor which made it difficult to read the notes and the signatures.

Safeguarding

- Information given to us by the trust showed that all SPC staff were compliant with Safeguarding Adults - Non Clinical Level 1 and 2 and Safeguarding Children & Young People Level 2.
- Staff understood their role with regards to protecting patients from harm or abuse and reporting any issues. This included identifying any risks to a patient's family such as children or vulnerable adults whose main carer may be a patient.
- The staff we spoke with were able to describe what constituted a safeguarding concern and were aware of how to raise a concern.
- There were procedures to keep children and vulnerable adults safe. Staff had access to the trust safeguarding policy on the intranet.

Mandatory training

- The trust provided evidence which demonstrated that all SPC staff, including the palliative care consultant, were fully compliant with their mandatory training. This included adult and paediatric resuscitation basic life support; Mental Capacity Act & Consent to Examination/ Treatment; Prevent Awareness Level 1 & 2; medicine management and patient handling.

Assessing and responding to patient risk

End of life care

- At the end of life, there were inevitable changes to the body such as weight and skin integrity. Staff used tools to assess risks to patients, such as pressure ulcers. Appropriate pressure relieving mattresses were given to patients at risk.
- An early warning system (EWS) was used by staff to identify if escalation of care was required. This system was used to identify patients who were deteriorating and may have required specialist team involvement.
- 'Principles of Care' documents were used by nursing and health care assistants for patients who had been identified as being in the dying phase to monitor discomfort and record symptoms.
- The SPC team told us they worked with medical and nursing staff on the recognition of the dying patient. However, they said there was often a lack of confidence amongst staff to formally identify a patient who was dying. This meant that the 'Principles of Care' document was sometimes implemented late in the patient pathway.
- We noted that the issue of missed opportunities to identify, discuss and plan for a dying patient was raised at the EOL steering committee.
- 555 referrals were made to the SPC between December 2015 and November 2016, of which 65% were cancer related and 35% were non-cancer related and included heart failure, stroke and chronic respiratory disease. The team saw 59.8% of patients within 24 hours of referral.
- The end of life care team supported clinicians with the completion of do not attempt resuscitation (DNACPR) documentation when appropriate.
- We looked at six completed DNACPR forms and noted that five forms had no record of review date. We also noted there were two different forms in use, with some slight differences in the review section.

Nursing staffing

- According to NHS England Specialist Level Palliative Care: Information for commissioners April 2016, there is no solid evidence or benchmark on staffing levels and ratios for commissioners and service providers. The SPC hospital team had four clinical nurse specialists, which equated with 2.6 whole time equivalent posts. We were told that there were times when the team felt under pressure as they responded to requests from other hospital staff. Their hope was that through education and reinforcement, generalist staff would grow in confidence to manage their patient's end of life care, and not feel they needed to refer to the SPC team, except for more complex patients.
- The SPC team had stable staffing, most of whom had worked for the trust for many years. There was no use of agency staff.

Medical staffing

- There was one full time palliative care consultant who worked over the course of the week. This meant that there was not always a palliative care consultant physically available on site. However, there was 24 hour consultant cover, which included telephone cover from Guys and St Thomas' hospital.
- The palliative care consultant told us they ensured they received regular clinical supervision and had an annual appraisal with a colleague in another specialism.

Major incident awareness and training

- The mortuary and its facilities formed part of the major incident plan; however staff expressed a view that with existing capacity pressures, there would be a limit to how many additional bodies they could manage to store should a major incident occur.
- We raised this with senior managers who acknowledged capacity could be an issue but confirmed there was a contingency plan in place which included liaising with local funeral directors to use their body storage facilities.

Are end of life care services effective?

Requires improvement

We rated effective as requires improvement because:

- The trust's End of Life Care Strategy (year 1) was not fully implemented.
- There were no audits done of end of life care plans.
- There was poor recognition of patients in their last year of life.
- There was poor recognition of the palliative care needs of the frequent re-attender.
- There was no bereavement survey carried out.
- Efficacy of symptom management was not measured.
- The trust performance in the End of life care Audit: Dying in Hospital 2016 was worse than the England average for four of the five clinical indicators.

End of life care

- The end of life care plan was not always initiated.

However:

- National guidelines in relation to palliative care were followed.
- We observed that staff paid particular attention to addressing symptoms of pain in their patients.
- Despite a worse than average performance overall, the trust scored highly for nutrition and hydration in the End of life care Audit: Dying in Hospital 2016.

Evidence-based care and treatment

- The trust did not participate in the National Survey of Bereaved People (VOICES): England, 2015 which explores the quality of care delivered in the last 3 months of life for adults who died in England.
- Palliative care was managed in accordance with national guidelines, which formed the basis of trust policy. For example, the guidelines for symptom control were based on World Health Organisation (WHO) guidelines for management of pain.
- There were no audits of care plans for the dying patient since they were introduced. Patients who were in their last year of life were not automatically identified when first admitted via urgent care services unless they were on an advanced directive end of life care plan or a DNACPR was in place from the community.
- We found on two patient records, where there were multiple admissions, no end of life care plan was initiated to assist medical and nursing staff with their decision making for future admissions.
- We discussed this with medical staff who told us that the emergency department was doing a study of frequent attenders. However, there was no plan in place to coordinate this with the SPCT.
- There had been no audit of the use of anticipatory medication since the last inspection in February 2014.
- A pilot study had been launched two weeks prior to this inspection which was a 'symptom observation chart in last days of life' with a view to auditing the efficacy of anticipatory drugs and whether the patient care should be escalated to the SPCT. The study would be finished two weeks following this inspection.
- A 'task and finish' working party was set up in response to EoLC patients being transferred to the discharge lounge in September 2016. Progress was slow on this with one meeting held so far and another one postponed.
- Local audits undertaken included a Bereavement audit, outcome of which was due to be reported later on March 2017. EoLC Documentation audit (Lewisham Community) and EoLC documentation audit - Specialist Palliative Care were due to be reported on in April and May 2017 respectively.

Pain relief

- We saw staff considered adequate pain relief for end of life care patients to be a priority and where needed, they sought guidance and input from the specialist palliative care team (SPCT).
- However, in the absence of an audit of pain relief, which had formed part of a recommendation in a recent Public and Health Service Ombudsman (PHSO) report, it was difficult for staff to be assured that the current dosages were effective. The concern was that there could be a delay in a patient receiving appropriate and adequate pain relief.
- In response to this, a new chart, 'Symptom Observation Chart in last days of life' was in the midst of a four week trial on one of the wards at the time of our inspection. The results of this trial were not known at the time of our inspection.
- Staff demonstrated an awareness of symptom control and the use of anticipatory medication. They told us everyone who was recognised as at end of life was prescribed anticipatory medication.
- We saw examples in the records of pain control managed with anticipatory medication. Drugs were administered by a syringe driver where the oral route had become inappropriate and symptoms become continuous. Some patients had syringe drivers, which delivered measured doses of drugs over 24 hours. These were set up and operated by staff trained to do so. We saw examples of appropriately prescribed syringe drivers, which nurses checked regularly to make sure they were functioning correctly and the patient was receiving the correct dosage of drugs.
- However, some nurses told us it was expected that they would involve the SPCT when a syringe driver was to be used.

Nutrition and hydration

- The trust scored highly in the End of life care Audit: Dying in Hospital 2016 for nutrition and hydration.

Where the national average was 18% for documented evidence of discussion regarding drinking and the need for clinically assisted hydration with the patient, the trust score was 37%.

- 57% of patients had clinically assisted hydration in place during the last 24 hours before death where the national average was 43% and 36% of patients were documented as eating in the last 24 hours where the national average was 26%.
- We spoke with a dietician who told us there was a proactive approach to referring patients. Ward staff identified at risk patients via a malnutrition screening tool and referred to a dietician. They said that nurses who cared for patients in the last twelve months of life encouraged them to take food and drink, and to offer alternatives to the usual hospital menu.
- The dietician told us there was a food first approach, with snacks offered little and often in recognition of diminished appetites and nursing and medical staff were very receptive to suggested eating plans. Red trays were used to serve food to patients at high nutritional risk. This alerted all staff that the patient was likely to need support and encouragement to eat.

Patient outcomes

- The SPC consultant told us they did not actively encourage all EoLC patients to be referred to the SPCT, as they wanted to encourage other specialisms to recognise their responsibility to the dying patient. They felt that where there were no complex needs, then the medical team should prescribe and treat. The SPCT told us that whilst not every patient nearing the end of life would be seen by the team, all those referred would be.
- We saw referrals were reviewed within hours, the patient visited and team members provided support to both patient and ward staff.
- We observed staff on the wards using an early warning system to monitor patients who were recognised as in the last few days of life. The patient was regularly reviewed and provided with appropriate care.
- If the patient was deemed to be nearing the end of life, the early warning system was discontinued and care planned in line with the five priorities of care for the dying patient. We found that in some cases, whilst good care continued, the end of life care plan was not initiated.
- Co-ordinate my Care (CMC) is the London End of Life care register. It allows healthcare professionals to electronically record patient's wishes and ensures that their personalised urgent care plan is available 24/7 to all those who care for them. It aims to support patients to remain in the place of their choosing at the end of life. The register is GP led, however any member of staff involved with the patient can enter patient information onto the system.
- It was an objective of the End of Life strategy to identify key leads who would be responsible for updating and entering information onto the register. They would also publicise the CMC register in order to ensure that staff accessed the information to inform their decision making and communication with patients and those identified as important to them.
- However, we were told that registration of patients was slower than expected, mainly due to the expectation that it was the responsibility of SPCT staff to transfer patients onto the register which was time consuming and difficult due to their small team size.
- A recent audit of 146 patient records who died on the Specialist Palliative Care community caseload between 1st December 2015 and 30th November 2016 included CMC registration. 50 of the 68 (74%) home deaths were registered on CMC and 79 of the 146 patients (54%) who died were registered on CMC.
- The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed worse than the England average for four of the five clinical indicators. These included whether there was documented evidence within the last episode of care that the patient would probably die in the coming hours or days. The trust score was 73% against a national average of 83%.
- The national average for a senior doctor (Consultant) being involved in the recognition of dying was 76% of cases, where the trust scored 51%.
- The trust score was 77% against a national average of 84% where there was documented evidence that the patient was given an opportunity to have concerns listened to.
- The trust scored particularly well for the clinical indicator for documented evidence within 24 hours of holistic assessment (80% compared to the England average of 66%).
- Some staff we spoke with were unaware of the outcome of End of Life Care Audit: Dying in Hospital 2016 and whether there was an action plan as part of the trust's response to it.

