This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

### Facts and data about this trust

#### Acute hospital sites at the trust

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital in Woolwich</td>
<td>Stadium Rd, Woolwich, London SE18 4QH</td>
<td>Royal Borough of Greenwich and the London Borough of Bexley</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>Lewisham High St, London SE13 6LH</td>
<td>London Borough of Lewisham</td>
</tr>
<tr>
<td>Some services at; Queen Mary’s Hospital in Sidcup</td>
<td>Frognal Ave, Sidcup DA14 6LT</td>
<td>London Borough of Bexley</td>
</tr>
</tbody>
</table>
The trust specialises in a range of services listed below:

- Children's services
- Clinical support services
- Corporate services
- Community services
- Critical care
- Elderly care
- Emergency services
- Maternity services
- Medical conditions
- Sexual health
- Surgical services

(Source: https://www.lewishamandgreenwich.nhs.uk/about-us)

The trust provides a comprehensive range of services to approximately 526,000 people in the boroughs of Lewisham, Greenwich and Bexley. It runs a range of community services in Lewisham and has some services at Queen Mary’s Hospital in Sidcup. Community services in Greenwich are provided by Oxleas NHS Foundation Trust.

The trust has 840 inpatient beds and 43 day care beds. There are 38 inpatient wards and the trust employs approximately 6,100 staff.

In 2016/17 the trust had a deficit of £62.5m and the draft plan for 17/18 has a target deficit of £53.1m.

The 2011 census found that a quarter of the population in Lewisham, Greenwich and Bexley were aged 19 or under. Bexley has the highest percentage of people aged 65 or over. In Lewisham, 46% of the overall population are from black, Asian and minority ethnic (BAME) groups, compared to 38% in Greenwich and 18% in Bexley.

The last comprehensive inspection of the trust was in March 2017 and raised concerns in a number of services. As a result we took regulatory action, which included serving requirement notices. A focussed inspection in May 2018 found some improvements in the services we inspected (medicine at University Hospital Lewisham and Queen Elizabeth Hospital and surgery at University Hospital Lewisham) but, it was noted there was still much work to be done.

The trust was subject to an investigation by NHSI into the trust's financial situation September – October 2017. The investigation was triggered by a number of concerns including the trust’s compliance with NHSI financial and workforce policies, the trust boards’ understanding of the drivers of the trust’s deficit and whether it had a credible plan to address the drivers. The report was published in November 2017 and following the trust’s response in December 2017 NHSI closed the formal investigation in February 2018.

Is this organisation well-led?

Leadership

Board Members

Of the executive board members at the trust, 12.5% were British Minority Ethnic (BME) and 50.0% were female.
Of the non-executive board members 37.5% were BME and 62.5% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>12.5%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>37.5%</td>
<td>62.5%</td>
</tr>
<tr>
<td>All board members</td>
<td>25.0%</td>
<td>56.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

We carried out a comprehensive inspection in March 2017 and following that inspection a new chair was appointed (had previously been a non-executive director) followed by a new chief executive officer (CEO) and chief nurse (CN) in April 2018. An interim director of finance and recovery (DoFR) had recently been appointed. Although new to the trust, the CE, CN and interim DoFR had significant NHS experience.

The medical director had been in post for several years and balanced the executive role with clinical responsibilities, which was a significant workload. There were plans to improve support for the medical director with the recruitment of deputy medical directors with dedicated time for responsibility for individual areas such as workforce and quality and safety.

The CN was also the director for infection prevention and control (DIPC) and the executive lead for end of life care and shared responsibility for quality and safety with the medical director.

The chief operation officer (COO) role had been dissolved and was in the process of being replaced by three roles who would all report to the CEO:

- Director of performance and recovery – interim post holder at time of inspection with plans to make a substantive appointment.
- Director of service delivery – interim post holder at time of inspection with plans to make a substantive appointment.
- Director of strategy - focusing on the Sustainable and Transformation Partnership (STP) for south east London, ‘Our Healthier South East London’.

The director of strategy joined the trust in 2010 and had a joint remit for planning alongside the DoFR.

The director of workforce and education (DWE) had been in post for several years.

The non-executive director (NED) body had a similar turnover with the appointment of three new non-executives in 2018. Five of the non-executives had a background in finance. The chair of the trust’s audit committee was transitioning to one of the new NEDs who was a qualified accountant, and the chair of the finance and performance committee had an MBA in finance.

At the time of the inspection the trust was made up of five clinical divisions which were:

- Acute and emergency medicine
- Children and young people
- Long term conditions and cancer
- Women and sexual health
Surgery and critical care
Community services were not a standalone division but were included in the appropriate divisions.

It was proposing to review the size of the divisions to ensure more consistent size in terms of staffing numbers and budget. There were also plans to establish a business support function for each division led by a business manager. The aim of the restructure was to create a flattened hierarchy and clarify roles and responsibility to allow for more devolved decision making and time for leadership development.

The proposed divisional structure is below:

Lewisham medicine and community
Queen Elizabeth medicine
Surgery
Women and children
Diagnostics and therapies

Leadership of the divisions were also changing to a structure headed up by a divisional director supported by a director of nursing and allied health professionals and a clinical director. Finance business partners sat alongside the divisional leadership teams. The divisional director would ultimately be responsible for the operational and financial performance of the division. As the structure was being implemented it was difficult to gauge the effectiveness of these changes.

Although some medical staff had attended a senior leadership and a new consultants programme, the medical director was looking at a further senior leadership and aspiring leadership programme for consultants.

Medicines optimisation within this trust was well led. The leadership staff in the pharmacy department were visible and ensured that medicines optimisation strategy plans were discussed in team meetings.

The trust had leads for safeguarding children and vulnerable adults. Child and adolescent mental health was provided by the local mental health trust for each hospital. It was the same arrangement for adults who presented at the hospitals with mental health problems.

Through various interviews, there was a consistent view of collective responsibility and of appropriate challenge between executives. However, as the new board formed, there was a question as to how the NEDs ensured their role of “critical friend” was balanced with the need to support the executive team. There was a clear enthusiasm for the changes being made by the new board.

Senior managers, clinicians, executives and non-executives we spoke with were positive about the recent and proposed changes, even though some of them were still in progress, and how they would help the trust move forward.

We found senior managers, nurses and medical staff were involved in decision making through attendance at the trust management executive (TME) meetings. This involvement had been strengthened since April 2018 and staff were positive about this change and welcomed the opportunity to be part of the discussions and engage with the executive team.

We were told the new executive team had really ‘inspired people’ and staff ‘looked forward to the CEO’s social media interactions’. The CN was described as having ‘liberating nursing staff to take responsibility and be accountable and to find ways to balance quality and safety’.

There was a programme of board visits to clinical areas and staff were positive about these visits and told us they found the executives and non-executives approachable.
The trust’s leadership team were aware of the challenges facing them and the top risks for the trust. Along with finance, the recruitment and retention of staff and improvement to the estate was crucial to them being able to bringing about sustained improvement.

At the inspection in March 2017 we found concerns with the trust’s was compliance with the Fit and Proper Persons Requirement (FPPR). In response the trust revised its FPPR procedure. A report to the board in June 2018 confirmed that all directors, executive and non-executive, had completed an annual self-declaration form confirming their continued compliance with the requirements for FPPR.

**Vision and strategy**

At the time of the inspection the trust was reviewing many of its strategies. This meant it did not have an overall vision and strategy. It was apparent that the trust was focussed on the immediate short term financial position out of necessity. This coupled with the change in leadership had resulted in the absence of an overall vision and strategy. Although it did not have a strategy the trust had developed a ‘road map’, October 2018 – April 2021. This outlined its current position in terms of patient and staff experience, meeting national standards along with the vision for 2021 and success measures.

The trust was at the beginning of the process of writing its strategy and long-term operational model, of which a new financial strategy would form a part. The chair of the finance & performance committee described the trust as being on a financial journey. We were told the approach to the strategy had been more engaging and collaborative, ‘it is not being done in a cupboard by directors’.

The financial plan for 2018/19 was therefore built separately to the developing vision, which added risk to the development of a well triangulated plan. There was an understanding across most of those asked of the trust’s financial position. Finishing the financial year 2017/18 with an underlying deficit of £62.5m, the draft plan for 2018/19 targets a reported deficit of £53.1m. The trust was aiming for a reduction of £15.7m in the underlying exit run-rate (a run-rate is the financial performance of the trust based on using current financial information as a predictor of future performance) from 2017/18. This was attributable to a 94.5% recurrent cost improvement programme (CIP) demonstrating an increase in operational efficiency. Delivery of the planned 2018/19 deficit required £25.5m of CIP which was an increase above the 17/18 delivery of £18.9m.

There were plans to reinvigorate service line reporting (SLR) which the trust had developed historically but which had not consistently been part of the organisations management information over the recent past. It was seen as an opportunity to increase engagement with the business and to view the finances through a different lens.

The director of strategy joined the trust in 2010 and had a joint remit for planning alongside the DoFR. The strategy team had been subject to turnover in key posts, which, while showing positive development of staff, had resulted in a capacity constraint in delivering a clear vision and strategy for delivery. The deputy director of strategy was credible and could talk clearly about the approach that would be taken to planning going forwards.

The trust did not have an up to date estates strategy but, was aware that success of the overall strategy was dependent on having the right estate. On appointment the CE had paused some of the major redevelopment plans until the workforce and clinical strategies had been approved. It
was anticipated the principles of the clinical strategy would be developed by April 2019 and the strategic outline case would progress in parallel with the clinical strategy. NHSI had agreed that development of estate development business cases would be progressed as a priority in 2018/19.

Both hospitals, University Hospital Lewisham (UHL) and Queen Elizabeth Hospital (QEH) were a mix of Private Funded Initiative (PFI) and trust buildings and they had different relationships and working arrangements with the relevant PFIs.

The trust had a draft mental health act policy but did not have a strategy/plan for the management of patients with mental health needs.

Some of the strategies that would feed into the overall strategy, for example workforce planning, were quite advanced and awaiting final approval.

Culture

Staff Diversity

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Medical Staff (%)</th>
<th>Qualified nursing staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>6.7%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.4%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Black</td>
<td>4.2%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other</td>
<td>0.7%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>0.4%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

NHS Staff Survey 2017 – results better than average of acute trusts

The trust had one key finding that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.15</td>
<td>4.06</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust had 22 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.51</td>
<td>3.75</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.85</td>
<td>3.9</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.88</td>
<td>3.91</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.38</td>
<td>3.44</td>
</tr>
<tr>
<td>KF6. Percentage of staff reporting good communication between senior management and staff</td>
<td>30%</td>
<td>33%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.86</td>
<td>3.89</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.7</td>
<td>3.76</td>
</tr>
<tr>
<td>KF11. Percentage of staff appraised in last 12 months</td>
<td>74%</td>
<td>86%</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.19</td>
<td>3.27</td>
</tr>
<tr>
<td>KF15. Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>47%</td>
<td>51%</td>
</tr>
<tr>
<td>*KF16. Percentage of staff working extra hours</td>
<td>75%</td>
<td>71%</td>
</tr>
<tr>
<td>*KF17. Percentage of staff feeling unwell due to work related stress in last 12 months</td>
<td>43%</td>
<td>38%</td>
</tr>
<tr>
<td>*KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>56%</td>
<td>53%</td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.48</td>
<td>3.63</td>
</tr>
<tr>
<td>*KF20. Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>76%</td>
<td>85%</td>
</tr>
<tr>
<td>KF24. Percentage of staff/colleagues reporting most recent experience of violence</td>
<td>65%</td>
<td>67%</td>
</tr>
<tr>
<td>*KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>31%</td>
<td>27%</td>
</tr>
<tr>
<td>*KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>29%</td>
<td>24%</td>
</tr>
<tr>
<td>*KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>35%</td>
<td>29%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.66</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.57</td>
<td>3.67</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

The findings of the 2017 NHS Staff Survey were reflective of what we found during our inspection in 2017. However, in subsequent inspections, including this one, we found that staff morale had
improved in the services inspected. There was still much work to be done but, staff were optimistic about the appointments of the CEO and CN and the changes in approach to communication which was felt to be more inclusive and informative.

The trust’s action plan in response to the 2017 survey included updates on the all actions to quarter 1 and showed that progress had been made in all objectives. The director of workforce and education (DWE) was the executive lead for the plan.

**Workforce race equality standard**

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for combined acute and community trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>33%</td>
<td>26%</td>
<td>32%</td>
</tr>
<tr>
<td>BME</td>
<td>30%</td>
<td>27%</td>
<td>31%</td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>29%</td>
<td>23%</td>
<td>27%</td>
</tr>
<tr>
<td>BME</td>
<td>30%</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>84%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>BME</td>
<td>66%</td>
<td>73%</td>
<td>71%</td>
</tr>
<tr>
<td>Q17b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>8%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>BME</td>
<td>17%</td>
<td>15%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Of the four questions above, the following questions showed a statistically significant difference in score between White and BME staff:

KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion white staff scored significantly higher.

Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues? BME staff scored significantly higher.

(Source: NHS Staff Survey 2017)

During the core service and well led inspections staff did not raise any concerns with us about equality or bullying and harassment issues in the core services we inspected

At the 2017 inspection we found the trust did not have a formal Workforce Race Equality Standard...
(WRES) plan. At this inspection the trust provided a WRES plan with timescales and nominated staff responsible for each action. We could see some actions had been progressed with some outstanding.

An initial EDI event was held in December 2017 with a further one held in March 2018. The event was hosted by the CEO and co-facilitated by some of the executive directors. The outcomes of the event informed the work of the EDI steering committee and network. EDI work was the responsibility of all executive directors but, was led by the CEO.

Other changes since the 2017 inspection included equality and diversity training and updates were now mandatory requirements for all staff. Recruitment panels had undertaken training on fair and efficient recruitment and the trust had rolled out unconscious bias and values based recruitment.
**Friends and Family test**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored slightly below the England average for recommending the trust as a place to receive care from August 2017 to July 2018, with the exception on May 2018 when the trust was similar to England average.

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from June 2017 to April 2018 were slightly above the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey found the trust performed worse than expected for three indicators (Educational Supervision, feedback, regional teaching), and the same as expected for the remaining ten indicators.

(Source: General Medical Council National Training Scheme Survey)

The trust had appointed seven Freedom To Speak Up Guardians (FTSUG) supported by a non-executive director and managed by the DWE. They had all received training by the National
Guardian Office and had recently made contact with other FTSUGs but, had yet to establish any formal/ongoing links.

There were seven FTSUGs but, during our discussion with three of them we were told they believed they were the only ones active. The FTSUGs had all previously worked for the trust and were keen to support the work of the trust. They came from a range of backgrounds, nursing, medical and management. Staff could contact them via a shared confidential email address and work had been done to publicise their role though posters and they had done ‘walkabouts’.

The FTSUGs responded to emails depending on which of them were available as they did not have a rota. Although the trust kept a log of the number of contacts and issues, information about action taken and outcomes were kept by the individual FTSUGs on their own computers or notebooks. The FTSUGs we spoke with were able to provide us with examples of action they had taken to resolve issues raised with them. We raised our concerns about how the FTSUGs were recording and storing information with the DWE.

The medical director was the named lead for duty of candour and the trust had a duty of candour policy. Compliance with duty of candour was recorded on the trust scorecard and presented to the trust board on a monthly basis. We reviewed the investigations of five serious incidents and found the duty of candour policy had been followed.

**Governance**

**Board Assurance Framework**

The trust provided their board assurance framework, which detailed five strategic objectives within each and accompanying risks. A summary of these is below.

1. Provide consistently safe, high quality patient-focused services
2. Create a strong, unified, sustainable and well-governed organisation
3. Strengthen and extended relationships with all our partners for the benefit of local people
4. Promote a caring workforce through good quality leadership and excellence in education
5. Secure the future of the organisation as a clinically-led, independent and commercially viable Trust

*(Source: Trust Board Assurance Framework – July 2018)*

There were six sub-committees of the board that reported to the board. These were clinical governance, finance and investment and performance, workforce and education, audit and risk, remuneration and appointments and strategic projects. They were all chaired by the CEO, chair or a NED. The principal duties of the sub-committees were clear and relevant. Audit and risk and strategic project committees met bi-monthly and the remuneration and appointments committee met as required.

Beneath the six sub committees there were a range of committees that reported to the trust management executive (TME). Information from the TME was then shared upwards with the six sub committees of the board.

The trust’s finance and performance committee (FPC) was chaired by a trust NED, who was an experienced professional with a background in governance, risk and accountability. The NED was joined on the FPC by various other executives including the Interim DoFR who provided NHS specific knowledge and experience. The remit of the FPC had just been expanded to include
performance and seemed to be typical and provided assurance to the board by considering amongst other items, the reported monthly financial position, the financial plan, investments and performance actions. The chair of the FPC provided an assurance update to the trust board.

The audit committee was chaired by the deputy chair, however, the chair was transferring to an alternative NED. The NEDs responsible for both committees ensured that roles and responsibilities were clear between the two committees.

The 2018/19 plan included a challenging CIP target of £25.5m. CIP delivery in 2017/18 was £18.9m. The trust CIP plan had a low risk profile with around only 17.3% of schemes RAG rated as red.

Following the deterioration of the financial position in 2017/18 the grip through the divisions was an area of significant concern following the recovery actions put in place by the trust, this grip appeared to be improving.

At the time of the inspection the director of service delivery was responsible for the delivery of clinical services through the trust’s five clinical divisions. The clinical divisions were led by a triumvirate of a senior nurse, divisional director (consultant) and divisional manager.

Within the divisions the governance structures included meetings at ward, team, service and divisional level to share information about complaints and incidents.

Medicines optimisation was discussed at various committee meetings and reports were sent to the trust board. The chief pharmacist reported to the director of operations and met regularly with the medical director. The medical director was the trust Controlled Drugs Accountable Officer. Regular discussions on controlled drugs (CDs) incidents and actions took place.

There were patient group directions (PGDs) in use across the trust. There was a ‘tracker’ document that helped staff keep up to date with PGD review dates. The trust medicines management (MM) nurse maintained oversight of this and ensured that nursing staff were appropriately trained to use relevant PGDs. Some issues had previously been highlighted with regards to medicines policies expiring and automatically being removed from the staff intranet. This issue had been fixed.

Pharmacy staff had regular training slots with the junior doctors and induction for nursing staff. Pharmacy porters received training with relation to the transportation and delivery of CDs. There were monthly meetings to ensure that outsourced outpatient pharmacy services were meeting their key performance indicators.

QEH was viewed as the most challenged site in terms of capacity, resources and clinical leadership and the medical director spent more time at that hospital. This was supported by the number of complaints and concerns received by CQC from patients and relatives.

During the core service inspection we found some services where the governance arrangements were not as effective as they could be. In the critical care unit at QEH we found that not all of the improvements made since the last inspection had not been sustained and although staff were aware that the unit had regressed no action had been taken.

However, the trust had also achieved some success in bringing about improvements at QEH. For example on one of the medical wards staff morale was poor and retention was low along with an increasing number of complaints and serious incidents. The number of beds on the ward was reduced along with a review of the acuity of patients placed there. The results of the family and friends test had improved since the changes.

Management of risk, issues and performance
Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£539.2m</td>
<td>£543.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>-£20.054</td>
<td>-£55.606</td>
</tr>
<tr>
<td>Full Costs</td>
<td>-£580.3m</td>
<td>-£599.5m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>-£20.2m</td>
<td>-£22.8m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)
**Trust corporate risk register**

The trust provided a document detailing their three highest profile risks. Each of these have a current risk score of 20 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewed TME 22/06/18</td>
<td>CRR 001</td>
<td>Workforce - Risk of inability to recruit, retain and provide adequate numbers of appropriately qualified substantive staff (junior doctors, nurses and other clinical staff) to maintain service quality and meet expected national standards - patient safety, service delivery, staff morale, financial and reputational risk.</td>
<td>20</td>
<td>8</td>
<td>31/03/19</td>
</tr>
<tr>
<td>New Risk added following TME review 22/06/2018</td>
<td>CRR 002</td>
<td>DAY CARE FACILITY QEH NOT FIT FOR PURPOSE - An area designed as a day care facility has changed incrementally over time and has become an area used daily for in patients along with day cases and procedures that should be undertaken in outpatients. This results in patients being cared for in an area not fit for purpose. There is insufficient space to care for the high numbers of day cases scheduled within the area and over winter the recovery area for the day theatre was opened as an escalation area. This leads to high stress levels for staff, low staff morale, poor patient experience and delays in pathways. Theatre recovery begins to get blocked from 3pm each day and patients are regularly recovered within Theatres. In addition due to ED patients being admitted overnight (average of 4-5 per night) the DCU staff come into a full ward in the morning. This means the Gynaecology patients that require misoprostol pessaries cannot have this as no bed space and they miss first slot on theatre list for the day. Poor patient experience during a very traumatic time.</td>
<td>20</td>
<td>12</td>
<td>31/09/18</td>
</tr>
<tr>
<td>Reviewed TME 22/06/18</td>
<td>CRR 003</td>
<td>RISK TO DELIVERY OF HIGH QUALITY PATHWAY FOR EOLC Patients: 1. End of Life rated 'Inadequate' QEH in 2017 CQC Inspection. 2. Adequate and sustainable 24/7 Service provision is risk for all three boroughs 3. Trustwide risk of failure to recognise EOLC patients and provide high quality care pathway and appropriate decision re: treatment escalation or ceiling Lewisham specific risk: Lewisham CCG have re-tendered the community specialist palliative care (SPC)</td>
<td>20</td>
<td>3</td>
<td>31/08/18</td>
</tr>
</tbody>
</table>
contract to St Christopher's Hospice and this service was due to start on 1st April 2018. The Trust was notified on 15th February 2018 that due to staffing issues for the new provider; St Christopher’s, the service would not commence until the 1st July 2018. The Trust has been asked to work with the new provider to support service provision between 1st April and 30th June however due to 3 members (2.6wte) of staff leaving the team as a result of the new service there are insufficient SPC CNS’ to continue to provide the existing service. There are currently c.100 patients on the LGT SPC community caseload.

The impact for patients is that there will be c.100 patients who will not receive any specialist palliative care advice and support for symptom management. This could result in patients being admitted to hospital for symptom management. The service will also not be able to support any new referrals which could also result in an increase length of stay and patients not achieving their preferred place of dying.

(Source: Trust Corporate Risk Register)

Following a series of external reviews of its risk management systems the trust had restructured the process for reviewing, moderating scores, adding and removing risks. One of the external reviews found the trust had a comprehensive risk management policy which contained many of the elements of good practice, for example, clear definitions and clear escalation processes.

All divisional risk registers had been reviewed as part of the whole trust review. During the core service inspection we reviewed the divisional risk registers and found many of them reflected the risks we found and we could see they had been reviewed and updated. However, some of the actions did not mitigate the risks and some measures which would have been relatively quick to implement had not been actioned in a timely manner.

Along with divisional changes the trust had reviewed the board assurance framework and provided a copy of the new corporate risk register and a draft corporate risk register scorecard. The draft corporate risk register score card (July 2018) noted that the lack of system capacity at QEH was resulting in inappropriate transfer of patients from the emergency department to escalation areas. This has been noted in our inspection reports since February 2015. New risks added to the score card included learning from themes identified through serious incident investigations and leadership capacity.

During the inspection top risks were consistently reported as workforce, the QEH day care facility, estates, and the trust’s financial position. The following two finance specific risks were reported through the Board Assurance Framework (BAF):

1. Risk of organisation being financially sustainable in the medium term due to:
   a. The trust’s ability to deliver recurrent financial efficiency targets;
   b. Significant fixed costs associated with the trust’s estate in relation to PFI and capital charges;
c. The imposition of financial penalties (including loss of STF funding) by commissioners and regulatory bodies;

d. Recognition that delivery of plan assumes delivery of the cap contracting levels with the trust’s main commissioners (Bexley, Greenwich and Lewisham) – underperformance by divisions risks non-delivery

2. Failure of commissioner plans to decrease demand for acute services. Risk that:
   a. Plans to manage demand fail, or
   b. Schemes successful and costs taken out of hospital – financial risk.

Mitigating actions include the identification of a medium term financial strategy, the establishment of a recovery programme board, work to understand the drivers of the deficit, STP engagement. It was noted that the BAF mitigations were not fully complete, and there were concerns following the interviews that risk management processes were not fully embedded yet.

Workforce was a significant risk for the trust and was the number one risk on the corporate risk register. As at July 2018 the vacancy rate was 17% against a target of 12%. Many of the vacancies were within nursing but, other staff groups were also severely affected including medical staff and radiographers. Since the appointment of the CEO and CN the workforce profile had been raised with attention paid to retention as well as recruitment. We were told the trust was trying to be more innovative and had focussed on developing apprenticeships with nursing associates and introduced the health visiting assistant practitioner in community services. The trust had dedicated recruitment staff in the divisions which was helping to reduce any delays in the system. At the end of quarter 1 2018/19 the trust had recruited 381 new staff including six nursing associates and the first physician associates to support acute and emergency medicine.

Resources and facilities for patients with mental health needs were variable. We were provided with the terms of reference for the trust’s mental health oversight board which included membership from the two mental health providers. The board reported to the acute and emergency medicine divisional management board. The focus of the board was on the mental health CQUIN and it was not clear from the terms of reference who chaired the board.

The trust also had meetings with the psychiatric liaison teams from both mental health providers. The minutes showed they discussed operational issues, number of patients attending and case studies. The minutes lacked detail about follow up on actions from previous meetings, proposed actions and named people responsible along with timescales for the actions. There was no reference to caring for patients with mental health needs on the corporate risk register or risk score card.

The trust medication safety officer maintained oversight of medicines related risks. There was a medicines audit programme in place. Audits were completed in a variety of areas including:

- controlled drugs
- safe and secure storage of medicines
- omitted doses and delayed doses
- clinical interventions

Medicine related risks were recorded on a pharmacy risk register, were reviewed monthly, and were visible to the trust board. Patient safety alerts were managed centrally by the patient safety and risk teams. They took responsibility for sending information to staff in each division.

Planning for winter pressures had identified a likely gap in the provision of pharmacy services. There was a plan to employ locum pharmacists to assist with this. There was ample opportunity for informal discussions that enabled benchmarking of the pharmacy services with local trusts.
The trust had a current business continuity plan and a major incident plan which was due for review in May 2018.

Information management

The board received holistic information on quality and sustainability. Board papers covered finance, quality, strategic and performance updates. Minutes of the audit committee, finance and performance committee and quality and clinical governance committee were shared with board attendees.

The board received an assurance update from the chairs of the finance and performance audit committee each month and a presentation of the previous month’s financial position which was presented by the interim DoFI. Other items were added to the agenda as appropriate. The trust board was scheduled to spend 10 minutes discussing finance, and 20 minutes discussing committee reports (including FIC and Audit). The finance report summarised the financial performance against plan, a summary of CIP performance and a breakdown of the forecast outturn. Historically there was an absence of analysis of the on-going underlying position, however, the trust was increasingly focusing on this.

Each division had a performance dashboard which reported on performance and safety and quality e.g. waiting times, falls, infection prevention and control, patient experience and length of stay. The dashboard was rag rated and information was grouped using the CQC domains and informed the board assurance framework.

The trust was aware of its performance and staff we interviewed during both the core service and well-led inspection were able to share with us specific information about their directorate’s performance and the quality and safety of care.

Managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. To manage patient flow regular bed meetings were held throughout each day with attendance from all key staff.

In some services, such as the emergency department (ED), board rounds took place three times each day. All members of the multidisciplinary team attended and all of the patients were reviewed.

Staff had access to the IT equipment and systems needed to do their work. There was a mixture of electronic and paper systems being used in the trust.

The trust’s electronic patient record (EPR) had been developed prior to the two hospitals becoming part of one trust. This meant there were different systems in use at each hospital and patients would have separate records at each hospital. During the summer of 2018 the two systems were merged which meant staff could see all the information about a patient in one place. Using one system would be more cost effective for the trust and provide a better experience for the patient.

New technology was helping staff to work more efficiently. Community staff in Lewisham were trialling mobile devices, laptops and tablets, to help them work more efficiently. Skype for
The business had been used by the neonatal intensive care team which reduced the need for staff to travel between the two hospitals for meeting and the medical equipment team had saved up to eight hours of staff time by introducing Skype team meetings.

In terms of medicines optimisation a project manager had been appointed to lead on compliance with Carter 1 agenda (a series of recommendations to improve the quality of care and finances in NHS organisations). Implemented changes were measured to analyse impact. Staff were kept informed of progress against the Carter 1 agenda via meetings and newsletters. Discharge summaries were produced electronically and sent to GP surgeries and community pharmacies (where needed). Staff accessed summary care records. There was a plan to implement an electronic prescribing system in the trust by April 2019. However, testing was delaying implementation.

The medication safety officer (MSO) tracked CD incidents and quarterly reports were sent to the CD local intelligence network. Senior pharmacy staff had a positive working relationship with the local police CD liaison officer. The MSO was informed of medicines incidents escalated to the National Reporting and Learning System by the trust patient safety team.

The trust had an established information governance committee and the trust’s Caldicott Guardian was a member of the committee. The trust’s compliance with the standards of the Information Governance Toolkit had improved since 2016 and was the second highest, in 2017/18 when compared to other local acute trusts.

Engagement

Ward, service and divisional teams received feedback from patients and carers through the Friends and Family Test, national patient survey.

At UHL there was a patient welfare forum (PWF) and at QEH there was patient user group (PUG). Both groups met monthly and minutes were taken by a trust facilitator. The PWF had a structured approach and visited the wards and outpatient clinics and worked with the trust’s patient experience team to bring about improvements. Examples of improvements included healthier snacks in the emergency department, new breast pumps for women who were breast feeding babies in the neonatal intensive care unit.

The PUG had changed their approach which meant they had undertaken less visits to wards and outpatient departments. They had worked with the patient experience group to bring about improvements in five key areas including food, internal communications and complaints.

Both groups recruited lay representatives to apply to join trust committees and interview panels. These roles had job descriptions and people went through an interview process. Members of the PWF had joined stakeholder panels for the selection of the chair and chief executive of the trust.

The trust had improved information for patients. A range of patient representatives were involved in the process and new information leaflets were available for patients including specific information requested by patients.

The local healthwatch groups met with the patient experience group. They told us that people commented on the improved care in the EDs and that the maternity services were very good and provided women with helpful explanations about their pregnancy and care.

The 2017 NHS inpatient survey showed an improvement on the 2016 survey. There were significant improvements across the admission process, helping patients keep clean, emotional support, and information around discharge. The trust was planning to introduce its own local patient surveys.
The trust had a structured and systematic approach to staff engagement. Communication systems such as the intranet and newsletters were in place to ensure staff had access to up to date information.

In 2017 staff were asked for their input, via a survey, into the quality priorities. Board members engaged with staff during their quality visits to clinical areas to learn about the service and challenges that staff had to manage. Some of the visits were unannounced and unaccompanied and following each visit the board member completed a report highlighting practice that should be shared and/or celebrated.

In relation to staff engagement in financial governance, the trust initially instituted weekly, moving to biweekly, financial reviews. Staff were engaged through regular communications, including a ‘Money Matters’ newsletter. Budgets were reset and additional training was provided for budget holders to ensure the relevant individuals took ownership of their financial position. Budget holders were required to sign a letter from the CEO that set out what was expected of them as a budget holder.

Staff at all levels and across all groups were positive about how the CEO engaged with them. They felt they were better informed about what was happening in the trust and more engaged in the decision making.

The new CEO had been working on a revised vision and set of values for the organisation and had been encouraging staff involvement through open sessions. Over 300 staff had attended these sessions and voted on the values that best fitted the organisation so that these were owned by everyone. The proposed vision and values had also been discussed with patient groups.

The trust celebrated staff achievements at annual staff awards which included the ‘healthcare hero’ award.

In terms of external engagement, historically the trust has had some difficulties and stresses working with commissioners, however these had improved over the past year, with agreement to reduce the level of claims and challenges, as well as a desire to drive forward performance improvements such as virtual clinics.

The trust did not seem to be taking a leading role in the STP, although some executive members described considerably more interaction than others. The CEO for example was on the South East London (SEL) STP Board. There were other examples of local provider collaboration described across the interviews mostly focused on resolving specific issues i.e. financial sustainability, procurement outsourcing and work placements across south east London tertiary providers. However, at least one of the NEDs was not sighted on trust engagement within the STP.

**Learning, continuous improvement and innovation**

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25</td>
<td>N/A</td>
</tr>
</tbody>
</table>
If you have a slightly longer target for complex complaints please indicate what that is here | N/A | N/A
Number of complaints resolved without formal process in the last 12 months? | 5,465 | N/A

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

**Number of complaints made to the trust**

The trust received 583 complaints from April 2017 to March 2018. Medical care received the most complaints with 208.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical care (including older people's care)</td>
<td>208</td>
<td>35.7%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>98</td>
<td>16.8%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>62</td>
<td>10.6%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>50</td>
<td>8.6%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>49</td>
<td>8.4%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>30</td>
<td>5.1%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>29</td>
<td>5.0%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>23</td>
<td>3.9%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>15</td>
<td>2.6%</td>
</tr>
<tr>
<td>CHS - Adults Community</td>
<td>10</td>
<td>1.7%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>5</td>
<td>0.9%</td>
</tr>
<tr>
<td>CHS - Sexual Health</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Medical care is an area we have received a lot of complaints about and informed the decision to inspect that service in May 2018 at QEH.
Compliments

From April 2017 to March 2018, the trust received a total of 246 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Urgent and emergency services</td>
<td>47</td>
<td>19.1%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>44</td>
<td>17.9%</td>
</tr>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>39</td>
<td>15.9%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>25</td>
<td>10.2%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>23</td>
<td>9.3%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>14</td>
<td>5.7%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>12</td>
<td>4.9%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>10</td>
<td>4.1%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>10</td>
<td>4.1%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>9</td>
<td>3.7%</td>
</tr>
<tr>
<td>CHS - Adults Community</td>
<td>6</td>
<td>2.4%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>AC - End of life care</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>CHS - Sexual Health</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>CHS - Children, Young People and Families</td>
<td>1</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)
Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Medicine (including older people’s care)</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>End of Life Care</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Surgery</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>Commission for the Accreditation of Rehabilitation Facilities (CARF)</td>
<td>N/A</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>N/A</td>
</tr>
<tr>
<td>Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)</td>
<td>N/A</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>N/A</td>
</tr>
<tr>
<td>Accreditation for Inpatient Mental Health Services (AIMS)</td>
<td>N/A</td>
</tr>
<tr>
<td>‘Quality Networks</td>
<td>N/A</td>
</tr>
<tr>
<td>ECT Accreditation Scheme (ECTAS)</td>
<td>N/A</td>
</tr>
<tr>
<td>Psychiatric Liaison Accreditation Network (PLAN)</td>
<td>N/A</td>
</tr>
<tr>
<td>Memory Services National Accreditation Programme (MSNAP)</td>
<td>N/A</td>
</tr>
<tr>
<td>Accreditation for Psychological Therapies Services (APPTS)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

The trust had systems to identify learning from incidents, complaints and safeguarding alerts to make improvements.

During 2017/18 the trust received over 5,500 contacts through PALS and formal complaints; the number of complaints received was a downward trend from 2016/17 when they received 743 complaints and from 2015/16, when the trust received 1,250 complaints.

Complaints were discussed at the complaints monthly steering group, divisional governance meetings, TME, trust board and the outcomes with learning group (OWL). The complaints manager told us the trust aimed to provide a full response within 25 and had a system to track complaints. Some complaints could take longer than 25 due to their complexity. When complaints were received they were triaged and sent to the relevant division to draft a response. Responses were reviewed by the complaints team before final sign off by the CEO..
Each hospital had a patient advice and liaison service (PALS) who aimed to resolve problems before they escalated to complaints. The complaints manager was also the manager for the patient experience team. Training on how to manage complaints was provided at induction and some ad hoc training had been provided for service managers.

Common themes from complaints were communication and patient care and treatment, many of which were about nursing care. This corroborated with the complaints and concerns we have received from patients and their relative/friends. One of the issues the trust was grappling with was embedding learning from complaints due to the reliance on bank and agency staff and staff turnover. Staff found they were having to repeat the messages several times and it was taking longer to bring about improvement. The recruitment and retention issues were having an impact on patient care and where complaints had been received about individual agency nurses these had been followed up with the agency.

We reviewed the records of five people who had made complaints. The responses indicated that effective investigations were undertaken. Complaints were linked to incidents through the outcomes with learning group where both were discussed. This provided the opportunity for a complaint to also be logged as an incident.

The 2016/17 complaints report found that all complaints had been acknowledged within the agreed timescales and responding to complaints within agreed timescales had improved by 35%. Surgery had received the highest number of complaints followed by acute medicine. Examples of improvements included the creation of a theatre liaison post to assist in coordinating CEPOD/non elective surgery. This was in response to several complaints from patients on the day care unit waiting for non-elective surgery who had experienced delays and poor communication from theatre and nursing staff.

The trust had systems for investigating and learning from serious incidents and deaths. A ‘mortality learning from deaths’ report presented to the trust board in September 2018 detailed the trust’s process on collecting and publishing specified information on deaths.

Two consultants who had attended structured judgement review (SJR) training were trainers for the trust and had trained over 50 staff from different disciplines. The trust was planning to introduce the medical examiner role in autumn 2018, which will be ahead of the extended timescale of 2019. The trust had a mortality review policy due for review in 2019.

We reviewed five investigations into serious incidents including unanticipated deaths and found many areas of good practice. There was one action plan where it wasn’t clear how learning had been shared with staff and another where although therapy staff were involved in the incident all of the actions were directed at the ward staff.

The recording and escalation of the deteriorating patient was found to be a recurring theme in the SJRs. To address this, the trust wide deteriorating patient working group had taken the lead on training for all staff on recognising the deteriorating patient. The most recent audit of National early Warning Scoring (NEWS) found that of the 108 patients audited 93% of patients who were deteriorating were escalated and managed in line with trust policy. Documentation and communication between teams remained an area for further improvement.

Prior to the inspection we were informed of two incidents involving patients who had choked after being given the incorrect diet. Following the inspection we were informed of another similar incident related to food which possibly indicates that learning from incidents is not being shared sufficient widely across the trust and/or learning is not embedded.
In the core services we inspected we found many staff had completed their safeguarding training. However, completion of level 3 training by medical staff was a concern along with their engagement in safeguarding issues.

We reviewed five safeguarding investigations and found gaps in some of the investigations and some key learning not identified. One recurring theme was the lack of ‘professional curiosity’. This was demonstrated in the case of a baby who presented in the emergency department with a suspected fracture buckle. There was a family history of alcohol abuse and domestic violence. The child was seen by the staff from different medical teams but it was not recognised or reported as an incident until day six. Another example was a child aged eleven who had had a contraceptive implant. The child had autism and the parent gave the incorrect date of birth. There was no formal check of age for eight days. When staff became aware of the problem it took three weeks to report it as an incident.

Pharmacy staff were supported to undergo training and development. In addition, the trust offered the structured training and education programme for pharmacists. This was in collaboration with local acute trusts in South East London who were aligned with King’s Health Partners. The programme offered newly qualified pharmacists career development as well as post graduate education.

Creative split pharmacy posts had been designed that encouraged joint working across primary and secondary care. This improved patient care as patients with complex medicines needs could be referred to colleagues in primary care. A new pharmacy technician in procurement was made rotational to attract applicants.

The trust MM nurse supported nurse training and implementation of guidelines and policies relating to medicines. The MSO also worked with the MM nurse to deliver training on incidents and lessons learnt.

Staff developed action plans to facilitate improvement in areas identified during the previous CQC inspection. For example, risk assessments would be implemented with regards to the drawing up of medicines in syringes within theatres.

The trust has an established partnership with King’s Health Partners (KHP), the Academic Health Science Centre for southeast London. It worked closely with KHP to deliver local clinical services, research, education and training activities.

Lewisham and Greenwich NHS Trust was part of the London (South) Comprehensive Local Research Network and the South London Academic Health Science Network. Participation in these networks provided local people with access to specialist and local care.

The enhanced staff training programme had delivered a significant reduction in pressure sores acquired by inpatients. The incidence of the most serious sores, known as grade 3 and 4 sores, had decreased by over 75%.

Three trust initiatives were shortlisted for national patient safety awards:

The respiratory team at Queen Elizabeth Hospital was shortlisted for an HSJ Patient Safety Award for their work in reducing harm in patients with chest drains.