End of life care

Competent staff

- End of life care training was not mandatory across the trust though there was a three hour introduction to end of life care within the Health Care Support Worker induction programme. All qualified nursing staff got a briefing on end of life care and SPC services within the trust as part of their clinical induction when they join the organisation.
- A three hour session was included as part of the preceptorship programme, band 5 and band 6 development programmes.
- An annual formal teaching session on end of life care for medical staff was held in 2016. Clinical issues related to end of life medical care were raised and discussed at this session. In addition, the SPC team and palliative care consultant provided a session on the junior doctor induction programme. The palliative care consultant told us they also provided ad hoc training on the wards as needed.
- Other staff told us they would benefit from the opportunity to spend time with colleagues discussing EoLC. They said that it was difficult to attend lunchtime sessions as it was often not possible to be released from the ward. There was a view expressed that the trust leadership could be more proactive about this.
- Link nurses for EoLC play a key role in supporting good practice. The trust End of Life Care strategy identified the need for all wards to have a link nurse practitioner with established governance links into the End of Life Care steering group for the year 2017-18.
- A Link Practitioner forum was established, and study days were led by clinical managers, with contributions from the SPCT. Members of the SPC team told us it was important that all wards had an active link nurse in EoLC as soon as possible in order to reinforce good practice in palliative care and EoLC care on the wards.
- We looked at training registers, including completion of e-learning and competency documents held by individual wards with regard to staff training in the use of syringe drivers.
- We saw that staff received training as they joined the trust. However, for those staff who had worked with the trust for a number of years, we noted that there had been no provision of refresher training since 2013.
- Band 5 nurses and above could set up and administer drugs via a syringe driver subject to completion of the appropriate training. Some staff we spoke with expressed a lack of confidence in the administration of syringe drivers, as they did not have regular experience of fitting one; in some cases they might only fit one per month and therefore were concerned that they would make a mistake. Some staff told us where possible; they avoided fitting the syringe driver and instead, asked for assistance from more experienced staff, or members of the SPC team.
- We spoke about this with a practice development nurse (PDN) who recognised this as an issue and had raised it as a training need with their line manager. They said that all previously trained staff were due to have refresher training and they were planning this in conjunction with other PDNs across the hospital. There was no cohesive information available at the time of this inspection relating to numbers of staff who required syringe driver training.
- Staff told us they had regular supervision and appraisal. The trust confirmed that the appraisal rate was 100% for the SPCT.
- We were told that there were limited training and developmental opportunities for some. For example, two people told us how training requested as part of their staff development plan had not been fulfilled, despite this training need identified in their plan for at least two years.

Multidisciplinary working

- Staff told us they worked in a multidisciplinary way with speech and language therapists, physiotherapists and dieticians, as well as community based SPCT colleagues. This meant that patients could be supported in the community as soon as they were discharged. We were told that there was a good relationship between SPCT hospital and community team, where the needs of the patients upon discharge were anticipated.
- The Lewisham SPC team had regular meetings with a local hospice to review communication and referral processes. These meetings occurred quarterly as part of the business meeting for the SPC team.
- EoLC work done in other specialisms was not shared or integrated. For example, the emergency department recently developed a frailty pathway but this had not been integrated with EoLC or palliative care.

End of life care

- Nursing staff told us they were very reliant on SPCT clinical nurse specialists to assist when a patient was dying or wished to return home. They often called the SPCT to provide emotional support as some staff expressed concern that they might 'miss something'.
- The process was that a member of the SPCT managed the fast track of the patient to home or to their stated preferred place of death. We were told that the logistics of this could be very time consuming and took up a disproportionate amount of the resources of the team as poor transport provision often delayed discharge.
- Members of the SPCT told us that there was a gradual cultural change whereby EoLC was seen to be everybody's responsibility, not just the SPCT, and where EoLC was not seen to be just for those patients with cancer.
- We saw clear lines of communication and joint working between the mortuary staff, staff in the bereavement centre and the SPCT.

Seven-day services

- There is a 9-5pm 7 day a week clinical nurse specialist visiting service covering the acute site and community. Between 5pm and 9am professionals have access to SPC advice via the SPC consultant rota staffed by consultants from local trust hospitals including Guys and St Thomas and Kings College hospital.

Access to information

- Staff told us a new IT system was introduced three months prior to our inspection which was not yet fully implemented. Members of the SPCT told us that the system was occasionally unresponsive, which had the effect of slowing down their work, but did not compromise patient safety.
- Co-ordinate my Care (CMC) is the London End of Life care register which allows healthcare professionals to record a patient's wishes with their permission and ensures their personalised care plans are available to all those who support them. A recent audit done by the SPC team showed that of the 146 referrals to the team between 1st December 2015 and 30th November 2016, 54% were registered on CMC. One objective of year 2 of the trust End of Life Strategy was to ensure improved access to CMC.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at five Mental Capacity Act (MCA) assessments and noted there were some inconsistencies amongst staff about its application. For example, despite a person scoring 10 out of 10 for cognition, nursing staff told us they queried the patient's capacity.
- We saw no evidence of a formal MCA assessment or record of a decision making process which involved the patient and their future placement. For example, where it was noted that the patient was not involved in a discussion about their care, a member of staff recorded 'too confused to discuss', but did not document what attempts were made to have a discussion with the patient.
- Staff told us they ensured that care given was in the patient's best interest. In cases where the patient's communication was limited, they observed body language and listened to any sounds which the patient might make to indicate their preferences.
- Results for End of Life Care Audit: Dying in Hospital 2016 evidenced that 84% of patients had a do not attempt cardiopulmonary resuscitation (DNACPR) order in place on patients' notes at the time of death where the national average was 94%.
- We looked at six completed DNACPR forms and saw that in most cases, they were appropriately completed, including where the DNAR decision was discussed with the patient and their next of kin. For example, on one completed form, the recorded notes showed that there was reflection on the patient's capacity and their ability to make decisions. Subsequent notes made four days later, when the patient's diagnosis was confirmed, documented further discussions with the patient and their next of kin about the patient's refusal of further treatment.

Are end of life care services caring?

Good

We rated caring as good because:

- The care shown by mortuary staff for the deceased and their relatives was compassionate and respectful.
- The profile of the Chaplaincy was raised since the last inspection in February 2014.
- Patients spoke well of staff and how caring they were.

End of life care

- Patients at the end of their life were supported to spend time with their loved ones and pets.

However:

- The spiritual needs of the patient were not always to the forefront of staff members' minds.

Compassionate care

- We observed examples of staff interacting with patients and those close to them with kindness and dignity. Staff told us they remembered that they were also supporting the families of the dying.
- Feedback from patients and their carers found that staff treated patients with dignity and respect, explained what was happening and were caring towards the relatives of patients.
- One patient told us told us how after they were admitted, their procedure had been postponed on two separate occasions. They told us that staff recognised the additional stress this placed on the patient and were reassuring and caring towards them.
- Another told us they "couldn't fault the staff", though there were times when they had difficulty understanding some of the nurses' accents.
- We found that patient confidentiality was respected in most instances. However, we noted patient's full names were written on whiteboards at the entrance of many wards. We discussed this with one matron, who told us that this had been previously raised by information governance, but there was no follow up or further mention of how this could best be resolved.
- Mortuary staff told us that the bodies transferred from the wards were generally well presented. They said that the incidence of them being wrapped too tightly, (something which was raised at the last CQC inspection in 2014) was a rare occurrence.
- Mortuary staff spoke with compassion about the deceased and their family members. They explained to us how they tried to make the experience of viewing the dead as straightforward as possible. This included meeting with the bereaved from reception to accompany them to the mortuary to view the body.
- They showed us how they made the viewing room child friendly when the deceased was a child or baby, this included strategically placing toys around the room.
- Mortuary staff provided tiny clothes and blankets, which they hand-made themselves, to dress the bodies in. Babies, no matter how small, were clothed and placed in baskets of different sizes, covered with a blanket.
- If a deceased patient had no known next of kin the hospital would arrange the funeral, and mortuary staff would attend. Staff told us they were often invited to funerals and where possible would attend, as they told us it was a privilege to be asked.
- Whilst there were no facilities for relatives to wash the body of the dead according to their specific religious and cultural practice, we were told that this had not been raised as an issue. There was a Mosque close by to which Muslims transferred their dead immediately after the body was released into their care.
- Staff were complimentary about the availability of the chaplaincy service, and commented that they would always come to the ward when called to support a patient.
- We spoke with the chaplain who told us how the chaplaincy team, which included full and part-time staff and a large body of volunteers, worked generically and in an inter-faith way. They told us pastoral and spiritual issues were the focus of their work. They also told us they offered support to staff members as required.
- The chaplaincy gave out resources such as prayer beads of different religions, crosses, and prayer cards to patients and relatives.
- Patient's property was delivered from the ward to the general office in green plastic patient property bags. It was stored ready for collection in a locked cabinet.

Understanding and involvement of patients and those close to them

- Members of the specialist palliative care team (SPCT) sometimes attended the wards to provide support to doctors in communicating difficult information to families and patients.
- We saw examples of good recording of discussions with the patient and/or their relatives about their end of life care plan. This included resuscitation and discontinuation of treatment.
- They also told us that wherever possible, they thought about ways in which to comfort and support the needs of the patient and their relative. On one ward we visited,

we saw staff bring together a wife with her very ill husband, both of whom were being nursed on separate wards. They were provided with afternoon tea and some privacy in each other's company.
- We were told of how a dying patient's pet was taken into hospital to spend time with them. This was an objective of the End of Life Care strategy delivery plan, and the hope was that this could be a regular part of the care offered to a patient at the end of their life.
- Mortuary and bereavement office staff demonstrated they understood where religious needs required a prompt burial, and worked hard to facilitate this. They also described how they had found appropriate devices to replicate candles, for example, so these could be placed next to the deceased.
- The bereavement officer provided a compassionate and responsive service to bereaved families and provided further advice as required. They telephoned relatives every day to update them when there were delays with releasing the body, for example, when an autopsy was required.

Emotional support

- In the last CQC inspection in February 2014, it was noted that patients were not routinely asked by staff whether they wished to speak with a member of the Chaplaincy, and relied on families to make this request. In the End of Life Care Audit: Dying in Hospital 2016 the national average for evidence of discussion with patients during the last episode of care regarding their spiritual/ cultural/religious/practical needs was 15% where the trust score was 10%.
- The chaplain told us that whilst there was improved recognition from ward staff about the importance of finding out about the spiritual needs of patients and their families, the chaplaincy still had much work to do to embed this in everyday practice. There was a section in the patient's care plan to document action, such as a referral to the chaplaincy service. When a member of the chaplaincy visited a patient, they placed a sticker in the patient's notes to alert staff to their visit.
- The chaplain told us that he was in discussion with his line manager to introduce spiritual care onto the induction programme as a way of embedding it in practice. In the meantime, the chaplaincy had introduced Faith calendars and a staff guide to spiritual care resources on every ward.
- In the most recent End of Life Care Audit: Dying in Hospital 2016, the hospital scored just below the national average (56%) to the question, 'is there documented evidence that the needs of the person(s) important to the patient were asked about' with a response rate of 54%.

Are end of life care services responsive?

Good

We rated responsive as good because:

- Referrals to the specialist palliative care team were seen within 48 hours was higher than the national average.
- Staff in the bereavement office delivered all of the details of a patient's death to the local registrar's office to spare the family returning to their relative's place of death.
- Dying patients and their relatives were offered privacy whenever possible.
- A wide range of staff were trained in effective communication skills to enable to them to engage with the dying and the bereaved.
- Staff in the mortuary, chaplaincy and bereavement office did all they could to assist the bereaved with the administrative aspects of their relative's death.
- There was evidence of learning from complaints.

However:

- In a recent audit, it was identified that a large proportion of patient notes did not have a copy of the Principles of Care for Dying Patients and there was poor completion of a patient's end of life care plan in nursing notes.
- Some doctors were slow to recognise a patient as at end of life and continued to actively treat.
- There was occasional over-reliance by nurses on the specialist palliative care team to give guidance on the needs of the dying patient.
- There was no formal rapid discharge pathway and in a recent audit, 25% of patients did not have a preferred place of death recorded.

Service planning and delivery to meet the needs of local people

End of life care

- The specialist palliative care team (SPCT) saw 59.8% of patients within 24 hours of referral and greater than 95% of patients within 48 hours which was well above the national average of 56%.
- The SPCT audited 146 records of patients who died on the Specialist Palliative Care community caseload between 1st December 2015 and 30th November 2016. Of these, the preferred place of death was not recorded on 37 (25%). 67 patients (46%) recorded home as their preferred place of death with 49 (73%) helped to achieve this. 14 (10%) recorded hospital as their preferred place of death and 12 (86%) achieved this.
- Staff told us that where possible, they endeavoured to place a dying patient in a side room for privacy and did not rush the grieving family away from the body. We saw an example of this on one ward, where the matron went to great effort to ensure there was a side room available for a patient deemed to be at end of life, who was being transferred from the emergency department.
- Staff were able to arrange for reduced rate parking tickets for family or friends who wanted to stay at the hospital to be with a dying patient.
- Staff in the bereavement office delivered all of the details of a patient's death to the local registrar's office which meant that all the family had to do was to collect the certificate of death when it was processed by the registrar. They told us this was of help to those families who found it difficult to return to the place of death of their relative.

Meeting people's individual needs

- All staff had training in equality and diversity as part of their induction. Guidance was available on wards, in the multi faith room and on the intranet to support staff in providing care in accordance with peoples religious and cultural preferences.
- People of all faiths and spirituality were catered for within the multi faith room. Prayer mats and religious texts were available for Christians, Jewish, Hindu, Sikh, Buddhist and Muslim religions.
- There was an ablution area for Muslims to wash themselves before prayer beside the multi faith room and a screen within the room for males and females to pray separately.
- The current location of the multi faith room was hard to find and the chaplain told us there were plans for a new place of prayer was part of the planned hospital building extension.
- There was limited provision of side rooms or quiet rooms on the wards for breaking bad news. Staff told us they were doing their best to promote privacy and dignity wherever they could.
- The hospital ran Sage and Thyme ® sessions (basic communication skills training for staff in any role, including porters, ward receptionists and volunteers) and had developed additional staff within the hospital to be trainers in this in order to extend the programme.
- In a report presented to the trust board in September 2016 by the Associate Director of Nursing, it was noted that patients were treated actively in their last days and hours of life. 88% patients continued to have routine nursing observations of temperature, pulse and blood pressure in the last 24 hours of life (the median number of occurrences being 8 times) and 54% patients were receiving IV antibiotics in the last 24 hours of life.
- There was uncertainty amongst some nurses about when to initiate an end of life care plan. For example, some told us that whilst they were competent to provide care for the dying patient, they relied on doctors to tell them when a patient was dying, before they initiated an end of life care plan. They also told us they would not make any amendments to the care plan without the support of the SPCT whom they relied upon to 'for their expertise'.
- Some nursing and medical staff told us that doctors frequently continued to actively treat patients and seemed reluctant to initiate end of life care or anticipatory care. This often resulted in late decision making and was often too late to facilitate discharge to the patient's preferred place of death.
- One doctor told us how frailty was not recognised alongside accompanying co-morbidities as a marker of patient decline. They told us how care of the dying was very much led by the medical team and decisions about end of life care were not especially multi-disciplinary.
- The PEACE plan (Proactive Elderly Persons Advisory Care plan) is a document to help health care professionals deliver the best care to frail, older people with life-limiting illnesses who are anticipated to be in the last year of their life and reside in a care home.
- One ward we visited had step down community beds, which was where patients needed less-intensive care than before and were moved to this ward. Whilst many

of these patients were frail elderly and had multiple admissions in the previous year, none were recognised as being in their last year of life and none had a PEACE plan or ACP in place.
- Staff told us they used different methods of communication with the dying patient or those with communication difficulties such as a person living with dementia or a person with a learning difficulty. They used picture boards which had basic signs and symbols for patients to point to There was a communication care plan in nursing notes in which nurses could document the patients preferred method of communication.
- A practice development nurse told us some staff lacked confidence in supporting a person living with mental ill-health and they had raised this as an educational need. However, there was a patient with a diagnosed mental illness on end of life care. We saw that the needs of this patient were very well supported, with every effort made by staff to ensure their comfort and safety.
- Two full-time chaplains and 9 part-time chaplains worked as one team across both trust sites. There was a chaplain available at all times at the request of anyone who was dying, whatever their religion or spiritual beliefs.
- There was a recruitment initiative working with volunteers already selected and trained by the hospital to receive specific chaplaincy training. There were 27 volunteers, representative of the local community and the different religions, who supported the chaplaincy team.
- The last CQC inspection in 2014 commented that the mortuary was difficult to find as it was a distance away from the wards. Mortuary staff told us that whilst the mortuary could not be made more accessible, they now met with the bereaved at reception and accompanied them to the mortuary.
- There were mixed reports of meal provision for families – it was subject to discretion. A nurse told us this had been raised as an issue and a token system was suggested, which ward staff could manage. However, they were unclear when this would be activated

Access and flow

- The trust did not have a formal rapid discharge pathway, but had recently established a Task and Finish group to develop and implement a pathway for discharge of all end of life care patients. There was no identified date by which this group would report on their findings.
- The SPCT facilitated the rapid discharge of a patient expected to die in the next few days. This included advice and guidance on care support required at home, completion of required Continuing Health Care funding documentation, and completion of community drug charts for injectable medications including syringe pump prescriptions.
- We were told the SPCT discharge planning included the development of an Advance Care Plan (ACP) and a Treatment Escalation Plan (TEP). Advance Care Planning concentrates on patient-driven decisions, with a patient who wants to plan their care ahead in case they lose capacity to make decisions. Treatment escalation planning is one mechanism of planning the care of a patient at risk of deteriorating, where all appropriate treatment options for the patient are laid out.
- Members of the SPCT told us that at times, a disproportionate amount of their time was taken up facilitating the administrative aspects of rapid discharge. This included coordination of transport and equipment and made discharges fragmented and reactive on occasion. They said this was exacerbated because there was no discharge coordinator post for SPC who could carry out these tasks.
- Nursing staff told us the SPCT responded quickly when asked to facilitate a rapid discharge and their response to out of hours calls was also very quick.
- Patients who were close to death were not moved from the ward. We saw evidence of partnership working with consultants who had on-going discussions with family members as the patient deteriorated.