The maternity team was shortlisted for introducing a new training scheme to support the safe delivery of twins.

The coordinated work of the Lewisham integrated medicines optimisation service (LIMOS) pharmacy team across the hospital, local care homes and community settings ensured smooth transfers for patients from one setting to another.
Urgent and emergency care

Facts and data about this service

The Emergency Department (ED) at Queen Elizabeth Hospital (QEH) provides a 24 hour, seven days a week service.

The ED consists of 20 major treatment trolleys, a four bedded resuscitation area with a paediatric resuscitation bay; a nine bedded blue area used for rapid assessment and treatment (RAT), a green area for ambulatory care consisting of five rooms, and a paediatric emergency unit consisting of eight trolleys and a high dependency unit.

The ED also has a clinical decision unit (CDU) consisting of two bays, two side rooms and six blue recliner chairs for patients. Each bay has five beds.

All walk-in patients including children above the age of one are streamed by an urgent care centre (UCC) nurse who determines if they are suitable for the UCC or if they need to go to the ED. Patients who are sent to the ED are then triaged by an ED triage nurse to a relevant pathway.

Children under the age of one, patients with referrals from their GP and patients undergoing chemotherapy are booked in directly to attend the ED.

The total number of attendances for ED at the trust is provided in the table below. From April 2016 to March 2017 there were 277,294 attendances at the trust’s ED as indicated in the chart above. This figure included children.

_Urgent and emergency care attendances at Lewisham and Greenwich NHS Trust compared to all acute trusts in England, April 2016 to March 2017._

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

The percentage of attendances in urgent and emergency care that resulted in an admission, increased in 2016/17 compared to the previous year (2015/16). In both years, the proportion
was lower than the England average for that year.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from March 2017 to February 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>39,309</td>
<td></td>
</tr>
<tr>
<td>Discharged*</td>
<td></td>
<td>143,644</td>
</tr>
<tr>
<td>Referred*</td>
<td>20,173</td>
<td></td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>4,944</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Left department#</td>
<td>6,786</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

Of all attendances, the majority (143,644) were discharged, with 39,309 being admitted to hospital. Additionally, 6,786 attendees left the department either before treatment or having refused treatment.

(Source: Hospital Episode Statistics)

Is the service safe?
Mandatory training

The trust had a programme of mandatory training for staff. A practice development nurse (PDN) managed mandatory training and induction for new staff. Staff told us they were supported to complete mandatory training by the matron and PDN. Staff were provided with dedicated mandatory training days to complete the mandatory training required for their role.

Mandatory training was delivered face-to-face and through e-learning. Staff were given protected time on their rota to complete mandatory training to help them keep up to date. However, staff told us the trust’s policy was changing and training weeks, where staff spent a dedicated week completing mandatory training, was being changed and staff would complete mandatory training when due.

Senior staff monitored completion rates for mandatory training against the trust’s minimum 85% target. Mandatory training compliance was a standard agenda item on senior management team (SMT) meetings.

The PDN was able to show us up to date training records for all nursing staff, from these it was easy to identify who was not compliant with their training. We viewed a spreadsheet the PDN kept to ensure staff had up to date mandatory training. Nursing staff mandatory training completion rates at the time of inspection met the trust’s 85% target.

The trust set a target of 85% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 at trust level for staff in urgent and emergency care is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution enhanced</td>
<td>203</td>
<td>204</td>
<td>99.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>216</td>
<td>223</td>
<td>96.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>212</td>
<td>223</td>
<td>95.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>209</td>
<td>223</td>
<td>93.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>207</td>
<td>223</td>
<td>92.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>207</td>
<td>223</td>
<td>92.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>195</td>
<td>223</td>
<td>87.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>186</td>
<td>223</td>
<td>83.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>184</td>
<td>223</td>
<td>82.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - HLS</td>
<td>160</td>
<td>196</td>
<td>81.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - PHLS</td>
<td>17</td>
<td>23</td>
<td>73.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>161</td>
<td>223</td>
<td>72.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>149</td>
<td>223</td>
<td>66.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and harassment</td>
<td>2</td>
<td>8</td>
<td>25.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Nursing staff in urgent and emergency care met the 85% target for eight of the 15 mandatory training courses made available to them.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control clinical</td>
<td>75</td>
<td>90</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>65</td>
<td>90</td>
<td>72.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>63</td>
<td>90</td>
<td>70.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>56</td>
<td>90</td>
<td>62.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>56</td>
<td>90</td>
<td>62.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>42</td>
<td>90</td>
<td>46.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>38</td>
<td>90</td>
<td>42.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>31</td>
<td>90</td>
<td>34.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>26</td>
<td>90</td>
<td>28.9%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in urgent and emergency care at the trust did not meet the 85% target for any of the 10 training courses made available to them. The highest completion rate for this staff group was 83.3% which is close to the trust’s target.

Queen Elizabeth Hospital

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the urgent and emergency care department at Queen Elizabeth Hospital (QEH) is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency planning</td>
<td>101</td>
<td>101</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>101</td>
<td>101</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution enhanced</td>
<td>92</td>
<td>92</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>100</td>
<td>101</td>
<td>99.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>100</td>
<td>101</td>
<td>99.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>99</td>
<td>101</td>
<td>98.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>99</td>
<td>101</td>
<td>98.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management</td>
<td>98</td>
<td>101</td>
<td>97.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>98</td>
<td>101</td>
<td>97.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - HLS</td>
<td>69</td>
<td>77</td>
<td>89.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>88</td>
<td>101</td>
<td>87.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - PHLS</td>
<td>16</td>
<td>20</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>74</td>
<td>101</td>
<td>73.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At QEH urgent and emergency care department the 85% target was met for 12 of the 14 mandatory training modules for which qualified nursing staff were eligible.

The divisional clinical strategy identified work in progress on plans to use staff across both UHL and QEH sites more flexibly.
Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control clinical</td>
<td>46</td>
<td>48</td>
<td>95.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>46</td>
<td>48</td>
<td>95.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>38</td>
<td>48</td>
<td>79.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>32</td>
<td>48</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>29</td>
<td>48</td>
<td>60.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>27</td>
<td>48</td>
<td>56.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>22</td>
<td>48</td>
<td>45.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>20</td>
<td>48</td>
<td>41.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>19</td>
<td>48</td>
<td>39.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At the time of our last inspection, medical staff training completion rates were lower than the trust’s 85% target for 11 of the 12 training modules. We still found medical staff mandatory training rates did not meet the trust’s target of 85% for two of the nine mandatory training courses for which they were eligible.

Safeguarding

All staff in ED, including therapies staff, had adult and children’s safeguarding training to a level appropriate to their roles and responsibilities. Higher levels of safeguarding training were completed, based on the level of responsibility each member of staff had.

Staff we spoke with understood and could identify the different types of abuse, such as neglect, psychological and emotional abuse, financial abuse, and physical and sexual abuse. Staff were aware of their responsibilities in relation to safeguarding vulnerable adults and children.

Staff had access to the trusts safeguarding policy on the intranet and knew how to access the trust’s safeguarding team for advice and guidance when required. Staff told us the safeguarding team were supportive in giving advice and guidance.

Staff we spoke with in the paediatric ED were aware of their responsibilities to protect vulnerable children. Staff were knowledgeable about paediatric safeguarding procedures. There was a safeguarding flag system on the electronic patient record for children with a child protection plan. The department had joined the child protection information sharing project supported by NHS digital. The project helps the NHS give a higher level of protection to children who present in unscheduled care settings. A database enabled healthcare staff working in these areas to identify if a child was subject to a child protection plan or was looked after by a local authority. Staff checked the database for all children who attended the department, and highlighted their name on records to confirm the check had been completed.

There were systems in place for recording and reporting suspected cases of female genital mutilation (FGM) within the department. If FGM was identified or suspected staff would inform the senior nurse or consultant. This would be followed up with referral to the safeguarding team. If staff suspected sexual exploitation this would be reported to the trust’s safeguarding team and recorded as a safeguarding incident and reported to the local authority social services and police. The trust set a target of 85% for completion of safeguarding training.

Trust level
A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 at trust level for staff in urgent and emergency care is shown below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>198</td>
<td>200</td>
<td>99.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>215</td>
<td>223</td>
<td>96.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - specialist</td>
<td>20</td>
<td>23</td>
<td>87.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff in ED at the trust, met the 85% training target for all three safeguarding training courses made available to them. 100% of staff in the paediatric ED had level 3 children and young people’s safeguarding training.

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>74</td>
<td>90</td>
<td>82.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - core</td>
<td>56</td>
<td>87</td>
<td>64.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At the previous inspection we found medical staff did not meet the trust’s target of 85% for any of the three safeguarding courses that were made available to them. We still found that medical staff safeguarding training was not meeting the trust’s targets. This did not meet the recommendations of the adults and children’s intercollegiate documents that state the level of training staff require based on roles and competencies for safeguarding children and adults, (Safeguarding children: Roles and Competencies, 2014: Adult Safeguarding: Roles and Competencies, 2018). However, it should be noted that the training rate in adult safeguarding at 82.2% was close to the trust's 85% target.

**Queen Elizabeth Hospital**

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 for staff in the urgent and emergency care department at Queen Elizabeth Hospital (QEIH) is shown below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Clinical Level 2</td>
<td>101</td>
<td>101</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
At QEH urgent and emergency care department, the 85% training target was met by nursing staff for all three courses that were available to them. Two courses had 100% compliance.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Clinical Level 2</td>
<td>45</td>
<td>48</td>
<td>93.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Young People Level 3 - Specialist</td>
<td>32</td>
<td>48</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in the urgent and emergency department at QEH, met the target of 85% for one of the two safeguarding courses made available to them.

Cleanliness, infection control and hygiene

The ED had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health (DoH) code of practice on the prevention and control of infections. This included: hand hygiene, use of personal protective equipment (PPE) such as gloves and aprons, and management of the spillage of body fluids.

There were housekeeping staff for cleaning all areas of the ED including the paediatric ED, “majors”, resuscitation, clinical decision unit (CDU) and waiting areas. We saw housekeeping staff cleaning the ED during our inspection.

Equipment we looked, including commodes and bedpans, were clean. Staff used “I am clean” labels to indicate that an item of equipment was clean, decontaminated and ready for use.

The urgent and emergency care scorecard for QEH recorded that between August 2017 and August 2018 QEH ED had met the trust’s 95% target for the cleaning and decontamination of equipment in all months in the period.

We reviewed patient areas across the wards as well as dirty utility areas and treatment rooms. All areas were visibly clean. Patients and relatives we spoke with were satisfied with the level of cleanliness on the wards.

Staff were ‘bare below the elbow’ and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing personal protective equipment (PPE) such as gloves and aprons when caring for patients. The ED displayed signage prompting people to wash their hands and gave guidance on hand washing technique. There was sufficient access to handwashing and drying facilities.

The urgent and emergency care scorecard recorded that between August 2017 and August 2018 hand hygiene compliance audits had been above the trust’s 95% target in all months, with the exception of August and November 2017, when the rate had been 94%.
During the inspection, we reviewed cleaning schedules and cleaning audits, which were fully completed. The matron also told us they did weekly walk-arounds with the cleaning supervisor.

Decontamination products were stored securely and were risk assessed using the control of substances hazardous to health (COSHH) guidelines.

Waste management, including those for contaminated and hazardous waste was in accordance with national standards. Waste was disposed of in a secure area and there was a separate area for clinical and domestic waste.

The hospital had a designated infection prevention and control (IPC) team, in accordance with the recommendation of ‘Criterion 1 of the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.’ The team included the designated lead for infection control and specialist infection control nurses. Staff told us they could approach the IPC team with any queries in regards to infection prevention and control.

**Environment and equipment**

The ED footprint posed problems in terms of having sufficient capacity to meet demands on the service. A newly built clinical decisions unit (CDU), which would increase the ED capacity and aid access and flow, was due to open in December 2018.

The ED had a separate entrance to the main hospital. The ED consisted of an emergency only main reception and an emergency ambulance entrance. There was a streaming desk and two main triage cubicles in the reception area. There were two additional triage cubicles used for taking bloods and conducting investigations in the reception area. There was a ‘majors’ area, a green area for ambulatory care, resuscitation area, rapid assessment treatment (RAT) area, a clinical decision unit (CDU) and a paediatric emergency unit.

Self-presenting patients arrived to the main urgent and emergency care department and were booked in at the reception desk. The reception area had permanent security presence. All points of entry to the paediatric ED, ‘majors’ area, resuscitation, ambulatory care, RAT and CDU had swipe card restricted access. However, the main corridor was being used as an escalation area. This did not have security cover at all times at both ends of the corridor. This meant there was a risk of unauthorised people gaining access to the escalation area where patients were receiving care or treatment in the corridor.

The ED had a range of specialist equipment, which was clean and maintained. Equipment checks in the unit were up to date. Equipment we viewed had maintenance stickers showing they had been serviced in the previous 12 months.

Sharps (needles) bins were located in all clinical areas. We checked six sharps bins and found these were correctly assembled and labelled; two bins were not in the temporary closure position. This meant the contents could spill out if the container was moved. All sharps bins were within a safe fill limit therefore reducing the risk of needle stick injury.
Staff maintained a documented programme of safety checks. For example, resuscitation trollies were checked daily and the outcomes of these checks were clearly documented.

The resuscitation area had five bays. This included a paediatric resuscitation bay, which had the appropriate specialised equipment to resuscitate children. Staff told us they sometimes used the paediatric resuscitation bay for adults if a child did not require the bay and all the adult bays were full. The location of the resuscitation unit was conducive for the rapid transfer of patients from incoming ambulances to the care of the emergency team. However, the resuscitation area did not have an X-ray gantry as recommended in the accident and emergency department health building note (HBN 15-01), section 17.29.

Access to the paediatric ED was via the hospital's main corridor and the main ED. The resuscitation trollies in the paediatric ED, ‘minors’ area, and ‘majors’ area had fully completed daily and weekly checks. This meant there was an effective process, which ensured emergency equipment was checked on a daily basis to ensure it was available and safe to use. Weekly checking records were complete with no missing gaps, which meant all equipment had been checked and was safe and available for use.

There was audio and visual separation of the paediatric waiting room and treatment room. This was in line with the Royal College of Paediatric and Child Health (RCPCH): ‘Standards for Children and Young People in Emergency Care Settings,’ 2012. All paediatric areas were secure with restricted access by swipe card for staff only.

Patients requiring a mental health assessment went to the psychiatric assessment room. The assessment room was visibly clean. We noted that the room was bare and windowless and did not provide a therapeutic environment for patients who were waiting for a long time in the ED. The assessment room had CCTV. The room had two doors; each door had a viewing panel for observation. Staff had access to an alarm system in the event of an emergency. The assessment room was anti- ligature and minimally furnished with weighted furniture. However, the room was not in sight of the nurse’s station in ‘majors’. This did not reduce the potential risk patients could pose to themselves or others. Staff told us they would not leave a patient in the psychiatric assessment room unless they were accompanied by a staff member.

During the inspection we observed two plastic chairs in the psychiatric assessment room that could be picked up and used by a patient in distress to harm themselves or others. We drew this to the attention of staff and the chairs were removed immediately.

The divisional risk register identified a risk from the number of ventilators circuits in the ED. The risk register highlighted that there was a risk due to increasing demand on services. A capital bid for four new ventilators had been submitted on the 24 July 2018 and was pending a decision.

Assessing and responding to patient risk

During our previous inspection in March 2017 we found the ED environment was sometimes overcrowded. We found there was still overcrowding in the ED with patients on trollies along the ED ‘majors’ corridor. This constituted a barrier to evacuation in the event of an emergency. On the 26 September 2018 there were three patients being cared for in the main hospital corridor. However, none of these patients had continuous medical monitoring or access to piped oxygen therapy or suction. A staff member told us cylinder oxygen was not provided as staff could not be sure when cylinders were empty, even though the use of cylinder oxygen was identified as
mitigating the risk to patients on the divisional risk register. However, staff added that patients who had an identified need for oxygen or suction would not be placed in the corridor.

Reception staff followed an escalation process if they were concerned about a patient. Staff alerted the streaming nurse, triage nurse or called the nurse in charge if they were concerned about a patient. Staff gave us examples of when they had implemented the escalation process. For example, patients suffering from severe chest pain. This process ensured patients who were acutely unwell were booked in and received treatment quickly.

Emergency ambulance crews pre-alerted the emergency department by telephone, when they were en-route with a critically unwell patient. Patients arriving by ambulance as a priority (blue light call call) were accepted and assessed immediately in the resuscitation area. The resuscitation area was located next to the ambulance arrival area. During our inspection, we observed patients arriving by ambulance. Patients were accepted and assessed immediately by the receiving clinicians within the resuscitation area.

Due to the unplanned nature of patient attendance, the department provided initial treatment for a broad spectrum of illnesses and injuries, some of which were life-threatening and required immediate attention. The ED had a resuscitation bay which consisted of four adult beds and one paediatric bed. The resuscitation bay was used to stabilise patients prior to them being stepped down to ‘majors’ care. The most seriously ill or injured patients were dealt with in the resuscitation area, as it contained the equipment and staff required for dealing with immediately life-threatening illnesses and injuries. Typical resuscitation staffing involved at least one attending doctor, and at least one and two nurses with trauma and skills in advanced life support (ALS), assigned to the resuscitation bay for the entirety of the shift. Resuscitation patients may have also been attended by resident specialists, such as radiographers, pharmacists and specialist doctors depending upon the skill mix needed for the patient.

Patients who exhibited signs of being seriously ill but were not in immediate danger of life or limb would be triaged to the ‘majors,’ where they would be seen by an ED doctor and received a more thorough assessment and treatment. Examples of “majors” included chest pain, difficulty breathing, abdominal pain and neurological complaints. Advanced diagnostic testing could be conducted at this stage, including laboratory testing of blood or urine, diagnostics and imaging. Medications appropriate to manage patients’ conditions would also be given. Depending on the underlying causes of the patient's symptoms, they could be discharged home from this area or admitted to the hospital for further treatment. However, there were seven escalation beds designated for use in the ‘majors’ area. This created obstacles to staff and patients moving around the department.

Patients whose condition was not immediately life-threatening would be sent to an area suitable to deal with them such as the “minors” area. These patients may still have had significant problems, including fractures and dislocations.

Children and young people were booked in at the main reception. Once patients were booked in they were admitted to the paediatric waiting room, which had secure access.

Children and young people had access to a paediatric assessment unit called the Hippo unit where children could go for further management or assessment. In our previous inspection we found the unit was closing at 10pm and this had resulted in children being returned to the main ED. However, during this inspection we found the hospital had extended the unit’s opening hours from 10pm to midnight to minimise the number of children that would have to return to the main ED. The five paediatric patient records we reviewed showed that they were all seen within 15
minutes for initial assessment. This meant children were assessed quickly to ensure care and treatment was given quickly.

The paediatric ED consisted of a triage area and five cubicles. The high dependency unit (HDU) provided specialist care for children requiring more observation, intervention or monitoring and was also used as a step-down bed for children requiring less intensive interventions than HDU care. The paediatric ED had the highest retrieval rates in the South of England.

The ED had introduced quality rounds as part of the department’s daily routine. There were quality round log books to record these in each area of ED including paediatric ED. Quality rounds were completed four hourly across ED areas including the waiting area and monitored the completion of patients NEWS and PEWS observations. The nurse in charge completed the quality round and spoke with staff about whether there were any changes in the patients’ condition during the round. The matron told us the only time the quality rounds wouldn’t be completed was if the ED was very short of staff. If a quality round was not completed it would be recorded as a safeguarding incident. Although the matron said when there were staff shortages the matron or professional development nurse (PDN) completed the quality round.

The service used a sepsis screening and treatment tool for adults and paediatrics, which was based on ‘Sepsis Six’, this is the name given to a bundle of medical therapies designed to reduce deaths and serious illness associated with sepsis. Sepsis care bundles were available for adults and the paediatric ED. Paediatric bundles were age appropriate.

In September 2018 82% of ED staff had up to date sepsis training. Sepsis training was included in the ED foundations of emergency care course. There were 20 nurses who had not completed sepsis training in September 2018. This was because they were new starters. They were booked to commence the foundations of emergency nursing course in October 2018 and January 2019.

Sepsis training was always covered in the junior doctors’ induction to ensure that all doctors were trained in sepsis recognition and treatment.

The lead paediatric nurse ensured that all nurses in the department undertook paediatric immediate life support (PILS) training, 100%. Healthcare assistants completed basic paediatric life support.

The consultant in charge of the department led board rounds three times a day. These were attended by all members of the multi-disciplinary team. All patients were reviewed, investigation results checked, treatment plans were reviewed and if necessary referred to a specialist team. This meant the doctor in charge had oversight of all the patients within the department and ensured patients were monitored and any changes in their conditions highlighted.

The trust scored “worse than” other trusts for two of the five Emergency Department Survey questions relevant to safety and “about the same” as other trusts for the remaining three questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a</td>
<td>5.6</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>
nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>7.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The national target is for patients to have ambulance handover within 15 minutes of their arrival in the ED. In our previous report we found the average time to initial assessment or triage was 36 minutes. During this inspection we found this had improved on the previous inspection, with between 74% and 84% of ambulance handovers being completed within 15 minutes between August 2017 and August 2018. However, the hospital’s performance was still worse than the England average.

The trust’s median time from arrival to initial assessment was consistently worse than the overall England median in each month over the 12 month period, from June 2017 to May 2018.

In May 2018 the median time to initial assessment was 14 minutes compared to the England average of 8 minutes.

Ambulance – Time to initial assessment from June 2017 to May 2018 at Lewisham and Greenwich NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Queen Elizabeth Hospital

From July 2017 to November 2017, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Queen Elizabeth Hospital. During this five-month period the value fluctuated between 35% and 38%.

From November 2017, there was a repeating cycle of deterioration followed by improvement:

- 37% up to 55% (November 2017 to February 2018), and after down to 41% (March 2018)
- 41% up to 50% (March 2018 to May 2018), and after down to 41% (June 2018)

Ambulance: Number of journeys with turnaround times over 30 minutes - Queen Elizabeth Hospital
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Queen Elizabeth Hospital

May-17

(Source: National Ambulance Information Group)

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From July 2017 to June 2018 the trust reported 467 “black breaches”, with a distinct peak being witnessed in the winter months. This is especially prevalent in December 2017 (99) and January 2018 (119).

Please note, the trust did not submit data for May 2018, therefore we are unable to comment on performance for this month.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

During our previous inspection we found staff training in resuscitation was below the trust’s 95% target. However, this had improved. During this inspection we found 100% of nursing staff had
completed higher life support (HLS) training. However, medical staff training rates were worse than the trust’s 95% target with 66.7% of medical staff having up to date training.

We viewed a spreadsheet that recorded waiting times for patients with mental health needs where there was a decision to admit (DTA). The spreadsheet recorded peaks in waiting times with the highest average waiting time being 339 minutes in June 2018 and 229 minutes in January 2018.

Patients had their mental health needs assessed alongside their physical health needs and patients with physical health needs were directly referred for a mental health assessment, ‘Self-harm in over 8’s: short-term management and prevention of reoccurrence’, National Institute for Health and Care Excellence (NICE, 2004); ‘Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2’, (NHS England, 2016); ‘Mental Health in Emergency Departments’, (The Royal College of Emergency Medicine, 2017).

We reviewed three mental health patients’ care and treatment records. We found the process for ensuring emergency department staff completed one to one observations of patients was not robust. For example, we saw that a patient assessed by the psychiatric liaison team as high risk, required one to one observations. An agency registered mental health nurse was booked to sit with the patient whilst they were in the ED. However, the notes showed that the nurse did not arrive until a day later. It was not clear from the notes how often the ED staff checked on this patient before the mental health nurse arrived. This meant patients had the opportunity to leave the ED or cause harm to themselves or others.

Staff developed a joint protocol with mental health liaison staff for observing patients at high risk of suicide and self-harm. This stated that a patient at high risk of harm to themselves should be placed under constant observation from the point of assessment. This protocol was last reviewed in April 2016. The protocol did not reduce the risk to patients at high risk as it was not always followed.

Staff were not aware that if a patient required physical restraint and sedation by injectable medicine (rapid tranquillisation), they should undertake physical observations of the patient hourly and in some circumstances physical observations should initially be every 15 minutes, (‘Violence and aggression: short-term management in mental health, health and community settings,’ National Institute for Health and Care Excellence (NICE, 2015). For example, we looked at the ED care and treatment record for a patient who had been administered rapid tranquillisation. The patient’s care notes and NEWS chart did not record any physical health observations being completed by staff in the first hour after the patient received rapid tranquillisation. This posed a risk to the patient as patients receiving rapid tranquillisation should be monitored closely due to a risk of seizures, airway obstruction, excessive sedation and cardiac arrest.

**Nurse staffing**

A band 8a Matron led the emergency care nursing team. The service had seven nursing teams led by band 7 senior sisters. The department had a nursing establishment of 122.4 whole time equivalent (WTE) nurses. The actual number of WTE nurses was 89. This meant the service were 33.4 WTE nurses short of established numbers in June 2018.

Staffing was identified on the divisional risk register. This recorded on 26 September 2018 that band six and band 7 nursing establishment was largely filled, but band 5 nurses recruitment and retention was an on-going challenge.

There was a nurse in charge and a non-clinical band 4 flow co-ordinator on each shift. We saw there were clearly defined roles and responsibilities for each of these roles. The nurse in charge
was responsible for the quality and safety of care delivered and the co-ordinator was responsible for flow through the department. These staff were clearly identified by different coloured uniforms.

The numbers and skill mix of staff was suitable for the needs of the emergency department. Senior staff allocated nurses between various clinical areas dependent on demand and patient acuity. Senior departmental staff maintained oversight of staffing within the emergency department. The department used an information board to show the number of nursing staff on duty. There were sufficient number of staff on shift during the period of our inspection. This consisted of four nurses in the paediatric ED area during the period of our inspection. Three paediatric nurses were rostered to cover the night shift.

During our inspection, we saw that there were always two nurses based within the ED resuscitation room. Current NHS Improvement (NHSI), guidance, ‘Safe, sustainable and productive staffing in urgent and emergency care,’ November 2017, states that there should be a minimum of one nurse for every two patients in the resuscitation room. The daily allocation reflected the number of nurses for each ED area and the nurse to patient ratio was one to two patients in the resuscitation area; and one to four in the ‘majors’ area. Two nurses were allocated to care for patients in the six bedded escalation area.

The paediatric emergency department had a senior nurse available at all times. All nurses within this area were trained paediatric nurses or nurses with paediatric experience and were overseen by a paediatric trained lead nurse. All staff within the paediatric emergency department were registered children nurses (RCNs) or were RGN with paediatric experience.

During our previous inspection from the 7-10 March 2017 we reported that patients were often waiting on trollies with ambulance crews by the main public corridor to the ED. During this inspection this had improved. LAS staff told us the hospital was meeting the 15 minute ambulance handover. This meant ambulance crews were not delayed in the ED. This had been achieved by seven escalation beds being created, including the use of the hospital’s main corridor. The ED matron told us the trust had supported the ED with the increase in escalation beds by providing a further two WTE nurses and a band 2 health care assistant. The matron said the use of the corridor was, “not ideal,” but said it allowed the hospital to release ambulance crews who had previously been waiting in the main ED entrance.

The ED at QEH had an escalation budget. Bank or agency staff were booked seven days in advance. If these staff were not required to work in ED they would be reallocated to another ward or department. The escalation budget funded four WTE nurses and four WTE HCA.

There was a nursing handover at the end of each shift to the incoming nurse in charge. The handover included any patients in the department who were acutely unwell, the escalation status, staffing status and any pressures effecting flow within the department.

Staffing was reviewed twice a day at handovers in the department and three times a day at the bed meetings. If the ED was short staffed, staffing across the whole hospital was reviewed and additional staff sought from other areas in order to support the ED.

The urgent and emergency care scorecard recorded that between August 2017 and August 2018 there had been no occasions when the average fill rate had been below the trust’s 80% standard.

The trust reported the following qualified nursing staff numbers as of March 2018 and June 2018 for urgent and emergency care:
<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>97.1</td>
<td>118.7</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>106.6</td>
<td>134.6</td>
</tr>
<tr>
<td>Trust total</td>
<td>204.7</td>
<td>255.3</td>
</tr>
</tbody>
</table>

Please note: the trust total may not equal the sum of the site totals due to some nursing staff working at both sites.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From July 2017 to June 2018, the trust reported a vacancy rate of 20.4% for qualified nursing staff in urgent and emergency care. This was worse than the trust target of 14%.

The breakdown of vacancy rate by site is provided below:

- Queen Elizabeth Hospital: 22.4%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

On the 25 September 2018 the paediatric ED had one WTE band 6 nurse vacancy and 2.6 WTE band 5 vacancies.

The ED had a rolling programme of recruitment via advertising in professional journals and NHS jobs website. The service had also attended jobs fairs to recruit staff. However, staff told us there was a lack of suitably experienced candidates for ED.

From July 2017 to June 2018, the trust reported a turnover rate of 12.0% for qualified nursing staff in urgent and emergency care. This was the same as the trust target of 12%.

A breakdown of turnover by site is provided below:

- Queen Elizabeth Hospital: 20.4%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From July 2017 to June 2018, the trust reported a sickness rate of 3.8% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 3.5%.

A breakdown of sickness rate by site is provided below:

- Queen Elizabeth Hospital: 3.9%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
From July 2017 to June 2018, the trust reported 11,371 total number of shifts. Of these, 48.1% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 31.1% of shifts were filled by agency staff. In addition 6.7% of shifts were not filled by bank and agency staff to cover staff absence.

The breakdown is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Bank shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>2,769</td>
<td>2,130</td>
<td>324</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>2,704</td>
<td>1,407</td>
<td>439</td>
</tr>
<tr>
<td>Total</td>
<td>5,473</td>
<td>3,537</td>
<td>761</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

Seasonal variations and increased demand was managed by the department’s escalation plan and the trust’s business continuity plans.

The ED was dependent upon agency and bank staff to fill shifts. Senior staff informed us that bank staff were mostly used in the main CDU which had lower acuity patients. A formal induction process had been implemented for agency staff following our last inspection in March 2017.

Mental health liaison nurses were available to assess patients throughout the day and night in the emergency department. The mental health service was hoping to meet the ‘core 24’ standard for 24-hour availability of staff to undertake mental health assessments.

The emergency department also booked an agency registered nurse for each shift when needed. These nurses provided care for patients with mental health problems, including enhanced levels of visual observation, where required.

Medical staffing

During our last inspection, the emergency department did not meet the requirements of the Royal College of Emergency Medicine (RCEM) guidelines of consultant cover within the department. The requirements state that consultant cover must be provided a minimum of 16 hours a day. During this inspection, we found consultant cover within the department still did not meet these requirements. Staff told us the ED had submitted a business case to the trust to provide 16 hours cover but this had not been approved.

On weekdays, consultants were typically present from 8am to 10pm, seven days a week. A consultant was on call at all other times. Other medical staff were rostered to provide cover for 24-hours a day, seven days a week. There was always an ED registrar on duty 24 hours a day, seven days a week.
One doctor covered the paediatric ED. The unit also had access to an on-call paediatric consultant. We saw copies of the medical staff rota and staff told us the cover was adequate.

The divisional risk register had been updated on the 26 September 2018 and recorded that the junior doctors’ rota was filled, but, that “pressure remains on the middle grade posts.”

The trust reported the following medical staffing numbers as of March 2018 and June 2018 for urgent and emergency care:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>36.1</td>
<td>65.5</td>
<td>55.1%</td>
<td>44.7</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>37.3</td>
<td>49.4</td>
<td>75.5%</td>
<td>40.8</td>
</tr>
<tr>
<td>Trust total</td>
<td>73.3</td>
<td>114.9</td>
<td>63.9%</td>
<td>85.5</td>
</tr>
</tbody>
</table>

Please note, the trust total may not equal the sum of the site totals due to some medical staff working at both sites.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From July 2017 to June 2018, the trust reported a vacancy rate of 35.3% for medical staff in urgent and emergency care. This was worse than the trust target of 14%.

A breakdown of vacancy by site is provided below:

- Queen Elizabeth Hospital: 38.4%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Medical staff told us they had recruited six junior doctors. This would reduce the ED vacancy rate from 38% to 20% when these doctors were in place.

The ED establishment for middle grade doctors was 12.5 WTE. The actual number of middle grade doctors was 10.

The divisional clinical strategy highlighted initiatives the trust was taking in regard to recruitment and retention of new staff. This included: continuous, year round recruitment drives for the middle grades posts; regular national and international adverts, various interviewing methods including telephone and skype interviews; recruitment via agency; national medical training initiatives (MTI) via the School of Emergency Medicine; formation of certificate of eligibility of specialist registration (CESR) programs to encourage senior registrar retention.

From July 2017 to June 2018, the trust reported a turnover rate of 42% for medical staff in urgent and emergency care. This was worse than the trust target of 12%.

A breakdown of turnover by site is provided below:
• Queen Elizabeth Hospital: 47.4%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From July 2017 to June 2018, the trust reported a sickness rate of 0.5% for medical staff in urgent and emergency care. This was much better than the trust target of 3.5%.

A breakdown of sickness by site is provided below:

• Queen Elizabeth Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From July 2017 to June 2018, the trust reported the following bank and agency staff usage in ED.

The following tables show a breakdown by site. Please note: percentages are a proportion of overall number of shifts at trust level for each staff grade:

**Queen Elizabeth Hospital**

<table>
<thead>
<tr>
<th>Location</th>
<th>Locum shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>449</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Middle grade</td>
<td>541</td>
<td>0</td>
<td>143</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>3,792</td>
<td>37</td>
<td>366</td>
</tr>
<tr>
<td>Total</td>
<td>4,782</td>
<td>37</td>
<td>511</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In December 2017, 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.

**Staffing skill mix for the 68 whole time equivalent staff working in urgent and emergency care at Lewisham and Greenwich NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>39%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>32%</td>
<td>23%</td>
</tr>
</tbody>
</table>
A handover was undertaken at the end of each shift with the incoming team, this included a brief summary of each patient in the department, including patients that were acutely unwell and patients that required review. This ensured the oncoming team had oversight of the patients within the department. We did not observe any handovers during our inspection.

**Records**

ED had introduced a ‘care card’ booklet in February 2018. This was an ED specific document which contained tools for patient assessment. A critical checklist was part of the ‘care card.’ Safety checklists have been shown to improve standardisation of documentation and demonstrated improvements in patient safety and care.

The ‘care card’ document included details of the presenting complaint, initial assessment of vital signs on arrival, triage colour, NEWS, allergies, plan of care and investigations required. The document kept patient information in one place, which meant staff could access patient information easily.

We examined 15 sets of patients’ notes including nursing assessments, medical assessments prescription charts and paediatric records. We found four records where staff had not signed or dated the paper based ‘care card.’ We asked staff about this and were told that the ‘care card’ record did not need to be signed or dated as this would be written in the patients’ electronic record. However, best practice would recommend that all patients care records should have an identified recorder and date.

We found inconsistencies in the documentation of clinical assessments. Staff recorded observations using national early warning scores (NEWS) and paediatric early warning scores (PEWS) and recorded allergies. However, we saw a nurse record a patient’s observations and personal history on a paper towel. The nurse told us they would enter the information onto the computer later, as there were no computers in the cubicle and other staff were using the computer at the nursing station. This practice meant there was a risk of patient information being mislaid or lost or staff forgetting where they recorded the information.

The matron told us the trust’s nurses prioritised critical checks in the ‘care card’, but recording of the care card could be “hit and miss with agency staff.” The matron said agency staff were not comfortable with the tick box method of recording in the notes. The use of the care card was due for review in August 2018. But, the matron said this had not been completed due to a really busy August and September delaying the review.

We saw a serious incident report dated March 2018 which recorded that a patients Nottingham hip fracture score had been incorrectly calculated. The incident had been investigated and one of the lessons learnt was that assessment tools were “able to identify risk, particularly in the most vulnerable patients when the risk can be greater.” However, the action plan did not specifically identify staff use of the Nottingham hip fracture scoring tool. It was therefore unclear, from the action plan, whether the trust was specifically addressing staff use of the tool.

We reviewed five sets of paediatric medical records and saw that a paediatric early warning score was documented on arrival in all records.
Medicines

Medicines including controlled drugs (CD) were stored safely and securely. Fridge and room temperatures for areas where medicines were stored were recorded each day. When temperatures were outside of the required range, staff took appropriate actions to safeguard medicines. Staff who were trained could give out medicines via a patient group direction (PGD). This minimised pharmacy dispensary waiting times. A senior nurse kept a list of the names of all the staff that were trained to use the PGD.

A ward pharmacist, a pharmacy technician and a pharmacy assistant had been appointed in the last 12 months to attend the department regularly. They provided medicines optimisation advice and support. Nursing staff on the ward told us that they were very appreciative of the support from the pharmacy team, and that medicines management had significantly improved because of them.

In November 2017 there was a removal of a record in the controlled drugs register which is not in accordance with the Misuse of Drugs regulations. The trust confirmed it was reported and investigated.

The trust’s scorecard recorded that between August 2017 and August 2018 there had been nine months when the trust’s 100% audit standard for daily CD checks and documentation had not been met. For example, the scorecard recorded that the overall average for the period was 91%. Furthermore, the scorecard recorded that the trust’s 100% standard for the safe and secure storage of medicine had not been met in any month during the period, with the overall rate being 67% in the period. Trust compliance for the safe and secure storage of medicine was compliant in 8 months out of the 12 months.

Staff were unaware of whether the trust had a rapid tranquilisation policy. However, the trust provided us with a draft copy of their rapid tranquilisation policy after the inspection. The policy followed best practice and referred to carrying out physical health observations on patients every 10 minutes for the first hour to safely monitor the patient.

Incidents

Staff reported incidents on an electronic incident reporting system. All the staff we spoke with during the inspection knew how to report an incident. For example, staff told us about an incident with a patient who had contracted a hospital acquired C.diff infection. In response to the incident the ED had introduced a ‘stools chart’ to monitor patients’ faeces.

Staff we spoke with told us they received feedback and learning from incidents through emails, during handovers and at staff meetings. For example, learning from incidents was included in the ED newsletter ‘Risky Business.’

We viewed the trust’s electronic incident reports dated from 1 September 2017 to 30 September 2018. There had been a total of 3409 incidents reported in this period. We requested from the trust data on incidents broken down by levels of harm. However, we received a spreadsheet and were unable to quantify precisely, using this media, the number of incidents based on levels of harm or incident types.

We saw evidence that senior staff conducted appropriate investigations into serious incidents and made recommendations for improvement. We reviewed four serious incident investigation reports. Overall, we found investigation reports were sufficiently detailed covering contributory factors, chronology, root cause, recommendations and lessons learnt.
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.

From June 2017 to May 2018, the trust reported no incidents classified as never events for urgent and emergency care.

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type and location was as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Queen Elizabeth Hospital</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm meeting SI criteria</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Disruptive/ aggressive/ violent behaviour meeting SI criteria</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Major incident/ emergency preparedness, resilience and response/ suspension of services</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>3</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

Of the nine serious incidents, two thirds took place at Queen Elizabeth Hospital, with treatment delays and slips, trips and falls being the two incident types mostly reported.

(Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)

The incident spreadsheet dated 1 September 2017 to 30 September 2018 recorded eight serious incidents involving ED services in the period. There had been two patient deaths investigated during this period, one causing severe or long-term harm to a patient, three moderate short-term harm incidents, and two resulting in no harm to patients.

The urgent and emergency care scorecard recorded that there were high rates of incidents which had been open since April 2014 at 26.1%, this was higher than the trust target of 10%.

The mortality review committee meeting reviewed mortality and morbidity at a trust wide level including the summary hospital-level mortality indicator (SHMI); this is data on the ratio between the actual number of patients who die following hospitalization at the trust and the number that would be expected to die on the basis of England average figures. Mortality and Morbidity meetings, which review deaths as part of professional learning, have the potential to provide hospital boards with the assurance that patients are not dying because of unsafe clinical practice. We saw that findings from these meetings were incorporated into teaching sessions with medical staff in the ED.

Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. 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.

We saw evidence that the duty of candour (DOC) regulation had been considered in serious incident investigations. The trust’s electronic incident reporting system contained a section for duty of candour. This included checks that the patient and/or relative had been given a verbal apology, had received a trust letter and been given a point of contact, as well as an offer to share the outcome of the investigation.

**Safety thermometer**

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 collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from May 2017 to May 2018 within urgent and emergency care.