Learning from complaints and concerns

- Complaints were reviewed at the End of Life care steering group.
- The trust provided us with an analysis of complaints between March and December 2016. Of the total written complaints just one related to palliative care (Medical (Including Surgical).
- This was logged as poor communication and we saw that the complainant received a response in a timely manner. The outcome of the response was that the complainant's experience was used to inform ward staff of the importance of good communication.

End of life care

- Staff we spoke with told us they were aware of this complaint and they endeavoured to keep family members up to date on the condition of their relative. They also said they proactively encouraged family members to remain with their relative until their death.

Are end of life care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was no stand-alone EoLC risk register.
- Staff told us they believed that EoLC did not have a high enough profile at trust board level.
- The responsibility for palliative care appeared to sit with the SPCT, rather than being seen as a hospital wide responsibility.
- Principles of Care for Dying Patients and use of the end of life care plan were not fully embedded in practice, as demonstrated in a recent audit.
- There was little evidence of planning for future service provision in the event of the SPCT losing their bid to continue to provide community services.

However:

- There was good ward level leadership.
- All staff were positive and demonstrated a proactive attitude towards caring for dying people.

Leadership of service

- The end of life care strategy stated that the executive lead for End of Life Care was the Director of Nursing and Clinical Quality. It also stated there was a non-executive director who was nominated as the End of Life care champion. However, there was no non-executive director identified with lead responsibility for promoting end of life in the trust.
- In the End of life care Audit: Dying in Hospital 2016, the trust confirmed that there was a lay member on the trust board with a responsibility/role for EoLC. However, when we requested a telephone interview with this person, we were told that there was no non-Executive Director for End of Life Care at the trust. Instead, the End of Life Care working group reported into the trust Integrated Governance Committee which was chaired by a non-executive director.
- We found that local leadership of the chaplaincy and the mortuary service to be good and nursing staff told us their local management was excellent.
- The nurses from the SPCT took responsibility and ownership of their service. They saw it as their responsibility to share best practice and to support staff caring for dying patients. They had a good understanding of their service, how it was performing and where the areas for improvement were.
- However, many staff we spoke with told us that EoLC did not have as high a profile with senior managers as they would wish. They said that there was no reference to palliative care or end of life care in the trust's annual report 2015-2016, although the trust subsequently told us that the trust's quality account for 2015-16 contained one EoLC objective. The lead cancer nurse covered both hospitals and staff told us a local manager would help to raise the profile of EoLC.

Vision and strategy for this service

- The trust board recently agreed an integrated strategy for palliative care and end of life care which set out the long term vision for end of life care in the trust 2016 – 2019. One of the corporate objectives for 2016/17 was to make improvements in the quality of the End of Life care pathways across the health care system.
- This strategy outlined plans to meet the needs of end of life care patients, and those identified as important to them as well as ensuring that staff were provided with the education and training required.
- As part of the Quality Strategy the trust had identified several key work streams to ensure the successful implementation of the strategy amongst which included approval and ratification of End of Life care guidelines and policies and review of pathway for the rapid discharge of patients going home to die. Progress would be overseen by the trust's End of Life care Steering group, which had its first meeting in November 2016.
- The trust gave final approval to a three year End of Life Care Strategy at a meeting in December 2016. This was based on the NHS guidance – Priorities for the Care of the Dying Person and One Chance to get it Right - developed in 2014 by the Leadership Alliance for the Care of Dying People. We saw that the 'principles of care for the dying', were developed as separate documents for in-patient care and more recently for those cared for in the community.

End of life care

- An End of Life Care (EoLC) steering committee was established to oversee the implementation of this strategy. The committee had its first meeting in November 2016 and feedback on progress in the first year of implementation was to be presented to the trust board at the end of March 2017.
- We spoke with the trust lead cancer nurse and Macmillan lead cancer nurse about progress to date with the strategy, with direct reference to their report to the trust board in September 2016. They said that ratification of the strategy at trust board level had taken longer than expected and acknowledged that not all parts of the 2016/17 objectives would be achieved by March 2017.
- For example, EoLC leads had not yet been identified; the review of the rapid discharge pathway was not yet completed and establishment of EoLC link nurses was inconsistent across the hospital.

Governance, risk management and quality measurement

- There was a governance structure in place with an EoLC working group reporting to the Quality and Safety Board. The membership was made up of representatives from stakeholder services and multi-disciplinary staff groups across the care pathway. A representative from palliative care was a member of the trust mortality Committee.
- EoLC had no specific performance report for the trust board, apart from the national audit data.
- There was no dedicated EoLC Risk Register but there was a palliative care representative at the monthly multidisciplinary team meeting at which risks were discussed and raised as appropriate. The clinical governance and complaints lead fed back on SI investigations at monthly ward managers' meetings.
- There were two current risks on the hospital wide risk register related to end of life care. One was about lone working and the other was related to insufficient assurance of evidence of discussion with relatives on DNACPR forms.

Culture within the service

- Members of the SPCT expressed frustration about the process for initiating simple changes. For example, they were still awaiting a decision to introduce an information folder to each ward. The proposed folder would contain guidance for care of patients in the last days of life, and contact numbers for the team. The rationale was to facilitate dying with dignity, comfort for patient and provide carers with support.
- Some planned EoLC improvements following the previous inspection had been put on hold with the merger of the trust. For example, the EoLC steering group had just recently been set up in November 2016. Whilst there was commitment from some divisions to this group, there was a feeling that representation from other medics was not very widespread.
- The EoLC consultant told us there is a view that all EoLC sat with the palliative care consultant, rather than seen as a shared responsibility. There were few formal forums to meet with colleagues divisionally.
- They believed that the impact of this was that opportunities were missed to identify some EoLC patients. They felt that more widespread representation on the steering group would help to embed the profile of EoLC patients with all those involved in their care.

Public engagement

- There was a recent public engagement exercise to discuss EoLC strategy. The agenda included an overview of national drivers and local End of Life Care provision for the trust; how patients and the bereaved were supported through the chaplaincy service and a discussion around the trust End of Life care strategy.
- The trust had never undertaken a bereavement survey to capture and understand the experiences of the bereaved. This was identified in the End of Life Care strategy 2016 – 2019, in which it was stated that a bereavement survey would be undertaken as a priority.
- However, whilst the EoLC report to the trust board in September 2016 stated that the survey would be ready to send out in January 2017, we were told that this was delayed and there was currently no report date for this survey.

Staff engagement

- The trust introduced Schwartz Rounds in 2016, where staff can share experiences in a safe, confidential and 'non blame' forum. These forums aim to build a compassionate workforce and improve relationships and communication between staff and patient, and among staff.

End of life care

- Sage and Thyme ® training, a foundation level programme of communication skills training for dealing with patients and families in distress, was introduced. It was noted that this was predominately undertaken by nursing staff and the trust was in the process of increasing the number of training sessions to all clinical staff.
- A matron told us that there was always a team debrief following the death of a patient. In addition, the trust ran a support line which staff could access at any time.

Innovation, improvement and sustainability

- We were told that the local CCG had given the trust notice that community specialist palliative care would in future have one provider rather than three as was the current situation. We saw minutes of the End of Life Care steering group meeting (05.12.2016) in which it was written that the tendering process would commence in April 2017 with the new provider taking over the service from October 17.
- In the event that the trust bid was unsuccessful this would mean that provision of weekend on-call and community cover would be seriously compromised. This had not been placed on the risk register, despite being told by senior nurses that the uncertainty was destabilising.
- In the 2016 annual staff awards the trust introduced a new category - Excellence in End of Life Care and the winner was a surgical ward at UHL.
- The trust was piloting an EoLC volunteer scheme and was devising a training and supervision programme supported through the chaplaincy service to offer emotional support to socially isolated patients who are dying.
- The trust had recently revised its visiting policy to facilitate open visiting in line with John's Campaign. This is a nationwide campaign launched in 2014 to facilitate the consistent presence of a family carer to enable the wishes of the dying patient be heard and attended to.

Outpatients and diagnostic imaging

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

Information about the service

University Hospital Lewisham offers a range of services and clinics for outpatients at various locations across the hospital site. This includes a wide range of clinics such as: general surgery, ear, nose and throat (ENT), breast surgery, cardiology, nephrology, respiratory medicine, neurology, orthopaedics, trauma, urology, ophthalmology, clinical oncology, endocrinology, rheumatology, gastroenterology, general medicine, anti-coagulation, pain management, and specialist bariatric clinics. It also provides physiotherapy for a range of conditions. The department provided 394,848 outpatient appointments between October 2015 and September 2016.