*(Source: NHS Digital - Safety Thermometer)*

Any patient who was going to be in the department for more than four hours or admitted to a ward had a venous thromboembolism (VTE) assessment undertaken. This was in line with The National Institute for Health and Care Excellence (NICE) guideline QS3; we saw completed VTE assessments within patient records.

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**Is the service effective?**

**Evidence-based care and treatment**

The department provided care, which was evidence based and in line with national guidance, such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) standards. Trust policies and procedures were available to view electronically. Staff we spoke with knew how to locate policies and procedures. However, there was no clear pathway for patients attending the ED with known or suspected mental health needs that reflected national and best practice guidance. Staff had developed a joint protocol between the ED staff and mental health liaison staff for observing patients at high risk of suicide and self-harm. However, this protocol was last updated in April 2016.
Guidelines were easily accessible on the trust intranet. Staff we asked were able to demonstrate how they could access policies and guidelines on the trust intranet. For example, staff showed us guidance related to NICE ‘head injury: assessment and early management’ clinical guideline (CG176).

There was a range of paediatric guidelines and policies in use within the paediatric ED, which reflected evidence based. For example, safeguarding policies.

Adherence with guidelines was encouraged through the development of the ‘care card’ to prompt staff in the use of best practice. However, we saw that a few staff did not always follow the prompts on the care card. For example, we saw staff not using prompts on the document and recording in the notes section.

Guidelines and audits were standard agenda items at governance meetings. For example, we reviewed minutes from the trauma steering group dated 31 August 2018 this had reviewed guidelines on the use of computer tomography (CT), a form of image scanning. The minutes also recorded that frailty audits were being introduced quarterly.

There was a programme of local clinical audits based on the needs of the ED. There was a red, amber, green (RAG) rated urgent and emergency care scorecard which monitored the outcomes of regular audits and the services key performance indicators (KPI). The scorecard was based on the CQC domains, safe, effective, caring, responsive, and well led.

We reviewed the external peer review gap analysis from the most recent trauma audit and research network (TARN). This dated from September 2016. The review found that ED were meeting the TARN standards for trauma management guidelines. The trauma steering group minutes dated August 2018 demonstrated that TARN standards were discussed at the meeting.

**Nutrition and hydration**

ED had introduced a quality round book. This recorded when patients were offered food and drink. We viewed the quality round book on 25 September 2018 and found food and drink rounds had been offered in accordance with the ED policy.

Support workers offered patients and relatives, food, hot and cold drinks throughout their stay in the ED. Support workers undertook four-hourly refreshment rounds, this ensured patients and relatives were offered regular refreshments. Support workers told us they had access to a variety of food for patients available from the hospital kitchen.

The matron told us about actions the ED had taken in response to a serious incident which involved the death of a patient with swallowing difficulties. We viewed the root cause analysis (RCA) investigation report following the incident. The RCA had lessons learnt and an action plan. The action plan included piloting of a new screening tool for early detection of swallowing difficulties. The action plan identified that the new screening tool would need to be adapted for use with specific patient groups. The action plan also recorded that a review would be completed. However, there was no scheduled date recorded on the RCA for the review.

In response to the incident the matron had emailed all ED staff and highlighted that they must check all documentation, including dietary information that accompanies patients on arrival at the ED. The incident and action plan had been disseminated to staff at handovers, this ensured permanent staff as well as agency and bank staff were aware. The matron told us it was “likely” that the multi-universal screening tool (MUST), this is a five-step screening tool to identify adults at risk of being malnourished, would be incorporated into the patient ‘care card' record. The MUST had not been included in the ‘care card’ patient record when it was introduced in February 2018.
The practice development nurse (PDN) had rolled out specific training for staff in the use of MUST. The PDN told us there were also plans to make training in the use of MUST part of staff mandatory training.

The urgent and emergency care scorecard dated August 2017 to August 2018 recorded mixed results in the period in the use of the ‘observations of care’ nutritional screening tool. The trust’s 90% target had not been met in seven months during the period. Rates of compliance ranged from 84% to 92%. The scorecard also recorded variable performance in regards to the documentation of fluid balance charts. Results dating from May 2018 to August 2018 showed compliance with the trust’s 90% standard ranged from 76% in May 2018 to 93% in June 2018.

In the CQC Emergency Department Survey, the trust scored 5.5 out of 10 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The quality rounds had been introduced in 2017, an aspect of this was that patients being offered food and drink every four hours was recorded and monitored.

**Pain relief**

The ED assessed and recorded a pain score for patients arriving in the department as part of their initial assessment in accordance with the ‘Faculty of Pain Medicines Core Standards for Pain Management.’

The national early warning scores (NEWS) chart was used to document patients’ pain scores following an initial pain assessment.

We saw evidence in children’s records that pain tools were used to assess children’s pain. We reviewed five medical records for children that presented to the paediatric emergency department. We saw that pain had been assessed and documented upon arrival in the department and triage. This was in line with the RCEM guidance on the management of pain in children.

The department used pictorial charts for patients that were unable to verbalise whether they were experiencing pain.

Patients we asked told us their pain was being adequately managed and that pain relief had been administered in a timely manner. We reviewed six sets of medication administration records which demonstrated appropriate pain relief had been prescribed and administered in a timely manner. The urgent and emergency care scorecard did not monitor pain relief. This meant the trust could not monitor pain management in patients as part of the overall performance scorecard.

In the CQC Emergency Department Survey, the trust scored 6.4 out of 10 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was the same as other trusts.

The trust scored 7.3 out of 10 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q35. Were you able to get suitable food or drinks when you were in the emergency department?

| 5.5 | Worse than other trusts |

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Patient outcomes**

The trust used an urgent and emergency services scorecard to monitor ED performance. This provided a comprehensive overview of regular audits urgent and emergency services had undertaken.

We saw that the trust had participated in national audits, such as those identified by the Royal College of Emergency Medicine (RCEM). The results were used to benchmark and compare with other trusts nationally. There was a clinical audit lead in place for the department that led on audit completion and compliance.

Local and national audits were presented at the quarterly emergency department clinical governance meeting. For example, meeting minutes for April to June 2018 recorded ED action plans in response to the fractured neck of femur audit. The minutes also recorded the presentation of a pain in children audit. The minutes recorded that the trust was “well above average” in assessing paediatric pain within 15 minutes, but, needed to improve the use of documented pain scoring.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Queen Elizabeth Hospital failed to meet any of the standards.

The department was in the upper UK quartile for two of the seven standards reviewed:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 56.3%; UK: 26%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 92.7%; UK: 77%.

The department’s results for the remaining five standards were all within the middle 50% of UK emergency departments; and for one standard, the department’s results approached the threshold for the upper UK quartile:

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

This department: 70.6% threshold for upper UK quartile: 70.8%); UK: 52%.

The department was not in the lower UK quartile for any standards.

In the 2016/17 Consultant sign-off audit, Queen Elizabeth Hospital failed to meet any of the standards.

The department was not in either the upper UK quartile or the lower UK quartile for any of the four standards reviewed.

The department’s results for three standards were all within the middle 50% of trusts:
• Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 10%; UK: 11%.

• Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 7.1%; UK: 12%.

• Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 10%; UK: 10%.

For the remaining standard, no result was reported for this department:

• Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age.

In the 2016/17 Consultant sign-off audit, University Hospital Lewisham failed to meet any of the standards.

The department’s results for all standards were within the middle 50% of UK emergency departments.

The department was not in either the upper UK quartile or the lower UK quartile for any of the four standards reviewed.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Severe sepsis and septic shock audit, Queen Elizabeth Hospital was in the upper UK quartile for six of the eight standards reviewed:

• Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 72.7%; UK: 30.4%.

• Standard 4: Serum lactate measured within one hour of arrival. This department: 72.0%; UK: 60.0%.

• Standard 5: Blood cultures obtained within one hour of arrival. This department: 64.0%; UK: 44.9%.

• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 78.7%; UK: 43.2%.

• Standard 7: Antibiotics administered: Within one hour of arrival. This department: 62.0%; UK: 44.4%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 52.0%; UK: 18.4%.

The department was not in the lower UK quartile for any standards.

The department’s results for the remaining two standards were both within the middle 50% of UK emergency departments.

(Source: Royal College of Emergency Medicine)

From June 2017 to May 2018, the trust’s unplanned re-attendance rate to A&E within seven days
was consistently worse than the national standard of 5% and also the England average.

Over this 12-month period, the trend in the trust’s performance was stable and limited to a narrow range from 9.8% up to 10.5%.

Unplanned re-attendance rate within seven days - Lewisham and Greenwich NHS Trust

(Source: NHS Digital - A&E quality)

Competent staff

The ED had an experienced practice development nurse (PDN) to provide support in the development and education of staff. The PDN had set up their own database to monitor staff training, appraisals and competencies.

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.

We saw there was an extensive induction and preceptorship programme for newly qualified nurses and each nurse was allocated a mentor. The training programme was comprehensive and covered areas including: bereavement, life support (basic, intermediate and advanced), sudden death, record keeping, the Mental Capacity Act and Deprivation of Liberty Safeguards, resuscitation, fluids, early warning scores (adult, paediatric and maternity) and infection control and prevention.

The department assessed the learning needs of staff by means of appraisal. Staff we spoke with told us the appraisal process was meaningful. Staff appraisals were aligned with the trust’s values, identified staff learning needs and included objectives individual staff members had met in the previous 12 months and staff members’ objectives for the next 12 months.

There was a ‘blog’ for doctors on the RCEM induction pathway. Junior doctors had access to scheduled teaching sessions. Junior doctors were positive about the learning and teaching opportunities within the department.

An aspect of the QEH strategy was linking junior clinical fellows (JCF) and middle grade posts with education fellowships to attract and retain medical staff.

The ED had a ‘case of the week’. Both medical and nursing staff could contribute to the ‘case of the week’. The ‘case of the week’ was displayed on a noticeboard in the staff corridor. The PDN
told us the ‘case of the week’ was intended to promote shared learning across staff groups. For example, we saw that a consultant had produced the ‘case of the week’ dated 3 August 2018, this involved the review of the care provided to a dermatological patient.

We had varied responses to staff being provided with education and training opportunities in excess of their mandatory training. For example, some staff told us the trust were not funding higher education in the form of masters’ degrees. However, the PDN told us they were being supported to complete a teaching qualification as it was relevant to their role.

There was an education strategy as an aspect of the divisional clinical strategy. For example, the strategy for QEH included recognition that higher education and continuous professional development (CPD) funding at the trust would be reduced. However, the strategy also included the introduction of a range of new in-house learning opportunities including an induction and support programme, feedback workshops, formal ‘buddy system’; career navigation and more support for staff wishing to move roles internally, increases in staff skills base, and career clinics.

Staff were supported with renewal of their professional registrations, such as with the nursing and midwifery council (NMC). The PDN recorded nurse competencies on a spreadsheet to enable monitoring of staff competencies and ensuring staff were up to date with current best practice based on national benchmark standards. The human resources department and the consultant lead oversaw medical staff revalidation.

There was always a member of staff who had completed advanced paediatric life support training on each shift within the paediatric department. This meant there was always someone with the correct skills and training to care for children.

From April 2017 to March 2018, 78.1% of required staff within urgent and emergency care at the trust received an appraisal compared to the trust target of 90%.

Queen Elizabeth Hospital

From April 2017 to March 2018, 93.2% of required staff within the emergency department at Queen Elizabeth Hospital received an appraisal compared to the trust target of 90%. However, the PDN highlighted that figures were skewed as staff had appraisals at different times. We viewed a spreadsheet that highlighted that most staff with appraisals that were overdue had dates for appraisals.

The breakdown by staff group is in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified allied health professionals (qualified AHPS)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>----------------</td>
<td>---</td>
<td>---</td>
<td>---------</td>
<td>-----</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (qualified nurses)</td>
<td>108</td>
<td>104</td>
<td>96.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>46</td>
<td>41</td>
<td>89.1%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>3</td>
<td>1</td>
<td>33.3%</td>
<td>No</td>
</tr>
<tr>
<td>Grand total</td>
<td>161</td>
<td>150</td>
<td>93.2%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Multidisciplinary working**

Staff generally demonstrated effective multidisciplinary team working. We saw that communication took place between a range of healthcare professionals to improve patient care and outcomes. Staff told us wards and departments communicated well with each other from both the adult and paediatric ED. We saw effective joint team working when critically ill paediatrics were bought to the adult ED resuscitation room.

Twice weekly multidisciplinary team (MDT) meetings took place and were attended by a pharmacist, physiotherapists, occupational therapists and senior ward nurses. In addition, daily MDT huddles took place on each ward that staff used to review patients who were recently admitted, those with complex needs and patients with a planned discharge.

An older adult’s mental health team was available on-call. This team provided as-needed support to ward-based staff and reviews for patients with complex or deteriorating needs.

Staff in the ED reported they worked closely with the joint emergency team (JET) which included a team of physiotherapist that attended the department to access patients’ mobility. The team included the social workers that assessed patients before they were discharged.

ED worked closely with the London Ambulance Service (LAS). We spoke with LAS staff during our inspection. A LAS manager told us they had a “very good” working relationship with the senior nursing staff at QEH. There was a fortnightly engagement meeting at the hospital with LAS. Senior nursing staff and LAS staff told us the meeting was the main reason for the ED improving the 15 minute ambulance handover time.

A dedicated pharmacist worked in the department and provided oversight of medicines management and support for staff.

The paediatric ED worked with other staff in external agencies to ensure patients received coordinated, specialist care. This included multidisciplinary working with health visitors, school nurses, social workers and the local authority safeguarding team.

The ED worked with child and adolescent mental health services (CAMHS). Staff told us CAMHS service were responsive.

The ED team and mental health liaison team had a monthly meeting. ED staff and managers described their relationship with the mental health liaison team as “good.” The ED staff and mental health liaison team met every two months. We reviewed the minutes of these meetings for May, July and September 2018. The ED consultant and service manager and MHLT staff attended these meetings. Staff discussed mental health act issues and operational procedures for assessing mental health patients in the ED.

**Seven-day services**
NHS England’s seven day services ‘Priority Standard 2’, states that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

The adult and paediatric emergency department at QEH was open 24 hours a day, seven days a week in accordance with the NHS seven days a week ‘Priority Clinical Standard 6.’

The emergency department had consultant presence between the hours of 8am and 10pm with on-call cover outside of these times. Other medical staff were rostered to provide cover for 24-hours a day, seven days a week.

ED nursing staff provided nursing care 24 hours a day, seven days a week. The join emergency team (JET) team was available seven days a week from 7.30am to 8.30pm. This was a team that provided rapid access to intermediate care services.

A dedicated band 7 pharmacist covered the CDU from Monday to Friday. The ED had access to 24 hours on call respiratory physiotherapy cover. Staff could also refer patients to the dietetic service during weekdays.

Portable X-ray was available on request and there was one radiographer on duty between midnight and 8am. However, ED staff did not have access to MRI scans out of hours.

Hospital chaplaincy services were available 24 hours a day, seven days a week.

The trust provided mental health nurse cover 24 hours a day, seven days a week for adults.

Health promotion

Staff provided information to patients on how to manage their condition and promote a healthy lifestyle. For example, we saw leaflets in the department providing information to patients and visitors on smoking cessation. The main ED reception area had an information point where visitors could access information on smoking cessation and drug and alcohol services.

All staff we spoke with knew how to refer patients to local services such as hostels. Patients were encouraged to self-refer to substance misuse and alcohol liaison services, but could be referred by staff if required.

Information on healthy lifestyles was available on the hospital’s public website. This included healthy eating and exercise advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff we spoke with were aware of the principles of the Mental Capacity Act (2005) in relation to patients that may lack the capacity to make a decision. Staff we spoke with were able to explain informed and implied consent.

Staff could explain the deprivation of liberty safeguards (DoLS). Although, staff told us a patient requiring a DoLS would usually have this completed on the ward, and this was not common practice in the ED.

Staff told us they recorded capacity assessments and best interest’s decisions in patient’s clinical records. A mental capacity checklist was available to support staff in conducting this. However, we were unable to review examples of mental capacity assessments during our inspection as
staff could not identify any patients who required a capacity assessment.

Staff on the paediatric ED were aware of ‘Gillick competence,’ this is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

**Trust level**

A breakdown of compliance for mental capacity act training courses from April 2018 to July 2018 at trust level for staff in urgent and emergency care is provided below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Consent to Examination/Treatment</td>
<td>215</td>
<td>223</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Consent to Examination/Treatment</td>
<td>58</td>
<td>90</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Queen Elizabeth Hospital**

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the urgent and emergency care department at Queen Elizabeth Hospital is provided below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Consent to Examination/Treatment</td>
<td>101</td>
<td>101</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Consent to Examination/Treatment</td>
<td>43</td>
<td>48</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Is the service caring?**

**Compassionate care**
All staff we spoke with in the ED were committed to providing a safe, compassionate and caring service. We followed an adult patient on their journey through the ED. The patient arrived in the ED by ‘blue light call’ ambulance. Staff were very caring and calm through the patients’ handover. All the staff acted with professionalism. The patient was treated with respect throughout, from the ambulance team through to the registrar’s assessment.

Patients we spoke with were mostly positive about the staff in the ED. A patient told us, “They have been amazing. When you think of what they have to put up with? They are all really busy.”

The risk register recorded that portable screens had been purchased to improve dignity and privacy for patients in the escalation area in the main corridor. However, this did not fully promote patients privacy and dignity due to the hospital’s main reception being in close proximity to the corridor. Staff used curtains, blankets and portable screens to maintain patients’ privacy and dignity in the main ED.

The trust’s urgent and emergency care Friends and Family Test (FFT) performance was consistently better than the England average from May 2017 to April 2018.

Between October 2017 (96% recommend) and March 2018 (92.6% recommend) the trend in the trust’s performance deteriorated.

In April 2018 the trust’s performance was 95.3% compared to the average England performance of 86.7%.

**A&E Friends and Family Test performance - Lewisham and Greenwich NHS Trust**

![Graph showing FFT performance](image)

*(Source: NHS England Friends and Family Test)*

**Emotional support**

We saw staff supporting patients emotionally and providing assurance to anxious and distressed patients throughout our inspection.

Reception staff spoke with patients in a reassuring manner and offered information on waiting times.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.
There was support available for the bereaved from the multi-faith chaplaincy service. We were given examples when staff had accessed the multi-faith chaplaincy to provide support for patients and their relatives.

There was a lack of availability of rooms in the ED where staff could break bad news or speak with patients and families. During our inspection staff were sometimes using a store room to speak with patients and families.

**Understanding and involvement of patients and those close to them**

Most patients and relatives we spoke with told us they were involved in their care and given explanations about their treatment. Patients said staff introduced themselves before attending to them and explained treatment, or what they were doing and why they were doing it, in a way patients could understand.

Patients said staff were patient and tried to understand them. All patients confirmed that staff obtained their consent before carrying out assessments.

Patients and relatives of paediatric patients told us staff had explained treatments and care in a way that their child could understand. We observed staff communicating with children in a way that was appropriate to their age and level of understanding.

We followed a child’s journey from being a ‘blue light call’ ambulance arrival to resuscitation. We saw staff liaising with carers and family members and offering explanations of what they were doing and why they were doing it at all stages of the child’s journey.

There was a range of printed information leaflets available to patient in the main ED reception area and paediatric ED reception. This included leaflets from the patient advice and liaison service (PALS) on raising concerns or making a complaint and ‘healthy start’ leaflets informing parents or carers of children of a voucher scheme to promote health eating.

The trust scored “about the same” as other trusts for all 24 Emergency Department Survey questions relevant to the caring domain:

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>2.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people

The matron told us August and September 2018 had been as busy as winter pressures for the Queen Elizabeth Hospital (QEH) urgent and emergency care department (ED). The matron told us the hospital had internal escalation processes, which included the use of the main hospital corridor, when demands on services outstripped the established capacity of the service to respond. The service had created seven escalation beds in the main corridor. However, the hospital had a new 52 bed clinical facility being built on-site. The hospital’s plans were for this to become the new ED clinical decision unit (CDU). There was a plan for this new facility to have three mental health beds.
During our previous inspection we found the ED was using escalation areas within the ED. This meant that patients were cared for on corridors around the ‘majors’ area leading to poor patient experience. We found this was still being practiced during this inspection.

The main hospital corridor had a cordoned off area that was next to a pair of open doors which led to the hospital’s main reception area, where there were shops, receptionists, public toilets and a coffee shop. On the morning of 26 September 2018 we saw three patients on trollies in the cordoned area of the main corridor. We entered the main reception area from the main corridor and found this was very busy. We saw hospital staff coming to the ED from the hospital’s main reception area, pulling the screens back to gain access to the doors to the ED department.

We conducted a follow up unannounced visit on 5 October 2018. We found the escalation area on the main corridor was prepared ready to take patients in the morning, with trollies and screens in place. Although there were no patients receiving care or treatment in the corridor. We saw signage saying ‘corridor closed – no entry’, displayed. The cordoned off area had five patient trollies and eight spare mattresses. The trollies had patient gowns and gloves on them. There were signs on the walls along the corridor with London Ambulance Service (LAS) and a number to indicate where ambulance staff should place patients. We returned to the main corridor escalation area later in the day and found the main corridor had been cleared.

Staff told us that when the main corridor was cordoned off, theatre 15 would be closed to patients and would be used for patients who were receiving care in the main corridor if they needed to use a bed pan or have a private conversation. Staff told us patients, “didn’t suffer as they still have medical and nursing care.” However, we saw the escalation area on the main corridor in use on 26 September, this did pose a risk to patients’ privacy and dignity, as well as causing inconvenience to staff, patients or visitors wishing to use the main corridor as they had to take a detour through the hospital’s main reception.

The ED had implemented a model of rapid assessment and triage (RAT). The aim of RAT was to provide early senior assessment of ‘majors’ patients. The model provides a means by which ED can achieve both their ‘time to assessment’ and ‘time to treatment’ indicators. The RAT was always run by the ED consultant. However, we did not see the RAT in operation at any time during our inspection as the RAT bay was being used as a clinical decisions unit (CDU) for the entire time we were on-site. The nurse in charge told us the RAT had been closed since the weekend, and that it was usually open at the weekends and used as a CDU on weekdays.

The matron told us they made the decision with the ED consultant about when the RAT would be operative in hours. The site manager on-call out of hours (SMOC) and site manager made the decision out of hours. Closure of the RAT had been recorded on the ED risk register on 29 November 2016. The risk was included in a list of risks identified as one risk on the risk register. The list included the RAT being used as a CDU to prevent 12 hour breaches for patients with decision to admit (DTA) due to a lack of beds on the wards. This put sick patients at risk of not being identified on arrival and having appropriate investigations and treatment plans from a consultant. The risk register recorded that not having a RAT also had risks for the ED achieving key performance indicators (KPI) such as total time spent in ED, patients leaving without being seen rates, and patients experience.

The RAT was used as a CDU for inpatients, who were assessed as DTA, due to lack of beds on the wards to transfer these patients. It did not have ward facilities such as a wet room. In mitigation the risk register recorded that ED were awaiting a response from a “winter pressure bid to be reviewed post 31st March 2017.” However, there were no updated records of this. The risk was again reviewed on 18 September 2018 when the risk register recorded a new clinical facility was to open in December 2018 and a new medical model would be introduced in April 2019.
Some staff raised issues about the ED at QEH sometimes being in escalation procedures when University Hospital Lewisham (UHL) was not busy. Staff told us they did not understand why patients could not be redirected or streamed to UHL when QEH was busy. The Royal College of Emergency Medicine document, ‘Initial assessment of emergency department patients’, February 2017, recommends streaming as a method of managing emergency department patients. However, staff we spoke with told us they were not aware of whether the trust had considered a streaming system between UHL and QEH to alleviate pressures on ED.

The clinical decision unit (CDU) is an inpatient ward for ED patients who have been assessed and need ongoing observation and treatment, but were expected to be discharged within 24 hours, once their treatment plan was completed. A senior manager told us the ED would refer suitable patients in the CDU to the ambulatory care unit in the morning to avoid patients spending hours waiting in the ED and to enable patients to get the treatment they needed sooner. Staff said this reduced pressure on the ED and avoided unnecessary hospital admissions. However, there were issues with patients with dementia being referred to the ambulatory care centre. Staff told us they could not refer patients who were wandering to the ambulatory care centre and there was a shortage of community mental health beds available. This sometimes resulted in dementia patients were not able to be discharged which meant beds in CDU were not available for new admissions. Staff told us QEH had responded to these concerns and a new frailty assessment facility was part of the plans for the new clinical facility.

The paediatric emergency department was compliant with the Royal College of Emergency Medicine (RCEM) standards for ‘Children and Young People in Emergency Care Settings,’ 2012. There was a dedicated section in the ED for children who had been admitted as an emergency. All children over the age of one month would be booked in via an urgent care system. Children would be assessed by a band 7 nurse paediatric trained nurse. Staff told us children had to be booked on to two systems, as ED had used the urgent care booking system until 2016. The urgent care department had changed their system and this had resulted in the paediatric ED using two systems.

Meeting people’s individual needs

The hospital’s main reception area had an information point where visitors could access information on services provided by the patient advice and liaison service (PALS), voluntary services, NHS direct, blood and transplant services.

During our previous inspection we observed there was no information in the ED waiting area about current waiting times. During this inspection there was still no formal method of informing patients of current waiting times. Although staff would write waiting times on a white noticeboard with a green marker pen. The noticeboard was in the left corner of the waiting room and may not have been visible to patients sitting in the far right of the waiting room. We did not see the waiting time being updated at any time during our inspection. The waiting time was recorded as “1 hour” throughout our inspection, even though patients we spoke with told us the waiting time was less than an hour.

The divisional risk register identified, on 29 November 2016, a risk due to the lack of a bariatric policy and equipment. The risk register highlighted that a bariatric patient had been held on a LAS trolley for eight hours in ED due to a lack of bariatric equipment at the trust. The risk register did not identify the date of this incident. In mitigation the risk register recorded on 6 September 2018 there was a corporate nursing review in progress as well as guidance for staff on obtaining bariatric equipment on the trust’s intranet. However, the risk had been on the risk register for nearly two years and had an expected date of completion of 31 March 2019. Staff we spoke with told us that when bariatric equipment was ordered it would take at least two hours for delivery as it was sourced from an external provider. This meant the risk register did not fully address the issue.
of long waits for bariatric equipment deliveries or what was available in the interim, whilst the review was in progress, for bariatric patients.

Patients’ attending the emergency department with mental health symptoms received an assessment within one hour of triage by the mental health liaison team. Patients with mental health needs who had been assessed as requiring admission to a mental health unit waited for a bed in the psychiatric assessment room. However, patients frequently waited up to 24 hours or more for a bed.

The psychiatric assessment room had two doors; both doors had clear glass windows. This meant patients using the room were visible to staff and the public from both the ED and the main corridor. This did not ensure patients privacy and dignity.

Patients with mental health needs had a mental health assessment as soon as possible when they had taken an overdose, harmed themselves, or may have posed a risk to others. ED staff booked a registered mental health nurse (RMN) to carry out observations of patients to reduce the risk to staff and patients. ED staff completed a brief assessment of patients’ mental health at triage and referred patients to the mental health liaison team as required to enable them to be assessed as quickly as possible.

The trust informed us that that the ED training course covered mental health awareness and that 51 nurses out of a total 91 eligible nurses that had completed this course (77%). A further 43 nurses were not at the development stage of their training to have completed the training. Mental health awareness was also covered in the foundation of emergency nursing course, 77 nurses had completed this and 17 nurses were booked onto courses due to commence in September 2018 and January 2019. The security lead had provided security staff with mental health awareness training in February 2017.

ED staff and managers told us caring for people with mental health needs was a challenge. The divisional risk register recorded caring for people with mental health needs as a new risk on 31 December 2017. The risk register highlighted that the ED were seeing increasing numbers of patients with mental health needs as a result of a lack of available community beds and the psychiatric assessment service (PAS) being withdrawn by community mental health services in May 2018. The risk had been submitted for inclusion on the corporate risk register on 18 September 2018.

Staff could access interpreter services for patients who did not speak English through a telephone helpline or face to face when required. There were leaflets displayed in the main hospital reception and ED in languages other than English. Staff told us they had access to written communications in other languages if they were required via the trust’s accessible communications department.

The ED had hearing loop assistive technology for patients with hearing impairment.

The trust had produced a hospital passport for patients with learning disabilities in conjunction with the Lewisham learning disability team. This could be carried by patients when they attended the hospital. However, we did not see any patients who were participating in the scheme during our inspection.

The trust informed us that learning disability training had been rolled out to staff on the training weeks in 2015. Staff (72%) had also received triage training in relation to learning disability patients in January and February 2017. However, the length of time since staff had received the specific training in 2015 did not address staff turnover and some staff may not have up to date training in meeting the specific needs of patients with a learning disability.
The trust informed us that staff had received training in dementia awareness and frailty training in 2016. This equated to 72% of staff. However, this meant some staff may not have up to date training in how to meet the specific needs of patients with dementia and frail older people. Patients in the CDU were offered food from a menu which included hot meals. Patients had different options for food including gluten free and kosher options.

The waiting area of the paediatric ED was decorated appropriately and was well-equipped and child friendly. There were sufficient activities to engage children and young people whilst waiting for care or treatment.

The trust scored “about the same” as other trusts for each of the three Emergency Department Survey questions relevant to the responsive domain:

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Access and flow

There had been some improvements in the access and flow in ED since our last inspection. However, demand and capacity still posed challenges in regards to the number of patients waiting in the department and length of time patients waited for admission. For example, the urgent and emergency care traffic light system scorecard gave every month between August 2017 and August 2018 a red rating for the total time patients spent in the ED.

During our previous inspection in March 2017 we found poor patient flow in the ED. A significant number of patients with decision to admit (DTA) remained in the ED, as there were no beds available on the wards. During this inspection we found patient flow had been variable in the previous 12 months, with seasonal variations reflecting winter pressures on the ED. We had concerns as to how the ED would cope with winter pressures in 2018 as staff reported that the ED had been very busy in August and September 2018. For example, on the 26 September 2018 there were 44 patients in total waiting to be admitted from the ED to an inpatient bed. The longest wait had been 49 hours. In mitigation, a senior manager told us that the opening of the new CDU would increase the CDU capacity.

Staff told us patients staying overnight in the ED did not cause issues in the summer, but, would cause issues once winter pressures set in. Staff told us that due to the hospital reconfiguring day surgery, escalation beds in day surgery which were usually available for ED escalation were not available in August and September 2018. A senior manager told us there would be 10 beds in day surgery allocated as escalation beds for the management of winter pressures.

During our previous inspection we found there were 393 trolley waits over four between September 2016 and February 2017, the average monthly trolley waits over four hours was 393. Between August 2017 and August 2018 there had been a reduction to an average of 361 hours during this period, with a peak in January 2018 when there were 764 patients waiting over four hours.

During our previous inspection from September 2016 to February 2017 there had been 35 patients who experienced a trolley wait of over 12 hours in the six month period. During this inspection this
had improved. For example, between August 2017 and August 2018 there had been 41 patients waiting over 12 hours in the 12 month period. Between September 2017 and February 2018 there had been 20 patients waiting over 12 hours.

The department had a patient triage, assessment, and streaming processes in place. The emergency department (ED) had its own dedicated entrance. Patients could present at ED at any time with any complaint, a key part of the operation of the ED was the prioritization of patients based on clinical need. Patients attending the ED main reception were initially seen by a receptionist and streaming nurse who assessed whether the patient would be seen in the ED or the urgent care centre (UCC).

Triage was normally the first stage the patient passed through, and consisted of a brief assessment, including a set of vital signs observations, and the assignment of a "chief complaint", for example, chest pain, abdominal pain, difficulty breathing. The patient was triaged by the triage nurse and ambulance crew or face to face in the main reception waiting area. There was a streaming desk and two main triage cubicles in the ED main reception area. There were two additional triage cubicles used for taking bloods and conducting investigation in the reception area. Staff told us patients with stable observation and that were not confused at handover from the London Ambulance Service (LAS), could go directly to the waiting area in the ED main reception.

During our previous inspection we found the ED reception waiting area was often overcrowded due to the volume of patients attending the department on daily basis. During this inspection we did not find the waiting area to the ED overcrowded. Patients we spoke with in the waiting area in September 2018 told us they were booked in promptly and had seen a clinician within 20 minutes of arrival at the ED. Although, some staff told us the lack of a “runner” for test results could lead to patients being delayed.

Most patients were initially assessed at triage and then passed to another area of the department, or another area of the hospital, with their waiting time determined by their clinical need. However, some patients completed their treatment at the triage stage. For example, if the condition was very minor and could be treated quickly; if a patient only required advice; if the ED was not a suitable point of care for the patient. Conversely, patients with evidently serious conditions, such as cardiac arrest, would bypass triage altogether and move directly to the appropriate part of the department. Paediatric patients were not streamed by a nurse and were directed directly to the paediatric ED for triage after booking in at reception.

ED had introduced a new role of flow coordinators. These were band 4 non-clinical staff. Flow coordinators from each area were responsible for handing patients over to coordinators in other areas of the ED if a patient moved in the ED. The coordinators managed patient information. This meant the patient and their details were handed to an identified member of staff. Nursing staff told us this had made improvements to the flow in ED as nursing staff did not have to complete the patients’ non-clinical documentation.

During our inspection, the matron and PDN were assisting staff to manage flow in the emergency department. Regular updates were provided to the site team throughout the day at bed meetings, these took place three times a day. This meant the site management team and senior staff had oversight of the department and the wider hospital’s capacity. A list of actions was agreed during the bed meetings and an update on these was provided at the next meeting. In addition, regular communication took place with London Ambulance Service (LAS) to advise LAS of pressures the department was experiencing.

The percentage of patients who leave the ED before being seen is recognised by the Department of Health as an indicator of patients’ dissatisfaction with the length of time they have to wait. During our previous inspection 4.5% of patients left the department without being seen. During this inspection the average number of patients leaving the department without being seen had
improved. Between August 2017 and August 2018 the rate was 2.5%. This was better than the trust target of 5% or less.

London Ambulance Service (LAS) were attending a stakeholder engagement meeting during our initial inspection visit on the 26 October 2018. They told us they would text staff and ask them to avoid QEH if possible when the ED was busy. However, LAS said they were aware of the pressure on other hospital emergency departments and often other hospitals were as busy as QEH.

During this inspection we found there had been improvements in the LAS handover times, with the department meeting the 15 minute target for ambulance handovers. There was also improved performance in regards to patients receiving treatment within one hour of arrival.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard in each month over the 12-month period from June 2017 to May 2018, and also was consistently better than the England average over the same time period.

From June 2017 to May 2018, the trend in the trust’s performance was stable and limited to a narrow range between 17 minutes and 23 minutes.

Median time from arrival to treatment from June 2017 to May 2018 at Lewisham and Greenwich NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

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 emergency department.

From July 2017 to June 2018 the trust consistently failed to meet the standard. In the same 12-month time period, the trust’s performance has fluctuated around the England average: from July 2017 up to December 2017, the trust’s performance was better than the England average; and between March 2018 and June 2018, the trust’s performance was worse than the England average.

Across the 12 months from July 2017 to June 2018, the trust’s performance showed a strong seasonal variation. Performance was best in July 2017 (92%) and stable up to October 2017 (92%); but after consistently deteriorated up to January 2018 (83%), when performance was worst. From March 2018 (84%) performance consistently improved up to the end of the 12-month period in June 2018 (89%).

Four hour target performance - Lewisham and Greenwich NHS Trust
From July 2017 to June 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was variable compared to the England average. From July 2017 to October 2017, the trust’s performance was consistently better; but from November 2017 to March 2018 it was worse; and then improved / was better than the England average from April 2018.

Across the 12 months from July 2017 to June 2018, the trust’s performance had a strong seasonal variation. However, after January 2018, performance consistently improved up to May 2018.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Lewisham and Greenwich NHS Trust
Over the 12 months from July 2017 to June 2018, 41 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2018 (19 patients) and March 2018 (21 patients).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-17</td>
<td>219</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>275</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>394</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>302</td>
<td>1</td>
</tr>
<tr>
<td>Nov-17</td>
<td>614</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>793</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1,306</td>
<td>19</td>
</tr>
<tr>
<td>Feb-18</td>
<td>834</td>
<td>0</td>
</tr>
<tr>
<td>Mar-18</td>
<td>920</td>
<td>21</td>
</tr>
<tr>
<td>Apr-18</td>
<td>468</td>
<td>0</td>
</tr>
<tr>
<td>May-18</td>
<td>337</td>
<td>0</td>
</tr>
<tr>
<td>Jun-18</td>
<td>374</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

From June 2017 to May 2018 the monthly median percentage of patients that left the trust’s ED before being seen for treatment was worse than the England average in the first five months (June 2017 to October 2017) and then better than the England average for the remaining seven months (November 2017 to May 2018). For the last five months of the 12-month reporting period (January 2018 to May 2018), the monthly value was very low.

From June 2017 (5.5%) to September 2017 (5.5%), the trust’s performance was stable (between 5.0% and 5.8%). From September 2017 (5.5%) to November 2017 (0.1%), there was a consistent improvement to very low numbers, which was sustained up to the end of the 12-month period in May 2018 (0.0%).

Percentage of patient that left the trust’s ED without being seen - Lewisham and Greenwich NHS Trust
From June 2017 to May 2018 the trust’s monthly median total time in A&E per patient (for all patients) was consistently higher than the England average.

From June 2017 (194 minutes) to March 2018 (232 minutes), the trend in the trust’s performance for this metric had deteriorated. In the last two months of the time period, there was an improvement (around 149 minutes).

**Median total time in A&E per patient - Lewisham and Greenwich NHS Trust**

(Source: NHS Digital - A&E quality indicators)

The urgent and emergency care scorecard dated from August 2017 to August 2018 had a red RAG rating for the total time both admitted and non-admitted patients spent in the ED for the entire period. The trust target was 240 minutes or four hours. The time non-admitted patients spent in the ED in August 2018 was 571 minutes; for admitted patients this was 1371 minutes.

(Source: NHS Digital - A&E quality indicators)
Discharge summaries were generated and sent to patients’ GPs electronically. This meant the patients’ GPs were informed of the patients’ attendance at the hospital ED and could follow up if required.

**Learning from complaints and concerns**

There was an information point in the hospital’s main reception that provided patients, carers and families with direct access to contact the patient advice liaison service (PALS).

Staff told us they escalated complaints to the nurse in charge. Staff said they would try to resolve complaints at the time it was raised wherever possible. If patients wished to escalate a complaint staff told us they would provide contact details for PALS.

Complaints could be made via telephoning or emailing the trust or PALS. There was a trust wide policy for the management of complaints. The ED displayed complaint information informing patients and visitors on how to make a complaint.

Departmental meeting minutes confirmed that feedback from complaints was fed back to and staff were informed of changes in procedure following complaints. Managers shared the outcomes of specific complaints to individual staff. Information on complaints was shared with staff in the ED newsletter.

We reviewed a complaint dating from 2018. We also viewed an investigation report, including a root cause analysis (RCA) relating to this complaint. The investigation report recorded that the learning from the investigation had been shared with staff at handovers, team meetings, and the trust wide ‘outcomes with learning’ group. The investigation report was shared with the patient and their family and contained an apology.

From April 2017 to March 2018, there were 111 complaints about ED.

The trust took an average of 33.8 working days to investigate and close complaints for this service.

The trust responded to 38.7% of complaints within the target period of 25 working days specified in the trust complaints policy.

The breakdown of complaints about ED by subject and location is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Queen Elizabeth Hospital</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>34</td>
<td>12</td>
<td>46</td>
</tr>
<tr>
<td>Communications</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>5</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Appointments</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Waiting times</td>
<td>5</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Admin/policies/procedures (inc patient record)</td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Transport (ambulances)</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67</td>
<td>44</td>
<td>111</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From April 2017 to March 2018 there were 47 compliments in urgent and emergency care. A breakdown by site is provided below:

- Queen Elizabeth Hospital: 23
- University Hospital Lewisham: 24

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

There were actions in place to improve leadership at the hospital and ED. However, some of the changes were relatively recent and leaders were familiarising themselves with their new roles.

There were new leaders at board level who had taken up their posts April 2018. Staff told us the new chief executive officer (CEO) was visible. We saw the CEO visiting the ED during our inspection. We spoke with the assistant chief operating officer (COO) who told us they were relocating to QEH to oversee operations on the QEH site.

The division moved to a site based clinical and management structure in 2016-17, with the divisional manager overseeing both University Hospital Lewisham (UHL), QEH, and community services to ensure continuity and alignment of the division and its objectives. The ED was part of the acute and emergency medicine (AEM) division and led by a divisional manager. The divisional manager was supported by a head of nursing for the AEM division.

Staff told us they were optimistic about the new senior leadership team. Some staff told us that in the past there had been tensions in the relationship between the senior leadership team and the ED. Staff told us things had improved with the appointment of a new chief nurse in April 2018. Staff on the paediatric ED told us the new chief nurse had been very visible on the unit.

A matron led the nursing team in the ED and a clinical lead led the medical team in the ED. All staff we spoke with described the local leadership team as supportive and visible within the department. During our inspection, we saw the local leadership team maintaining a visible presence and assisting at times of high demand. The local leadership team were located within the department, which allowed them to have oversight of all areas. For example, staff told us the matron would provide nursing assistance on the ward when the ED was busy.

Consultant leadership in the department was committed and consultants demonstrated clinical ownership of patients in the department. Consultants had oversight of the patients and demonstrated awareness of patients with the potential to deteriorate.

**Vision and strategy**

During our previous inspection the trust had an emergency care redesign programme which was part of a trust wide transformation programme covering all aspects of emergency patient pathway across two ED sites. However, senior managers told us this had been “shelved” due to the
redesign programme being over ambitious and undeliverable. The trust had developed a new clinical strategy in April 2018.

The key initiative under the clinical strategy included a new clinical decisions unit (CDU). We discussed our concerns about the use of corridors being used as escalation areas. Senior managers told us this was a temporary measure and would cease in December 2018 with the opening of the new CDU. However, other staff told us the ED strategy was driven by meeting the four hour wait target. They told us escalation trollies in the “majors” corridor would continue to be used for escalation.

Staff we spoke with raised concerns about the lack of a mental health strategy for the ED. Staff told us they were increasingly treating patient with mental health needs.

The trust had an overarching vision and values, ‘one trust – serving our local communities.’ The values were incorporated into staff induction, recruitment processes and staff appraisals. The trust’s values were displayed on posters throughout the ED. Although, the trust values were in the process of being reviewed.

**Culture**

Staff were proud of the care they provided, even though there were challenges in managing the ED demand and capacity.

Staff we spoke with expressed enthusiasm and motivation for working in the ED. However, some staff were frustrated at the constant use of the ‘majors’ corridor and main corridor as escalation areas. Staff told us the restrictions of the environment meant they could not always provide quality care for patients.

Staff told us there had been some improvements in ED and some areas of deterioration since our last inspection. Areas of improvement included the introduction of non-clinical flow coordinators and better staffing. However, some staff told us that they did not feel previous senior managers had listened to staff concerns and had minimised risks. For example, a staff member told us “putting patients in corridors has become normalised.” Staff told us the main corridor had been used as an escalation area every day during the winter months from January 2018. Staff also said the acuity of patients being cared for in the corridors had risen.

Staff told us the culture was positive and inclusive at local level, but some staff felt this did not extend to the wider organisation. This was mainly due to a perceived lack of support from the trust senior leadership team in tackling the long delays patients experienced within the ED, waiting for review or admission. Some staff told us there was a culture at the trust that ED patients were the responsibility of the service and not the wider organisation. Staff felt there should be pathways in place for patients to be diverted to University Hospital Lewisham (UHL) at times of high demand. Staff we spoke to were aware of the role of the trust’s ‘Freedom to Speak Up Guardians’, and how they would access them if required. Staff told us there was an open ‘no blame’ culture in the ED where staff were encouraged to report incidents to drive learning in the department.

**Governance**

The ED had a clinical governance structure, which provided accountability and facilitated communication from ward to board. This included monthly emergency department clinical governance meetings.

The clinical governance meetings were attended by the divisional director, head of nursing, consultants, senior matrons and senior non-clinical staff. We reviewed governance meeting minutes and saw that the leadership team discussed the AEM performance scorecard, staffing,
serious incidents, complaints, and finance and quality improvement projects. Action points were raised following each meeting.

Minutes we viewed from the January to March 2018 and April to June 2018 governance meetings recorded a concern about nurses moving patients to the clinical decisions unit (CDU) before being seen by an ED doctor and nurses making decisions without a doctor. This was not in accordance with the hospital’s procedures. The minutes recorded that nurses were under a lot of pressure which needed to be discussed and resolved. The minutes recorded that this would be discussed at the next senior management team (SMT) meeting. We did not see any reference to the outcome of this issue in the following governance meeting minutes dated April to June 2018. We requested the SMT meeting minutes from the trust. Following our inspection the trust informed us that the discussion had been a verbal discussion outside of the SMT with the staff involved, and the lead consultant had led this. However, this meant there was no written record of the issue having been addressed and nursing staff having been informed.

Management of risk, issues and performance

The AEM division maintained a risk register. Staff used the risk register to identify potential risks and identify any mitigating plans to address the identified risks. The risk register had 56 identified risks. Eight of these risks were specific to QEH ED and 19 were trust wide risks.

Senior staff routinely discussed risks at clinical governance meetings. However, we found mitigating actions on the risk register did not fully address identified risks. For example, the escalation area on the main corridor had been added to the risk register on 29 November 2016. This recorded risks to the escalation area in the main corridor including access to piped oxygen and suction. The mitigating actions were recorded on the 18 September 2018 as, “new clinical facility to open in December 2018.” However, this did not clearly address the issues of patients having access to piped oxygen and suction in the interim period.

There was a further example of mitigating actions not being robust or timely on the ED risk register. A risk recorded on the risk register on 29 November 2016 catalogued a number of risks to patients with a decision to admit (DTA) in the ED, some of which should have been identified as individual specific risks and recorded as separate risks with action plans. For example, these risks included: bed shortages, medicine stocks, a shower that was unsuitable for people with a disability, and a lack of ward health care assistants (HCA). The action plan was reviewed on 18 September and recorded “new clinical facility to open in December 2018.” Mental health had been added to the risk register on the 16 November 2016. Identified risks were catalogued and did not include paediatric mental health. Although paediatric services were mentioned in the mitigation plan. Actions in mitigation had been updated on 14 September 2018 recording that there had been “progress on implementation of the mitigation plan” and the risk had been submitted for inclusion on the corporate risk register.

The urgent and emergency services scorecard provided a method of monitoring key performance indicators (KPI). We viewed the scorecard dated from August 2017 to August 2018. The scorecard was red, amber, green (RAG) rated. The scorecard enabled managers to gain an overview of ED services and plan quality improvement objectives.

The service had a mental health oversight board. The board included members of the trust, local mental health trust and the clinical commissioning group (CCG). The trust had a service level agreement (SLA) with the local mental health trust for mental health liaison and Mental Health Act management.

Information management
The divisional risk register identified issues with the trust intranet. The risk register recorded that there was an identified risk of policies/guidelines ‘dropping off’ the intranet. This meant there was a risk of out of date documents being used or lack of access to approved guidelines and a potential impact on the clinical care of patient. In mitigation the risk register recorded that this had been “highlighted” to the clinical effectiveness team. The risk had a completion date of 31 December 2018.

Patients booked in at the main reception. The streaming nurse decided whether the patient would be booked in with the ED or the urgent care centre (UCC). The UCC used a different IT system to the system used in the ED. Staff told us they would go to the UCC and ask staff there if they required further information on a patient referred to UCC.

**Engagement**

The department monitored patient satisfaction through patient surveys and feedback forms. Patients were asked to complete a Friends and Family Test survey (FFT). Senior staff told us they met with patients and their relatives to resolve complaints and applied learning to improve ED services.

The ED had a log of actions taken in response to feedback from patients. For example, in response to feedback from the hospital’s patient user group in January 2018, the ED had introduced water jugs at the main reception. Staff were also producing a range of leaflets for patients in ED, including a card for patients to keep with them which gave their details, which staff had seen them and what tests they needed.

There was an annual staff survey. We viewed the action plan in response to the 2017 staff survey. This recorded that the ED appraisal rate at 88% was in the higher quartile than other divisions in the trust. The staff survey action plan recorded that the ED was an extreme outlier for violence and harassment in the work place, scoring 33% compared to the trust average of 4%. The action plan also related this to the high numbers of mental health patients attending ED. In response the action plan recorded the ED were working with the mental health team to improve the flow of patients with mental health needs through ED and working with the trust security team to ensure a timely response to calls for assistance.

The staff survey for ED had a higher percentage, 66% compared to a trust average of 55%, of staff reporting they felt under pressure to attend work despite feeling unwell. This was related to staff feeling responsible to attend work due to the number of staff vacancies. The staff survey action plan recorded that the ED had a continuous recruitment programme for both medical and nursing staff to address staffing shortages.

There was a ‘You said – We did’ board for staff in the staff corridor. For example, staff had asked for new trauma mattresses in June 2018. The board recorded that work was in progress on trialling new trauma mattresses.

There was a monthly clinical risk newsletter, ‘Tackling risk in ED’, produced by a consultant and the PDN. There was also a newsletter, ‘Risky Business’ which fed back learning from incidents. All staff could contribute to the newsletter. A consultant ran an electronic suggestion box; all staff could make suggestions to improve systems or general improvements. The ED also had a positive event email, where staff could compliment each other. A staff member told us, “ED is a busy environment, it’s important that we recognise each other’s contributions.”

**Learning, continuous improvement and innovation**
There was a new 52 bed clinical decisions unit (CDU) which was scheduled for opening in December 2018. This would provide increased capacity in ED.

There was a comprehensive education strategy as an aspect of the divisional clinical strategy. For example, the education strategy for QEH included: the introduction of an in house mentorship course; the introduction of an accreditation of respiratory and cardiac nursing course; the use of the trust’s skills academy for improving CPD; the introduction of a capital nursing project for the implementation of foundations of emergency department care course; an income generating emergency department training provision for HMP Belmarsh; an induction and support programme, a feedback workshops, a formal ‘buddy system’; career navigation and more support for internal movement; an increase in staff skills base; and career clinics.
Surgery

Facts and data about this service

The surgery core service at Lewisham and Greenwich NHS Trust operates from two locations; Queen Elizabeth Hospital and University Hospital Lewisham.

Across Queen Elizabeth Hospital and University Hospital Lewisham there are 160 surgical inpatient beds located in eight wards and units.

A breakdown for each hospital site can be found below:

Queen Elizabeth Hospital

Queen Elizabeth Hospital has 78 surgical inpatient beds located across four wards and units:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic trauma</td>
<td>28</td>
</tr>
<tr>
<td>Post - colorectal and general surgery</td>
<td>39</td>
</tr>
<tr>
<td>Mixed emergency surgery</td>
<td>11</td>
</tr>
</tbody>
</table>

The trust had 21,262 surgical admissions from March 2017 to February 2018. Of these, 6,606 (31.1%) were emergency admissions, 12,282 (57.7%) were day case admissions, and the remaining 2,374 (11.2%) were elective admissions.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.
Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Queen Elizabeth Hospital

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the surgery department at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>22</td>
<td>22</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>168</td>
<td>183</td>
<td>91.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>159</td>
<td>183</td>
<td>86.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>158</td>
<td>183</td>
<td>86.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>157</td>
<td>183</td>
<td>85.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>152</td>
<td>183</td>
<td>83.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>149</td>
<td>183</td>
<td>81.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>149</td>
<td>183</td>
<td>81.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>137</td>
<td>183</td>
<td>74.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - HLS</td>
<td>109</td>
<td>161</td>
<td>67.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and harassment</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>119</td>
<td>183</td>
<td>65.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>115</td>
<td>183</td>
<td>62.8%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital surgery department the 85% target was met for five of the 13 mandatory training modules for which qualified nursing staff were eligible.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control clinical</td>
<td>109</td>
<td>129</td>
<td>84.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>102</td>
<td>129</td>
<td>79.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>97</td>
<td>129</td>
<td>75.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>77</td>
<td>129</td>
<td>59.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>76</td>
<td>129</td>
<td>58.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>71</td>
<td>129</td>
<td>55.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>68</td>
<td>129</td>
<td>52.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>67</td>
<td>129</td>
<td>51.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>63</td>
<td>129</td>
<td>48.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>52</td>
<td>129</td>
<td>40.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital surgery department the 85% target was not met for any of the 10 mandatory training modules for which medical staff were eligible. Mandatory training was completed on a rolling basis and was dependant on when the staff member had joined the trust. However, there was no confirmation the compliance target would be met within the rolling year.

Staff told us due to staff shortages this sometimes led to lack of oversight and robust monitoring for mandatory training compliance. For example, staff told us the scrub nurses training was below
target due to lack of staff and therefore time.

Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning and by trainer delivered sessions. Staff said they were supported with professional development through additional training courses and revalidation. Staff had the responsibility of completing their own mandatory training, although line managers were able to monitor through e-mail alerts sent to them.

Sepsis training was provided at induction and was part of an annual hospital life support resuscitation course, which was a scenario based training course and was mandatory every year.

Safeguarding

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Queen Elizabeth Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 for qualified nursing staff in the surgery department at Queen Elizabeth Hospital is shown below:

### Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children &amp; Young People Level 2</td>
<td>158</td>
<td>183</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Clinical Level 2</td>
<td>150</td>
<td>183</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital surgery department, the 85% target was met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

### Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children &amp; Young People Level 2</td>
<td>88</td>
<td>103</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Clinical Level 2</td>
<td>109</td>
<td>129</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Young People Level 3 - Core</td>
<td>18</td>
<td>26</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital surgery department, the 85% target was met for one of the three safeguarding training modules for which medical staff were eligible.

Staff had a good understanding of safeguarding and knew how to raise and escalate concerns. During our inspection staff had escalated two safeguarding concerns and had made sure the correct procedures were followed to keep the respective patients as safe as possible. The incidents related to ensuring the patients had safe packages of care when they were discharged from the hospital.

There was a dedicated safeguarding team within the hospital and they had links and regularly met with local authorities. Staff told us the safeguarding team were easy to access and the
process of escalating concerns was simple.

We saw information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

In general cleanliness in the theatres and surgical wards was good, although there were areas which were not as good. Some of the sluice rooms had overflowing linen bins and some commodes and rapid infusers did not indicate whether they had been cleaned. However, other areas we observed were of a good quality.

Ward based cleaning was carried out by an external company. We saw a cleaning work schedule displayed in the wards, which provided information on the areas of the ward and times they were due to be cleaned. We observed staff cleaning the ward during our inspection using the correct colour coded equipment.

We saw information relating to incidence of infection and cleaning audits were displayed on the wards. Audits, for example of harm free care and hand hygiene for the months of March to August 2018 showed results had been 90% or greater, which exceeded the trust target of 85%.

During our observations of care, staff washed their hands and used personal protective equipment (PPE) compliant with hospital policy. Hand gel was available throughout the surgical areas of the hospital and at the point of care. This was an improvement since our last inspection.

Elective surgery patients were screened for methicillin resistant Staphylococcus aureus (MRSA) and effective procedures were in use to isolate patients when appropriate. The day care unit (DCU) no longer used side cubicles to place inpatients who had been identified as having MRSA. This was an improvement since our last inspection.

We received information of concern regarding the infection control of instruments and missing instruments in surgical packs within theatres. We visited the hospital and services decontamination (HDSU) service and found a comprehensive system was in place to track and trace instruments and identify areas of concern. In relation to the amount of production packs issued each month (approximately ten thousand or more for the whole trust), the proportion of packs missing instruments ranged from three to four each month. This represented approximately 0.09% of incidents reported and was below the trust target of 0.25%. We spoke with various members of staff within theatres, and nobody said they had concerns regarding missing instruments or dirty production packs. We therefore, could not corroborate the concerns raised, as the incidents reported by staff and the data from the HDSU was minimal.

Environment and equipment

Since our previous inspection the day care unit (DCU) had been upgraded and reopened to run purely as a day surgery service. The unit no longer accepted inpatients escalated from the emergency department. There were ringfenced beds and separate consultations rooms. The theatre recovery area was not being used as an escalation area and the whole unit had been redecorated. The area now had separate single sex patient waiting areas. The department was notably spacious and appeared clean and tidy, which was an improvement on previous findings. Therefore, most of the concerns raised at our previous inspection had been addressed.

We found some of the main theatres were in need of repainting but on the whole the main theatre area was spacious and appeared clean and tidy. However, we did see trailing cables on the floor of one theatre and the cables were draped around a door frame and secured with surgical tape. Although paediatric patients were recovered in the main recovery unit, the bay was placed at the end of the room and staff were able to screen the area to accommodate privacy.
Ward 12 and Ward 17 still had cold air vents, where the temperature could not be controlled. Staff told us this was an issue which could not be resolved. This meant some patients felt cold and had to be given extra blankets.

We found most equipment had labels to show they had been tested and serviced. Resuscitation trolleys were fully equipped and daily checks had been completed by staff.

There had been a shortage of cystoscopy scopes due to a number needing repair. This was identified as a risk on the surgical risk register. As of the middle of August 2018 the trust had raised a new business case but there was no further information on its progress at the time of our inspection, and as a result the problem remained.

Theatre staff told us they had difficulties with the purchasing and authorisation of much needed equipment. Staff told us they had not received a response or updated information regarding broken ECG leads that needed replacing in the recovery unit, despite e-mailing the lead of equipment purchasing on numerous occasions. This made staff feel frustrated and concerned that essential equipment required to keep patients safe was not being managed.

There were arrangements for the safe handling, storage and disposal of clinical waste within the patient bays and ward areas we visited. This was an improvement since our last inspection. However, stronger oversight and management of clinical and linen waste in a number of the sluice rooms was needed to ensure effective infection control processes were followed.

At our inspection of March 2017 rooms 5 and 6 on ward 12 had been used to accommodate additional patient beds for patients escalated from the emergency department. This had posed a safety risk as emergency lifesaving equipment could not get through to all patients within the room. The room was no longer used to accommodate additional beds.

Assessing and responding to patient risk

Patients risks were assessed at pre-admission, and details such as allergies, medical history, venous thromboembolism (VTE) assessments and cardiac assessments were recorded. The department liaised closely with anaesthetists and consultants on particular patient concerns. Pre-operative notes we reviewed demonstrated pre-assessments had taken place.

Risk assessment tools were used in patient records and included falls risks, cognitive assessment tools, and pressure ulcer risks. However, we found assessments for the nutritional tools used were not fully completed on five sets of records we reviewed.

Staff used the National Early Warning Score (NEWS) on surgical wards. The NEWS tool improves the detection and response to clinical deterioration in adult patients. Theatre recovery staff had recently started to use the NEWS score for every last two patient observations of care, before they were transferred to the ward. However, this was not fully embedded into the unit at the time of our inspection. News audits from March 2018 to August 2018 showed all departments scored above 90%. Staff told us they knew who escalate concerns to. However, a serious incident report we reviewed identified that staff did not escalate a patient with a high NEWS score to the correct team. In theatre recovery patients were recovered on a one to one basis whilst intubated or receiving opiates and then the ratio was two patients to one member of staff. Paediatric patients were recovered by two qualified staff.

We saw the World Health Organisation (WHO) Five steps to safer surgery checklist was used correctly. The WHO was a set of checks staff completed to increase the safety of patients undergoing surgery. The most recent six-monthly audit showed a 100% compliance rate.

Medical outliers were still placed on surgical wards, but mainly on wards 15AB, where the trust had employed a medical senior house officer (SHO) to assist with assessments. This was an improvement since our last inspection. However, acutely unwell outlier patients were being sent to the ward when there was set criteria to follow. For example, staff told us cardiac patients placed in the ward meant nursing staff did not always have the equipment, and if they did, could not always understand the machine readings as they were not trained to do so.
The trust had recently introduced a treatment escalation plan used to ensure every patient had their ceiling of care considered and documented formally. However, this was in its infancy and most staff we spoke with had not started using the forms.

## Nurse staffing

The trust reported the following qualified nursing staff numbers as of March 2018 and June 2018 for surgery by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>175.9</td>
<td>196.9</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>162.2</td>
<td>210.9</td>
</tr>
<tr>
<td>Trust total</td>
<td>338.1</td>
<td>407.7</td>
</tr>
</tbody>
</table>

Please note, the trust total may not equal the sum of the site totals as some nursing staff work cross-site.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

### Vacancy rates

From July 2017 to June 2018, the trust reported a vacancy rate of 18.5% for qualified nursing staff in surgery. This was higher than the trust target of 14%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 10.9%
- University Hospital Lewisham: 25.8%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

### Turnover rates

From July 2017 to June 2018, the trust reported a turnover rate of 9% for qualified nursing staff in surgery. This was lower than the trust target of 12%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 9.8%
- University Hospital Lewisham: 7.3%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 5.3% for qualified nursing staff in surgery. This was higher than the trust target of 3.5%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 5.6%
- University Hospital Lewisham: 5.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From July 2017 to June 2018, the trust reported that 34.5% of qualified nursing shifts in surgery were filled by bank staff and 33.9% of shifts were filled by agency staff. In addition, 3.9% of shifts were not filled by bank and agency staff to cover staff absence.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Bank shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>3,852</td>
<td>5,081</td>
<td>559</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>3,392</td>
<td>2,024</td>
<td>260</td>
</tr>
<tr>
<td>Total</td>
<td>7,244</td>
<td>7,105</td>
<td>819</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Overall, we found there was sufficient nursing cover on the surgical wards. The difficulties arose when unfilled shifts were not covered. These were usually filled with bank or agency staff; however, there were occasions when these were not filled and this placed pressure on staff with an increased workload. This meant they were unable to attend to patients as quickly as they would have liked to.

Ward 17 had three registered nurse vacancies and relied on bank and agency staff to fill the gaps. The staff had recently left and a full recruitment campaign was being addressed to recruit the vacancies. The hospital used regular bank staff, and the bank staff we spoke with during the inspection could clarify they worked on a regular basis at the hospital.

Nursing staffing figures were displayed in each ward. Overall, we found the planned staffing levels matched the actual numbers.

At our last inspection we raised concerns regarding the reduction from two health care assistants (HCAs) to none on ward 15B on the night shift. Staff had told us that due to the layout of the ward they were sometimes unable to attend patients who required more support. During this inspection the additional HCAs had been reinstated and staff were able to tell us they had seen a reduction in patient falls. This was an improvement since our last inspection.

Since the day care unit had reopened purely as a day surgery service the department nursing staff was fully established.

Staff told us the recruitment process was sometime laborious and one staff member told us an
internal recruitment application took three months to complete after they had been successful in the application process.

**Medical staffing**

The trust reported the following medical staffing numbers as of March 2018 and June 2018 for surgery by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>123.1</td>
<td>113.4</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>122.2</td>
<td>169.8</td>
</tr>
<tr>
<td>Trust total</td>
<td>245.3</td>
<td>283.1</td>
</tr>
</tbody>
</table>

Please note, the trust total may not equal the sum of the site totals due to some nursing staff working cross-site.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of 27.1% for medical staff in surgery. This was higher than the trust target of 14%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 16.3%
- University Hospital Lewisham: 34.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From July 2017 to June 2018, the trust reported a turnover rate of 40.4% for medical staff in surgery. This was higher than the trust target of 12%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 39.0%
- University Hospital Lewisham: 42.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 1.4% for medical staff in surgery. This was lower than the trust target of 3.5%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 2.5%
- University Hospital Lewisham: 0.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From July 2017 to June 2018, the trust reported the following bank and agency usage for medical staff in surgery.

The breakdown by site is shown in the table below.

Queen Elizabeth Hospital

<table>
<thead>
<tr>
<th>Location</th>
<th>Locum shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>765</td>
<td>305</td>
<td>29</td>
</tr>
<tr>
<td>Middle grade</td>
<td>1,262</td>
<td>363</td>
<td>105</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>431</td>
<td>139</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>2,458</td>
<td>807</td>
<td>231</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)
Staffing skill mix

In December 2017, 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 similar to the England average.

Staffing skill mix for whole time equivalent staff working at Lewisham and Greenwich NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>35%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Medical rota at the hospital were only partially established, which led to a reliance on temporary bank and agency medical staff to maintain a safe service. This was a high risk on the surgical division risk register. The hospital had recruited six anaesthetist consultants as well as two specialist registrars onto the hospital rota. The trust was exploring partnerships with other NHS trusts for joint appointments to tackle the shortfall. The trust was also exploring new models of care including nurse consultants and a flexible staffing model.

During our inspection we found theatre staffing for patient procedures followed Association of Peri-operative Practice (AFPP) guidelines.

The surgical division risk register highlighted there was a shortage of pharmacy, dietetics, speech and language therapists and occupational therapists. The physiotherapist lead told us there were two Band 6 vacancies within the physiotherapy team and this was seen as a risk on the risk register.

(Source: NHS Digital Workforce Statistics)

Records

We reviewed fifteen patient records across surgical services. We saw most of the records were appropriately completed, legible and organised. However, some of the patient records were not in chronological order. The clinical documentation audit 2017-18 for the surgery division indicated this was an area for improvement. Some of the patient records were still loose within their files which meant they could become lost. This had not improved since our last inspection.

We saw there had been an improvement in the security of patient records, as all patient record trolleys had security locks placed on them. However, there were a few occasions during our inspection when we saw the records trolley was left open and unattended meaning records could easily have been accessed. In ward 15 a patient record was left unattended on a piece of
equipment in the corridor. We drew this to the attention of staff and the record was removed and appropriately stored.

Nursing records were well documented but some assessments were incomplete, for example on the nutritional assessments the patients’ weight was not always indicated and some assessments did not include the date of the assessment. We saw risk assessments had been completed for falls prevention and pressure ulcers.

**Medicines**

Medicines were not always managed safely and effectively. Staff were not writing dates of opening on liquid medicines, or on blood glucose solutions for calibration. This meant that there was a risk the products were being used beyond their expiry dates. Two out of date bags of saline were found stored in the blood sample fridge within the theatre department.

We saw poor practice in theatres with regards to the drawing up of medicines into syringes in advance of administration. We saw two syringes with liquid drawn up that were labelled as suxamethonium but had not been dated. We saw irrigation fluids being stored in a warming cabinet for use in theatres. The products were not labelled appropriately with the date they had been warmed as per the manufacturer’s instructions. It was not clear if staff had a trust policy to adhere to in this area. We saw some irrigation fluids stored in a warming cabinet were not labelled with the date they had been warmed. Staff were unable to provide assurance that medicines were always stored at the correct temperatures to remain effective.

We saw there were many occasions when patients left the hospital without their discharge medicines. In one case, we saw a patient had left without their prescribed supply of injections to stop blood clots forming in blood vessels. We were not assured actions had been taken to ensure the patient was safe.

However, medicines (including controlled drugs) were stored securely. Staff monitored temperatures of medicines storage areas. When temperatures were found to be outside of the required range, we saw staff took appropriate actions to safeguard the effectiveness of medicines.

Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly. Pharmacy staff visited wards area each day and conducted medicines reconciliation. (Medicines reconciliation is the process of ensuring that the list of medicines a person is taking is correct.) Staff could access medicines supplies and advice out of hours. Pharmacists and pharmacy technicians counselled patients on their medicines. There was a satellite pharmacy dispensary for the surgical wards. This reduced waiting times for patients needing medicines to be dispensed.

Patients could discuss any medicines queries with the ward based pharmacy staff. The trust also had a dedicated medicines information line that patients could call.

**Incidents**
Never Events

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.

From June 2017 to May 2018, the trust reported no incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type and location was as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Queen Elizabeth Hospital</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Environmental incident meeting SI criteria</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>4</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

Staff told us they reported incidents through the electronic system. Learning from moderate to serious incidents was shared at handover meetings and ward meetings. We saw theatre meeting minutes which showed serious incidents and incidents identified to their particular area were discussed and lessons learnt shared with staff. Quarterly governance meetings had a set agenda for serious incidents from both sites to be discussed during the meeting.

Staff had a good understanding of the reporting of incidents of all levels. However, staff told us that due to operational pressures they sometimes did not report low level incidents, partly because they did not feel any changes would be made. This meant the trust was unable to capture all information which could identify themes and trends. Some staff said they did not always receive feedback on low level to moderate incidents, just an e-mail to acknowledge their incident has been logged.

Ward staff could describe actions taken and lessons learnt from a recent serious incident. This demonstrated information had been shared through surgical services, and we saw the new processes put in place for each ward as well as extensive training for staff.

However, a recent serious incident within the hospital highlighted processes were not entirely effective when assessing and responding to patient risk. The incident showed differences in risk assessment tools used between the main recovery area in theatres and the main wards. During our inspection we saw changes had been made with the assessment tools being used, but they were not fully embedded and some staff were still getting used to using the tools correctly. We fed this back to the hospital and on our return visit we found staff were now using the assessment tool properly.
The trust investigated serious incidents by conducting root cause analysis investigations and we saw duty of candour had been initiated for each serious incident we reviewed. Duty of candour is a process of open and honest practice when something goes wrong.

There were monthly mortality and morbidity meetings held by the mortality review group. The purpose of the meetings was to share and review adverse patient outcomes with a view to identify themes and trends and clinical safe practice. We reviewed recent meeting minutes which showed a good attendance and shared learning.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

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 collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed the trust reported two new pressure ulcers, no falls with harm and three new catheter urinary tract infections from May 2017 to May 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Lewisham and Greenwich NHS Trust

![Safety Thermometer Graph]

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Staff told us they had good access to the tissue viability nurses (TVN). Nurses placed a request on the system and the TVN would come and assess the patient.

Staff told us there was a pressure ulcer panel who met on a weekly basis. The ward manager did a synopsis and if the panel thought there was a high risk they were given a slot on the panel to attend to get support and actions addressed.

Is the service effective?
Evidence-based care and treatment

The hospital based their policies and pathways on National Institution for Health and Care Excellence (NICE) guidelines. In general staff followed and carried out care and treatment within these guidelines. Staff could access guidance from the trust intranet. However, a lack of vital policies, such as specimen management and correct site surgery were a high risk on the surgical division risk register. Delays due to staff absence, meant the hospital had not progressed any further in ensuring the vital policies were developed and updated. This meant staff may not always have the correct guidance to follow for certain treatment and procedures.

From records we reviewed, the hospital followed the Royal College of Nursing (RCN) guidance for catheter care and NICE guidance on falls prevention, pressure area care and venous thromboembolism (VTE). We saw VTE assessments were checked at pre-operative stages as part of the safety checks.

There was a clinical audit programme which highlighted surgery services involvement in national and local audits. Consultants had good knowledge of patient outcomes regarding their specialities and nursing staff were able to discuss local audits for their area, for example hand hygiene audits.

We observed staff undertaking chlorhexidine skin preparation for a patient correctly completed as per NICE CG74: Prevention and treatment of surgical site infections.

Nutrition and hydration

On the majority of occasions food and fluid charts were completed. However, we found not all the malnutrition universal screening tools (MUST) were completed in the patients records we viewed. For example, for two records there was no patient weight listed and no date for when the patient was assessed and the tool was completed with a score of 0. A recent serious incident highlighted the nutritional tool used required adaptations and the trust were still in the process of investigating this at the time of our inspection.

Recent changes had been implemented into the surgical wards in respect of nutrition and hydration. Nursing staff completed a morning dietary need sheet for each patient and this was given to the kitchen staff on each ward. For example, the sheet indicated whether the patient was nil by mouth, or needed a red tray. Healthcare assistants then collected each meal from the kitchen staff, and individually gave them to each patient. This ensured nursing staff had more oversight on the meals given to each patient and the support they required. Health care assistants remained in each patient bay to assist with those patients who required more support.

Most patients we spoke with said the food was good and they received plenty of fluids during their stay.

Pain relief

Overall patients pain was managed well by staff. However, a few patients told us occasionally there was a delay in their pain relief, but they felt this was due to staff being overstretched and busy and was not done intentionally. This correlated with feedback from some staff who said they were unable to attend call bells as quickly as they would have liked, due to their busy workload, especially when short staffed. One patient told us they did not feel the medical team addressed their pain well, but overall most patients told us staff were quick to respond if they were in pain. Staff used a pain score to monitor pain levels. Records we reviewed showed pain was assessed routinely and patients confirmed this when we spoke with them.

However, there were differences in the pain scores used between the theatre recovery team and the main wards. The scores used within the recovery team ranged from 0-3, with 3 being the most severe. The wards used a pain score with a different range. Therefore, a 3 score was not
necessarily regarded as high score within the surgical wards. Staff told us this could potentially be misinterpreted when a patient was transferred between wards and said a uniform score would be beneficial.

The hospital had a dedicated pain team and staff told us they were easy to access.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

**Elective admissions:**

From February 2017 to January 2018, all patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

For the same comparator (the corresponding England average):

- Patients in colorectal surgery had a lower than expected risk of readmission for elective admissions
- Patients in ENT had a higher than expected risk of readmission for elective admissions
- Patients in General Surgery had a similar expected risk of readmission for elective admissions.

**Elective Admissions – Trust Level**

![Graph showing relative risk of readmission for elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*

**Non-elective admissions:**

From February 2017 to January 2018, all patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

For the same comparator (the corresponding England average):

- Patients in general surgery and in trauma & orthopaedics had a higher than expected risk of readmission for non-elective admissions
- Patients in urology had a similar expected risk of readmission for non-elective admissions

**Non-Elective Admissions – Trust Level**

![Graph showing relative risk of readmission for non-elective admissions](image)
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity (Source: HES - Readmissions (01/02/2017 - 31/01/2018))

Queen Elizabeth Hospital

Elective admissions:

From February 2017 to January 2018, all patients at Queen Elizabeth Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

For the same comparator:

- Patients in general surgery, in colorectal surgery and in urology all had a lower than expected risk of readmission for elective admissions.

Elective Admissions - Queen Elizabeth Hospital

Non-elective admissions:

From February 2017 to January 2018, all patients at Queen Elizabeth Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

For the same comparator (the corresponding England average):

- Patients in general surgery and in trauma & orthopaedics had a higher than expected risk of readmission for non-elective admissions
- Patients in urology had a similar expected risk of readmission for non-elective admissions.

Non-Elective Admissions - Queen Elizabeth Hospital
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

(Source: Hospital Episode Statistics)

National Hip Fracture Audit

Queen Elizabeth Hospital

Queen Elizabeth Hospital participated in the 2017 National Hip Fracture Audit.

- The risk-adjusted 30-day mortality rate was 8.3% which was within the expected range. The 2016 figure was 10.7%.

- The crude proportion of patients having surgery on the day or the day after admission was 64.2%. This result was below the national aspirational standard of 85% and put Queen Elizabeth Hospital in the bottom 25% of hospitals. The 2016 figure was 71.7%.

- The crude perioperative medical assessment rate was 97.2%. This result was below the national aspirational standard of 100% but placed Queen Elizabeth Hospital in the top 25% of hospitals. The 2016 figure was 97.5%.

- The crude proportion of patients documented as not developing a pressure ulcer was 97.9%. This result was below the national aspirational standard of 100% and placed Queen Elizabeth Hospital in the middle 50% of hospitals. The 2016 figure was 87.2%.

- The crude overall hospital length of stay was 21 days. This result placed Queen Elizabeth Hospital in the middle 50% of hospitals. The 2016 figure was 19.8 days.

(Source: National Hip Fracture Database 2017)

Bowel Cancer Audit

The trust participated in the 2017 Bowel Cancer Audit.

- 64.5% of patients undergoing a major resection had a post-operative length of stay of greater than five days. This result was better than the national aggregate for England and Wales (69.5%). The 2016 figure was 71%.

- The risk-adjusted 90-day post-operative mortality rate was 5.6% which was within the expected range. The 2016 figure was 1.5%.

- The risk-adjusted 2-year post-operative mortality rate was 14.3% which was within the expected range. The 2016 figure was 13.8%.

- The risk-adjusted 30-day unplanned readmission rate was 12.0% which was within the expected range. The 2016 figure was not reported.
• The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 45.3% which was within the expected range. The 2016 figure was 42.3%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not participate in the 2017 National Vascular Registry audit.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

The trust participated in the 2016 National Oesophago-Gastric Cancer Audit.

• Poor quality data was provided by the trust on age and sex adjusted proportion of patients diagnosed after an emergency admission. Poor data quality means that over 15% of records had the referral source missing. In 2015 no figure was reported because of poor data quality.

• A value for the risk-adjusted 90-day post-operative mortality rate was not calculated because the trust was not eligible for this audit metric. In 2015 no figure was reported for the same reason.

• The crude proportion of patients treated with curative intent in the Strategic Clinical Network was 42.2%. This result was assessed as significantly higher than the national aggregate (37.6%). This metric is defined at strategic clinical network level. The network can represent several cancer units and specialist centres. The result can be used as an indicator for the effectiveness of care at network level. Better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

The National Emergency Laparotomy Audit (NELA) allocates three ratings for each audit metric used to assess a process of care:

• A green rating (a positive finding) indicates performance above 80%
• An amber rating (neither a positive or negative finding) indicates performance between 50% and 80%
• A red rating (a negative finding) indicates performance under 50%

Queen Elizabeth Hospital

Queen Elizabeth Hospital participated in the 2016 NELA.

The hospital received an amber rating for each of the four audit metrics used to assess a process of care:

• The crude proportion of cases with pre-operative documentation of risk of death (69%). This result was based on 103 cases.

• The crude proportion of cases with access to theatres within clinically appropriate time frames (71%). This result was based on 87 cases.
• The crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with a consultant surgeon and an anaesthetist present in the theatre (76%). This result was based on 66 cases.

• The crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (80%). This result was based on 49 cases.

The risk-adjusted 30-day mortality for Queen Elizabeth Hospital was 14.6%. This result was within the expected range and based on 103 cases.

The trust produced an action plan against the four amber rated metrics. For example, for the last metric there were a number of very experienced staff grade anaesthetists on the rota who were perfectly capable of managing relatively healthy and stable patients. For that reason, the hospital always had lower proportion than the national average for this index. All the cases were discussed with an on-call consultant prior to going ahead. From the surgical point of view, they consistently had a consultant surgeon present in theatre when risk of death was greater than 5%.

(Source: National Emergency Laparotomy Audit)

Trauma Audit and Research Network

Queen Elizabeth Hospital

Queen Elizabeth Hospital participated in the 2016 Trauma Audit and Research Network (TARN). The risk-adjusted in-hospital survival rate following injury was assessed to be similar to expected compared to other hospitals. This result was based on 178 cases.

(Source: Trauma Audit and Research Network)

National Ophthalmology Database Audit

The trust did not participate in the 2017 National Ophthalmology Database Audit.

(Source: National Ophthalmology Database Audit)

National Joint Registry

Queen Elizabeth Hospital

Queen Elizabeth Hospital participated in the 2017 National Joint Registry.

No data was available to calculate a case ascertainment rate for the 2017 National Joint Registry, and the audit results reported below for Queen Elizabeth Hospital should be interpreted in the context of this.

The hospital was within the expected range for each of the four audit metrics used to assess care:

• The risk-adjusted five-year revision ratio for hips, excluding tumours and neck of femur fractures. This result was based on 164 cases.

• The risk-adjusted 90-day mortality ratio for hips, excluding tumours and neck of femur fractures. This result was based on 140 cases.
• The risk-adjusted five-year revision ratio for knees excluding tumours. This result was based on 168 cases.

• The risk-adjusted 90-day mortality ratio for knees excluding tumours. This result was based on 166 cases.

(Source: National Joint Registry)

National Prostrate Cancer Audit

No analysis is available for the trust or its hospitals for each of the three audit metrics reported on at a site level.

(Source: National Prostrate Cancer Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

• Groin hernias
• Varicose veins
• Hip replacements
• Knee replacements

The proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, and the proportions of patients who reported a worsening can be viewed on the left.

In 2016/17 performance for the procedure of groin hernia was:

• Worse compared to the England average based on the EQ VAS; but
• Better compared to the England average based on the EQ-5D Index.

In 2016/17 performance for the procedure of hip replacement was:

• Better compared to the England average based on the EQ VAS; and
• Similar to the England average based on the EQ-5D Index and Oxford Hip Score.