The diagnostic imaging department provides x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), mammography and interventional radiography.

During our inspection we spoke with twelve patients and relatives, twelve staff and looked at eight patient records.

The previous inspection in 2014 rated the outpatients department and diagnostic imaging as requires improvement.

Summary of findings

We rated this service as requires improvement because:

- Many patients complained about the waiting times in the outpatient clinics. They said they had not been given any update information about waiting times.
- There was a lack of shared working across the trust within outpatients. Not all staff were aware of how to use the electronic reporting system.
- The environment in general diagnostic imaging was not fit for purpose. Some equipment was in urgent need of replacement.
- There was a shortage of radiographers and radiologists.

However:

- Medicines were stored and administered safely.
- All patients we spoke with told us they had been treated with dignity and respect.
- The availability of medical records available at clinic appointments had improved since the last inspection.
- The diagnostic imaging service had robust plans in place for improvement.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff in outpatients were not clear on what to report as incidents.
- A never event had occurred in diagnostic imaging in October 2016 during the inspection reporting period.
- Mandatory training in some subjects did not meet the trust target of 85%.
- We found that although recruitment had been successful in some areas, there remained a shortage of radiographers and radiologists.
- The environment for general diagnostic imaging was not fit for purpose and equipment needed replacing.
- There were two different systems in place for the storage and retrieval of diagnostic images causing delay and inaccessibility to timely results.
- At the time of inspection, there were 2,270 unreported films in the system due to a lack of reporting staff.

However:

- Huddle meetings had been introduced which had improved communications.
- Robust radiation protection procedures were in place.
- The areas were inspected were visibly clean.
- Medicines were found to be stored securely.
- The accessibility to medical records had improved since the last inspection.

Incidents

- Incidents were recorded on an electronic software system (SAFEGUARD). Staff in diagnostic imaging told us the system was easy to use and they were encouraged to report incidents and near misses. Staff in outpatients told us they rarely reported any incidents. This meant the trust could not be assured that all incidents in the department were being reported.
- Feedback and lessons learnt were shared in staff meetings, morning "huddles" and via email. We saw this demonstrated when we reviewed minutes of the radiology meetings. In addition we spoke with the newly appointed quality lead for diagnostic imaging who told us they had raised awareness of the incident reporting procedure with all staff and ensured reports were available for all governance meetings. We saw the number of open incidents for diagnostic imaging had reduced from 204 in November 2016 to 83 at the time of the inspection.
- The trust recorded one never event regarding a wrong site biopsy arising from diagnostic imaging in the reporting period from January 2016 to September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- We looked at the associated never event paperwork and saw the correct investigation process was being followed. The staff we spoke with were aware of the event.
- During the period January 2016 to September 2016 there were two serious incidents recorded in diagnostic imaging. These incidents had been investigated and root cause analysis undertaken. One incident involved the wrong site biopsy. Staff were able to describe how the incident happened and what lessons had been learnt to improve practice.
- The outpatients department had recorded 209 incidents of which the majority were categorised as causing no harm.
- Staff told us the radiation protection advisor was easily contactable in case advice was needed for any reportable incidents required under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2000. We noted there had been no reportable incidents in 2016 although all incidents relating to radiation exposure were recorded as 'red' on the incident logging system. At the time of the inspection there were 8 red incidents open. These were being appropriately investigated.
- Staff we spoke with understood the duty of candour and had a good understanding of being open and honest with patients. The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff told us the process had been followed in speaking to the patient involved with the never event.

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean. The cleaning schedules we saw across both outpatients and diagnostic imaging were completed daily for each of the clinical rooms.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Alcohol gels were available outside of all clinical rooms on the outpatients department with clear signage asking staff and patients to gel their hands prior to entering. However, we did not observe any staff or patients using the gel throughout the duration of the inspection.
- Hand hygiene audits for outpatients reported and average of 95% compliance over a twelve month period.
- Personal protective equipment, such as disposable gloves and aprons, was readily available in all clinical areas and we observed staff using it.
- Clean equipment in the room had 'I am clean' stickers to ensure staff knew the equipment was clean and ready for use.
- Not all the sinks in the outpatient and diagnostic imaging department were compliant with HBN 0009 Infection Control in the Built Environment (March 2013), which is department of health best practice guidance.
- All soft furnishings were wipe able and were overall in good condition.
- The vinyl floor in the departments was in good condition and there were no carpeted areas.
- Mandatory training records showed that 85% of nursing staff in outpatients had attended infection control training against a target of 85%.
- The diagnostic imaging department told us they were given prior notice of infectious patients by the infection control team. They would try to see the patients at the end of the list where possible and once the imaging room had been used, the cleaning team would be contacted and the room deep cleaned before making it available for further use.
- The outpatients department had infection prevention and control link nurses in place that attended infection control meetings and then reported back to the rest of the team.
- Radioactive spillage kits were available in nuclear medicine and staff knew how to use them. All radiation waste within nuclear medicine was disposed of appropriately and the process fully documented. Reports were sent weekly to the Radiation Protection Advisor and monthly to the Environment Agency.
- We observed good waste streaming with the use of hazardous waste bins and recycling bins. We found the temporary closure on sharps bins was not used. This contravenes the Health and Safety legislation on waste regulation.

Environment and equipment

- The diagnostic imaging department's risk register included replacing ageing imaging equipment. The three general rooms in need of replacement had equipment ranging from between sixteen and twenty years old. Staff told us the business case had been written for the replacement of equipment but had not yet been approved.
- The business case for a second MRI machine to help support the growing demand had also been submitted but not yet approved.
- There was resuscitation equipment available across outpatients and diagnostics. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis. The outpatient teams took responsibility for checking by staff rota.
- The departments had arrangements in place for the maintenance and testing of equipment. However, we found some equipment in the ENT clinic had not been tested for over a year. The weighing scales had not been recalibrated since April 2016.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.
- There were radiation warning signs outside any areas that were used for diagnostic imaging which we observed were in working order. This ensured visitors or staff could not accidentally enter a controlled area.
- The diagnostic imaging department had a quality assurance programme in place for all the various pieces of equipment including CT and MRI. The results were recorded to demonstrate the equipment was fit for its intended use.

Medicines

- Medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the outpatients department. We reviewed a sample of ten medicines in the outpatient department, which were all within the manufacturer's use by date.
- Lockable fridges were available for those drugs needing refrigeration; temperatures were recorded daily when the department was open. Fridge temperature recordings were within the required range.
- Prescription pads were stored securely but staff told us there was no audit to formally record the usage of the pads.
- We checked the contrast throughout the diagnostic imaging department and all bottles of contrast were found to be in date.

Records

- We reviewed eight sets of patient notes for patients having consultations within outpatients. The records were complete, legible and signed.
- We spoke with staff in the medical records department. They provided the service for all the outpatient clinics across the hospital. The records were stored in a secure area that could only be accessed by authorised staff.
- Following the merger between UHL and QEH, a new system called iCARE was rolled out across the trust. This caused issues for missing notes from clinics, more so for the QEH site. The recent audits undertaken from March to December 2016 showed that notes were available for 98.93% of the clinic appointments.
- A business case had been approved for radio-frequency tagging of notes. Staff told us the project was due to start in June 2017.
- A patient archiving computer system (PACS) was in use for the storage of diagnostic imaging tests. However, staff told us and we saw in the radiology 'deep-dive' report of December 2016 that the systems was not always compatible with the radiology information system (RIS) or across site with QEH. Two different PACS and RIS systems were in operation which resulted in results not always being available on the PACS system for clinicians to view in a timely manner. Staff told us a business case had been submitted to install one system across both sites to improve safety and efficiency.
- We saw evidence that the radiographers had checked and documented patient pregnancy status in line with departmental protocol.
- Confidential patient information was visible on the x-ray viewing equipment in the general x-ray waiting area. Patients waiting on trolleys could view the screens that were in close proximity to them. Other patients were able to walk freely through the area and view the screens.

Safeguarding

- We saw records to confirm that nursing staff in the division had reached 79% for safeguarding adult's level 2, 96% for children and young people level 2 and 100% for children and young people level 3.
- Staff were able to identify the steps they would take if they identified a safeguarding concern. The policy was accessible for all staff and flowcharts were visible in key outpatient staff areas for reference.
- Senior staff within the outpatient clinics had completed level 3 safeguarding children training. Staff within the plaster room told us one of the level 3 staff would always be present if a child was seen in the department. This meets the requirements of the intercollegiate guidance.
- Safety procedures such as the 'pause and check' protocol from the Society of Radiographers were observed in radiology to ensure the right patient got the right scan at the right time. Where invasive procedures were used in the diagnostic imaging department, staff used the World Health Organisation (WHO) Surgical Safety Checklist for Radiological Interventions. This reduced the risk of harm during operative procedures by using evidence based practice and safety checks. However, there was no evidence and staff told us that they did not audit the use of the checklist which meant the organisation could not be assured that the process was being followed consistently.

Mandatory training

- Mandatory training included a mix of computer based modules and practical face to face modules. The latter were grouped into combinations of training days so that more than one subject was delivered during the session.
- All the staff we spoke with were aware of the mandatory training they were required to undertake.
- We saw records that showed nursing staff in outpatients had met or exceeded the trust target of 85% in seven out

of the 19 mandatory training modules. Fire safety for clinical staff, had the lowest completion rate of 51%. The outpatient nursing staff had an overall completion rate of 81% against the 85% target.