In 2016/17 performance for the procedure of knee replacement was:
• Worse compared to the England average based on the EQ VAS and EQ-5D Index; and
• Similar to the England average based on the Oxford Knee Score

In 2016/17 performance for the procedure of varicose vein was:

• Better compared to the England average based on the Aberdeen Varicose Vein Questionnaire and EQ-5D Index; but
• Worse compared to the England average based on the EQ VAS

(Source: NHS Digital)

Competent staff

Appraisal rates

From April 2017 to March 2018, 69.5% of required staff within surgery at the trust received an appraisal compared to the trust target of 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>355</td>
<td>304</td>
<td>85.6%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>6</td>
<td>5</td>
<td>83.3%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>238</td>
<td>159</td>
<td>66.8%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>21</td>
<td>9</td>
<td>42.9%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff – Hospital</td>
<td>133</td>
<td>56</td>
<td>42.1%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>4</td>
<td>1</td>
<td>25.0%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>15</td>
<td>2</td>
<td>13.3%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>774</strong></td>
<td><strong>538</strong></td>
<td><strong>69.5%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Queen Elizabeth Hospital
From April 2017 to March 2018, 71.6% of required staff within surgery at Queen Elizabeth Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group is in the table below:

The trust target of 90% was not met for either qualified nursing staff or for medical staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>189</td>
<td>166</td>
<td>87.8%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>124</td>
<td>82</td>
<td>66.1%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; dental staff hospital</td>
<td>71</td>
<td>29</td>
<td>40.8%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
<td>No</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
<td>No</td>
</tr>
<tr>
<td>Grand total</td>
<td>387</td>
<td>277</td>
<td>71.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

Appraisal completion was a risk on the surgical risk register. Not all staff we spoke with had received an appraisal. Those who had their appraisals told us their learning needs and development opportunities were discussed within the meeting. Senior staff we spoke with told us the paperwork required for each appraisal was overwhelming and sometimes, due to the heavy caseload and staff shortages, they were unable to complete them in the required timeframes.

However, we found there were good opportunities to attend courses and most staff complemented the practice development nurse (PDN) and the work they had done to develop staff training. For example, the PDN was developing training on chest drains for Ward 12 nursing staff, so they could become the dedicated ward to treat those patients and have the appropriately trained staff.

We spoke with a variety of staff from across the professions who could tell us of the additional training they had received. For example, one nurse was completing a spinal course so they could become the link nurse for surgical services. Another staff member had recently completed training in the fundamentals of orthopaedics. Another had just completed in-house training for a surgical nursing course.

We spoke with the inpatient physiotherapy lead who told us they had cross site teaching for Band 7 and 8 staff and other physio staff had monthly training according to their banding.

In ward 15AB there were gynaecology trained nurses who assisted with patients undergoing gynaecological surgery.

There was local induction training for theatre staff within each speciality complete with an induction pack with competency booklet. Each new staff member had a link member to train and sign off competencies.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Multidisciplinary working

Staff from across the professions worked together as a team to ensure patients received effective care and treatment. We attended a surgical ward multidisciplinary meeting, where each individual patient’s treatment pathway and care package was discussed. Conversations took place on additional support the patient required and expected timeframes to help patient recovery. During the meeting staff displayed an in-depth knowledge of each individual patient and their requirements. There was good interaction and collaborative working between nurses, allied health professionals and junior doctors.

We attended a mid-morning bed site meeting which involved nursing staff from all clinical departments across the hospital. Each of the nurses at the meeting was able to provide updates on patient’s requirements, such as possible discharge dates, times and additional support the patient needed. This enabled the bed site team to manage the flow of patients through the hospital and also provided opportunities for discussions on areas which required increased support. The interaction and communication between staff was relaxed, supportive and opportunities for staff to express any concerns was made in an open and transparent environment. This was an improvement since our last inspection.

Staff were able to access specialist input from the safeguarding team, pain management team and palliative care team. All staff we spoke with felt they were well supported by internal speciality teams and felt the communication and relationships with other teams was strong.

Seven-day services

The hospital catered for emergency surgery 24 hours seven days a week. Two theatres were designated for emergencies and a trauma list ran at the weekends.

Investigations, such as computerised tomography (CT) scans, blood tests and x-rays could be accessed seven days a week.

At weekends a senior staff supervisor acted as a co-ordinator between the surgical wards and was a point of contact for nursing staff. Consultants provided seven-day cover for surgical wards and there were on-call consultants.

The service had round the clock access to mental health liaison support staff if there were concerns associated with a patient’s mental health.

Health promotion

Those patients requiring additional support to improve their health and wellbeing were identified during pre-operative consultations. There was a smoking cessation team and the staff made diabetes and vascular referrals where necessary.

The hospital provided a range of information leaflets to aid patients with their health. We saw leaflets in the surgical wards on medicines, which provided information on storage, what side effects were and how medicines should be taken. There were supportive contact telephone lines for patients.

For anyone wishing to stop smoking, a team was available to provide advice and information and options of different clinics.

A dietitian from the trust ran free shopping for health tours in local supermarkets. They were able to help with diabetes, healthy eating and heart health and to improve general nutritional knowledge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 85% for completion of mandatory training.

Queen Elizabeth Hospital

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the surgery department at Queen Elizabeth Hospital is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>158</td>
<td>183</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>91</td>
<td>129</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital, the 85% target for Mental Capacity Act (MCA) training was met for nursing staff, but not medical staff, who had a completion rate of 71%.

Staff understood their roles and responsibilities regarding consent and the MCA. We observed consent was checked before surgical procedures and treatment. Consent was included in the pre-assessment and WHO checklist. Records we viewed showed consent had been sought and confirmed pre-treatment.

Consent was usually a two-stage process, where the patient was provided with information before the treatment and further consent was confirmed with the patient that they still wished to proceed. For emergency surgery, consent was signed in a single stage due to time constraints.

Staff we spoke with in pre-assessment said best interest meetings were held for those patients who lacked capacity for elective surgery. The meeting would involve the consultant, the patient and their next of kin or carer.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

We saw good examples of patient care where staff were compassionate and kind. Patients we spoke with were able to tell us staff were kind and attended their needs.

Staff we observed were kind and treated patients with compassion. We observed many interactions where staff treated patients in a dignified manner. We observed staff showing an encouraging, sensitive and supportive attitude towards patients. Staff respected patient’s dignity by closing curtains around them, when providing treatment. Patients knew individual staff
members names and comments we received from patients included “I would give this place A+ and the doctors and nurses were marvellous”.

A patient’s relative commented that staff when providing personal care for their relative were “gentle and dignified” and they provided the “appropriate meal time help”.

We spoke with a patient awaiting surgery and had previously been treated by the same surgeon said they had received “outstanding care”.

Friends and Family test performance

From May 2017 to April 2018 the Friends and Family Test response rate for surgery at the trust was 15%. This was lower than the England average of 28%.

Queen Elizabeth Hospital

From May 2017 to April 2018 the Friends and Family Test (FFT) response rate for surgery at Queen Elizabeth Hospital was 19%. This was based on 3,121 responses.

A breakdown of FFT performance by ward for surgical wards at this hospital with total responses over 100 is below. All the wards scored 92% or above over the whole 12-month period.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy &amp; Day Care</td>
<td>2125</td>
<td>15%</td>
<td>96%</td>
</tr>
<tr>
<td>WARD 17</td>
<td>378</td>
<td>49%</td>
<td>100%</td>
</tr>
<tr>
<td>WARD 18</td>
<td>337</td>
<td>44%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 19</td>
<td>188</td>
<td>35%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

During the inspection we observed staff attend to a patient who was distressed. They managed to provide supportive care to calm and reassure the patient.

There was a chaplaincy service that provided spiritual and religious care for patients. The service was available throughout the night and day. We saw information available to patients on how to contact the service. A multi-faith prayer room was based at the hospital which provided a quiet and private space for patients and visitors.

At handover meetings, staff discussed the patient’s wellbeing and emotional support they required.

Understanding and involvement of patients and those close to them

Patients we spoke with told us they were given clear information regarding the benefits and risks of their treatment and were given the opportunity to ask questions. A patient who had abdominal pain told us they had scans and other tests to identify the problem and felt the hospital had thoroughly investigated their problem.
We observed that staff and patients knew each other’s names, and patients seemed relaxed so that informal discussions with staff took place. Patients told us they felt involved in their pathway of care and treatment.

Theatre staff arranged for a patient who needed childcare for their children who had special needs, to stay for two nights at the hospital for post recovery as she was not able to attend to her children.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The hospital worked with local commissioners and stakeholders to ensure the service was responsive as possible. During our inspection the hospital had reopened the day care unit to solely function as a day surgery unit, with ring fenced beds to avoid late cancellations. Previously the day care unit was not operating as an effective service as the majority of patients were inpatients or escalated from the emergency department. It was too early to tell of the impact this had on the surgery division but initial evidence showed positive results. Within the week of being open, there had been no cancellations.

**Average length of stay**

**Queen Elizabeth Hospital**

**Elective patients:**

From March 2017 to February 2018, the average length of stay for all elective patients at the Queen Elizabeth Hospital was 3.1 days, which is shorter than the England average of 3.9 days.

- Average length of stay for elective patients in general surgery, trauma & orthopaedics and colorectal surgery was shorter than the England average.

**Elective Average Length of Stay - Queen Elizabeth Hospital**

![Bar chart showing average length of stay for elective patients](chart)

*Note: Top three specialties for specific site based on count of activity.*

**Non-elective patients:**

From March 2017 to February 2018, the average length of stay for all non-elective patients at Queen Elizabeth Hospital was 4.9 days, which is the same as the England average of 4.9 days.

- Average length of stay for non-elective patients in trauma & orthopaedics was shorter than the England average.
• Average length of stay for non-elective patients in urology was longer than the England average.

• Average length of stay for non-elective patients in general surgery was similar to the England average.

Non-Elective Average Length of Stay - Queen Elizabeth Hospital

![Average Length of Stay Chart]

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

There was a new dementia lead for the hospital (in progression) and they provided guidance and support for staff, patients and relatives. We received positive feedback from staff on the new dementia lead and the work they had done to support relatives. For example, for one distressed relative they had arranged a 20-minute reiki session. They had also been instrumental in purchasing a television for ward 17 patients. Staff told us how beneficial this was in terms of offering entertainment and stimulation for the patient and encouraged mobilisation as the television was placed in the day room.

Patients had access to a translation service if required and there was a translation touch board in the hospital. When patients pressed a button this provided information on the services of the hospital in the language they desired.

At our previous inspection we raised concerns regarding the environment within the day care unit (DCU). It lacked patient privacy, was cramped and patients with infections were placed in side cubicles, which had no sufficient amenities such as handwash basins. At this inspection we found the DCU now had separate areas for patients to wait until their treatment. The areas afforded more privacy and dignity and the side cubicles were no longer used for infected patients. We found this was an improvement since our last inspection.

Children, patients with learning disabilities and patients who expressed significant anxiety about their surgery were placed at the front of list wherever possible. This was discussed and determined in team briefings in the morning.

At pre-assessment colorectal patients needing iron infusion were sent straight to ambulatory care where they were given a dose of iron infusion. This meant the two-week pathway to treatment was not delayed for the patient.

The pre-assessment team was able to make arrangements for those patients requiring additional support. For example, they liaised with theatre staff for a patient who was wheelchair bound and required a hoist for support. The theatre staff were able to pre-plan the supportive services the patient required and the treatment went smoothly without any delay.
The surgical risk register stated there was inappropriate pre-operative, peri and post-operative medical care for bariatric patients and the hospital was not adhering to NICE guidelines. Therefore, we were not assured bariatric patients were receiving the best care and treatment.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From May 2017 to April 2018, compared to the England average, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse in six months, better in five months and similar in one month.

Over this 12-month period there was a gradual improvement in the trust’s performance in terms of both the absolute value and also the value relative to the England average:

- In June 2017, 57% of the trust patients for surgery began treatment within 18 weeks compared to the England average of 70%.
- In April 2018, 69% of the trust patients for surgery began treatment within 18 weeks compared to the England average of 65%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

From May 2017 to April 2018 two specialties were above the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>84.2%</td>
<td>72.8%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>88.9%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.3%</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

Over the same period one specialty was below the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>31.6%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>25.0%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0.0%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>48.9%</td>
<td>60.7%</td>
</tr>
</tbody>
</table>
Cancelled operations

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.

Over the two-year period up to quarter 4 of 2017/18, after the first three months (quarter 1 2016/17), there were no patients who were not treated within 28 days after a cancelled operation at the trust. Over the same period the England performance for this metric varied between 6% and 11%.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Lewisham and Greenwich NHS Trust

![Graph showing the percentage of cancelled operations at the trust compared to England over a two-year period]

Over the same two-year period, the percentage of cancelled operations at the trust was better than the England average in seven out of the eight quarters. For the remaining quarter (quarter 2 of 2017/18) the trust was similar to the England average.

From quarter 3 of 2016/17 up to quarter 2 of 2017/18, the trust performance compared with itself deteriorated. After this the trust performance improved: in quarter 4 of 2017/18, the percentage of cancelled operations was half the England average.
From the trust quality scorecard, we saw the RTT for incomplete backlog and incomplete pathways, for the majority of all surgical specialities were highlighted red, which meant they were an area of concern for the trust. The trust had agreed with local commissioners a trajectory to recover the RTT position by April 2019. The recommissioning of the day care theatre and restructuring the day care unit to function as a day surgery service was a step in the right direction to help recover the RTT position. We saw RTT recovery action plans which had been broken down into surgical specialties and the actions the trust was taking. Most of the actions involved the recruitment of specialty professionals which was proving a difficult task for the trust. However, we saw the trust had made job offers for several positions.

Since the day care unit (DCU) had been reopened and operated as a day surgery service, staff told us there had been no cancellations on the day and no cancellations in pre-assessment. However, it was too early for us to evidence the positive impact this had on surgical services as a whole as the DCU had only been in operation for one week. Initial feedback from staff showed a positive reaction to the access and flow of surgical patients. However, staff within DCU were still concerned at how durable the new arrangements would be and how robust they would be in the face of escalating bed pressures, in particular in the winter pressures period.

Staff we spoke with in pre-assessment told us they potentially had a three month backlog, due to high cancellations which stemmed from the DSU not running effectively historically. Since the DSU has been running purely as a day surgery unit, they intended to operate weekend clinics with the help of staff from the DSU to address the backlog.

Staff in recovery told us they had seen an immediate improvement in the flow of patients through theatre. However, they had experienced difficulties in the late afternoon for those day surgery patients that required inpatient beds. This sometimes caused a “bottleneck” in the afternoon, but was not as problematic as it had previously been.

We attended a bed site meeting and found there were six day surgery patients who had required inpatient beds. This placed an additional pressure on the bed site team to find inpatient beds.

Overall theatre utilisation sessions were below the trust target of 85%. For the period of June 2017 to June 2018 the average score was in the 70% region. Staff told us they were frustrated with the CEPOD emergency lists which appeared to be ineffectively organised and did not usually until 10.30 although scheduled to start at 8.30 in the morning. This list was booked on a first come basis and although there was a planning meeting at 7.30 there was no nurse representation.
The trust was not always meeting its 62 day target for all specialities for patients with cancer. The scores had recently improved but this was still seen as a risk. The trust had recently introduced better pathways but there was more work to be done to improve their response.

There was a surgical assessment unit (SAU) where patients were sent from acute care or via GP referrals. The referrals usually came through a surgical registrar who would triage the calls. Staff told us there was a better pathway in place to transfer patients to the Lewisham site and there was a designated person they could now contact. Staff said the system was still in development but they had seen an improvement with the flow of patients.

The hospital had recruited four physician assistants who were to be ward based doctors that supported the patient journey. It was anticipated the team members would support juniors doctors and release time, enabling the junior doctors to focus on discharge planning earlier in the admission and specifically early prescribing of TTOs to avoid delays on discharge day. However, patients still waited for their medication and sometimes left the hospital with the option of returning another day for their medication which was not ideal.

(Source: NHS England)

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were 49 complaints about surgery services.

The trust took an average of 46 working days to investigate and close complaints for this service.

The trust responded to 18.4% of complaints within the target period of 25 working days specified in the trust complaints policy.

The breakdown of complaints about surgery services by subject and location is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Queen Elizabeth Hospital</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Appointments</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Transport (ambulances)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>End of life care</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>22</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>
Number of compliments made to the trust

From April 2017 to March 2018, were 10 compliments within surgery.

A breakdown by site is provided below:

- Queen Elizabeth Hospital: six compliments

Unfortunately we are unable to provide commentary on themes.

Is the service well-led?

Leadership

There were clear lines of leadership and staff knew who led their service and who they reported to. On the whole, we received positive feedback from staff on the overall leadership within the surgical division. However, there was a reduced morale amongst the medical staff and the trust were in the process of reviewing the capacity and capabilities and reviewing and implementing a new trust structure.

Staff from the day surgery unit told us the clinical lead who had led the changes within the unit was inspirational, open to discussion and approachable. There was more scrutiny and oversight within the DCU and a clear vision of the service.

Staff told us they felt the new chief executive was willing to guide and drive the service forward to improve quality and performance. They told us they had visited their area and seemed open and approachable. Nursing staff gave positive feedback on the new chief nurse and had recently seen changes made for the good. They said their voices could be heard.

Staff felt supported by matrons, junior sisters and ward managers. Staff we spoke with said managers were approachable and listened to their concerns or issues when they were raised. Staff said they were confident in raising concerns and their managers had an open door approach.

Vision and strategy

The trusts vision and strategy was yet to be embedded into surgical services. Due to new leadership within the trust and surgical division the new leadership team were taking their time to reconsider values and vision. We viewed meeting minutes of a first cross site ward leaders vision session. The purpose was to build healthy relationships between the leaders of the surgical wards in the division and begin to create a vision for the future.
Most staff we spoke with told us they were not engaged with the current vision and strategy even though they had received a lot of information from the trust. Staff felt under the guidance of the new chief executive and chief nurse, the direction of the service was more positive than it had been in a long time. With the opening of the DCU, staff were encouraged and more engaged in the trusts values and recognised that changes were happening.

**Culture**

We observed a more motivated and happier nursing staff at this inspection than on the inspection of May 2018, particularly in the DSU and ward 15AB. This was because they had seen changes take place that had a positive impact on their working life and patient care. Staff within DSU were positive of the changes made, but were concerned at the changes made to their pay. It was too early to indicate if this would have an impact on the morale of staff.

Staff still told us they felt overwhelmed at the operational pressures and staff shortages and a lot of staff told us they felt ‘tired’.

The reduced morale amongst the medical staff was a risk of the surgical risk register. Most staff we spoke with were happy with their immediate managers and the training they received from their peers. However, due to staff shortages they felt overstretched and felt the trust had lacked strong direction. Most staff were hoping to see positive changes with guidance from the new chief executive.

Overall, staff we spoke with said they were proud to work for the trust and that it was a good place to work. They were more positive about the direction of the service since the new chief executive had arrived at the trust. However, most staff were concerned that the recent changes made within DSU could not be sustained when operational demands increased and as one member of staff told us, this made them feel ‘jittery’.

On the whole most staff described good teamwork within the division. We saw good examples when staff worked well together, both in theatres and on the surgical wards. There was respect between specialities and between staff of different disciplines and grades.

**Governance**

There were governance arrangements to ensure performance and quality of the surgical service was continually monitored. Low morale within the medical staff had led to a lack of engagement with the governance agenda and safety quality improvement projects. The trust was in the process of reviewing the leadership capacity and capabilities with a new trust structure launched, which was still in its infancy.

There were monthly surgical clinical governance meetings attended by clinical leads, matrons, staff from critical care, anaesthetists and a patient representative. From the meeting minutes we reviewed, there was a set standardised agenda which covered incidents, risks, patient stories, complaints, research and development and national survey findings. There were local governance meetings for each surgical speciality and ward meetings. These meetings discussed concerns. Incidents, updates related to their localised area. We found information from the surgical clinical governance meetings had been disseminated down to the local ward and division meetings. For example, serious incident outcomes.

Staff we spoke with were clear about their roles and responsibilities who led the service and their level of accountability. There was a programme of clinical and internal audit used to monitor performance and quality.

**Management of risk, issues and performance**

A monthly clinical scorecard was shared with surgery leads and provided oversight on performance for surgical clinical indicators. Results were displayed so previous months results could be compared to see if performance had improved. The scorecard gave an indication of themes and trends that could be picked up if there were concerns.
There was a surgical division risk register which covered both sites. Most risks we reviewed were identified by staff and were meaningful. We saw there were regular monitoring and reviews. However, some of the risks were long-standing and limited progress had been made. For example, one risk placed on the register in 2016 showed no change had been made for all updates. The risk related to inappropriate pre, peri and post-operative medical care for bariatric patients. Risks which were identified as serious were placed on the trusts corporate risk register. We identified one risk which had been progressed to the corporate risk register and this related to the lack of morale amongst medical staff. Risks were discussed in monthly clinical governance meetings and risks were addressed in sister’s meetings. If new risk was identified this was sent to the head of nursing for consideration.

There were local top risks within each surgical ward and these related to patient falls, pressure ulcer and infection control. Discussions took place on risks during staff handover meetings and ward meetings.

However, we were concerned that measures to rectify a risk were not always actioned in a timely manner. Risks identified from a serious incident from six months ago were still not actioned. Although the hospital had addressed the larger scale risks, the small risks had not been fixed. For example, a contributory factor to one serious incident, had been that staff had not seen important patient information as it had fallen from the behind the patient’s bed. At the time of our inspection the ward was still in the process of sourcing sufficient hooks to be used. This was a simple fix that should have been actioned quickly.

Within theatres, safety alerts were sent to the theatre matron who then shared them through monthly audit meetings and team briefings.

Information management

Information was shared through a variety of ways, daily ward and theatre handovers, safety briefings, multidisciplinary meetings and bed site meetings.

Each surgical ward displayed information on performance and quality indicators such as harm free care and recent audits.

The trust had ways of capturing performance through their monthly quality scorecard which was shared from the executive board to the divisional leads for each surgical specialty. Information on audits and performance could be compared from month to month so risks could be identified.

The trust was in the process of moving towards a paperless single electronic system for patient records, so information could be captured from the start to end of the patient’s pathway.

Engagement

People using the service were encouraged to give their opinion on the quality of the service. Leaflets about the friends and family test and Patient Advice Liaison Service (PALS) were available on all wards. The public were able to become members of the trust, where they received regular information about the hospital through an e-mail newsletter. They were invited to open days and seminars and were consulted on any major changes, and could participate in focus groups and surveys.

Staff could participate in the annual staff survey. We saw improvement plans to monitor key trust wide actions. For example, health and well-being activities were more focused on physical and mental well-being.

The trust held annual staff awards in recognition of good care.
Learning, continuous improvement and innovation

The hospital had purchased two red zimmer frames for patients living with dementia and were auditing the outcomes to see if can be spread across the trust. The red colour provided greater colour contrast and recognition for these patients.

The hospital had made a film “Fiona’s film,” which was shared with staff. The film gave staff the opportunity to speak about the additional in-house training they had received within surgical services and how this had improved their confidence and patient care.

The clinical effectiveness department had a monitoring system for oversight of new clinical procedures and innovations. The surgery division had nine active innovations currently being monitored for surgical procedures.

Patients at pre-assessment requiring colorectal treatment and patients with cancer were provided with all pre-assessment checks including anaesthetist assessments on the same day. This meant the two week pathway for patients was not delayed. This was unique to the Queen Elizabeth Hospital location.

The physiotherapist lead told of us work that had started on an reablement pathway so patients received more responsive therapy and earlier intervention on discharge. The therapists were working with reablement carers to give them the skills to assist patients. The pathway also included occupational therapists assessing patients within 72 hours of being home and leaflets were given to patients on what to expect

Critical care

Facts and data about this service

The trust had 40 critical care beds as of April 2018, across the two sites. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Lewisham and Greenwich NHS Trust and England.

This trust

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>12.5%</td>
</tr>
<tr>
<td>Adult</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

England

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>23.3%</td>
</tr>
<tr>
<td>Paediatric</td>
<td>7.9%</td>
</tr>
<tr>
<td>Adult</td>
<td>68.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Queen Elizabeth Hospital

Queen Elizabeth Hospital has 18 critical care beds; 10 of these are dedicated level 3 beds and the remaining 8 are used to provide level 2 care. Staff told us the beds were used flexibly, as per patient needs and if required, the unit could accommodate up to 13 level 3 patients.

(Source: Trust Routine Provider Request)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 85% for completion of mandatory training.

Queen Elizabeth Hospital

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the critical care department at Queen Elizabeth Hospital is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>66</td>
<td>67</td>
<td>98.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>66</td>
<td>67</td>
<td>98.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>64</td>
<td>67</td>
<td>95.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>63</td>
<td>67</td>
<td>94.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>62</td>
<td>67</td>
<td>92.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>61</td>
<td>67</td>
<td>91.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - HLS</td>
<td>55</td>
<td>67</td>
<td>82.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>55</td>
<td>67</td>
<td>82.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>51</td>
<td>67</td>
<td>76.1%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital critical care department, the 85% target was met for eight of the 11 mandatory training modules for which qualified nursing staff were eligible.

Staff told us they were allocated protected time to complete classroom and e-learning modules of their mandatory training. Staff told us they were able to review their compliance with mandatory training through their training accounts. Individual staff and their line manager received alerts when their mandatory training was about to expire. This meant that staff were able to book their training in advance and managers were able to monitor compliance as part of supervision.
At Queen Elizabeth Hospital critical care department, the 85% target was met for two of the 10 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training.

**Queen Elizabeth Hospital**

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 for staff in the critical care department at Queen Elizabeth Hospital is shown below:

### Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>64</td>
<td>67</td>
<td>95.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital critical care department, the 85% target was met for each of the two safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children and young people level two had a 100% completion rate.

### Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital critical care department the 85% target was met for each of the two safeguarding training modules for which medical staff were eligible.
Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults as well as children and young people and could locate and describe the trust safeguarding policy. All the staff we spoke with knew how to contact the trust safeguarding team and gave examples of situations in which they would do so.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Cleanliness, infection control and hygiene**

There were dedicated staff for cleaning the critical care unit and they were supplied with and used nationally recognised colour-coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination. Cleaning staff understood cleaning frequency and standards and said they felt part of the team.

There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required. Staff adhered to infection control precautions throughout our inspection such as cleaning hands when entering and exiting the unit and bed spaces, and wearing personal protective equipment when caring for patients. Side rooms also had signs displaying presence of infection and the doors remained closed. We observed bed space curtains were labelled with the date they were last changed.

The doors leading to the clinical areas of the unit dispensed alcohol gel automatically when touched and alcohol gel dispensers were also present at patients' bedside.

The clinical areas we visited were clean and all the patients we spoke with were satisfied with the cleanliness. Other areas within the critical care unit, such as the relatives’ room, quiet rooms and nursing stations, were clean and tidy.

Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns in relation to hospital-acquired infections, such as MRSA or C. difficile and performance in these areas was comparable to similar units.

The critical care unit followed the trust isolation policy for the use of side room and staff worked closely with the infection control team in the management of patients admitted with infectious diseases. Two of the six side rooms on the unit were pressure controlled rooms and had a decontamination lobby in line with best practice guidance.

We looked at the equipment used on the units, including commodes and found them to be clean. Staff used ‘I am clean’ green stickers to indicate that equipment was clean and ready for use.

Staff completed infection control audits, such as hand hygiene, waste management and decontamination of equipment on a monthly basis and we saw that compliance rate was above 95% for all of these audits for the last six months prior to our inspection.

**Environment and equipment**

Sharps bins were available at each bed space and within the medicines preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line.

Emergency equipment such as resuscitation trolleys and difficult intubation trolleys were available and the contents of these were checked on a daily basis by the shift leader. Documentation found on the trolleys specified which items needed to be checked on which trolley and demonstrated these checks were happening on a daily basis. However, we saw that the checks for the resuscitation trolley were recorded in two separate books and staff were unable to explain why this
was the case. On inspection we found one item of equipment which had passed the expiry date shown on the packaging. We noted that staff had documented on three separate occasions during checking that this item had expired but no action was taken to replace this equipment. We highlighted our finding to the matron, who immediately replaced the equipment.

Therapy staff we spoke with told us they have access to all the equipment required to carry out rehabilitation, including a new seated and bed based cycling machine, which they had recently acquired. The effectiveness of the cycling equipment was due to be monitored as part of a clinical audit.

There was one arterial blood gas analyser available on the unit and we saw evidence of daily calibration, with no gaps evident.

The in-house electrical and biomedical engineering department maintained medical equipment including ventilators. We saw evidence equipment servicing was up-to-date and staff maintained a log to ensure necessary testing was carried out within the required timeframe.

The environment in the main bays was small and cramped and meant the service was not following Intensive Care Society standards regarding space between beds. Staff told us private conversations could not happen at the bed space and it was sometimes difficult to have all the equipment required for procedures around the bed due to the cramped space. The leadership team told us estates was one of the top risks and talks were underway to discuss the potential design of a new critical care unit on site. However, the timescale for achieving this was unclear as only preliminary discussions with architects had taken place at the time of the inspection.

Space around the bed was limited and full of equipment. There was a general lack of storage space on the unit, which meant a large number of equipment such transfer aids (hoists and other therapy equipment) and hemofiltration machines were stored in the corridors.

Staff told us they had access to the necessary equipment to provide safe care to patients. A computer terminal had recently been made available at each bed space in order to facilitate obtaining pathology results and in preparation for the roll out of electronic prescribing and records.

Staff told us of an ongoing issue with the emergency buzzers in one of the areas of the unit. Because of the way the buzzers were wired, when the emergency buzzer was activated in that area staff in other areas were unable to hear it and were therefore unaware that assistance may be required. This was on the critical care risk register and all staff were aware of the mitigating plan of always having two members of staff present in that area.

**Assessing and responding to patient risk**

As part of our inspection, we observed a consultant-led ward round. The ward rounds were attended by the consultant, doctors in training, pharmacist, nurse and dietician on weekdays. The ward round included a full, systematic review of the clinical needs of patients and addressed their immediate risks and medical status. We saw evidence of good consistent team decision-making and review practices.

All clinical staff had received training on sepsis testing, treatment and risk management. This included the use of the national Sepsis 6 care pathway and the use of National Institute for Health and Care Excellence (NICE) guidance.

Patients’ conscious levels were recorded using the Glasgow Coma Scale (GCS) and Richmond Agitation-Sedation Scale (RASS) was used to monitor agitation in sedated patients. We saw evidence of this in the records we reviewed.
Following the last inspection, we saw that the unit had developed some guidance for staff on the use of Confusion Assessment Method for intensive care unit (CAM ICU) to assess for risks of delirium, in line with current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. The local guidelines stated CAM-ICU should be recorded every eight hours. However, we did not see evidence of delirium screening in three out of the four records we reviewed during the inspection. In one of the records, we saw some delirium screening had been documented on some days but not consistently.

The critical care outreach team (CCOT) was part of the site management team and received referrals for deteriorating patients directly from ward staff. Staff throughout the trust used the National Early Warning Scores (NEWS) to identify deteriorating patients and staff referred all patients with a NEWS score of 5 or above to the CCOT. This included patients in maternity and the emergency department. CCOT was a 24/7 services with planned staffing of two nurses during the day and night shifts. When the critical care rota had two consultants during the day, one of the consultants was available to carry out ward round or review any deteriorating patients alongside the CCOT.

The outreach nurses we spoke with told us they were often asked to cover other areas with staff shortages. For example, on the second day of our inspection, one of the outreach nurses had to open up the discharge lounge due to staff sickness.

The CCOT received an average of 3-4 new referrals per day as well as following up all ITU discharges and patients with tracheostomies. Data submitted by the trust showed that 36% of the critical care outreach work was following up on patients discharged from the critical care unit.

Data submitted by the trust showed that 40 patients waited for more than four hours to be admitted to critical care, once a decision was made that they required level 2 or 3 care. This was not in line with FICM standards.

National Safety Standards for Invasive Procedures (NatSSIPs) were published in September 2015 to help NHS organisations provide safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur. The NatSSIPs cover all invasive procedures including those performed outside of the operating department.

A NHS England patient safety alert required all NHS organisations to identify procedures that met this requirement and develop local Safety Standards for Invasive Procedures (LocSSIPs) by September 2016. The trust quality and safety committee ratified the vascular access devices (VAD) Policy for Adults, which constitutes a LocSSIP. There were also no other LocSSIPs in use on critical care, despite procedures meeting this requirement, such as chest drains and tracheostomies, being carried out regularly on the unit.

During the last inspection, we highlighted the risk of patients being transferred to University Hospital Lewisham (UHL) for surgical tracheostomies due to not having ear, nose and throat (ENT) specialist on site. The trust had taken action and we were informed that the ENT specialist now travelled to the Queen Elizabeth site regularly.
Nurse staffing

The trust reported the following qualified nursing staff numbers as of March 2018 and June 2018 for critical care:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th></th>
<th>June 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
</tr>
<tr>
<td></td>
<td>WTE staff</td>
<td>WTE staff</td>
<td></td>
<td>WTE staff</td>
<td>WTE staff</td>
<td></td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>68.5</td>
<td>87.2</td>
<td>78.5%</td>
<td>65.1</td>
<td>86.6</td>
<td>75.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The senior nurses and matron were very proud of their recent recruitment drive, which had resulted in 13 new nurses joining the team on the critical care unit. On the second day of our inspection, we saw some of the new starters were completing their first supernumerary shift on the unit.

From July 2017 to June 2018, the trust reported a vacancy rate of 18.4% for qualified nursing staff in critical care at Queen Elizabeth Hospital. This was worse than the trust target of 14%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

However, the vacancy rate had improved at the time of the inspection due to the recent appointment of 13 additional nurses.

From July 2017 to June 2018, the trust reported a turnover rate of 19.3% for qualified nursing staff in critical care at Queen Elizabeth Hospital. This was worse than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From July 2017 to June 2018, the trust reported a sickness rate of 3.7% for qualified nursing staff in critical care at Queen Elizabeth Hospital. The trust target was 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From July 2017 to June 2018, the trust reported 4,736 qualified nursing shifts in critical care. Of those, 65.6% were filled by bank staff and 1.9% of shifts were filled by agency staff. In addition, 21% of shifts were not filled by bank and agency staff to cover staff absence.
The data specific to the critical care unit at Queen Elizabeth Hospital is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Bank shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth hospital</td>
<td>1,903</td>
<td>91</td>
<td>361</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The nursing leadership team told us and we saw evidence during the inspection that bank shifts were usually covered by staff already working on the unit or at the trust’s other critical care unit at UHL.

Medical staffing

The trust reported the following medical staff numbers for June 2018 for critical care.

<table>
<thead>
<tr>
<th></th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>7.4</td>
</tr>
</tbody>
</table>

However, at the time of the inspection, the medical staffing on the unit had changed. The issues with consultant staffing were highlighted during the last inspection. Three long-term locums, who were appointed following the last inspection, had left. Currently there were 3.5 permanent consultants working on the critical care unit.

We were informed at the time of the inspection of the appointment of two additional consultants, who were to take up their post in the near future.

We looked at medical rotas for July to September 2018 during the inspection. We saw evidence the medical rota was filled by some short-term locums and that there were some gaps on the rota, whereby only one consultant was present. There was a total of 20 shifts where only one consultant was on duty during these three months. This meant that the outreach team did not have access to a consultant to review deteriorating patients on wards or on their tracheostomy and follow up ward rounds. This was not in line with Faculty of Intensive Care Medicine (FICM) guidelines.

When two consultants were on duty, the level of cover met Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS) standards. However, when there were gaps in the rota, consultant cover was below the FICM guidance ratio of 1:15.

All the doctors we spoke with on the unit told us it was very difficult to provide safe and effective care when there was only one consultant on duty.

The clinical lead informed us that patient numbers should be limited to 15 when there was only one consultant on duty and this had been discussed at the critical care delivery group meeting.
However, reducing bed numbers had not been formally approved by the trust and we did not see evidence that patient numbers on the unit was limited to 15 when there was only one consultant on duty.

There were two doctors (trainee or middle grade level) and one junior doctor on each day shift but the junior doctors did not work on the night shift.

There was not always an airway trained doctor on each shift but, staff told us they would usually contact the anaesthetic doctor, who was airway trained, if required.

The clinical lead told us one consultant has recently been appointed and was due to start soon after our inspection. Moreover, interviews were planned for the week after our inspections for locum consultants post.

There was a sustained reliance on locum staff to fill medical rota. Data submitted by the trust for the period of July 2017 to June 2018 is shown below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Locum shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>167</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Middle grade</td>
<td>184</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>8</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>359</td>
<td>10</td>
<td>31</td>
</tr>
</tbody>
</table>

*Source: Routine Provider Information Request (RPIR) – Total staffing tab*

**Records**

Relevant information related to each patient’s critical care admission was documented in paper medical records kept at the patient’s bedside.

We reviewed five sets of patient notes and found records were clearly written and dated, with legible signatures. Patient records recorded evidence of input from nurses, doctors and other allied health professionals. Patients had their care needs risk assessed and appropriately recorded, with risk assessments completed including nutritional risk assessment, venous thromboembolism and other care bundles.

Although we did not see twice daily ward rounds the trust told us following the inspection that they did occur. However, we did not find documentation relating to a second ward round daily in the records we looked at. We also saw that some of the notes were in a poor condition with records not filed in a contemporaneous manner. Staff told us this because the critical care unit ward clerk post had been vacant for the last three months.

We saw that some of the documentation was not in line with trust policies. For example, delirium screening was not documented in most of the records we reviewed. We records did not include stickers for the equipment used when inserting nasogastric tubes, despite the matron and dietician informing us this was the expectation.
Medicines

Medicines were stored securely, including intravenous fluids and medicines required to be stored in a refrigerator. We saw that all controlled drugs were stored in wall-mounted units and the keys to these cupboards were kept with the nurse in charge, when not in use. Some staff reported accessing the keys from the nurse in charge was at times an issue as it meant leaving their specific area and could potentially lead to delays.

Staff checked the temperature of the fridge used to store medicine daily and were aware of the process they should follow should the temperature be outside of the normal range.

We found a freezer, with a broken door, which contained bags of fluids. Staff told us this freezer had been out of use for some time. We highlighted this to the matron, who confirmed that the fridge should have been removed from the unit and assured us he would take the necessary actions to arrange this.

Medicines were stored in each area to allow for easy access. Staff told us cupboards used to store medicines were colour coded according to the colour of the key which opened specific cupboards.

However, the labels on the cupboard aimed at indicating the colour of the key were not plain. It stated the name of medication, which were not necessarily stored in that specific cupboard. For example, we asked staff to open a cupboard labelled atropine but found potassium inside. This could lead to serious medicine errors, especially for bank and agency staff that may not be familiar with the environment. We discussed this with the matron and pharmacist and they both acknowledged the risk, although they had not identified this prior to the inspection.

We reviewed four paper-based prescription charts and saw they were fully completed, including details of any missed doses. Allergies were also clearly documented.

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.

From June 2017 to May 2018, the trust reported one incident classified as a never event for critical care. The incident occurred in January 2018 at the Queen Elizabeth Hospital and was for a retained foreign object post procedure.

The senior staff told us the incident had been fully investigated and the learning had been shared during team meetings and handovers.

We also saw evidence from team meeting minutes that learning from this incident was shared with staff.

The medical staff we spoke with during the inspection were aware of this never event and told us the incident and the learning from it had been shared to all medical colleagues. However, some of the more junior nursing staff were not aware of this never event.

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in critical care which met the reporting criteria set by NHS England from June 2017 to May 2018. The SI was the same patient safety incident reported in the never events section above.

(Source: Strategic Executive Information System (STEIS))
Safety thermometer

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 collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 25 new pressure ulcers (grade 2) and one Grade 3 pressure ulcer which was classified as unavoidable, between August 2017 and August 2018. There were no falls with harm and no new catheter urinary tract infections during this same period.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The critical care unit contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.

Policies and guidelines were accessed by staff via the intranet, although some printed copies were available at each bedside in for quick reference. However, when we reviewed these bedside folders, we noted that a number of policies were past their review dates and some guidance was not version controlled or dated. This meant that staff could potentially be accessing out of date information.

Nurses adopted link roles in certain areas, such as pressure area care and infection control. Link nurses attended meetings and training with specialist teams and used critical care meetings and training days to deliver up to date information and guidance. They also acted as a daily resource for their colleagues.

Staff used national Sepsis 6 and National Institute for Health and Care Excellence (NICE) guidance to assess for sepsis and to provide treatment. There was an up to date local sepsis policy in place that reflected national best practice and had been updated to accommodate national changes.

All patients received daily physiotherapy as required by NICE guidance and intensive care society standards. All patients were screened within 24 hours and their rehabilitation needs were identified at the time. Rehabilitation progress was measured using the evidence-based Chelsea Critical Care Physical Assessment Tool (CPAx) and the Manchester Mobility Scale, so patient progress could be monitored.

We saw that staff used specific ‘care bundles’ based on national best practice guidelines. Care bundles in use on the unit included ventilator acquired pneumonia (VAP), venous thromboembolism (VTE) and catheter care. We saw compliance with the care bundles was audited monthly with good compliance scores.
Nutrition and hydration

Patients’ nutrition and hydration needs were assessed on weekdays by nursing staff and the dietician during the ward rounds. We saw evidence of comprehensive assessments from the dietician in two of the records we reviewed, with clear feeding regimes in place. At weekends, nursing staff were responsible for initiating enteral feeding if required. We saw there was a clear pathway and algorithm to guide nursing staff.

A recent audit conducted by the critical dietician showed that all patients admitted to the unit started enteral feeding within 24-48 hours.

We observed fluid monitoring recorded on the patient records and staff told us patients on a fluid restriction were highlighted during the handovers.

When reviewing patient records, we saw there was consistent input from dieticians and speech and language therapists were involved, when required. Staff from each team worked together to assess each patient’s dietary needs, including risks for malnutrition and dehydration.

Patients we spoke with said they were happy with the quality and frequency of food. One relative said that it had been difficult to obtain a gluten free meal when their relative was admitted in the evening but the dietician went through the menu with them the next day to clarify the options they could choose.

Pain relief

Pain relief was managed primarily by consultants on critical care, although input from the specialist pain management team was available on request.

We saw staff monitored patients’ pain levels through regular recording of pain scores. Staff used a non-verbal pain assessment to establish individual pain needs when a patient was not able to communicate verbally. This included by interpreting body language and facial expression. Where patients were ventilated, staff used the Richmond Agitation-Sedation Scale to assess pain.

However, we observed a patient admission to the unit where the patient was complaining of severe pain and staff continued with the transfer of the patient from the trolley to the bed, without first administering any pain relief. That patient told us they did not feel their pain was well managed initially but, had improved subsequently.

Patient outcomes

The trust contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of the care delivered and the patient mortality could be benchmarked against similar units nationwide. We used data from the 2017/18 Annual Report.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The unit had an audit nurse who was responsible for completing data entry for audit information including the ICNARC database.

For the critical care unit at the Queen Elizabeth Hospital, the risk adjusted hospital mortality ratio (all patients) in 2017/18 was 1.1. This result was within the expected range and based on 810 admissions. The figure in the 2016/17 annual report was also 1.1.

For the critical care unit at the Queen Elizabeth Hospital, the risk adjusted hospital mortality ratio
patients with a predicted risk of death of less than 20%) in 2017/18 was 1.5. This result was within the expected range and based on 521 admissions. The figure in the 2016/17 annual report was 1.3.

ICNARC data showed that unplanned readmission to critical care within 48 hours of discharge was 1.8%. This was worse when compared with results for similar units and nationally; which were 1.3% and 1.1% respectively.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Competent staff

From April 2017 to March 2018, 91.6% of required staff within critical care at Queen Elizabeth Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group is in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>75</td>
<td>69</td>
<td>92.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>6</td>
<td>5</td>
<td>83.3%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>83</td>
<td>76</td>
<td>91.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not submit appraisal and revalidation data for medical staff in critical care.

According to the Faculty of Intensive Care Medicine (FICM) core standards training requirements, 50% of qualified nursing staff in intensive care units should have a post registration award in critical care nursing. We saw evidence the unit was meeting this requirement but the senior nursing staff told us it was becoming increasingly difficult to access enough places on the course due to funding issues. However, the team had been very proactive and used some charitable funds money as well as research participation grants to fund additional places. The practice development nurse told us being able to secure funding for the training was a worry year on year.

Nurses appointed to the unit spent their first six weeks as supernumerary members of staff, which was in accordance with FICM requirements. This period was to allow adequate time for registered nurses to develop basic skills and competencies to care for a critically ill patient.

We saw evidence all newly appointed nurses received an induction and competency pack. The nurses were then allocated a mentor who was responsible for signing off their competencies, prior to working independently.

The training and development programme in place supported nurses through each step of the National Competency Framework for Adult Critical Care Nurses. This programme consisted of in-house training and assessment as well as attendance at university modules.

Nurses and healthcare assistants received regular supervision and annual appraisal and said they found these to be useful processes to reflect on their progress and to identify their training needs.

There was a full time practice development nurse in post and additionally one of the band 6 nurses on the unit rotated in the practice development post every six months. The nurses on the unit spoke very highly of the practice development team and the training and support they provided.
Staff we spoke with told us that they felt well supported by their manager and were able to ask for additional development opportunities.

Doctors, other than consultants, told us the training programme on the unit was not well structured and they did not feel the formal teaching was adequate. There was no consultant led teaching due to consultant vacancies although some of the trainee delivered training for the junior doctors.

However, the doctors felt they received good informal teaching during ward round and handovers.

Due to the difficulties the trust had experienced in recruiting permanent consultants, there was of locum consultants covering a large proportion of the rota. Staff were unable to tell us of the induction the locum consultants received to ensure they were practicing in line with trust policies and guidelines. The clinical lead did not have oversight of any performance issues with locum consultants and told us they would rely on nursing staff escalating such issues.

**Multidisciplinary working**

At the last inspection, we noted the unit did not have a multidisciplinary team meeting (MDT). During this inspection, we saw that the physiotherapists had taken the lead in setting up a weekly MDT, where patients who has been on the unit for four days or more and any complex patients were discussed. The MDT was led by the physiotherapist and attended by nursing staff, medical staff, dietician and pharmacists. Staff discussed and agreed short term and longer-term rehabilitation goals, in line with NICE guidance 83. Staff ensured that patients’ emotional, social and psychological needs were also considered.

The critical care unit did not have dedicated occupational therapist (OT) cover and staff told us the physiotherapists led rehabilitation on critical care and would usually make the referral to OT when needed.

We saw evidence of good multidisciplinary working between staff on the unit. Staff told us there was a friendly and supportive working environment and we saw nurses and allied health professionals (AHP) demonstrated good communication and effective teamwork. Staff we spoke with described the teamwork as “fantastic” and spoke highly of their colleagues and the quality of their work.

Doctors worked collaboratively with nursing and physiotherapy staff to plan and implement ventilator weaning programmes (when patients’ reliability on breathing machines is reducing and they are able to do more breathing on their own).

AHPs told us there had been a marked improvement in multidisciplinary team (MDT) work in the last year. They felt that their opinions were actively sought and valued.

Intensive Care Society (ICS) recommendations state that there should be a minimum ratio of one physiotherapist to four patients. The CCU was funded for 2.5 WTE physiotherapists and was therefore just meeting this recommendation. However, physiotherapy staff could not always attend the daily ward rounds due to staffing numbers.

Therapist and nursing staff worked collaboratively to implement rehabilitation plans for each patients and we saw nursing staff and therapists working together to complete patient care tasks and rehabilitation during the inspection. For example, nursing staff were responsible for putting patients on the cycle programme in the afternoon, as directed by physiotherapist. We saw evidence this was happening in the records we reviewed.
Seven-day services

A consultant intensivist was available on-site within one hour of being called for high risk patients 24-hours, seven days a week.

Microbiologists and radiologists were available Monday to Friday with on-call services available out of hours.

The critical care outreach team provided services 24-hours, seven days a week.

There was 2.5 WTE physiotherapy staff on weekdays with other staff rostered to provide cover at weekends. The team provided a full respiratory and rehabilitation service, including an on-call respiratory service out of hours.

Health promotion

Staff signposted patients to specialist and community health services on discharge. This included smoking cessation and drug and alcohol services, as required.

Staff provided guidance on health promotion strategies including for good mental health at the follow up clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

Queen Elizabeth Hospital

A breakdown of compliance for MCA training courses from April 2018 to July 2018 for staff in the critical care department at Queen Elizabeth Hospital is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In critical care at Queen Elizabeth Hospital, nursing staff met the 85% target for MCA training.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care at Queen Elizabeth Hospital, medical staff did not meet the 85% target for MCA training.

Doctors completed mental capacity assessments with patients whose capacity to make decisions was in question. Specific capacity assessments were completed when key decisions about the patients’ care were needed and best interests decisions were made when the patient was unable to consent.
Staff we spoke with were familiar with DoLS, and demonstrated a good understanding of consent and mental capacity. We saw evidence of a risk assessment and capacity assessment for the use of mittens in patient records.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Is the service caring?**

**Compassionate care**

All the patients, families, and friends we spoke with were happy with the care and treatment they received on the unit. Some patients called the staff “fantastic” and “gentle and caring.” Another family said they “could not have wished for anything better” and they would not change anything.

The relative of a patient with learning difficulties told us how staff had been understanding and patient and the ‘care and treatment had been excellent.’

Other relatives told us they were always welcomed on the unit and staff spent time explaining ‘all the machines and what they are for.’

We observed several interactions between staff and patients; we saw staff speaking to patients in a calm and reassuring manner, and listened to what patients had to say.

The critical care unit participated in the friend and family test (FFT) and we saw that between May and August 2018, over 90% of people who responded said they would recommend the unit.

We noted many thank you cards and letters received from patients praising the care they had received were displayed on the unit. These included compliments from relatives where their family member died. They referred to the extreme kindness demonstrated by staff when their relatives were on the unit and following their death.

Patient’s privacy and dignity could at times be compromised due to the environment. Beds were within close proximity of each other and conversations could be easily overheard.

**Emotional support**

Nurses and doctors told us they recognised that the environment of the critical care unit could be intimidating and because of that, they reminded each other to take time to explain and give reassurance to patients and relatives alike.

There were two quiet rooms, one on the unit and one outside, that staff could use to relay sensitive information to relatives.

A multi-faith spiritual team was available to provide support within the hospital 24 hours per day. Feedback from patients and relatives was positive and they told us staff had been reassuring and comforting during difficult times.

Staff told us they were unable to access psychology support for patients on the unit and if they were concerned about a patient, they would have to refer to the psychiatric liaison team.
There was also a lack of information on external organisation offering support for patients and relatives, who have experienced a critical care stay. Staff did not signpost patients and their relatives to these organisations.

**Understanding and involvement of patients and those close to them**

Patients told us staff always kept them informed of the treatment plans and staff explained any test they were due to have. During the ward round, we observed the medical team interacting with the patients who were awake and explaining their treatment.

A relative of patient with learning disabilities told us on admission doctors had initially asked them to wait outside and they had to be assertive and explain that they needed to be present to calm the patient and help them understand what was happening. They were then allowed to be present throughout any medical intervention.

Staff told us they used patient diaries on the unit and encouraged visiting relatives to input into these. We saw two examples of patient diaries but noted these only contained information written by staff and did have personal items such as pictures.

Relatives and patients told us staff always introduced themselves and explained their roles when they first arrive on the unit.

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**Is the service responsive?**

**Service delivery to meet the needs of local people**

The critical care unit served a combination of specialities, including post-operative surgical patients and medical patients. ICNARC data for the year 2017/18 showed that the large majority of patients (78.2%) admitted to the unit were non-surgical emergency admissions. Only 4.2% of patient admitted that year were booked admissions following elective surgery.

Staff told us there was a booking process for surgeons to book a critical care bed and there had been no cancellation of elective surgery due to unavailability of critical care bed in the last year.

The unit was commissioned to provide 18 critical care beds, which they used flexibly to accommodate level 3 and level 2 patients. The unit had an additional unfunded escalation bed, which could be utilised for short period of time when the unit was at capacity.

A critical care outreach team (CCOT) supported the unit 24 hours a day seven days a week with two nurses on duty day and night. The CCOT were responsible for supporting ward staff with all aspects for the critically ill patient-pathway including early identification and assessment of patients requiring admission to the unit and follow-up post discharge.

**Meeting people’s individual needs**

There was limited information available to relatives about local charities where they could obtain support. All the leaflets available on the unit were in English, although staff told us they could request leaflets in other languages, if required.

A translation service was available for patients who did not speak English as their first language. Staff could access interpreters via the telephone or make bookings for interpreters to attend face-to-face meetings.
Psychiatric support was available on request and staff told us they could obtain support from the team quickly if needed.

Despite having a large number of delayed discharges, the unit minimised mix sex breaches by caring for male and female patients in separate areas of the unit, whenever possible. We did not see evidence of mix sex breached being recorded as incidents and the unit was not collecting data on the number of mix sex breaches.

Patients, who were well enough, were able to access disabled toilet facilities on the unit. However, there were no washing facilities for patients on the unit.

The hospital did not have accommodation on site for relatives who lived a significant distance away or who had difficulties accessing the hospital while patients were admitted. Staff told us relatives were encouraged to go home and rest but would be were allowed to stay in the quiet room, in special circumstances, such as when a patient is at the end of life. We saw there was no drink making facilities available for relatives, who may be sending long periods on the unit.

Food menus offered a range of options including healthy option, softer choices, and vegetarian, kosher, halal. However, staff and patients told us the choice for special diets such as pureed or gluten free was often limited. We were informed the catering services was out to tender at the time of the inspection.

The critical care unit did not currently have funding to provide a multidisciplinary follow up clinic as recommend by FICM standards. There was currently a nurse led clinic in place and patients were invited to attend to discuss their stay on the unit and any ongoing issues they may be experiencing. We saw that between January to September 2018, 77 patients were invited to the follow up clinic but only 23 attended. Staff told us they were in the process of developing a business case for an MDT clinic.

**Access and flow**

From May 2017 to January 2018, the adult critical care bed occupancy for the trust was lower than or similar to the England average. In February 2018, 100% bed occupancy was reported, compared to the England average of 85.4%. Following this spike in the bed occupancy, there was a downward trend: 86.5% in March 2018 (England average 82.6%), and 71.4% in April 2018 (England average 82.0%).

Please note, data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

**Adult critical care Bed occupancy rates, Lewisham and Greenwich NHS Trust.**

![Graph showing bed occupancy rates](image)

*(Source: NHS England)*
According to the Faculty of Intensive Care Medicine (FICM) core standards, discharge from intensive care to a general ward should occur within 4 hours of the decision. Patients must be moved to a more suitable environment without unnecessary delay and there should not be a non-clinical reason preventing such a move.

For the critical care unit at the Queen Elizabeth Hospital, there were 6,570 available critical care bed days in 2016/17. The percentage of bed days occupied by patients with a discharge delayed more than eight hours was 8.0%. This compares to the national proportion of 4.9% (England, Wales and N. Ireland). The figure in the 2016/17 annual report was 6.2%.

6.2% of patients were discharged straight to home compared with 8.9% in similar units and 5.7% nationally. This meant that during their wait for a bed on a ward, the patient’s condition improved sufficiently so they no longer required continued hospital admission.

Senior staff on the unit told us delayed discharges was still an issue due to unavailability of beds on the wards. Senior nursing staff now attended the bed meetings three times a day to continually liaise with the site management team and facilitate transfers to the wards.

Staff also submitted data on the number of available critical care beds between this site and the critical care unit at UHL twice a day. Staff told us that if the unit was at capacity, they would start planning potential transfers to UHL critical care unit.

All staff recognised that delayed discharge was a big issue and this was included on the critical care risk register. However, staff told us they were usually able to admit patients requiring critical care onto the unit in a timely manner. Data submitted by the trust showed that 11 patients had their admission to critical care delayed for four hours or more due to unavailability of beds in the last 12 months.

For critical care unit at the Queen Elizabeth Hospital, of the 857 relevant admissions in 2017/18, 0.2% had a non-clinical transfer out of the unit. This was comparable to similar unit and nationally. The figure in the 2016/17 annual report was 2.6% and the unit had been an outlier for this metric.

Of the 513 relevant admissions in 2017/18, 0.6% were non-delayed, out-of-hours discharges to the ward (these are discharges which occurred between 10:00pm and 6:59am). This was significantly lower when compared to similar units (2.6%) or nationally (2.0%). The figure in the 2016/17 annual report was 2.9%.

(Source: Intensive Care National Audit Research Centre (ICNARC))
Learning from complaints and concerns

From April 2017 to March 2018 there were five complaints about critical care services.

The trust took an average of 42 working days to investigate and close complaints for this service.

The trust had not responded to complaints within the target period of 25 working days as specified in the trust complaints policy.

The breakdown of complaints about critical care services by subject and location is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Queen Elizabeth Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>3</td>
</tr>
<tr>
<td>Patient Care</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From April 2017 to March 2018, there were no compliments recorded for critical care at Queen Elizabeth Hospital site, although we noted many thank you cards praising staff for the care received on the unit.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Critical care was part of the surgery, theatres and critical care division. The divisional leadership team consisted of a divisional manager, a divisional clinical director and heads of nursing.

The local leadership team comprised of a head of nursing, matron and clinical lead. Staff described the matron as visible, approachable, supportive and proactive. Band 7 nurses were responsible for overseeing the day-to-day management of the critical care unit and were allocated as the supernumerary nurse in charge of each shift. Each band 7 nurse managed a team of band 5 and 6 nurses and was responsible for their appraisals and supervision.

The clinical lead at the time of the inspection was interim and had been in post since April 2018. We were informed the substantive clinical lead was currently on sabbatical. Most of the staff we spoke with told us they had not met the clinical lead and were unclear of his role on the unit.

Senior staff on the unit told us the medical leadership was disengaged, as the clinical lead did not attend the critical care unit at Queen Elizabeth Hospital. We interviewed the clinical lead, who confirmed he was based at University Hospital Lewisham and was unable to have full oversight of the unit or provide direct leadership and support to the medical staff working on the unit.

Our last inspection and the South London critical care network peer (2017) review highlighted a lack of medical leadership and during this inspection staff told us and we saw that this was still the case. Although action plans were developed following the peer review, progress has been slow due to the high number of consultant vacancies and reliance on locum staff. The current lead did not have allocated time in the job plan to lead the critical care team cross-site and had not visited...
the QEH critical care unit. The interim divisional manager acknowledged this and informed us there was a consultation underway to propose adding additional leadership sessions to the job plan of clinical leads and clinical directors.

**Vision and strategy**

The last inspection highlighted the absence of a strategy and vision for the critical care unit. During this inspection, staff were unable to tell of the vision and strategy, other than some plans for a new unit. We requested the strategy document for critical care but this was not provided.

The leadership team told us the vision was to harmonise clinical guidelines, practice across the two sites, and improve cross-site working relationships. All new consultants post were advertised as cross-site working and the leadership team felt this would enhance the sharing of best practice and learning in the trust.

Staff were aware of the trust values and how the new chief executive and chief nurse were currently gaining staff feedback to review these values.

**Culture**

We found the culture on the critical care unit was one of openness in which staff from all disciplines interacted well with each other. Senior nursing staff spoke of the strong commitment to equality and diversity on the unit.

Nursing staff commented that there was a culture of ‘no blame’ from the nursing leads. Everyone was encouraged to learn from incidents and staff said the individual feedback they received after any incident was constructive and helpful.

Staff told us the matron was very supportive and interested in staff wellbeing. All staff were asked to rate each shift they had worked as green, amber or red. Staff told us the matron and senior nurses reviewed the feedback card and spoke to individual staff to address any concerns raised.

We saw that senior nursing staff encouraged and supported junior staff and that ward rounds were used as an opportunity to share knowledge and develop skills. This was done in a way that gave confidence to those who were less experienced. Staff told us they felt their opinion was valued.

The medical staff we spoke with told us they received support from the consultants on duty and other senior staff.

**Governance**

Since the last inspection, the unit had introduced a weekly multidisciplinary meeting, which included morbidity and mortality (M&M) discussion and current challenges presented by complex patients in the unit. The team reviewed each patient death at the meeting and included staff at all grades in discussions of the events leading to their death as a strategy to identify opportunities for learning.

All senior staff and members of the wider MDT working on critical care attended a monthly governance meeting. We attended one of these meetings during our inspection and we saw that staff discussed all incidents, complaints as well as review performance of the unit. The risk register was also reviewed as part of the meeting. Any items or issues identified from the critical care
A governance meeting that require escalation were discussed at the monthly surgical divisional governance meetings.

We looked at previous minutes of these meetings and noted that the clinical lead was not in attendance. We were told the governance for the critical care unit at this site had been delegated to one of the consultants, who attended this meeting regularly.

The critical care delivery group had been re-instated following the peer review in 2017 to oversee quality and safety of the critical care unit across both sites.

There were still no regular cross-site meetings for consultants, which limited the opportunity for cross site learning and sharing of information.

**Management of risk, issues and performance**

The senior team used a risk register to identify, track and mitigate risks. We reviewed the version of the critical care risk register submitted by the trust and found the contents largely reflected our inspection findings, for example consultant vacancies, the environment and delayed discharges.

The leadership team acknowledged that consultant recruitment was one of the top risks for the unit. Concerns highlighted during a peer review and the last inspection included the patient to consultant ratio, long-term consultant vacancies and a lack of medical leadership. Although there had been some improvement in the months preceding our inspection, we found these concerns were again present at the time of the inspection and we were not reassured that the leadership team had a long-term plan on how to address these. The short-term plan was to reduce the number of patients on the unit to 15 when there were gaps in consultant rota. However, it was unclear how the unit would practically manage this day to day and what impact this would have on patients requiring critical care admission. The senior staff acknowledged this would still leave the critical care outreach team with no consultant support, which was not in line with FICM standards.

Although the critical care delivery group met on a monthly basis, we saw from the minutes of the meeting and the action log that some actions had been open since April 2018 and there were no realistic timescale set to address these issues. For example, ‘To complete a risk admission for WTE consultant intensivist vacancies to increase the risk score on the register’ was open since April with no updates available on progress made to date. Another action open since April was ‘to develop a model for quality rounds on critical care’ and this was still not in place at the time of our inspection.

The last inspection highlighted that there was no approved standard operating procedure (SOP) for the outreach service as well as no admission policy for the critical care unit. Staff we spoke with during the inspection were unaware if these documents were in place. We requested these documents and the trust submitted both of these documents in draft formats as these were awaiting approval from the quality and safety committee. It was unclear when these SOPs would be presented to the committee.
Information management

Staff we spoke with told us they were able to access the information they needed to provide safe and effective care. Patient records were mostly in paper form.

Staff stored paper medical records securely when not in use in areas with restricted access. We saw staff locked computer screens when not in use, which helped to prevent unauthorised access to confidential information.

We saw staff completed incident forms when they observed lapses in information management. For example we incident form was completed when records belonging to a patient was misfiled in another patient records.

All staff had access to their work email and we were shown that they received organisational information on a regular basis including updates and changes to policy and procedures.

Engagement

The matron and band 7 nurses held monthly team meetings with the critical care nursing team and staff told us their opinion and ideas for improvement was actively sought. Staff told us the matron kept them fully informed of risks and mitigating plans in place. We saw a copy of the risk register was available in the staff room.

A patient representative had been invited to attend a recent critical care meeting and had provided feedback to staff as well as assisting with the development of a patient information leaflet.

The nurse running the follow up clinic also emailed staff to feedback on each patient that had attended the session. Staff told us it was nice to hear the progress the patients had made since discharge as well as receiving their feedback.

Staff also told us the chief executive and director of nursing held regular forums to engage staff in the vision values of the trust.

Learning, continuous improvement and innovation

The critical care unit was actively participating in a number of research studies and had recently recruited a research nurse.

The unit was also participating in the Get It Right First Time (GIRFT), a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations.

The training programme for all nurses on the unit was in line with the National Competency Framework for Adult Critical Care Nurses.
Maternity

Facts and data about this service

We inspected Queen Elizabeth Hospital maternity services during an announced visit on 25 and 26 September 2018.

The trust has 148 maternity beds across two sites:

- 73 beds at Queen Elizabeth Hospital
- 75 beds at University Hospital Lewisham

Queen Elizabeth Hospital

The maternity service at Queen Elizabeth Hospital consists of an obstetric-led delivery service, a midwife-led birth centre and maternity ward (antenatal and postnatal). There is a day assessment unit and antenatal clinic. The 73 maternity beds at the hospital are made up of:

- 31 beds on the maternity ward
- 21 beds on the obstetric delivery suite
- 9 beds on the midwife-led birth centre
- 7 beds on the day assessment unit
- 5 beds on the antenatal clinic

Community-based midwifery services

The community-based maternity service for the trust catchment area provides services to women living in the Greenwich, Bexley and Lewisham local authority areas. Antenatal and postnatal care is provided in children's centres and GP surgeries, and in woman's homes.

Specialist maternity services

The trust provides specialist antenatal services for diabetes, for women with raised BMI ('Pregnancy Plus') and for women with additional vulnerabilities including alcohol / drug misuse, homelessness and social care concerns from the obstetric-led units. There is also specialist provision through a satellite clinic at Queen Mary’s Hospital, Sidcup.

Two consultant midwives, one based on each main hospital site, offer additional care to women with complex conditions and women birthing outside of guidance.

(Source: Routine Provider Information Request – sites tab; and Acute context)

Deliveries

From January 2017 to December 2017, there were 7,966 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.
A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

### Profile of all deliveries (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>Lewisham and Greenwich NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7,814</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>119</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother's age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>213</td>
<td>2.7%</td>
</tr>
<tr>
<td>20-34</td>
<td>5,557</td>
<td>70.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>1,765</td>
<td>22.2%</td>
</tr>
<tr>
<td>40+</td>
<td>398</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7,933</td>
<td></td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

### Gestation periods (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>Lewisham and Greenwich NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Gestation period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>10</td>
<td>0.1%</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>495</td>
<td>7.1%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>6,408</td>
<td>92.2%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>37</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,950</td>
<td>498,704</td>
</tr>
</tbody>
</table>

The trust has a higher number of older mothers at the trust compared to the England average, with 27.2% being 35 or over, compared to 22.1%.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

**Number of deliveries at Lewisham and Greenwich NHS Trust by quarter**

![Graph showing the number of deliveries per quarter from 2015/16 Q4 to 2017/18 Q3.](image)

From January 2016 to December 2017, the count of deliveries in each quarter (2016/17 Q4 to 2017/18 Q3) is lower than the count of deliveries in the corresponding quarter of the first 12 months (2015/16 Q4 to 2016/17 Q3).

(Source: HES - Deliveries (January 2016 - December 2017))

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.
Mandatory training

Mandatory training for staff in the maternity unit did not always meet the trust targets. The trust set a target of 85% for completion of mandatory training.

The maternity leads told us of the difficulties in getting mandatory training rates to meet the trusts target of 85% due to the high number of staff on current maternity leave. As a result, the maternity service was looking at a number of ways to resolve this including allowing staff members to access the mandatory training system from home. Staff recognised the improvements required to ensure compliance with trust targets.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 at trust level for staff in maternity is shown below:

Nursing and midwifery staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>299</td>
<td>335</td>
<td>89.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>298</td>
<td>335</td>
<td>89.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>295</td>
<td>335</td>
<td>88.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>285</td>
<td>335</td>
<td>85.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>280</td>
<td>335</td>
<td>83.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>273</td>
<td>335</td>
<td>81.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>273</td>
<td>335</td>
<td>81.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>267</td>
<td>335</td>
<td>79.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>237</td>
<td>335</td>
<td>70.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus – HLS/NLS maternity</td>
<td>229</td>
<td>332</td>
<td>69.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>197</td>
<td>335</td>
<td>58.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and harassment</td>
<td>5</td>
<td>11</td>
<td>45.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for five of the 13 mandatory training modules for which qualified nursing staff were eligible.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>65</td>
<td>73</td>
<td>89.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>54</td>
<td>73</td>
<td>74.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>54</td>
<td>73</td>
<td>74.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>53</td>
<td>73</td>
<td>72.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>48</td>
<td>73</td>
<td>65.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>48</td>
<td>73</td>
<td>65.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>37</td>
<td>73</td>
<td>50.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>34</td>
<td>73</td>
<td>46.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>34</td>
<td>73</td>
<td>46.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>26</td>
<td>73</td>
<td>35.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
In maternity the 85% target was met for one of the 10 mandatory training modules for which medical staff were eligible.

**Queen Elizabeth Hospital**

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the maternity department at Queen Elizabeth Hospital is shown below:

### Nursing and midwifery staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management</td>
<td>150</td>
<td>164</td>
<td>91.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>144</td>
<td>164</td>
<td>87.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>142</td>
<td>164</td>
<td>86.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>137</td>
<td>164</td>
<td>83.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>134</td>
<td>164</td>
<td>81.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>134</td>
<td>164</td>
<td>81.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>131</td>
<td>164</td>
<td>79.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>130</td>
<td>164</td>
<td>79.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus – HLS/NLS maternity</td>
<td>129</td>
<td>164</td>
<td>78.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>111</td>
<td>164</td>
<td>67.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>104</td>
<td>164</td>
<td>63.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and harassment</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital maternity department, the 85% target was met for three of the 12 mandatory training modules for which qualified nursing staff were eligible. Senior staff told us the training year ran from April till March so there was a number of months left for staff to complete their mandatory training and show as compliant. Some of the mandatory training was completed yearly and others were two or three yearly. Senior staff told us that they were on track to show compliant for the year in a number of training subjects.

### Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>27</td>
<td>33</td>
<td>81.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>25</td>
<td>33</td>
<td>75.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>24</td>
<td>33</td>
<td>72.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>21</td>
<td>33</td>
<td>63.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>16</td>
<td>33</td>
<td>48.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>14</td>
<td>33</td>
<td>42.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>13</td>
<td>33</td>
<td>39.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>13</td>
<td>33</td>
<td>39.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>11</td>
<td>33</td>
<td>33.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>10</td>
<td>33</td>
<td>30.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital maternity department, the 85% target was not met for any of the 10 mandatory training modules for which medical staff were eligible.
Safeguarding

Safeguarding processes were used by staff to keep adults and babies safe from avoidable harm. All of the staff we spoke to were able to give detailed explanation of their duties in relation to safeguarding concerns. The staff we spoke with were able to confidently inform us of what a safeguarding concern would be and their process for reporting this. Female Genital Mutilation (FGM) and domestic violence were some of the issues that had been identified and reported by maternity staff. The trust intranet had contact details for staff requiring further advice or support with safeguarding referrals.

The service had a ‘Best Beginnings’ team which consisted of staff trained in specific areas. As part of this team the maternity unit had a dedicated safeguarding lead midwife who reported to the head of midwifery. The safeguarding lead was a point of contact for all other staff and provided updates, training and awareness of subjects associated with safeguarding. Staff told us letters were sent to all expectant women advising they would need to attend at least one midwifery consultation alone without any partner or relative present. A protected 15 minutes at the start of maternity consultations allowed staff to ask questions relating to matters such as abuse, domestic violence and FGM and any other safeguarding concerns without partners being present.

The staff were able to demonstrate learning and improvements in practice from the investigation of serious incidents. All staff received email, a monthly newsletter and discussions during meetings where issues relating to safeguarding were discussed. This gave staff an opportunity to learn from safeguarding incidents to help improve awareness and practice going forward. Staff were able to show us learning from safeguarding incidents and spoke positively about the importance of learning from these.

The lead midwife for safeguarding told us an increase in safeguarding referrals had been around drug and alcohol abuse, domestic violence and forced pregnancy. Therefore, other midwives took on the role of being specialist in each of these areas to ensure there was a point of contact for other midwives. Each of these specialised midwives shared learning with other staff through open workshops where staff could gain knowledge and understanding of some of the safeguarding issues prominent in the local demographic area.

Staff received training in process, best practice and safety systems in relation to safeguarding adults and babies. All midwives were required to be trained to Safeguarding adult’s level two and safeguarding level three for children and young people.

We spoke to senior staff regarding their safeguarding mandatory training figures. We were told that due to a high number of staff being on maternity leave it was challenging to get their figures to the trusts own target. Senior staff told us they were working with staff to allow them access to the trusts e-learning system from home so they could complete their training whilst away from the unit.

The trust set a target of 85% for completion of safeguarding training.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted.
to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust submitted the following information on their safeguarding referrals within the maternity services at Queen Elizabeth Hospital.

<table>
<thead>
<tr>
<th>Date</th>
<th>Total Bookings</th>
<th>Maternity Safeguarding Notifications</th>
<th>Multi-agency Safeguarding Hub (MaSH) Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2018</td>
<td>396</td>
<td>60 (15%)</td>
<td>14/60</td>
</tr>
<tr>
<td>August 2018</td>
<td>376</td>
<td>60 (16%)</td>
<td>10/60</td>
</tr>
<tr>
<td>September 2018</td>
<td>Figures not yet available</td>
<td>66</td>
<td>22/66</td>
</tr>
</tbody>
</table>

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 at trust level for staff in maternity is shown below:

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>291</td>
<td>335</td>
<td>86.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - core</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - specialist</td>
<td>230</td>
<td>324</td>
<td>71.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>57</td>
<td>73</td>
<td>78.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - core</td>
<td>50</td>
<td>73</td>
<td>68.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was not met for any of the two safeguarding training modules for which medical staff were eligible. There were a number of months left for staff to gain the required training module before the end of the training year and show as compliant.
Queen Elizabeth Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 for staff in the maternity department at Queen Elizabeth Hospital is shown below:

Nursing and midwifery staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>138</td>
<td>164</td>
<td>84.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - specialist</td>
<td>99</td>
<td>164</td>
<td>60.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital maternity department the 85% target was not met for any of the two safeguarding training modules for which qualified nursing staff were eligible.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>24</td>
<td>33</td>
<td>72.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - core</td>
<td>16</td>
<td>33</td>
<td>48.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Queen Elizabeth Hospital maternity department the 85% target was not met for any of the two safeguarding training modules for which medical staff were eligible.

The trust had a child abduction policy, which was available on the intranet as well as in paper copy form. We checked the paper version was the newest version available on the intranet. Staff we spoke with were aware of the policy and where to locate it.

Cleanliness, infection control and hygiene

Trust wide policies for infection prevention and control (IPC) and hand hygiene were available to guide and support staff. Policies on the internal intranet were version controlled and staff notice boards had the latest version of the hand hygiene policy available. Staff showed us how to access policies relating to IPC and senior staff showed us evidence of completed IPC and hand hygiene audits.

The environment looked physically clean and we observed cleaning staff maintaining good levels of cleanliness in all maternity units. We noticed that on newly cleaned items, a green ‘I am clean’ sticker was used and a date recorded of when the item had been cleaned. Furniture appeared clean and without tears or marks and conformed to the Health Building Note (HBN) 00-09: Infection control in the built environment. We saw breast pumps, birthing pools; Cardiotocography (CTG) monitoring and ultrasound machines which were visible clean. Cleaning schedules were observed on the back of doors and within department areas. The dates showed cleaning had taken place several times daily and when requested by staff.

All areas we visited had personal protective equipment available (PPE), including gloves, aprons, face masks and long gloves for more invasive procedures. We saw cleaning products available for staff to use and these were stocked securely in a locked cupboard.
Women with potential infectious diseases or those that were immune-compromised were cared for in an isolated room away from other women. We saw good practice when staff attended to these women, ensuring they donned the correct PPE before making contact. We saw good hand washing between each woman contact and all staff we saw were bare below the elbows.

Hand hygiene audits were completed monthly. This involved staff being observed washing their hands after contact and ensuring staff were washing their hands according to the National Institute for Health and Care Excellence (NICE) guidance on effective hand decontamination. Women and partners we spoke with commented that they had seen staff cleaning their hands and felt the environment was sanitary.

Waste was managed effectively within the department and we saw evidence that sharps boxes were correctly labelled and sealed. Sharps boxes were filled below the minimum level and segregated correctly. Products of conception were stored in line with guidance in a correctly ventilated environment.

Alcohol-based hand sanitisers were located on the entrance and exits to all maternity units. The sanitisers we checked were full and working correctly. We observed a member of staff asking a relative to use the hand sanitiser prior to entering the ward. Toilet areas were clean and sufficient hand cleaning soap was available.

**Environment and equipment**

Staff told us that they had access to the right equipment for them to carry out their role effectively. Staff said any equipment they required was readily available and stocked within the department. Emergency equipment was easily accessible and was placed in areas where most people congregated such as waiting rooms and on the maternity ward. We saw evidence of re-ordering of equipment in the stock room and staff were clear whose job it was to check the stock and ensure equipment was ordered in a timely manner.

All of the maternity units were accessible by a key card entry system. Staff told us the importance of making sure that nobody else got through the door at the same time they are entering. We saw evidence of this as a member of staff asked someone who they were here to see before opening the locked door, thus ensuring the person did not gain unauthorised entry. Staff showed us the policy for lost key cards and the reporting process for this. Staff assured us that any breaches in security were taken seriously and reported in the correct way.

On-site security was positioned at the entrance to Ward 7 (the main maternity ward) to ensure every women, partner and relative signed in and out upon entry and exit of the ward. Partners and women were asked to minimise the amount of cigarettes they had to ensure they did not disturb other women. Security for the ward was manned between 8am and 10pm, after this the ward manager was responsible for ensuring the correct entry and exit procedure was adhered too. The ward manager had a camera monitor positioned at the nursing station which showed who was at the door awaiting entry.

All equipment we checked was safe tested. Expectant mothers and relatives were asked not to bring personal equipment onto the ward that required plugging into the hospitals electrical socket. If expectant mothers or their relatives did bring in a device that required electricity then the ward manager was able to get this tested by the estates department the same day.

The community midwives had their own equipment which was kept within the maternity unit. The kit included suction units, Entonox gas, suturing sets and other maternity items. We checked to ensure all of the equipment was in date, clean and properly sealed and found this was the case.
The community midwives informed us they had been given a personal safety alarm provided by the trust and it was to become mandatory for all staff to wear these on home visits. There was a buddy system which meant midwives were in contact with their buddies to ensure safety throughout their shift. None of the community midwives we spoke with had dealt with any potential dangerous or hazardous situations. They told us there were adequate safety checks to minimise potential risks. All community based midwives carried a mobile phone.

Assessing and responding to patient risk

We saw evidence of comprehensive risk assessments that had been carried out for women using the maternity service and plans which were developed in line with national guidance. Risk assessments took place at time of booking (around 8-10 weeks of pregnancy). These included social and medical risk assessment as well as booking a consultation with the screening team. The screening team tested high risk women for infectious diseases which could be harmful to mother and baby, such as Human Immunodeficiency Virus (HIV), hepatitis B and syphilis.

There was evidence the use of Modified Early Obstetric Warning (MEOW) score was used and this was recorded in the medical notes of each expectant mother. We reviewed 11 records and nine of these had completed MEOW scores. We saw completed audits which showed staff were compliant in completing these scores correctly. The staff we spoke with were able to tell us the process that happened if a woman had an out of normal range score.

Emergency medications were kept on the birthing centre in a locked but accessible place. Staff told us that they kept emergency medications in case of deterioration in the woman’s health. However, staff told us the priority was to get the woman into a ward or theatres and assured us they did not attempt to manage emergency situations in the birthing centre.

The maternity unit did not have an obstetric theatre located within the department but they did have two dedicated operating rooms located in the main theatre area. The main theatre area was situated next door to the maternity unit and was easily accessible from the labour ward. We checked the two dedicated obstetric theatres and saw emergency medications, obstetric and resuscitation equipment in line with national guidance. The service was compliant with the World Health Organisations (WHO) surgical safety checklist that supported safer care and reduction in patient safety incidents. The maternity lead said these were audited weekly and any learning was shared at joint meetings held between maternity and theatre staff. We reviewed six records which required a WHO surgical checklist and found that all six had it completed appropriately as per guidance.

The maternity lead showed us a transfer policy to be followed by staff in case a mother or baby deteriorated and needed to be transferred to more specialist care. Midwives and medical staff we spoke with were able to tell us about the transfer policy and we saw evidence this was regularly reviewed and criteria existed to ensure staff understood when it was appropriate to transfer a woman to further care. Community midwives told us if a woman deteriorated in the community then an ambulance would be called for them to be transferred to hospital. The community staff we spoke with said they had a good working relationship with the local NHS ambulance trust and felt confident in their ability to attend quickly.

High risk women were discussed at multidisciplinary team (MDT) meetings. We observed one of these meetings, which included a consultant obstetrician, a consultant microbiologist, a registrar microbiologist, a paediatric fetal medicine obstetrician and members of the midwifery and nursing team discussing women on the unit. High risk women had a detailed plan written in their care
notes and each member of staff told us they felt comfortable raising concerns and inputting treatment suggestions during these MDT meetings. We were told these meetings happened weekly and on an ad-hoc basis if women presented with complex needs.