- We saw local reports in diagnostic imaging that over 85% of staff had completed the mandatory training relevant to their roles.

Assessing and responding to patient risk

- All the staff we spoke with in the outpatients department knew how to respond if a patient became unwell. If a patient became unwell in outpatients, the service had a clear protocol to follow. Staff would assess the patient using the National Early Warning Score (NEWS) and either treat the patient within the department or, if the department could not meet their clinical need, transfer the patient to the emergency department for a full assessment and treatment.
- All nursing staff were required to complete basic life support for adults and paediatrics**.** The completion rate was 83% against a 100% target for this mandatory training course.
- We saw several patients lying on trolleys and beds in the general x-ray area that were unsupervised. We spoke with staff who told us this was a regular occurrence although they were not aware of any incidents that had arisen because of this. There was no formal policy in place for the supervision of patients at the time of our inspection. One staff member told us they would just expect staff walking by to have a quick review of the patient's condition. We did not observe any staff reviewing the patients in the corridor.
- Staff in the MRI unit told us they completed a mock scenario for a patient having a cardiac arrest on a yearly basis. Learning from the scenario was formally recorded and shared with staff in the daily huddle. They also gave all new staff a comprehensive induction programme including scenario planning around a foreign body in the eye, which is a key risk factor for having an MRI.
- Referrals to the diagnostic imaging department were managed by the PACS team. At the time of the inspection, all patients were being given appointments in under four weeks, which exceeded the diagnostic waiting time of six weeks.
- At the time of inspection, there were 2,270 unreported films in the system due to a lack of reporting staff. This meant there was a potential risk to the patient of non-escalation of important findings. We were told by staff that there was no risk assessment in place to manage this issue.
- Senior managers had not ensured the process underpinning the WHO checklist for interventional radiology was audited.
- The diagnostic imaging department gave a questionnaire to patients having an MRI or CT scan and took a blood test for patients having a contrast agent. This meant the service was able to reduce the risk to patients who may have allergies, heart complications, renal failure and metallic foreign bodies.
- The department was supported by an external radiation protection service. They provided the radiation protection advisor (RPA) and medical physics expert (MPE).This provided external scrutiny of whether the hospital was complying with IR(ME)R regulations. We looked at the latest RPA report and saw the department was mostly compliant and had an action plan in place that was being monitored and updated.
- There were radiation protection supervisors (RPS) allocated to the department. We saw evidence that they had appropriate training.
- Dose reference levels had been established for all the X-ray rooms.

Nursing and diagnostic imaging staffing

- There was no set guidance for safe staffing levels in the outpatient department. Staff told us the rotas were completed in good time and needs were determined based on the clinics running each day. There was a split of 60% healthcare assistants to 40% registered nurses with an establishment of 24 whole time equivalent. There were currently 18.5 whole time equivalents in post.
- Information provided by the hospital showed that in December 2016, there was a 12% vacancy rate in the adult outpatients department. Staff told us there was regular use of bank staff to fill the vacancy gaps. If any new bank or agency staff were used, they were given a comprehensive induction programme and the mandatory training they were expected to complete.
- As from December 2016, the outpatients department recorded a turnover rate of 15% against a trust average of 7.6%.
- The diagnostic imaging department had workforce shortages in most areas of the service, specifically

consultant radiographer, band 7 sonographers and band 3 Radiology Department Assistants. A newly appointed Head of Imaging had started a recruitment plan looking at overseas recruitment and new graduates. The vacancy rates were improving.

Medical staffing

- Medical cover for the clinics was arranged within the specific divisions. The doctors we spoke with said it worked well although the clinics were often overbooked.
- Radiology reported a vacancy rate of 37% for medical staff which equates to five whole time equivalent radiologists. Staff told us there was increasing pressure on the service due to the vacancies. Locum staff had been recruited and were working well within the team.
- There was no consultant cover on site after 6pm. This service was outsourced to a private company. Oversight of the service was now in place and monitored via the monthly discrepancy meetings held by radiologists.

Major incident awareness and training

- Staff in the outpatients department were aware of the trust's business continuity policy; senior staff understood their roles and responsibilities within a major incident. Staff told us there were staff allocated to assist in the event of a major incident.
- Staff understood their responsibilities if there was a fire in the building.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate the effective domain in outpatients and diagnostic imaging.

Evidence-based guidance was available; however there was limited evidence of audit to demonstrate effectiveness.

Not all staff had received an annual appraisal and performance against the trust target of 90% was low across the division.

There was a good range of skill mix within diagnostic imaging and competency assessments were in place to ensure good practice was maintained and monitored.

Evidence-based care and treatment

- Staff told us they were able to access national and local guidelines via the internet and internal system.
- Staff confirmed managers shared clinical governance information with them and any changes to policies and procedures. However, the staff we spoke with in outpatients were not able to give any examples of evidence based practice or be able to refer to specific guidelines in place.
- Imaging staff had good working knowledge of IRMER 2000 regulations and how they impacted on their working practice.
- The trust had established a combination of local and national diagnostic reference levels (DRLs) within radiology. DRLs are typical doses for examinations commonly performed in radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly
- Radiographers checked all referrals to ensure patients were booked for the correct imaging tests. Staff told us the investigations did not take place if the correct patient information was missing.
- We looked at the electronic notes for the diagnostic imaging department discrepancy meetings. These were in line with the Royal College of Radiologists (RCR) publication 'Standards for Learning from Discrepancy Meetings', October 2014. The meeting was held monthly and a full record of attendance was kept.
- We looked at the audit schedule for the specialties and diagnostic imaging. The Clinical Effectiveness Team registered all audits identified for inclusion in the clinical audit programme 2016-2017.
- Clinical audit activity was monitored at the Directorate level Audit and Governance meetings, monthly at the Divisional Risk and Governance Meetings, bi-monthly at the Clinical Audit and Guidelines Group, and bi-annually at the Quality and Safety Committee and Integrated Governance Committee.

Pain relief

- If pain relief was required in the outpatient department, staff could give patients a prescription which could be taken to the on-site pharmacy at the hospital.

- Local anaesthetic was available for minor procedures undertaken in the clinics.

Patient outcomes

- There was no formal record or audit of patient waiting times for clinics. We observed many of the clinics running considerably later than planned.
- Between October 2015 and September 2016, the follow up to new rate for UHL was lower than the England average. Rates below the England average are seen as more efficient as it means more new patients are being seen rather than the same patients returning for follow up appointments.
- We looked at five sets of patient notes. All contained a completed patient outcome form. Staff told us the forms were updated on the electronic system at the end of each clinic.

Competent staff

- The staff we spoke with told us they had been given an appraisal within the last twelve months. They had all found it a helpful process.
- However, the division fell short of the trust target for completion of appraisals was 90%. We saw reports of the completion rates for all staff groups across the hospital. In the financial year 2015/16, the nursing and midwifery staff reached 68% completion and allied health professionals reached 75% completion. We saw a further breakdown within the LTCC division. This showed a completion rate of 63.9 % in October 2016.
- We saw evidence of staff competencies in MRI for cannulation.
- We saw certificates in nuclear medicine for the administration of radioactive substances advisory committee (ARSAC) certificates for radiologists in the diagnostic imaging department.
- Competency assessments were in place for outpatients and diagnostic imaging and induction processes were in place for new staff. All new staff completed a corporate and local induction.
- On-line training had been developed by diagnostic imaging for the insertion and checking of naso-gastric tubes.
- They was a good range of skill mix across both diagnostic imaging and outpatient teams. Specialist nurses worked in the outpatient clinics. Diagnostic imaging employed a consultant mammographer and were in the process of recruiting to another similar post.
- Nurses were aware of the need to revalidate their professional registration and processes were in place to ensure nurses did not work unless their registration was current.
- Radiographers told us that new departmental leadership was supportive of radiographer role progression.
- We saw that all employed radiography staff were registered with the Health Care Professions Council (HCPC).
- Patients told us they felt the staff were competent and able to do their jobs effectively and safely.

Multidisciplinary working

- Staff reported they worked well as a team.
- We observed good multi-disciplinary working. Therapies staff worked together in a multi-disciplinary approach across the hospital. Physiotherapy clinics were held in outpatients.
- There was little cross site cover across the site for both diagnostic imaging and outpatient staff. This meant the departments did not work closely together. A staffing review in diagnostic imaging had resulted in cross site modality leads which had started to improve the cross site working relationships and encourage efficiencies across the service.

Seven-day services

- The outpatient clinics were held Monday to Friday.
- The diagnostic imaging service provided a seven day on-call service. This was in line with NHS Services priority clinical standard 5, 2016.
- The radiologist service was outsourced from 6pm to 8am each weekday and at the weekends. Radiologists covered from 8am-6pm on a Saturday and Sunday and were available on site to do CT/MRI and ultrasound cases as required.
- Radiographers worked a shift system to cover the seven day service.

Access to information

- Patient details including past medical history were present within the paper records we reviewed
- Patient investigation results, including blood tests and diagnostic imaging were available electronically.