We saw evidence the ‘fresh eyes approach’ had been adopted in the interpretation of cardiotocography (CTG). The Royal College of Midwives provided guidance on the ‘fresh eyes approach’ which aimed at reducing the misinterpretation of CTG readings. Staff told us they took competency of CTG reading seriously and had implemented an annual mandatory training session which tested every member of staff’s ability to read a CTG recording. If a member of staff failed to interpret a reading correctly then an individualised improvement plan was implemented for the member of staff. Staff we spoke with felt positive about this and felt the annual CTG reading competency test was a positive introduction. Staff we spoke with who had been on a CTG interpretation improvement plan felt it was a supportive measure and not punitive. We saw evidence that a buddying system was used in CTG readings. This meant a second member of staff interpreted the CTG reading to see if they agreed with the first person’s interpretation. We saw documented evidence within women’s care notes this had taken place.

Staff we spoke with had training on sepsis recognition and management. There was a sepsis recognition and management policy located on the trust intranet. There was a midwife with specialist knowledge and skills in relation to sepsis who other staff members were able to approach for advice and support. We saw evidence that NICE guideline 51 (recognition, diagnosis and early management of sepsis) had been used effectively and sepsis management tools had been documented within women’s notes. Any potential sepsis patients were discussed with the microbiologist at the earliest opportunity.

**Nursing and midwifery staff**

Safe midwifery staffing for maternity settings (NICE NG4) was used to identify any staffing red flags. Midwifery staffing ratios were determined through the review of activity and a rota administrator was responsible for putting together a rota. This then required sign-off by the matron of the department.

An experienced midwife acted as shift co-ordinator for the labour ward. This role meant the staffing could be adjusted accordingly throughout the shift, allocating staff to higher activity or priority areas. The shift co-ordinator told us that sometimes it was necessary to request staff from the maternity ward to help out on the labour ward. We were assured this would only happen if it was safe for women and no area was left without the minimum required staff.

From January 2017 to December 2017, the trust had a ratio of one midwife to every 25.7 births. This was similar to the England average of one midwife to every 25.5 births, and an improvement on the ratio for the earlier time period from November 2015 to October 2016 of one midwife to every 29.9 births.

*(Source: Electronic Staff Records – EST Data Warehouse)*

The maternity dashboard showed in July 2018 that 100% of women received one to one care from a midwife whilst in established labour.

Senior staff told us staffing was their biggest challenge. There had been a high proportion of staff on maternity leave at one time. Planning was sometimes difficult as a result, but staff we spoke with felt confident patient safety was never compromised. A review of the maternity unit rota showed us gaps were often filled with bank staff, which consisted of regular midwives picking up over time on the ward in their normal capacity. We were told if community midwives had extra resource or lower activity then they would be asked to come into the birthing centre to work.
Community midwives we spoke with said this was not something they considered to be a problem as it allowed them time to bond with other staff within the unit and treat women with more complex needs.

For women having elective caesarean sections, they were cared for on a one to one basis by a midwife who had specific training in spinal anaesthesia. If a general anaesthetic was used in cases of emergency caesarean sections, an anaesthetist remained with the women and handed over to a midwife who had specific training on high risk recovery and taken back to the maternity unit.

**Total staffing**

The trust reported the following qualified nursing staff numbers as of March 2018 and June 2018 for maternity by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
</tr>
<tr>
<td></td>
<td>WTE staff</td>
<td>WTE staff</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>146.6</td>
<td>157.5</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>153.6</td>
<td>162.0</td>
</tr>
<tr>
<td><strong>Trust total</strong></td>
<td><strong>300.2</strong></td>
<td><strong>319.5</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of 6.3% for qualified nursing and midwifery staff in maternity. This was better than the trust target of 14%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 6.9%
- University Hospital Lewisham: 5.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From July 2017 to June 2018, the trust reported a turnover rate of 15.9% for qualified nursing and midwifery staff in maternity. This was similar to the trust target of 12%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 16.0%
- University Hospital Lewisham: 15.8%

Both sites performed worse than the trust target for turnover.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 4.8% for qualified nursing and midwifery staff in maternity. This was worse than the trust target of 3.5%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 5.6%
- University Hospital Lewisham: 4.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From July 2017 to June 2018, the trust reported the following bank and agency usage for nursing and midwifery staff in maternity services.

<table>
<thead>
<tr>
<th>Location</th>
<th>Bank shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital Lewisham</td>
<td>3,115</td>
<td>264</td>
<td>402</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>3,987</td>
<td>95</td>
<td>609</td>
</tr>
<tr>
<td>Total</td>
<td>7,102</td>
<td>359</td>
<td>1,011</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Medical staffing

The safer childbirth/RCOG recommendations (Royal College of obstetrics and gynaecology) were being met to ensure there was sufficient obstetric consultant staffing levels within the maternity unit. One consultant obstetrician told us there was challenges to staffing but this was normally at grades lower than consultant. As a result, a consultant would often ‘act down’ into a vacant registrar shift to ensure there was sufficient cover for the unit. We saw evidence that new consultants posts had been filled with staff set to commence working on the unit from November 2018. Two consultants we spoke with said although staffing levels had been a concern, they were satisfied that patient safety and care had never been compromised.

There were sufficient anaesthetic cover to ensure emergency caesarean section surgery could be carried out. Staff also told us they had never experienced any problems asking an anaesthetist to administer a spinal block or epidural.

Women we spoke with felt they had enough staff to care for them during their stay on the unit. Women told us they felt, at times, they appeared to be a lot of staff around and queried if there was too many.

During our inspection we observed ward rounds taking place at 8am and another at 1pm for any member of staff that started their shift after the morning ward round. Discussions took place
between a consultant obstetrician, registrars and junior doctors. Junior medical staff we spoke with felt supported and felt they had time to ask staff questions and seek support if unsure.

We spoke with senior staff within the maternity unit who informed us they were now fully staffed, waiting for two consultant posts to start in November 2018.

The trust reported the following medical staffing numbers as of March 2018 and June 2018 for maternity by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>30.3</td>
<td>40.5</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>36.2</td>
<td>44.3</td>
</tr>
<tr>
<td>Trust total</td>
<td>66.5</td>
<td>84.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From July 2017 to June 2018, the trust reported a vacancy rate of 21.3% for medical staff in maternity. This was worse than the trust target of 14%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 24.2%
- University Hospital Lewisham: 18.6%

Neither site the trust’s target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From July 2017 to June 2018, the trust reported a turnover rate of 41.2% for medical staff in maternity. This was worse than the trust target of 12%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 34.4%
- University Hospital Lewisham: 47.2%

Both sites were worse than the trust’s target.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 1.8% for medical staff in maternity. This was better than the trust target of 3.5%.
The breakdown by site was as follows:

- Queen Elizabeth Hospital: 2.6%
- University Hospital Lewisham: 1.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From July 2017 to June 2018, the trust reported 523 shifts in maternity. Of those, 74.2% were filled by bank staff and 11.1% of shifts were filled by locum staff. In addition 8.4% of shifts were not filled by bank and locum staff to cover staff absence.

The trust did not provide data for University Hospital Lewisham, therefore the data in the table below for Queen Elizabeth Hospital only.

<table>
<thead>
<tr>
<th>Location</th>
<th>Locum shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>169</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Middle grade</td>
<td>196</td>
<td>57</td>
<td>24</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>23</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>388</td>
<td>58</td>
<td>44</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)
Staffing skill mix

In December 2017, 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 about the same as the England average.

Staffing skill mix for the 76.5 whole time equivalent staff working in maternity at Lewisham and Greenwich NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>34%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>39%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

During our inspection we viewed 11 care records of women who had used the maternity service in the previous 48 hours or whom were still on the ward at time of inspection. All 11 care records we viewed were completed in line with records management code of practice for health and social care. We saw evidence that NICE QS22 Statement 3 (minimum set of antenatal test results) was adhered to and all test results were clearly documented and actioned upon.

Records were held securely within the unit, often behind the nursing station or the reception desk. The records were kept in lockable mobile storage trolleys. Hand written records were clear, concise and easy to understand. It was clear who the clinician was who had written the entry and the decision making process they had undertaken in a women’s treatment. We saw good rationale for emergency caesarean section surgery.

Staff told us there were sometimes difficulties with accessing records as the department was midway through a phase of transferring care records electronically. Staff told us that new booking in for the first time would have their notes contained within the electronic system and existing records would remain paper based. If a woman presented without a set of their own care notes then staff could find out essential detail from the electronic system. We viewed four electronic care records and seven paper copy records.

All records had risk assessments carried out and a venous thromboembolism (VTE) risk assessment was completed for each person admitted onto the maternity unit. New-born warning scores were recorded as well as women’s body mass index (BMI) and family medical history. We saw evidence that a screening assessment had taken place and documented results were clear.
Women’s choices and preferences were documented clearly and information regarding prescription medication, alcohol intake, medical history and additional needs was completed fully.

Community midwifery staff we spoke with said women’s care records remained with the women at home so they could be accessed easily when required. The staff said they uploaded information onto their electronic system in case the paper copy was to be mislaid. Staff told us this could have an impact on their time availability because they would need to document the same information in a paper care record and on the electronic system. The midwifery team told us they would soon be getting portable electronic devices and this should make recording information easier and more simplified.

**Medicines**

Medicines and medicines related stationary conformed to the Nursing and Midwifery Council (NMC) Standards for medicine management. Medicines were stored correctly in locked cabinets in an alarmed room. One set of keys opened the door with a master key held by the main trust switchboard. Drug cupboards were locked and controlled drugs (CD) were kept in a lockable unit that was opened only by key code. This key code changed monthly for security reasons. CD’s were checked once daily by two registered midwives to ensure the correct stock was present. This was recorded and logged in accordance with Trust policy.

We viewed a variety of medicines and noted these were in-date and in their original packaging. Medicines were stored in a way that minimised clutter or confusion and the signing in and out book was fully completed and clearly identified who had taken the medicine.

Staff explained to us the process of ordering new medicines and told us a hospital pharmacist would visit the ward each day. A pharmacy technician visits once a week to identify low stock. If items needed replacing outside of the pharmacist’s visit, there was a paper ordering form. Details on this form were clear and the reasoning for ordering new medicines was clearly documented.

We observed safe disposal of used medicine vials into a sharps box. If women bought their own medicine onto the ward, this could be locked up at the woman’s bedside or locked in the medicines room. Staff were aware of the trusts medicine management policy and had reported no incidents in the last 12 months relating to missing or misplaced medicines.

Medicine fridge temperatures were checked and some ranges were out of the normal expected range. We saw evidence that staff had reported out of range temperatures to the pharmacy lead and documentation showed what advice staff were given. Additional checks were put in place to ensure temperatures were recorded correctly. We viewed a log that highlighted who had checked the fridge, the temperature, the time and the date. At the time of inspection, there was no medication in the fridge.

There was additional emergency resuscitation drugs kept in the medicines cupboard at the request of the pharmacy lead. Community midwives had their medicines storage cupboard located in the medicines room. Community midwives did not carry their own key to the room and would require the birthing centre matron to open the room for them.
Incidents

Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and near misses. There was a good culture of incident reporting and staff understood how to report an incident and where to locate the trust policy on incident reporting. Senior staff told us staff regularly report incidents but some reported incidents were information only. Senior staff felt there was a culture of over-reporting but would prefer it that way than under-reporting.

Staff told us they received individual feedback from any incidents they had reported and case studies were based on real life incidents to enhance learning.

Reported incidents were reviewed by the head of maternity and themes identified. Action plans were in use to ensure common incidents were addressed and mitigations implemented to decrease the incident from re-occurring. The online incident reporting system alerting senior managers once an incident had been reported and depending which department reported the incident, would depend which matron would oversee the investigation. Senior staff told us they had attended route course analysis training and regularly reviewed incidents together to see if there was any common learning which could be implemented across the wider maternity service.

Learning from incidents was shared via email, in daily ward huddles, handovers, one to one meetings and ‘Just Take 5’ sessions. Meetings with all maternity staff were held monthly in line with the safe childbirth recommendations. These meetings were designed to share learning from incidents and gave opportunities for staff to question certain practices. Senior staff told us they supported a culture that was open to challenge during a women’s care and treatment in the hope incidents would decrease.

We reviewed meeting minutes which all included examples of lessons learnt from incidents. One incident included incorrect advice being provided to a patient regarding the use of an anticoagulant medication. We saw firm documentation that showed key staff were reminded to document clinical decisions and ensure this information is clearly communicated to both women and staff. No harm came to the patient as a result of this incident.

We saw evidence of two incidents that had recently been reported, which included the misinterpretation of test results. We saw an action plan had been implemented and extra training developed for staff in this area.

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.

From June 2017 to May 2018, the trust reported one incident which was classified as a never event for maternity. The incident occurred in April 2018 at the Queen Elizabeth Hospital and related to a retained foreign object post procedure. At the time of inspection this incident had been downgraded and investigation continuing.

(Source: Strategic Executive Information System (STEIS))

There was a thorough process to investigate and determine unexpected deaths.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018.
The breakdown by incident type and location was as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Queen Elizabeth Hospital</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother only</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>9</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Please note, the total number of incidents includes the never event above, which was a Surgical/invasive procedure incident meeting SI criteria. Also, one maternity/obstetric incident meeting SI criteria (mother and baby) is missing from the table. This could be because it took place at the patient’s home.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The maternity service had its own dashboard which showed national comparisons to other NHS trusts. Measures such as post-partum haemorrhage, infection, emergency caesarean section rate and screening for infectious diseases was displayed. We saw evidence of a trust wide safety thermometer. This allowed staff to see how they compared with other hospitals within the trust.

Safety thermometer information was displayed in an open corridor in the birthing unit so staff and service users were able to see how the department compared nationally. Information such as cleanliness and infection rates, natural births and number of falls was displayed. This started that the normal birth rate was 59.3%, the emergency C-section rate was 19.8%, the breastfeeding rate was 78.1% and the one to one care rate in labour was 100%.

The safety thermometer was also available to staff electronically on the trust computers and in the staff room.

Is the service effective?

Evidence-based care and treatment

Care and treatment was in line with national evidence-based guidance. There was evidence of NICE guidelines being used effectively with care, treatment and support offered in line with latest legislation. All the staff we spoke with were aware of best practice guidance and said policies were easily accessible via the organisation’s intranet. We reviewed a number of electronic policies
specifically for the maternity unit and saw all had been reviewed, were version controlled and were in date.

We saw evidence the safer childbirth guidance had been implemented and protocols for intra-partum care were in place. Staff told us there was lots of guidelines surrounding evidence based treatment for people receiving maternity care. Therefore, the staff room notice board had the latest guidelines attached and staff were emailed regularly with latest evidence and protocols to follow. We saw evidence that NICE guidance was being used and we specifically saw documented evidence of this.

Staff told us they monitored fetal growth from 24 weeks by measuring and recording the symphysis fundal height as recommended by MBBRACE-UK and in line with NICE guidance. Staff demonstrated there was a clear escalation policy and pathway for abnormal findings.

Women with risk factors for gestational diabetes were identified and offered glucose tolerance testing in line with latest guidance (NG3, 2015). Staff handovers specifically referred to the psychological and emotional needs of women, and we saw documented evidence of support packages in place for those who had additional needs.

During our inspection, staff told us sepsis recognition and treatment was a key priority for everybody working in the department. Staff showed us where to locate the NICE guidance (NG51: Sepsis recognition, diagnosis and early management). We saw reference to this guideline within each woman’s care record highlighting key sepsis recognition tools.

Staff told us women who were suspected to be experiencing depression were referred for a mental health assessment in line with NICE CG90 (recognition and diagnosis of depression in adults). We saw documented evidence of specialist mental health involvement contained in the women’s care record.

**Nutrition and hydration**

Staff in the maternity unit told us the importance of supporting mothers with feeding their newborns and the promotion of breastfeeding. Staff also told us it was important for women to have a choice to breastfeed and they supported whatever choices mothers made. Staff told us a discussion regarding feeding took place before the birth to ensure women had enough information to make informed choices.

The maternity unit was an accredited level three baby friendly service. This accreditation was provided by UNICEF and meant the unit had demonstrated support to mother babies with infant feeding choices and encouraged development of close and loving relationships between parents and baby.

The unit had a dedicated kitchen for parents to prepare milk for their babies. The unit did not supply milk to mothers but did have an emergency supply in the eventuality a woman had not bought milk to the unit themselves. There was a refrigeration unit with daily temperature checks. At the time of inspection the fridge was empty but we saw evidence of daily checks.

Community midwives we spoke with told us the importance of promoting choices for women with feeding their babies. Midwives had documented discussions about feeding choices. The service offered workshops for women to attend, where they were showed techniques for breast and bottle feeding. Women we spoke with had attended these workshops and found them to be useful, especially for first time parents.
Women on the unit told us they had been offered food and drink during their stay. A hot meal was provided once per day with a variety of choices. If hungry outside of the hot meal times then the ward staff could order a snack box which contained a small drink, a sandwich, one piece of fruit and a packet of crisps. Staff told us these were easy to order and delivered quickly to the ward at any time of the day or night.

Pain relief

During the inspection we reviewed a number of medical records which clearly documented pain relief discussions. Entonox was readily available in each room of the birthing centre and on the labour ward. Women we spoke with said they were offered pain relief and found it to be satisfactory with controlling pain.

Staff told us there was an on-call anaesthetist who would attend to perform epidural and spinal block procedures. Staff told us the anaesthetist would present to the ward once bleeped and make their own assessment of the women’s pain. We saw documented evidence of discussion regarding the risks of these procedures. The service did not record information that showed the time the anaesthetist was called to the time the women had received a pain relief procedure to ensure this was conducted within 30 minutes as per AAGBI Obstetric Anaesthetic guidance.

We saw evidence that pethidine had been offered to women and used. We saw medicines stocked appropriately and pethidine was stocked within the community midwifery medication cupboard.

We saw documented evidence of pain scores recorded in the medical records we reviewed. Staff used a gradient of 0-10 (0 being no pain, 10 being the worst) to record pain measurements of women.

Staff told us that for women with a history of using recreational opioids discussions did not include the usage of opioids for pain relief. Instead these women would have an assessment to determine the best pain relief control for them. Care records recorded opioid abuse to minimise staff offering this type of pain control.

Community midwives told us an ambulance would be called to attend to a labouring woman at home if pain relief was unmanageable with pethidine and Entonox.

Patient outcomes

Information about the outcomes of peoples care and treatment (both physical and mental) was routinely collected, reviewed and monitored. Audits were performed to show how the trust performed locally and nationally in comparison to other maternity units. The service participated in the UK national screening committee antenatal and new born screening education audit. Although we did not see evidence of this audit, senior staff told us this was being completed. Local audits were also carried out and senior staff advised us they had recognised a higher percentage of unplanned caesarean sections were happening and work had begun to understand the reasons for this. As part of this, senior staff were reviewing records to understand the rationale for this type of surgery.

Senior staff were able to demonstrate positive service improvement from the use of auditing. Staff told us hand hygiene audits had revealed gaps for improvement and work was undertaken to enhance the frequency of handwashing and this was discussed in daily handovers. Senior staff told us audits were used positively to enhance service improvement and to identify areas of concern.
There were a number of audits carried out on the unit that included: staffing levels, risk management, mortality, readmissions, complaints, transfer-out (when women were transferred to other areas of care), breast feeding, safeguarding concerns and carbon monoxide related indicators (including smoking). We saw evidence that any outliers were investigated with an action plan to follow up and discussion with staff around any areas of concern. Senior staff told us they supported the use of audits on the unit to ensure they target areas for improvement. We saw evidence the audits were discussed in the unit ‘Just Take 5’ monthly newsletter. The results of audits were also available in the staff room to ensure staff were up to date on how the unit performed locally and nationally.

The unit contributed towards a number of national audit programmes, as seen below:

**National Neonatal Audit Programme**

**Queen Elizabeth Hospital**

In the 2017 National Neonatal Audit, the results of Queen Elizabeth Hospital for the two audit measures relevant to maternity services were:

**Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 100 eligible mothers identified for inclusion in this audit measure, 87.9% of whom were given a complete or incomplete course of antenatal steroids. This was within the expected range and compared to the national aggregate of 86.1%.

The hospital met the audit’s recommended standard of 85% for this measure.

**Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

There were 20 eligible mothers identified for inclusion in this audit measure, 70.0% of whom were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5%, and put the hospital in the top 25% of all units.

(Source: *National Neonatal Audit Programme, Royal College of Physicians and Child Health*)
Standardised Caesarean section rates and modes of delivery

From April 2017 to March 2018, the total number of caesarean sections was similar to expected. For the same time period:

- the number of elective caesarean sections was lower than expected; and
- the number of emergency caesarean sections was similar to expected.

### Standardised caesarean section rate (April 2017 to March 2018)

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>Lewisham and Greenwich NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>548</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>1,607</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>2,155</td>
</tr>
</tbody>
</table>

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery, the table below shows the proportions of deliveries recorded by method in comparison to the England averages from April 2017 to March 2018. The trust had a similar profile of deliveries when compared to the national averages.

### Proportions of deliveries by recorded delivery method (April 2017 to March 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Lewisham and Greenwich NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>2,155</td>
<td>27.2%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>960</td>
<td>12.1%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>4,818</td>
<td>60.7%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>7,933</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

1. Includes elective and emergency caesareans
2. Includes forceps and ventouse (vacuum) deliveries
3. Includes breech and normal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)
Maternity active outlier alerts

There are two active maternity outliers at the trust, with action plans being followed up by the CQC.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.02.

This is up to 10% higher than the average for the comparator group rate of 4,000 or more births per annum, at 24 weeks or later and was worse than expected. We saw staff had logged this on an action plan and were holding MDT meetings to work out a way to reduce this figure.

(Source: MBRRACE UK)

Competent staff

The unit had good arrangements to support and manage staff to deliver effective care and treatment. The unit had recognised a training need in interpretation of CTG’s and implemented an annual mandatory CTG competency test for all staff. The midwives worked across the unit including the birthing centre, labour and postnatal ward and antenatal clinics. This gave the midwifery staff a rounded understanding of a women’s journey within the unit and broadened their knowledge of each specialist area.

Community midwives we spoke with told us they had the opportunity to complete shifts on the main maternity unit. The on-call community midwife could be called upon to complete a shift on the unit when staffing levels were low. The community midwives we spoke with told us this was a positive aspect as it gave them opportunity to develop their skills in more acute clinical areas.

Workshops and training sessions were provided by senior staff on the unit. We saw evidence of training on diabetes awareness, mental health recognition, antenatal screening, healthy lifestyles and bereavement support. Staff we spoke with found this training sessions useful and told us they were often facilitate at quieter periods so maximum staff could attend.

Regular appraisals were carried out for staff on the maternity unit and we saw documented evidence of this. During each appraisal training needs were discussed and recognised with an individualised plan agreed to support staff to further their skills and knowledge. Staff told us these appraisals were useful and all training needs identified were addressed.

Senior staff ensured there were regular updates provided to staff on the latest clinical guidelines or changes to practice. These were discussed at daily handovers and for staff off duty, on holiday or on long term sick, updates were provided to all staff through internal email. Staff told us they were given protected time to read the latest guidelines.

Staff we spoke with told us they felt confident with the equipment in the maternity unit. Staff said they would not operate any equipment without the correct training. We viewed a number of training manuals and guidelines which assisted staff in using a variety of maternity equipment.
Appraisal rates

From April 2017 to March 2018, 71.4% of required staff within maternity at the trust received an appraisal compared to the trust target of 90%.

Queen Elizabeth Hospital

From April 2017 to March 2018, 68.8% of required staff within maternity at Queen Elizabeth Hospital received an appraisal compared to the trust target of 90%.

The trust has reported a completion rate of 142.9% for medical staff.

The breakdown by staff group is in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>7</td>
<td>10</td>
<td>142.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (qualified nurses)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (qualified nurses)</td>
<td>178</td>
<td>124</td>
<td>69.7%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>82</td>
<td>50</td>
<td>61.0%</td>
<td>No</td>
</tr>
<tr>
<td>Grand total</td>
<td>269</td>
<td>185</td>
<td>68.8%</td>
<td>No</td>
</tr>
</tbody>
</table>

Two of the five reported staff groups met the target for appraisal completion.

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

Multidisciplinary working

We saw good evidence of multidisciplinary working across the maternity service. Midwives, midwifery support workers, doctors, theatre staff and other hospital personnel had good working relationships. We saw an MDT meeting consisting of a microbiologist, midwifery staff, obstetricians and sonographers. Staff told us these meetings were beneficial in ensuring women received the best possible level of care.

Staff told us interactions with multidisciplinary members were respectful, open and honest. Staff felt able to raise concerns and suggestions and felt these were listened to and actioned upon where appropriate. The midwifery coordinator told us she enjoyed being in charge of the shift and when she asked staff to move location to work this was rarely challenged and staff got on with what they had been asked to do.

During the inspection we observed a number of handovers when staff were changing shift. We saw positive, supportive conversation from a range of disciplines in an open forum. Staff of all grades told us they were encouraged to challenge ideas and that ‘no idea was considered stupid, no matter what it is’.

Community midwives told us they had formed a good relationship with the local ambulance trust for their area. They told us they hold monthly meetings with senior staff to discuss operational pressures and come up with ideas on how midwives can ease the burden on ambulance staff attending pregnant women.
Staff told us that previously, relationships with theatre staff could be challenging. We were told that when theatre staff were busy there could be more challenge to accept women for surgery. In an attempt to ease tensions and form relationships with theatre staff, it was decided that more meetings would take place between maternity and theatre staff. Senior staff told us this had eased tensions and meant staff had a good understanding of each departments work pressures. Midwifery staff we spoke to said they have daily contact with theatre staff and as new relationships formed, the tension between the two departments was easing.

**Health promotion**

The unit had specialist trained midwives offering women with various needs appropriate support. We spoke with a smoking cessation midwife who was tasked with helping pregnant women stop smoking. This midwife had attended specialist training and was now offering support to other midwives on the unit. Smoking cessation classes and workshops were held regularly and offered women advice and support around stopping smoking. Staff told us the aim was to demonstrate to women the effect carbon monoxide had on an unborn child and not to make women feel belittled or embarrassed about smoking, rather to offer support on how to stop. We spoke with one woman who had been through a smoking cessation workshop and had stopped smoking as a result. She told us the class was positive, upbeat and ‘an eye opener’ with lots of information she had not previously considered.

Staff provided a number of other workshops to pregnant women at all stages of their pregnancy. We saw evidence of a health living workshop which promoted exercise, diet and nutrition advice. Staff provided information on vaccinations, weight loss and conditions common during pregnancy. Women we spoke with had attended a number of workshops and praised the information they had received. Staff told us they enjoyed putting these workshops on because they felt it was very beneficial to women’s health.

We saw evidence in women’s care records of discussions around promotion of health. We saw advice had been given on smoking, alcohol intake, dietary information and single parenthood.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children’s Act 1989. Staff demonstrated how women and partners were supported to make decisions in line with relevant legislation. We saw documented evidence in a woman’s care record related to possible lack of capacity and saw comprehensive assessments had been made and a referral to a mental health specialist was required.

Staff told us of the importance of seeking consent for examination and treatment and had jointly discussed the Department of Health reference guide for consent. We saw evidence in care records that consent had been gained and risks had been discussed.

We spoke with five women who had recent examinations conducted in the midwifery unit and all of them told us they had been asked for consent prior to the examination occurring. Women told us a chaperone was offered in cases of vaginal assessment and this was corroborated with what we saw documented in the women’s care records.

Maternity staff showed awareness of the Deprivation of Liberty Safeguards (DoLS) and gave examples of when this had been applied. Staff told us they regularly discussed DoLS assessment,
learning and practical examples during team meetings. Minute meetings we viewed corroborated this.

Staff undertook training on the MCA and consent to examination or treatment, with figures shown below.

**Mental Capacity Act and Deprivation of Liberty Safeguards training**

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

**Trust level**

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 at trust level for staff in maternity is shown below:

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>305</td>
<td>335</td>
<td>91.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff in maternity met the target for MCA training with 91% completion.

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>50</td>
<td>73</td>
<td>68.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in maternity did not meet the trust’s target for MCA training completion, with a rate of 68.5%.

**Queen Elizabeth Hospital**

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the maternity department at Queen Elizabeth Hospital is shown below:

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>144</td>
<td>164</td>
<td>87.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff in maternity at Queen Elizabeth Hospital met the trust’s completion rate target of 85%, with 87.8%.
Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>23</td>
<td>33</td>
<td>69.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in maternity at Queen Elizabeth Hospital did not meet the trust’s completion rate target with 69.7%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

We spoke with eight women who had accessed the maternity unit and were at varying stages of their pregnancy, some of the women we spoke with had recently given birth. All eight women and partners we spoke with were overly complimentary of the service they had received. Women told us they felt supported to make decisions, were given choices and made to feel welcomed by maternity staff.

Women told us they had opportunity to visit the birthing centre prior to giving birth and were given ample opportunity to ask questions to their nominated midwife. We observed assessments taking place and saw the dignity and privacy of women being respected. Staff pulled curtains around women and ensured conversation noise levels were kept to a minimum to ensure other people did not easily over hear confidential details.

We observed domestic cleaning staff, consultants and health care assistants knocking on doors and asking women if it was ok to come in. We saw staff using people’s names according to how they wanted to be addressed. All rooms had windows which had privacy glass that meant members of the public were unable to see in. Women told us their care was always compassionate and had their needs and wishes adhered too.

We saw staff speaking to women offering advice and support. Discussions were professional but friendly and provided women with information they needed. Staff told us they understood that every pregnancy journey is different and varying levels of care and support was needed for each individual. Expectant fathers we spoke with also felt involved in their partners care and spoke positively of staff taking time to inform and support them.

We observed staff ensuring mothers had the necessary equipment they required before leaving the unit after birth. We saw staff advising women to call the maternity service if they required any further information or advice.

Friends and Family test performance

Please note no data for any of the four maternity Friends and Family Tests was published by NHS England for November 2017 because of data quality concerns. For the same reason no
data were published for the maternity (postnatal community) Friends and Family Test for July 2017.

Because November 2017 data is not included in the charts below, May 2017 has been included to provide 12 months of data. For postnatal community, because July 2017 and November 2017 are not included in the chart, April 2017 and May 2017 have been included to give 12 months of data.

**Friends and family test performance - antenatal**

From May 2017 to May 2018 the trust's performance in the maternity Friends and Family Test for antenatal care was consistently 90% or higher, and overall the trend was neutral.

Performance compared with the England average has fluctuated: the trust is worse than the England average in six months, the same in one month and better than in the remaining five months.

In May 2018 the trust scored 93% (compared to the England average of 95%) and in May 2017 it scored 100% (England average 96%).

**Friends and family test performance (antenatal), Lewisham and Greenwich NHS Trust**

![Graph](image)

**Friends and family test performance - birth**

From May 2017 to May 2018 the trust's performance in the maternity Friends and Family Test for birth was consistently 93% or higher, and overall the trend was neutral.

Performance compared with the England average has fluctuated: the trust is worse than the England average in eight months (and in four of these months the difference was equal to or less than 1%), the same in two months and better than in the remaining two months.

In May 2018 the trust scored 97% (compared to the England average of 97%) and in May 2017 it scored 93% (England average 97%).

**Friends and family test performance (birth), Lewisham and Greenwich NHS Trust**

![Graph](image)
Friends and family test performance - postnatal ward

From May 2017 to May 2018 the trust’s performance in the maternity Friends and Family Test for postnatal ward care was consistently 84% or higher. Performance was consistently worse than the England average.

In the first seven months of the time period, the trend was neutral but in the last five months of the time period, there was a downward trend. The trust scored 92% in December 2017 and 88% in May 2018.

In May 2018 the trust scored 88% (compared to the England average of 95%) and in May 2017 it scored 89% (England average 95%).

Friends and family test performance (postnatal ward), Lewisham and Greenwich NHS Trust

Friends and family test performance - postnatal community

From May 2017 to May 2018 the trust’s performance in the maternity Friends and Family Test for postnatal community care was consistently 97% or higher, and overall the trend is neutral.

The trust scored 100% in 6 of the 12 months in the time period and performance was better than the England average in 11 of the 12 months.

Friends and family test performance (postnatal community), Lewisham and Greenwich NHS Trust

(Source: NHS England Friends and Family Test)
CQC Survey of women’s experiences of maternity services 2017

The trust performed similar to other trusts for each of the 19 questions in the CQC maternity survey 2017:

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.85</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.75</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.35</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.99</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.26</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.22</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.33</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a member of staff help you within a reasonable amount of time?</td>
<td>8.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.41</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.70</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.43</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.92</td>
<td>About the same</td>
</tr>
<tr>
<td>Area</td>
<td>Question</td>
<td>Score</td>
<td>RAG</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td>------------------</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>6.85</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Was your discharge from the hospital delayed?</td>
<td>4.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed after the birth, did a member of staff help you within a reasonable amount of time?</td>
<td>6.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.64</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.30</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Was your partner who was involved with your care able to stay with you as much as they wanted?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.47</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

**Emotional support**

Staff we spoke with were able to tell us the importance of providing emotional support to women using the service. Midwives told us their priority was to ensure women using the service felt at ease during their pregnancy as this was both good for the women and the unborn child. Anxieties, worries and concerns were addressed throughout a women’s pregnancy journey and there was a dedicated e-midwife responsible for answering emails from women. This email system was designed to address simple worries women may have and we saw examples where women had emailed in about travelling on long-haul flights, immunisation questions and concerns regarding the use of hair dye. The e-midwife aimed to respond back to women within 48 hours and we saw evidence that replies had been sent back much sooner than this.

Staff also told us they informed women to call the maternity unit at any time they had any questions, queries or concerns. This was corroborated with women we spoke with who told us that when they had called the midwifery unit, their call was answered promptly and they were given satisfactory advice. We saw evidence of these phone calls and a log was kept by staff to detail what advice had been given, the time it was given and to whom it was given too.

There was a bereavement midwife in post who would offer support to bereaved women. The bereavement midwife told us she had all the essential training, skills and resources required to offer good support to women and their families. There was a bereavement suite that had a bed, sofa and reading material away from the main midwifery unit. The room was quiet and well decorated. We saw ‘thank you’ cards left by women who had used the room and these were positive in description. There were available memory boxes that staff could give to women and hand and foot prints could be created.

The unit had a refrigeration unit specifically for keeping placentas and babies who had passed away. This was locked and accessible by staff only; the refrigeration unit was kept in the bereavement office and was overseen by the bereavement midwife. We saw all items contained in the refrigeration unit were labelled correctly and were emptied daily to the main hospital mortuary.
Women had access to perinatal mental health midwives based on the unit. This was in line with NICE guidance (QS115). This team had the specialist skills to assess, support and manage women’s mental health wellbeing during pregnancy. A specialist perinatal midwife told us she was able to gain support from other mental health trained nurses within the hospital to help form decision making.

Understanding and involvement of patients and those close to them

We spoke with eight women and six partners who told us they had both been involved in their choices and preferences at various stages throughout the pregnancy. Women felt their ideas and suggestions were listened too and they did not feel pressured to make decisions they were not comfortable with. Women told us they had been advised about the health benefits of breast feeding but did not feel pressured into doing this by staff.

Partners who we spoke with felt included in the pregnancy journey and told us they had been offered classes they could attend alone. These classes were provided by the midwifery unit to help expectant fathers understand how to look after a new-born.

Two partners told us joint decisions of care had been made throughout the women’s pregnancy and they did not feel excluded from the decision making. All of the women and partners we spoke with were happy with the service they had received and all said they had been jointly supported in their decisions along their journey.

During our inspection we noticed information boards contained information advice for parents of a new-born baby. We saw an information board about both partners having skin to skin contact with their new-born and an information board with information for new dads.

For women who did not have a partner, we were told staff were engaging with the family member they had bought alone to support them. We spoke to one women and her mother who both agreed they had been involved in decision making throughout.

Is the service responsive?

Service delivery to meet the needs of local people

Cross-site working between University Hospital Lewisham (UHL) and Queen Elizabeth Hospital meant that women’s care plans were always met. Staff told us of the importance care continuity and we observed support given to women as they progressed between the different stages of the maternity service. We saw evidence that women were given treatment choices which were fully explained to them.

Staff told us of the importance of continuity of care and how they strived to ensure women had continuous input from their nominated midwife. Staff told us of the importance to provide support to women who transitioned between antenatal, labour, birth and postnatal care. We saw evidence that women had been given choice in treatments, with enough information supplied regarding each treatment choice.

Women with spoke with told us antenatal care was readily and easily available and referral to the service come via their own GP or an online self-referral. Women told us they were seen ‘relatively quickly’ from time of referral to their first midwifery assessment. Information given to women was provided in a format that was easy to understand and accessible to pregnant women with
additional needs. We saw a number of leaflets and information in the waiting room of the antenatal clinics and we observed information leaflets being provided to women after their consultation.

Midwives were trained to support and deliver care to a number of women who required additional support, such as teenage pregnancies, obesity, women with disabilities and women who were dependant on alcohol and drugs. We saw stickers within the women's care records which highlighted if the woman had an additional supportive need.

The layout of the unit was considerate to women, carers and relatives who had disabilities. There were signs around the unit that informed women and partners regarding the parking arrangements at the hospital and how to claim money back if they became an inpatient.

**Bed Occupancy**

From October 2016 to March 2018 the bed occupancy levels for maternity were consistently higher than the England average.

Over quarter 4 of 2017/18 (January to March 2018) the trust bed occupancy rate for maternity was 86.1% compared to the England average of 58.5%.

The chart below shows the occupancy levels compared to the England average over the period:

**Bed occupancy levels at Lewisham and Greenwich NHS Trust compared to the England average.**

(Source: NHS England)

**Meeting people’s individual needs**

In 10 of the 11 care records we saw documented evidence that a women's antenatal, fetal medicine, labour, pain relief, labour and postnatal needs had been addressed. Women we spoke with said they had continuity of care and had the same midwife throughout. We also spoke with
partners who told us they had been offered support and attended workshops on parenting for expectant fathers.

Where English was not a first language, staff had access to language line and could get an interpreter during a consultation. If the appointment was pre-booked then an interpreter could be arranged before attendance. Community midwives told us this was the same in the community and language line was easy to access any time of day.

Midwives asked to speak to women alone at least once during their pregnancy journey, normally at the second or third consultation (when a relationship had formed between midwife and patient) to ensure sensitive topics could be discussed confidentiality. Topics included FGM, domestic abuse and forced pregnancies.

We saw reclining chairs and beds were able to sleep on if their partner had to stay on the unit overnight. We saw evidence of food and drink being supplied to relatives and pillows, duvets and lockable bedside cabinets for use.

There was a dedicated team for screened women for infectious disease or diseases harmful to baby. Everybody had an appointment with the screening team and if required, would be assessed by a fetal medicine midwife. The team spoke positively about their duties and were sensitive to potential difficult discussions if a woman screened positive for an infectious disease.

Women who had suffered from a stillbirth or neonatal death were offered a bereavement pack which included information about obtaining a post-mortem to investigate the cause of death. The pack we viewed contained information is a sensitive manner with drawings and pictures. The bereavement pack described the different types of post-mortems and gave detailed information to help parents make an informed choice. The bereavement pack was typically provided by the bereavement midwife who was able to answer any questions the bereaved parents may have.

The Best Beginnings team had a midwifery lead for perinatal mental health. The lead for this told us staff were supported in recognising mental health concerns during a women’s pregnancy and clearly explained the process for offering support services. The midwifery mental health lead attended the wider trust mental health steering group to gain an understanding of wider trust issues in relation to mental health.

Access and flow

Prior to inspection there had been concerns regarding cancellation of clinics and delayed appointments. The trust told us this was due to staff shortages nationally for consultant obstetricians. Senior staff told us they had recruited four new obstetric medical staff to help decrease the number of cancelled clinics. These medical staff were due to begin in November 2018.

Women went through a maternity pathway which spanned the length of their pregnancy. Depending on risk and additional need, women could deviate from the pathway into more specialist care. Clinics typically ran daily from 8am until 5pm or later. Saturday clinics were being held to alleviate backlog of appointments.

Contact details for the in-hours and out-of-hours services was provided in case of any concerns or queries. Staff told us these calls were taken by midwifery staff and documented discussions placed in a log book. Community staff also told us they provided contact details for women at home in case of emergency or urgent advice. We saw the promotion of the 111 service if a woman felt they needed assessment.
Postnatal care was provided to support women transferring from postnatal care back into the community. We saw evidence at the daily ward round of the decisions made to discharge mother and child and arrangements for other women to take the vacant beds. Community midwives were also kept informed regarding bed capacity on the maternity unit in case women needed to attend the unit from the community.