Outpatients and diagnostic imaging

- Staff from outpatients and diagnostic imaging attended the Patient Tracking List information meeting held on a weekly basis. Key information was sent to general managers and senior team leaders to action.
- GP referrals were sent electronically to diagnostic imaging and staff processed these on a daily basis.
- Staff were able to show us the location of corporate policies on the hospital's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most of the staff we spoke with were aware of the relevant policies on the intranet. However, some staff were not able to give a clear explanation of the Mental Capacity Act 2005 and how it might apply to their role.
- We saw an in date policy on consent which included the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) policy.
- Verbal consent was observed in the X-ray room and the orthopaedic outpatient clinic. The consent process included a discussion of the risks to the patient and an opportunity for the patient to ask questions. However, we observed two consultations with the same consultant. The explanations for surgery were brief and very little time for questions was offered. We spoke with one patient after their consultation and they were not clear on what was happening next as regards their surgical treatment.
- Three patients we spoke with told us they had been asked for their consent before they received treatment.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- We saw compassionate, caring interactions between staff, patients and relatives.
- Overall patients commented positively about the care provided.

However:

- The general diagnostic imaging area did not provide patients with privacy and dignity. The area was an open thoroughfare for staff and other patients.
- Staff did not always update patients on clinic waiting times.

Compassionate care

- We observed good interactions between nurses, radiographers, medical staff, healthcare assistants and administration staff and the patients, although it was clear in some clinics that staff were extremely busy. One staff member told us they could not always update the patient information board regarding length of clinic waiting time as they were too busy.
- We spoke with twelve patients and carers across the departments. Patients expressed frustration at long clinic waiting times, but overall we were told the staff were very compassionate.
- The results of the Friends and Family survey from February 2017 showed that 92% of patients would recommend the service to others. This was marginally below the England average of 93%.
- The general diagnostic imaging area did not provide patients with privacy and dignity. The area was an open thoroughfare for staff and other patients.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt well informed about their care including any investigations that were planned. Three patients we spoke to said the clinics often ran late and they were not given an explanation as to why. They said this made them feel frustrated.
- One patient showed us their information leaflet about attending for a MRI scan and said they found it helpful. Information leaflets for other diagnostic imaging tests were sent to the patients with the appointment letter outlining the procedure and any preparation required.

Emotional support

- We observed a specialist clinic for bariatric patients. The specialist nurse outlined the support available to the patients and how they would assist patients experiencing emotional distress.
- We saw that clinics had access to clinical nurse specialists (CNS) who formed part of the multi-disciplinary team to provide support to patients with a cancer diagnosis, as well as their families and carers.

Outpatients and diagnostic imaging

- Nurses or healthcare assistants acted as chaperones for any patients who requested the service. Chaperone facilities were also available in diagnostic imaging.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There were long waiting times for clinics. The length of time a patient waited in the outpatient area before being seen was not recorded.
- Between October 2015 and September 2016, the trusts did not attend (DNA) rate was higher than the England average.
- Between December 2015 and November 2016, the trust's referral to treatment time (RTT) for non-admitted patient pathways was worse than the England overall performance.
- There was a mixed performance for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment of cancer.
- Only 75% of complaints within the LTCC division were dealt with within the agreed timescale against a target of 95%.
- Patients did not have good access to refreshment areas in outpatient clinics.

However:

- Between December 2015 and November 2016, the percentage of patients waiting more than six weeks for their diagnostic tests was lower than the England average.
- The trust was meeting the operational standard of 93% for people being seen within two weeks of an urgent GP referral for suspected cancer.

Service planning and delivery to meet the needs of local people

- There were no extended days for offering outpatient appointments. This meant patients had limited options to attend appointments that were convenient for them.
- The diagnostic imaging department provided an appointment service for general x-ray from 8am-5pm. Some patient referrals could be seen on a walk-in basis.
- The CT and MRI service offered some extended days and occasional weekend sessions.
- Between October 2015 and September 2016, the DNA rate (patient non-attendance) was higher than the England average at an average of 12%.
- Senior staff told us there was a plan in place to review many of the issues identified within outpatients. Early work was in progress to conduct a demand and capacity analysis to assess and effectively manage the demands on the outpatients department. Managers told us the model would be used to inform how much extra capacity needed to be built into the system.
- Diagnostic imaging reports were outsourced after 6pm each day to ensure a timely turnaround.

Access and flow

- Hospital Episode Statistics for October 2015 – September 2016 showed that 394,848 outpatient appointments were made at University Hospital Lewisham.
- In November 2016, the trust's referral to treatment time for non-admitted patient pathways for outpatient services was worse than the England overall performance. This data showed 86% of patients were treated within the 18 weeks versus an England average of 90%.
- In November 2016, the trust's referral to treatment time for incomplete pathways for outpatient services was better than the England overall performance and similar to the operational standard of 92%. This data showed 92% of patients were treated within the 18 weeks versus an England average of 90%.
- The percentage of people seen by a specialist within two weeks for all cancers was similar to the operational standard of 93% from quarter three 2015/16 to quarter two 2016/17.
- The percentage of people waiting less than 31 days from diagnosis to first definitive cancer treatment was above the England average and the operational standard of 96% from quarter three of 2015/16 to the present reporting date.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive cancer treatment was below the England average in quarter three of 2015/16 and quarter two 2016/17. Improvements had been made in quarter one of 2016/17.

Outpatients and diagnostic imaging

- We saw that weekly patient tracking list (PTL) meetings were held to monitor the position of each outpatient specialty in regards to the 18 week target. Areas of concern were highlighted at this meeting and cascaded down to the relevant teams.
- Waiting times for diagnostic imaging were monitored and recorded. The percentage of patients waiting more than six weeks for a diagnostic test ranged from 0% in December 2015 to 0.2% in November 2016.This was overall lower than the England average.
- The average clinic overrun time during our inspection was more than one hour. No audit was undertaken of clinic wait times although all staff acknowledged this was an on-going problem.
- The cancellation policy states that a minimum of six weeks' notice should be given for cancellation of clinics. We looked at clinic cancellation data from December 2015 to November 2016. We noted that 4.5% were cancelled within six weeks of the appointment date and 5% were over the six weeks. The main reasons for clinic cancellations were reported as annual leave, sickness and the recent doctor's strikes.
- Waiting times were displayed on white boards in the waiting areas for patients but not routinely updated with an accurate wait time.

Meeting people's individual needs

- Staff told us they had training in caring for patients living with dementia and were able to give examples of how they would support patients in attending outpatients.
- Changing rooms in general x-ray were unisex cubicles. They were not wide enough for any wheelchair access and were very small even for an able bodied person to change.
- Outpatients and diagnostic imaging staff had access to an interpreter service. The staff we spoke with were all aware of the service and how to access it.
- We were told the water fountains had been removed from patient waiting areas due to being a spill hazard. Water from a jug was on offer in the orthopaedic clinic but the information about this being available was not visible in the main waiting area. This meant patients did not have easy access to hydration during clinic waits.
- Some high stools were available in the orthopaedic clinic. There were no bariatric chairs or couches in outpatients or diagnostic imaging for patients who might require them.
- The layout of the outpatient clinics was confusing as it was situated in different buildings and on different floors. We followed the signs to the dermatology clinic which was located outside but were not able to find it. We asked the receptionist about directions for patients. The appointment letter stated the clinic was located next to the ambulance station but with no further details or a map.
- The waiting areas across both outpatients and diagnostic imaging were variable. Some were spacious and in good decorative order whereas others were cramped and in need of redecoration.
- The reception desk in the orthopaedic clinic had a section suitable for wheelchair users. However, this was covered in boxes and would not have been accessible to the patients.
- The bariatric specialist nurse ran a monthly support group for their patients and each patient was given a personal contact number.
- Staff told us of a new learning disabilities support post and two learning disabilities champions within the department. This offered an increasing amount of support for those with learning disabilities and their carers.

Learning from complaints and concerns

- We saw minutes of departmental and clinical governance meetings detailing discussions about complaints received and learning from investigations.
- We saw complaints had not been managed within the recommended time frames with complaints taking an average of 55 days to investigate against a trust policy of 25 days.
- The common themes for complaints were in relation to medical and surgical treatment, communication, staff attitude, clinic waiting times and administration.

Are outpatient and diagnostic imaging services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- Slow progress had been made from the recommendations raised in the CQC inspection in 2014.

Outpatients and diagnostic imaging

- There was limited cross site working for outpatients with the exception of senior staff and specialist radiographers.
- It was not clear that learning from complaints had been acted upon.
- There were key vacancies within diagnostic imaging.

However:

- Diagnostic imaging services had implemented cross site working with key senior posts.
- Quality indicators were now measured on a dashboard and were reviewed on a regular basis by the directorate senior management team.
- Staff enjoyed working at the hospital and were proud of their work. They understood the trust's vision and values.

Leadership of service

- There were clear management structures in place and staff felt supported by their direct line managers.
- The diagnostic imaging senior team told us they were more confident for the future of the service. They felt a focus on diagnostic imaging with the improvement plan and the steps towards becoming ISAS accredited were positive. ISAS stands for the Imaging Services Accreditation Scheme. Work had commenced on recruitment and reviewing cross site protocols and procedures to allow more consistency across the service.

Vision and strategy for this service

- Senior staff told us diagnostic imaging services were in transition and the strategy was making progress. They were able to articulate the five year strategy and what improvements had been made to date and what further work needed to be done.
- The staff we spoke with in outpatients were less clear of the strategy for developing their services and were not clear of the overall vision. There was little evidence of cross site working with the exception of senior staff and specialist radiographers. However, all staff expressed a commitment to providing high quality, compassionate care for their patients.
- Several staff in diagnostic imaging told us they felt the department was now more stable under new permanent leadership.

Governance, risk management and quality measurement

- The outpatients and diagnostic imaging departments were part of the long term conditions and cancer division (LTCC), with the divisional lead feeding back to the board.
- Governance, risk and quality meetings were in place at directorate and departmental level. We looked at minutes from the outpatient's weekly operational group meeting, the monthly LTCC governance meeting and the diagnostic imaging governance meetings. Appropriate risks, policy and process reviews and other key safety information were discussed in detail at each meeting.
- The directorate used a performance scorecard providing information on RTT performance, complaints and incidents. This information was disseminated to the department leads. Staff in diagnostic imaging told us they had only recently engaged with this process and were now represented at meetings to be able to act on the information.
- Risk assessments and risk registers were in place for both outpatients and diagnostic imaging. However, not all the risks to service users had been identified such as storage of records in a safe area and challenges with the layout of the services.
- Staff in diagnostic imaging were able to tell us they key issues on their risk register and those that were on the corporate risk register that affected their service. Some staff felt the trust had been very slow in responding to key risks such as replacement of ageing equipment.
- Following a review of the Trust wide Serious Incident report presented to the Trust Board in June 2016, the Board requested a more comprehensive report summarising the detail of the quality and safety issues which had arisen within the service of radiology. The report was completed in December 2016 and outlined the key safety and quality issues as Workforce, Information Technology, Communication e.g. there is a lack of a unified Picture Archiving and Communications (PACs) and Radiology Information System (RIS) across both sites which necessitates differences in standard operating procedures across the sites and Infrastructure.
- We found in speaking to senior staff that some actions had been progressed such as increased cross site working with the modality leads, a recruitment and retention programme and discrepancy meetings in line

with Royal College of Radiologists guidelines. However we found in other areas highlighted in our 2014, for example in the variable environment and replacement of ageing equipment, progress had been slow with little actual improvement made in the intervening period.

Culture within the service

- There was a positive culture in the departments. However, the latest report from the Staff Friends and Family Test showed only 64% of staff would recommend the division as a good place to work.
- Staff supported each other and we saw good evidence of teamwork.

Public and staff engagement

- Member of the public were invited to leave their comments about the service they had received by means of questionnaires.
- We noted a lack of information boards for patients in both services. The boards in outpatients were very outdated with one board, for example, the only patient comment card displayed was from 2014.
- Staff in MRI told us they had a daily huddle which was an opportunity to briefly come together as a team with their colleagues and share key information for the day ahead.
- We saw minutes from both outpatient's and diagnostic imaging staff meetings. These had not always been regular in the past but were not in place and staff told us they were a helpful forum for exchange of information.

Innovation, improvement and sustainability

- We spoke with senior members of staff in diagnostic imaging and we were told about the future plans in the desire to gain ISAS accreditation and new equipment to support and sustain the service.
- Diagnostic Imaging had been success in winning a bid for developing CT colongraphy reporting radiographers.
- A recent Macmillan project had been piloted in outpatients to improve accessibility to Systemic Anti-Cancer Therapy (SACT). The project had been reviewed and 100% of patients were satisfied with the care provided and felt it had improved their overall experience of the service.
- In November 2016, the lead pharmacist won a staff award.

Outstanding practice and areas for improvement

Outstanding practice

Services for children and young people

- The rotation program for new nurses to the service meant, not only that nurses were able to learn new skills but also had established good working relationships and understanding of each areas challenges and practices.
- The uniquely designed door handles that had been installed on the doors to the neonatal unit demonstrated the culture was focused on reducing infection risk in the neonatal unit.
- The 'tops and pants' scheme provided a simple, effective way for positive and negative feedback to be raised by children and young people using the service and the display of this within wards demonstrated improvements in care.

Areas for improvement

Action the hospital MUST take to improve

- Ensure effective systems to assess and monitor the quality and safety of the care and treatment in all services across the hospital.
- Address and improve issues of medicines management in surgery and services for children and young people.
- Address and improve issues of cleanliness and infection control in medical care, surgery and maternity and gynaecology.

Action the hospital SHOULD take to improve

- Ensure mandatory training targets are met in all services at the hospital.
- Improve its recruitment processes to mitigate vacancy levels in medical, nursing and allied health professional staff.
- Merge maternity guidelines across both major hospital sites and within community midwifery.
- Address performance targets currently not being met as detailed above.
- Ensure complaints are dealt with in accordance with trust timeline targets.
- Ensure that service and department leaders are aware of issues and concerns within their departments and act to rectify them.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) (2) (g) **There were significant medicines management issues in main theatres and in services for children and young people.** • There was a Controlled Drug (CD) not stored in a locked cupboard. Further, an anaesthetist was planning to use a vial of CD for more than patient, despite the vials being single use. The CD was not disposed of appropriately, and no record was made of the volume destroyed. • There were incomplete entries and missing signatures in the CD books for Theatres 2 and 3. During our inspection, we observed a member of staff asking another to sign as a witness for CDs that had been issued that morning that they had not, in fact, witnessed. • In services for children and young people, medications were not locked within cupboards, which was not in line with best practice. • Some medications were not stored in their original packaging, which meant that there was a risk of staff unknowingly administering out of date medications. • Action had not been taken appropriately by staff when fridge temperatures had been recorded as being outside of the required ranges. **The hospital must take action in response to all of these issues and ensure it is compliant with Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe Care and Treatment.** **The hospital must take action to:**

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Requirement notices

- Ensure that all staff, including agency and bank staff are fully aware of the Trust's CD and medication management policies. Reg 12(2) (g);
- Ensure that all CDs are disposed of appropriately. Reg 12(2) (g);
- Ensure that the CD books are fully and accurately completed, and are completed contemporaneously. Reg 12(2) (g).
- Ensure that medications are stored in locked cupboards. Reg 12 (2) (g)
- Ensure that there is no risk to staff unknowingly administering wrong or out of date medications due to removal of medicines from their original packaging. Reg 12 (2) (g)
- Ensure immediate action is taken when medicine fridge temperatures are recorded as being outside of the required ranges. Reg 12 (2) (g).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1), 17 (2) (a) 17 (2) (b) 17 (2) (f)** • The hospital did not have effective systems to assess and monitor the quality and safety of the care and treatment in all services across the hospital including ED, surgery, critical care, services for children and young people, end of life care and outpatients and diagnostic imaging. • In ED there were insufficient systems in place to manage the fundamental issues of capacity and flow within the ED. ED performance was below the objectives set out in the delivery plan. • In medical care, systems and processes around incident reporting did not always ensure staff reported all incidents or near misses or that staff received feedback on incidents and there was no evidence of learning from serious incidents, particularly in relation to VTE assessments. • Vacancies in medical care were high, in particular in relation to nursing staff and junior doctors. Five of the

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Requirement notices

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

- Although the hospital was actively trying to recruit into nursing posts, there was limited evidence of success.
- Systems and processes in medical care around incident reporting did not always ensure staff reported all incidents or near misses or that staff received feedback on incidents and there was no evidence of learning from serious incidents, particularly in relation to VTE assessments.
- The leadership on medical wards had failed to recognise that the standard of infection control processes, including waste management and adherence to the control of substances hazardous to health guidance, was variable. Hazardous waste was not always managed in line with national and international best practice safety guidance, including in storage and access control.
- There were discrepancies between what staff on the medical care wards said the risks in the service were and the understanding of risks in the leadership team.
- In surgery, information governance practices were poor, with patient records being left unlocked and unattended in public areas throughout the hospital.
- There were significant vacancy levels within the service, and high staff turnover.
- The hospital leadership team in surgery were unaware of the issues with medication within theatres.
- The hospital leadership team in surgery had failed to recognise or address breaches of Infection Prevention and Control (IPC) policy, potentially placing patients at significant risk of infection.
- There was no documented strategy for the critical care service, and there were concerns around the medical leadership and governance arrangements.
- There was no clinical ownership of the unit risk register in critical care, as this sat within the surgical directorate.

This section is primarily information for the provider

Requirement notices

- There were no scheduled multidisciplinary meetings for the critical care team to review patient care and goals of treatment in a unified way. Frequency of ward rounds used for this purpose did not meet Faculty of Intensive Care Medicine (FICM) core standards.
- We found that local maternity leadership at the hospital had overlooked the basic issues of poor cleanliness and out of date equipment checks and the potential clinical, infection control and patient safety risks they posed.
- There was a risk to clinical outcomes and patient safety due to maternity guidelines not being merged across the Lewisham and Greenwich sites and some guidelines also being out of date.
- In services for children and young people there were low levels of attendance at governance and safety boards which reduced opportunities for sharing of information to the appropriate people.
- End of Life Care (EoLC) did not appear to have a high profile at local senior hospital or trust board level. There was no named EoLC non-executive director on the board and the end of life care corporate target was not referred to in the trust's annual report 2015-2016.
- There had been lack of effective executive action to address issues of long waiting times in the outpatient clinics. There was a lack of shared working between ULH and the other locations across the trust within outpatients.

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) (2) (e) (h) **There were significant infection prevention and control issues in medical care, surgery and maternity and gynaecology.**

This section is primarily information for the provider

Requirement notices

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

Requirement notices

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

The hospital must take action in response to all of these issues and ensure it is compliant with Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe Care and Treatment. Regulation 12 (2) (e) (h).

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...