Learning from complaints and concerns

Staff told us they treated complaints and concerns seriously and had a number of procedures in place to support women with a complaint. We saw information on a public noticeboard explaining how to make a complaint. Staff told us they tried to resolve individual complaints and concerns before they escalated into a written complaint. Senior staff were responsible for investigating complaints and identifying any themes that were occurring. Staff told us they were open to criticism and supported women to speak up if they felt something wasn’t right in their care.

From April 2017 to March 2018 there were 50 complaints about maternity services.

The trust took an average of 33.5 working days to investigate and close complaints for this service; however one complaint was still open at the time of our visit.

The trust responded to 36.0% of complaints within the target period of 25 working days specified in the trust complaints policy.

The breakdown of complaints about maternity services by subject and location is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Queen Elizabeth Hospital</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>10</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Waiting times</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Appointments</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Transport (ambulances)</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Admin/policies/procedures (inc patient record)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
<td><strong>19</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From April 2017 to March 2018, there were 27 compliments within maternity at the trust.

A breakdown by site is provided below:

- Queen Elizabeth Hospital: 17
University Hospital Lewisham: 10

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

There was a clear leadership structure across the maternity service. The head of midwifery reported to the divisional director of nursing and there was a deputy head of midwifery in post. There were two matrons in post, one responsible for antenatal and intra partum care, one situated mainly around the birthing centre. The other matron was responsible for post-natal care and was situated mostly on the labour ward. There was clear leadership throughout the whole maternity pathway and the leadership team had the correct skills, knowledge and professional qualification to carry out their roles.

Each shift had an experienced midwifery co-ordinator who oversaw running of the department on a shift by shift basis. We saw evidence the co-ordinator was able to assess risk and decide where staff were placed effectively to ensure patient safety. The community midwifery leaders felt part of the hospital maternity unit and attended regular meetings on the unit.

Staff we spoke with, including midwives, midwifery support workers, health care assistants and admin staff felt supported in their roles. Staff told us independent of their managers that they had trust in the leadership of the maternity unit and felt the senior members of staff were engaging and open to ideas and suggestions.

Staff told us there was a ‘door always open’ policy, which meant staff could approach the leadership team with any queries they had. Staff we spoke with told us the unit was ‘like a family’ and although there were clear leaders, everyone’s voice was heard and everyone’s opinion mattered.

Senior leaders promoted ongoing staff progression and supported applications from student midwives wanting to take up a substantive post once qualified. We saw evidence of regular monthly appraises where staff we asked about career progression opportunities and supported to learn extra skills.

Vision and strategy

There was a clear strategy within the maternity unit. We saw the maternity strategy on the staff noticeboard situated in the staff room. Staff told us the strategy was presented in a clear way and was easy to understand. Staff also told us they had constant engagement in the strategy and during initial implementation of the strategy, staff were asked for their thoughts and opinions of what it should contain.
Senior leaders we spoke with in the unit told us the strategy for the unit and appeared excited to start a new strategy in the coming months. Leaders found staff were fully engaged in putting a strategy together and they were proud of the commitments they had made to the progression of the maternity unit.

The strategy contained information relating to new guidelines such as the better births recommendations. The strategy focused heavily on provided services to help women stop smoking during their pregnancy and this was reflected in the post of a stop smoking midwife in the unit.

At the time of inspection the finance director for the trust was maternity champion at board level.

**Culture**

Staff we spoke with were proud of the work they did and spoke positively about the culture within the unit. Staff told us they worked effectively together and felt supported by management to progress within their careers. Staff told us learning was a big theme within the department and their top priority was to learn from mistakes and incidents in order to give the best care they could. Staff told us that occasionally upsetting situations occur throughout a women’s pregnancy and they were always offered the right support by their peers and management during these difficult times.

There was an open and honest culture which was void of blame or stigma. Two nurses we spoke with said they had been recruited from overseas and felt very welcomed to the unit and one member of staff became emotional when talking about the support she had received from staff on the unit.

The matrons were responsible for analysing and recording themes in incidents reported by staff. Where an incident happened as a result of interpretation of results or a specific failure in competence, managers put together a learning pack for staff members to improve their knowledge and skills. Staff felt this was a supportive measure and welcomed any opportunity to enhance their learning.

**Governance**

We saw evidence of effective structures, systems and processes to support the delivery of high quality care. The head of maternity told us good governance was a key priority for the unit. Staff at all levels were able to clearly tell us their roles and responsibilities in relation to good governance.

The maternity unit produced monthly its own ‘Just Take 5’ newsletter that included examples of incidents and the learning from these. Contained within this newsletter was good governance examples including specific case studies, learning points and the latest maternity guidelines. Senior staff told us staff had this newsletter emailed to them and it was also discussed daily at handover. Each week a specific theme would be discussed at handover, the theme would change weekly. During our visit, the theme for the week was recognition and treatment of sepsis.

We reviewed minutes from meetings held within the unit which included representatives from all areas of maternity. The minutes we reviewed showed us that safeguarding updates, incident reporting, staff developmental opportunities, new guidance and data gathering were topics discussed at a monthly MDT meeting. This meeting had representatives from the maternity unit including a consultant obstetrician, registrars and junior grade doctors, microbiologist, midwifery
staff, specialist staff and support staff. We saw actions that were required for the following monthly meeting.

**Management of risk, issues and performance**

Senior staff were able to show us the risk register for the maternity unit and explain the actions and mitigations for each risk. Wider staff understood the purpose of a risk register and offered suggestions at monthly meetings on items that may require action through the risk register.

Staffing was the top risk on the register and we saw actions that showed us a recruitment drive had taken place and new members of staff were to start in post from November 2018.

The maternity unit had its own dashboard that showed how well the unit was doing against national average. Transfer out rates were displayed as well as staffing ratios and induction statistics.

**Information management**

Minutes from meetings we reviewed sufficiently covered quality and sustainability with input from staff at all levels. Staff we spoke with said they were able to confidently find information they required on the trust intranet. Staff were able to show us where policy and other important information was kept on the intranet.

We saw data and statistical analysis which helped monitor, manage and report on a variety of maternity specific information. We saw an annual screening report which demonstrated the number of women positively screened for infectious diseases and how this compared to the national average. This data was useful to staff to understand the local demographic and the challenges local populations face. Staff told us the information gathered was used to engage members of the public. As an example, staff told us if there were more women diagnosed with HIV then this would allow staff to put on workshops which offered advice and support for people living with HIV.

Staff told us information gathered was confidential and anonymous. The storage of records and data on the trusts management system was in line with the trusts own information governance policy. This policy included the safe usage of encryption and tips of minimising data security breaches.

**Engagement**

People’s views and experiences were gathered and acted upon to shape and improve the maternity service. Staff told us they set up monthly walking groups where new mothers and pregnant women were invited to walk around the local grounds. This meeting was designed for women to get to know each other as well as provide feedback to staff about how they found the service and any improvement recommendations.

Women were also invited to a number of workshops that provided support and advice to new and expectant mothers. Staff told us these workshops were similar to a market place where external partners were placed in stalls that women could walk around. Staff told us representatives from leading baby and infant products attended. We spoke to a number of women who had attended these workshops and they told us they found them useful, supportive and interesting. Partners
were also able to attend as well as close relatives. Women and partners were invited to leave feedback on their experiences and suggested areas for improvement.

Learning, continuous improvement and innovation

During the inspection it was clear staff strived for continuous learning, improvement and innovation. Staff were keen to understand complaints and incidents where things had not gone well. Themes were collated and staff picked apart real life scenarios to gain a better understanding of how things could be improved. Staff regularly took time to resolve problems, reflect on learning and challenge process. This was evident in minutes we saw of staff meetings, which showed staff member’s actively challenging thinking and critiquing their own work. Community midwives were keen to hear ideas from the main maternity unit so their own practices could be improved.

One innovation the maternity unit had implemented was an education bus which was a physical trolley taken around to staff to promote various themes. For example, there was an education bus which highlighted disability week, the idea was strike up conversations with staff members and to ensure they had an understanding of the topic. The education bus allowed members of staff to make a drink whilst discussing the theme of that particular bus. Staff found this very useful and reflected that what may have seemed a novel idea at the time of suggestion, it was working well at highlighting themes to staff.

End of life care

Facts and data about this service

The trust provides end of life care at one of its sites, University Hospital Lewisham. The trust has arrangements to provide specialist palliative care at Queen Elizabeth Hospital. The service is provided by Greenwich and Bexley Community Hospice; although the medical staff are employed by the Trust, the nursing and administrative staff are employed by the Hospice. All staff are managed by the Hospice and hold honorary contracts with the Trust.

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

In view of the above this section should be read in conjunction with other sections of the hospital report as all hospital nursing and medical staff could be involved with care of dying patients.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

Queen Elizabeth Hospital

Specialist palliative care at the hospital is provided by the Greenwich and Bexley Community Hospice (GBCH) in-reach hospital team. The staff who provide this service are not employed by the trust.

The GBCH in-reach hospital team provide a visiting service Monday to Friday between 9am and 5pm. Outside of these hours on-call advice is available by telephone to GBCH and via an email
service.

A proposal was submitted to local clinical commissioning groups (CCG) recently to address provision of a seven-day specialist palliative care service at the hospital.

(Source: Hospital Episode Statistics)

The trust had 1,766 deaths from March 2017 to February 2018.

(Source: Hospital Episode Statistics)

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**Is the service safe?**

**Mandatory training**

The trust set a target of 85% for completion of mandatory training.

**Queen Elizabeth Hospital**

A breakdown of compliance for mandatory training courses for qualified nursing staff and medical staff in the specialist palliative care team department at Queen Elizabeth Hospital is not available as the relevant staff who provide this service are not employees of the trust.

**Safeguarding**

**Safeguarding training completion rates**

The fundamental standard on safeguarding as set out in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that children and adults using services we regulate must be protected from abuse and improper treatment. Providers should establish and operate systems and processes effectively to ensure this protection and to investigate allegations of abuse as soon as they become aware of them.

Staff had a good understanding of safeguarding and knew how to raise and escalate concerns.

There was a dedicated safeguarding team within the hospital and they had links and regularly met with local authorities.

Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.

**Queen Elizabeth Hospital**

A breakdown of compliance for safeguarding training courses for qualified nursing and medical staff in the specialist palliative care team at Queen Elizabeth Hospital is not available. The relevant staff who deliver this service are not employees of the trust.

**Cleanliness, infection control and hygiene**
The post-mortem area looked cluttered and cramped due to a very large number of plastic storage tubs stacked on part of the floor towards the rear of the room, on and under one of the post-mortem tables and some of the steel table height work shelving which was fixed around the rear and right walls. The tubs contained clinical waste stored in formalin for examination. We were told the reason for storage in that location was the forced ventilation and air conditioning as formalin fumes are hazardous. We spoke with the peri-natal pathologist and the Chief nurse about this and we were assured storage and disposal issues would be resolved swiftly. We were provided with a copy of the standard operating procedure (SOP) relating to the disposal of tissue specimens; dated 14 November 2017. However, it specifically does not relate to the clinical waste in the tubs and we were told there is no policy in place which does. We also noted the presence of the tubs was commented upon in the September 2017 Human Tissue Authority (HTA) compliance audit for premises, facilities and equipment and the March 2017 Generic non-clinical risk assessment under control of substances hazardous to health (COSHH).

We were not provided with a recent IPC audit although we note hand hygiene amongst staff trust wide for last year was 96% and during our inspection we observed good use of both PPE and IPC protocols by staff.

An infection prevention and control team (IPCT) provide a service across the trust and at QEH comprises of a lead clinician for infection control, a senior matron for infection prevention, two infection prevention nurses and an infection control administrator.

The mortuary unit was visibly clean and appeared in good repair. Staff had suitable changing and washing facilities and access to personal protective equipment (PPE).

Although the mortuary was equipped with two post mortem tables equipped with extraction and wash down facilities we were told they had not been used for over a year. A number of post mortems of babies were carried out each year by the on-site peri-natal pathologist.

Porters were trained in the care and safe storage of bodies they delivered to the mortuary. They were also responsible for cleaning and immediate spillage. The mortuary staff were responsible for the regular scheduled cleaning. Suitable equipment and cleaning products were available along with coloured waste bags in line with COSHH requirements.

**Environment and equipment**

The mortuary unit comprised of the bereavement team offices, rooms set aside for meeting with bereaved family members, a viewing area, a body storage area and a post-mortem room.

The storage area comprised of 35 adult fridges; including four bariatric fridges (for bodies above average size and weight) and six compartments for babies. There were also some temporary fridges which could be utilised and an arrangement to use two off-site private facilities in the event of a local disaster or other emergency.

The mortuary fridges were all connected to a computer controlled temperature panel in the storage area which sounded an alarm should any fridge deviate from the set high or low limits. Out of hours the alarm would still sound within the mortuary but the system would also alert the hospital switchboard so an engineer could be called. We saw the main engineer had placed an instruction sheet next to the panel explaining what needed to be done to other engineers if he was unable to attend.

There was a covered concealment trolley to be used by the trained portering staff for moving bodies from the wards to the mortuary. Nursing staff were required to place bodies leaking fluids into a body bag prior to transfer by the porters.

The family areas were welcoming; with suitable furniture and provided the necessary levels of privacy when required.
The hospital’s syringe drivers; a small battery powered infusion device used for delivering measured doses of pain medication, are looked after by the electro biomedical engineering department (EBME). QEH used two makes of syringe drivers; one for adult end of life patients and another for children and young people on end of life care.

Assessing and responding to patient risk
The trust introduced a treatment escalation plan (TEP). This identified treatment options for staff to discuss with the patients and or their relatives as well as any decisions on whether resuscitation would be attempted. However, the TEP was introduced in September 2018 and it was too early to assess any evidence that the TEP was working.

Our last CQC inspection report (September 2017) highlighted a number of areas where end of life recognition and care could be improved. During this inspection we observed a greater awareness around care for dying patients throughout the hospital.

The SPCT had recently introduced a revised referral form. The aim was to make referrals to the team more consistent and easier for the medical and nursing staff to supply the required information. This in turn helped to speed up the referral/decision process. SPCT team members told us the new form was working well and had been well received on the wards.

We observed many of the ward computers displayed a ‘care for the dying patient’ screensaver which gave SPCT contact details. The trust had an end of life care intranet page through which staff could access the trust’s end of life care strategy, principles of care for the dying in various media formats and information about proactive elderly advanced care (PEACE). The PEACE plan is a document to help health care professionals deliver the best care to frail, older people with life-limiting illnesses (such as those with Parkinson’s, Advanced dementia and Cancer) who are anticipated to be in the last year of their life and reside in a care home. It records discussions between the older person and/or their representatives and the geriatric team about what that best care might look like in the future when the older person’s health starts to decline further. Discussions may cover topics such as feeding, infections and whether coming back to hospital might be a beneficial or detrimental event for the older person.

In the patient records we reviewed we were able to see staff had used the national early warning score (NEWS) to monitor patients and help to identify if escalation of care was required. We also noted use of the malnutrition universal screening tool (MUST) and Waterlow scores to risk assess for pressure ulcers.

End of life care staffing
The staff for the QEH specialist palliative care team (SPCT) are provided under contract by the Greenwich and Bexley Community Hospice. The service is commissioned by both the Greenwich and Bexley CCG’s and relies on the support of voluntary contributions to the hospice by local people.

There was still not sufficient staff to provide a seven-day SPCT service.

Plans to have an end of life link nurse on every ward has had a low take up from staff and at the time of inspection only the emergency department (ED) and two other wards had one.

The SPCT consisted of a senior consultant who is on site at QEH two days a week, three clinical nurse specialists (CNS), a nurse consultant and administrative support. An experienced Staff
grade Doctor is also part of the team. The team were using the hospital’s discharge team to facilitate any rapid discharges of patients to their homes or other preferred place of care. At the time of our inspection the SPCT provided support Monday to Friday between 9am and 5pm. Outside of these hours and at weekends hospital staff could contact the hospice for advice. When the SPCT consultant is not available through leave or sickness we were told two other hospice consultants were available to attend or give advice over the telephone during core SPCT hours. A funding request for additional CNS is in place which would help to allow the team to provide seven-day coverage.

The hospice’s chief executive and the SPCT team’s senior consultant, nurse consultant and team leader are part of the Lewisham and Greenwich NHS Trust end of life steering group.

The SPCT estimated they had the capacity to assess and review approximately 85 patients per month. At the time of our inspection SPCT staff were providing care and support for 25 patients.

The bereavement team consists of one supervisor and two full time staff members. The supervisor is responsible for the teams at QEH and UHL and will cover for staff on leave or sick.

The mortuary staff consists of a mortuary manager and a mortuary technician. The perinatal pathologist was also based in that area.

The chaplaincy staff consists of one full time chaplain and four part-time chaplains, two of which were based at QEH while the other two could work on either site as required. In addition, there were 16 trained volunteers who provided pastoral care for patients.

Records

We reviewed 10 sets of records for end of life patients on a number of wards. We noted each record had two sets of notes. One set was completed by the nursing staff and the other by medical staff; doctors and allied health professionals (AHP) such as speech and language therapists, occupational therapists and dietitians etc. To get the complete picture of the patient’s condition and treatment plan both sets of notes should be read. The SPCT also complete records on patients on their hospice electronic record system.

Mortuary and bereavement staff had told us patient records would occasionally arrive in a poor state with loose and misplaced pages. We were also told bodies would infrequently arrive without name tags or the wrong tag.

The trust’s clinical documentation audit 2017-2018 found of the sampled QEH records only 74% were fully bound and only 22% had all the pages in the correct section. Of the ten sets of records we reviewed for end of life patients two had pages loose.

Most of the sets of records we reviewed contained do not attempt cardio pulmonary resuscitation (DNACPR) forms. The forms were completed by doctors involved in the patients care and are designed to record the medical decisions and wishes of the patient and/or their family members regarding their wish for resuscitation not to be attempted should it become necessary. Two records did not record a Mental Capacity Act 2005 (MCA) assessment even though the patient’s DNACPR noted the patient lacked capacity to decide about resuscitation. The MCA assessment is a patient safeguard and assumes a patient has capacity to make decisions about their care and treatment unless it is proved otherwise.

Of the records we reviewed we found the nursing charts to be inconsistent and the care plans to be too brief with little in the way of guidance. The care plan did not always fit with the principles of care for dying patients.
There was a plan to implement a centralised end of life care patient record and tracking system to ensure staff had rapid, seamless access to care plans and medicine reviews. This was due to be implemented by April 2019.

Specialist care givers such as the SPCT, the chaplaincy, occupational therapists (OT) and speech and language therapists (SALT) placed a sticker onto the patient notes to indicate their involvement with the patient. The SPCT sticker for example gave additional information about how to contact the team both during working hours and out of hours and at weekends.

Porters who had received mortuary training were responsible for moving the deceased patients from the ward location to the mortuary. Upon arrival they would complete a log sheet and place the patients’ medical record file into a storage box alongside the master record book. The master record book was only completed by the mortuary staff as it was the official record. There was also a small white board which the porters would also record the names of the deceased and which fridge they had been placed into. We were told this was a practice the mortuary staff were hoping to change as on occasion it led to errors; which although easily identified could take time to fix.

**Medicines**

Medicines available for end of life care were detailed on the hospital’s intranet as well as current trust guidelines relating to medicines. Staff accessed the online British National Formulary (BNF) from any computer on the ward. The BNF provides guidance on prescribing, dispensing and administering medicines.

Syringe drivers were present on wards likely to require them and readily available to others on request.

A pharmacist we spoke with confirmed medicines to take away (TTA) for end of life patients having a ‘rapid discharge home to die’ would always be prioritised. Often these would take the form of prefilled single use syringe medicine such as for pain relief. This type of medicine use is called PRN from a Latin phrase translated as ‘when necessary’.

We saw evidence of anticipatory medicines prescribed for end of life patients. Anticipatory medicines are also known as ‘just in case’ medicines and are prescribed in advance of an actual need so they can be administered readily if required.

A pharmacist visited the wards each day, screened prescription charts and spoke with the multidisciplinary teams.

Staff had access to medicines disposal facilities such as sharps bins and green bags for medicines to be returned to pharmacy.

Staff could access a stock list for each ward when looking for medicine stock. Staff could also access medicines out of hours from the emergency drug cupboard.

Controlled drugs (CD) were stored and managed appropriately. CDs were checked at least once daily by two qualified nurses. Pharmacy staff also conducted quarterly controlled drugs audits.

Medicines were stored securely in locked cabinets and fridges within locked clinical treatment rooms. Only relevant clinical staff could access them. There was a mixture of keys and digital locks on doors and cabinets.

**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.

From June 2017 to May 2018, the trust reported no incidents classified as never events within end of life care.

Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from June 2017 to May 2018.

(Source: Strategic Executive Information System (STEIS))

There was a total of seven incidents involving end of life care reported in the year ending September 2018. Upon investigation four of the incidents did not directly relate to end of life care. Of the remaining three; one was downgraded to a non-incident, one involved a no injury fall whilst the patient was off the ward with relatives and another was a classified as an unavoidable pressure ulcer.

Staff could describe the incident reporting procedure but some were unable to provide evidence of learning or change in practise resulting from those reported.

Discussion of incidents and emerging themes was a standing agenda item at each cross-site end of life steering group meeting.

Incidents reported by mortuary and bereavement staff were mainly around patient identification; wrong or no name tags upon arrival in the mortuary, and the poor condition of patient records. The clinical effectiveness team leader for QEH reviewed and reported on patient deaths as part of the monthly mortality review meeting.

Is the service effective?

Evidence-based care and treatment

Patients are defined as ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advance, progressive, incurable conditions;
- general frailty and co-existing conditions that mean that they are expected to die within 12 months;
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition;
- life-threatening acute conditions caused by sudden catastrophic events

(One chance to get it right, June 2014, Leadership Alliance for the Care of Dying People).

We found the policies, procedures and processes complied with national guidelines and good practice recommendations; care and treatment provided was based on national guidance. The mortuary staff followed the Human Tissue Authority (HTA) guidelines.

The trust had implemented an end of life care plan based on the ‘five priorities for care of the dying person’ One chance to get it right (2014):
1. The possibility that the person may die is recognised and communicated clearly, decisions are made and actions taken in accordance with the person’s needs and wishes and these are regularly reviewed and decisions revised accordingly.

2. Sensitive communication takes place between staff and the dying person and those identified as important to them.

3. The dying person and those identified as being important to them, are involved in decisions about treatment and care to the extent that the dying patient wants.

4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

5. An individual plan of care which includes food and drink, symptom control, and psychological, social and spiritual support is agreed, co-ordinated and delivered with compassion.

The new approach recognised that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life.

The trust’s multi-disciplinary End of Life Care Working Group developed a set of Principles of care for dying patients. The Principles act as an aide memoire to support clinicians in the development of individualised end of life care plans and the provision of high quality care for patients identified as likely to be in the last days/hours of life. We found the principles were available on the hospital intranet and we also noted a printed version which included a daily care plan review on the reverse formed part of the patient’s medical care record.

The SPCT undertook an audit to check the quality of the referrals to the palliative care team. The content of referrals to the SPCT had been found to be poor and although the referral form had been redesigned it had not been audited.

They chose July 2017 for their audit month as it was the first month referrals were scanned into the electronic patient record system. There was a total of 75 referrals made: 10 routine, 63 urgent and 2 emergencies. They found 75% were made by doctors and the remaining 25% were made by nursing staff including clinical nurse specialists (CNS). On closer look at the actual referral forms it was concluded that almost half (47%) were of poor quality. Of the 75 patients referred 60 were seen by the SPCT, one patient was discharged and 14 patients died before they could be seen. As a result, the SPCT redesigned the referral form. This form is now in use throughout the hospital and no audit has yet been done.

Another audit completed in December 2017, 'Clinical Documentation Audit 2017-2018', provided an overview of how well staff were following the standards in the clinical documentation policy. A total of 220 sets of patient records from 12 medical specialities were included in this audit. The records were selected from both trust’s sites between 1 April and 31 October 2017. At QEH, 5% of the patients had been identified as ‘not for resuscitation’. Whilst there were a number of audit questions, most worthy of note perhaps is that in 83% of cases the patient’s family was involved in the DNA-CPR discussions. In addition, the patient identification section and the date of the DNA-CPR order on the trust DNA-CPR form were legible and at the front of the notes 100% of the time. This was in line with our own observations during the inspection.

The awareness throughout the hospital of end of life care has improved since our last inspection but some nursing staff expressed concerns to our inspection team about end of life decisions at weekends. Nurses told us junior doctors on-call did not want to take responsibility for end of life treatment or referral and kept active treatment going. We were also told some doctors and consultants were treating rather than moving onto end of life care or referring very late. One consultant said to a member of our inspection team when asked about a patient “I’m not giving up on them yet”.

The trust was at the data entry stage for the National Care of the Dying Audit. The audit will look at 80 deaths spread proportionately across the trust. The aim of the national audit is to report on the care provided to dying patients and their relatives to highlight areas for improvement in clinical practice and influence policy/funding/research agendas. There was still work to do on action plans and implementing changes. The report was expected to be published in 2019.
Nutrition and hydration

We saw evidence in patient records of referrals to the dieticians and the speech and language therapists (SALT) for specialist nutritional input into the patients care. SALT gave advice regarding alternatives to solid food if patients were having difficulty eating or swallowing. We also observed use of the malnutrition universal screening tool (MUST) as well as eating and fluid intake charts. We did note some inconsistency in the frequency and the way in which these tools were completed and used.

We were only able to speak with one end of life patient regarding their thoughts on the quality of the food available; they reported it was not too bad.

The hospital used the ‘red tray’ system to help staff identify which patients need extra attention when eating, or needed foods that had a modified texture (such as mashed or pureed foods). These patients had their meals served on a red tray.

Pain relief

The SPCT worked alongside the ward staff to provide symptom pain control and advice in line with the trust policy.

Reviewing patient medical records showed patients who were approaching the end of their lives were prescribed medicines to help manage their pain. We also noted the use of anticipatory medicines which were prescribed in advance of an actual need so they could be administered readily if required.

We saw evidence of pain relief medicine administered via syringe drivers in circumstances where the use of oral medicines had become inappropriate for a patient and their need for the relief constant.

We did however note some inconsistency in which pain relief was recorded in the nursing notes. We saw days when a pain score was not recorded and an instance of pain being recorded as zero over several days yet pain medicine was prescribed and given.

Patient Outcome

Not all patients identified as requiring end of life care were referred to or were accepted by the SPCT. These were patients who presented with no complex medical needs and it was felt their medical team on the wards should be confident and competent to prescribe and treat them. The SPCT were involved in additional training for ward staff and advice was available from the SPCT if required or circumstances changed.

We saw that the SCPT regularly reviewed the patients referred to them.

Treatment escalation plans (TEP) were introduced at the hospital shortly before our inspection. The aim was to encourage the discussion and documentation of plans for treatment in cases of expected or unexpected deterioration of the patient. They encouraged forward planning and improved communication between medical and nursing staff and between staff and patients.

Proactive elderly advanced care (PEACE) plans were also introduced to help provide the best care for those patients approaching the end of their life and who reside in care homes.
The impact of the TEP plans has not yet been audited due to their recent introduction and the PEACE plans had not been audited. However, it was planned in the hospital’s end of life care strategy for year three 2018/2019.

The records we reviewed for patients who had DNACPR decisions in place had the decision forms clearly displayed at the front of the record which made it easier for staff to be aware of the patient’s wishes.

There was no organisational dashboard to monitor the number of patients identified as end of life across the trust. It was on the end of life risk register since April 2018 and it had been decided it required the rollout of the electronic patient record before it could be properly implemented. The SPCT at QEH could provide figures for patients referred to them.

Competent staff

The SPCT were employed by the Greenwich and Bexley Community Hospice who were in turn responsible for their training, appraisals and professional development. In the CQC report on the hospice published in March 2017, we said “The training staff received included a range of health and safety courses such as safe moving and handling, fire safety, food hygiene, emergency aid and infection control. Training related to the needs of people using the service included palliative care, pain and symptom management, dementia care, person centred care, malnutrition, assistance with eating, and bereavement training in confidentiality and diversity was mandatory for all staff. A high proportion of staff had a qualification in palliative care. Nurses received training before they could administer any medicines (including injectable medicines). This training was followed up by competency assessments. Staff were supported to undertake further education within palliative care. The Hospice had an Advancing Practice Team responsible for ensuring Hospice staff had access to external and internal training”.

There was an EoLC link nurse system in place which established governance links into the EoLC steering group. The chair of the link practitioner forum was a member of the EoLC steering group. The EoLC link practitioner forum was supported by the SPC team. However, at the time of our inspection there was only link nurses in ED and two other wards. The SPCT were working hard to encourage other staff to sign up.

The hospital provided education and training programmes for healthcare assistants (HCA’s), band 5, 6 and 7 nursing staff in palliative and end of life care training. The trust also provided Sage and Thyme training which is a foundation level programme of communication skills training for dealing with patients and families in distress. ‘SAGE & THYME’ is a mnemonic that provides a memorable structure for conversations, based on the evidence behind effective communication skills: Setting – Ask – Gather – Empathy – Talk – Help - You – Me – End. Currently this training has mainly been for nursing staff although we were told junior doctors could lack confidence in having difficult conversations with patients and relatives.

The hospital porters who agreed to undertake it received mortuary training in all aspects of collecting, transporting and booking bodies into the mortuary. Infection prevention and control and the proper use of personal protective equipment were also covered. Due to the nature of the work this training was not mandatory, although 50 of the 51 porters had been trained.

Multidisciplinary working

Relevant professionals were involved in the assessment, planning and delivery of patient care. We observed good working relationships between a range of health professionals within the trust. The weekly palliative care multidisciplinary meetings were attended by a range of professionals,
including doctors, nurses, social workers, allied health professionals (AHP) and members of the chaplaincy.

Members of the SPCT acted as a point of reference for any ward staff that needed support or advice. They also attended meetings for the different specialties to anticipate any patients whom they may need to support. Nursing and medical staff told us there was good communication with the SPCT. Ward staff knew how to contact the SPCT both within and out of their working hours.

The SPCT had a good working relationship with the hospital’s discharge team and in conjunction with other members of the hospital team and community services. Between them could arrange rapid discharges to a patient’s home or other places such as local hospice.

During our inspection we observed occupational therapists, dieticians, speech and language therapists and members of the chaplaincy speaking with patients and their nursing and medical staff. We also observed their involvement written in the medical records we reviewed. The use of stickers by the various AHP’s made identifying their notes much easier.

Membership of the end of life steering group meetings was broad and attendance was variable.

Members of the bereavement team and the mortuary staff appeared to have a good working relationship which enabled them to arrange family visits for viewings and collecting necessary paperwork as distressing as possible. The bereavement team also had good relationships with the hospital’s medical staff which meant they could get death certificates signed in good time.

Seven-day services

The SPCT were still only able to provide a Monday to Friday, 9am to 5pm on site service. Weekdays after 5pm and all day on weekends and bank holidays a telephone advice service was provided by the Greenwich and Bexley Community Hospice. Staff for the SPCT are provided by the hospice under contract to the hospital.

The lack of a seven-day capability for on-site SPCT cover was on the trust end of life risk register and a business case to increase staffing levels has been made to the Greenwich and Bexley CCG’s.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard:

Queen Elizabeth Hospital

A breakdown of compliance for MCA training courses from April 2018 to July 2018 for qualified nursing and medical staff in the specialist palliative care team at Queen Elizabeth Hospital is not available. The relevant staff who provide this service are not employees of the trust.

Is the service caring?

Compassionate care

We saw members of the chaplaincy attending patients who had asked for them and speaking to patients to offer their services. The chaplaincy could provide various items to patients free of charge upon request such as holding crosses, prayer beads and religious texts suitable for various beliefs.
A member of the chaplaincy held a monthly cremation service for non-viable foetuses which family members and staff could attend.

We observed a tea party organised by staff on an elderly care ward. Six patients sat at a table enjoying tea, cakes and singing. We also observed lots of activity by various therapists whilst the tea party was going on. We were told staff arranged a tea party two or three times a week to stimulate and entertain the patients.

We spoke with a relative of an end of life patient who said, “the staff here are amazing, I love this hospital. Another relative had a stroke here and they had excellent care. They gave me plenty of information”.

We spoke with some family members of a patient who had recently died. They said they had paid about £50 per week in parking fees while their family member had been in the hospital. They were told the yellow day rate button had been discontinued as staff were taking advantage of it. They had not been told about the special arrangements in place for relatives of long term patients.

Whenever possible ward staff would try to accommodate relatives’ requests to remain with a dying patient.

**Emotional support**

The chaplaincy team provided spiritual and bereavement support for patients and their families throughout the hospital. The team could arrange for support for all the main faiths and non-religious emotional support for those who were not religious.

A non-religious annual service to remember and commemorate adults who have died had been arranged for shortly after our inspection. Leaflets were available during our inspection.

The hospital’s bereavement team have a booklet titled ‘help and advice in the first few days following a death in hospital’ which is made available to relatives of patients who have died. It explained in simple terms the various legal and other processes which may need to be done following a death.

**Understanding and involvement of patients and those close to them**

In the patient medical records, we reviewed in each case where relevant the medical team had recorded conversations had with patients and/or their relatives regarding treatment plans. This was especially noted when reviewing DNACPR documents.

The bereavement team provided a compassionate and responsive service to bereaved families and provided further advice as required. It was understood certain religions required their dead were buried as soon as possible after death. In such circumstances, the team tried to ensure that all the relevant paperwork was completed as soon as possible so the family could register the death.

The bereavement team kept relatives updated of any delays with releasing the body; for example, where a post mortem was required. They also offered practical advice and sign posted relatives to other services as required.

**Is the service responsive?**

**Service delivery to meet the needs of local people**
Each ward had a discharge team who was responsible for organising patients discharge from hospital. For end of life care patients this often needed to be done quickly if they were to get the patient to their chosen place to die. The SPCT liaised with that member of staff and could arrange a rapid discharge often within a day and sometimes a few hours. Often other AHP’s were involved such as occupational therapy services who would organise specialist equipment to be set up at the patient’s home.

The SPCT were employed by the Greenwich and Bexley Community Hospice working at the hospital under contract. This meant they could liaise directly with their colleagues at their own and other local hospices to facilitate a rapid discharge there.

Patient records demonstrated that the SPCT was responsive to all palliative care patients and not just those patients with a cancer.

The hospital did not have any designated end of life or palliative care wards or beds; patients were nursed as required across all wards.

The feedback to our team was generally very positive regarding the SPCT referral process and it was hoped the revised referral form will improve things further.

Meeting people’s individual needs

End of life care patients were allocated side rooms whenever possible and if it was their wish. Patients at risk of infection or those who were infectious were prioritised for side rooms to prevent cross infection with other patients.

The chaplaincy team could respond to requests for spiritual support for all the major faith groups and had the ability to provide support for other faiths when required. They could provide this service seven days a week between 9am and 5pm; with a 24 hour on call service. In addition to the ordained members there were 16 trained volunteers able to provide pastoral care.

All staff had training in equality and diversity as part of their induction. Guidance was available on wards and on the intranet to support staff in providing care in accordance with peoples’ religious and cultural preferences.

The multi-faith room provided a place of worship, quiet time and prayer for people of all faiths and none. Prayer mats and religious texts were available for Christians, Jewish, Hindu, Sikh, Buddhist and Muslim religions.

The introduction of the treatment escalation plans (TEP) were introduced in September 2018 and the principles of care for dying patients being so prominent on the intranet and within patient medical records supported staff to provide good quality care. Staff we spoke with told us the profile of the dying patient had been raised since our last inspection.

Mortuary viewing facilities were appropriate and allowed relatives privacy. Viewing was usually arranged through the bereavement officer who accompanied relatives to the mortuary. Nurses were responsible for recording the deceased’s belongings and either handing them over to relatives or delivering them to the bereavement office for safekeeping.

There were car parking spaces outside the rear of the mortuary unit which was supposed to be set aside for bereaved family members attending the bereavement team offices. However, we were told hospital staff would often park there. The bereavement team supervisor told us she had raised this with the hospital management.

Access and flow
We requested data to establish the number and percentage of patients seen within 24 hours and 48 hours when referred to the SPCT. The trust provided the response that 60.5% of patients were seen within 24 hours and 77.7% of patients were seen within 48 hours of referral. The trust provided data that showed the mean waiting time was 1.3 days with the median being 1 day. However, there was no time frame given or number of patients provided.

Learning from complaints and concerns

From April 2017 to March 2018 there was one complaint about end of life care services regarding facilities.

The trust took 27 working days to investigate and close the complaint for this service.

The trust did not respond to the complaint within the target period of 25 working days specified in the trust complaints policy.

(Source: Routine Provider Information Request (RPIR) - Complaints tab)

From April 2017 to March 2018 there were two compliments within end of life care.

A breakdown by site is provided below:

- Queen Elizabeth Hospital: one compliment
- University hospital Lewisham: one compliment.

We are unable to provide commentary on the themes of these compliments.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The hospital’s complaints department told us that with the family’s permission they recorded family feedback meetings and provide them with a copy. This was especially useful for family members as the meetings may take place a short while after their bereavement when some people may not be best placed to absorb what they are being told. It also demonstrated the trust’s willingness to be open regarding complaints.

Complaints about the service were reviewed by the end of life steering committee. Emerging themes discussed included lack of accuracy of death certificates. Minutes recorded in response to this noted that the trust planned to introduce the Medical Examiner role before April 2019. The Medical Examiner would review all deaths not subject to a Coroner’s inquest daily and provide a review of the death certification to ensure deaths were accurately reported.

We found leaflets throughout the hospital telling patients and relatives about how to access Patient Advice and Liaison Service (PALS) to make a formal complaint. The trust website had a section on how to make a complaint.

We spoke to members of the PALS team who told us whilst the patient was alive relatives spoke to them about practical things such as car parking costs and communication issues with medical staff. We were told PALS were often able to help with communication issues between staff and patient/relatives by contacting the staff directly. If a patient had died then PALS said they would assist the relative to make a formal complaint if they wished to do so.

Is the service well-led?
Leadership

Hospital staff we spoke with spoke highly of the chief executive and the chief nurse; both newly appointed in April 2018. Staff told us the profile of end of life care had been raised throughout the hospital since our previous inspection. Although there had been progress, it was still being embedded. Attendance at the end of life steering group in July 2018 showed that there were problems identifying patients who were dying, problems with discharge incidents and equipment not being replaced.

We noted at the last CQC inspection in March 2017 there was no non-executive director (NED) with lead responsibility for promoting end of life care in the trust. This was no longer the case and the trust chair was now the non-executive lead for end of life care and frequently attended the end of life steering group meetings as well as taking an active interest in general end of life matters.

The trust’s executive lead for end of life care was the Chief Nurse. Both the NED and the Chief Nurse regularly attended end of life care steering group meetings.

The Greenwich and Bexley Community Hospice provided the staff for the hospital's specialist palliative care team (SPCT) under contract. The team’s medical consultant and the hospice’s nurse consultant also attended the steering group meetings.

The cellular pathology manager maintained oversight of the mortuary service. Day to day operation of the mortuary including supervising the booking in and the release of bodies was undertaken by the mortuary technician.

Vision and strategy

An end of life care strategy was in place for 2016 – 2019 that established the trust’s planned trajectory of development and improvement in end of life care. The end of life care working group had established the strategy against national guidance including National Institute of Health and Care Excellence (NICE) guidelines for the care of dying adults in the last days of life and the 2015 National Palliative Care and End of Life Care Partnership Ambitions for Palliative and End of Life Care.

The aims and objectives of the strategy were to:

- Improve the consistency of care for patients dying under the care of Lewisham and Greenwich NHS Trust.
- Improve the confidence and competence of staff in the provision of care to dying patients through education and training.
- Improve the symptom control of dying patients.
- Improve the care and support for patients’ families including following bereavement.
- Develop and implement Individualised care plan documentation with associated information resources
- Work in partnership across organisational boundaries to improve the communication of care for dying patients.

The End of Life Care (EoLC) steering group was established to oversee the implementation of the end of life care strategy 2016-19. It had a wide-ranging brief that included reviewing the risk register, incidents and complaints. It also reviewed and ratified policies and had agreed the introduction the treatment escalation plan (TEP) which incorporated the principles of care of the
dying and the delayed bereavement survey. The steering committee discussed trust issues, which affected the safe care of those patients at the end of life such as staffing shortages on the wards.

Minutes we reviewed showed that attendance was variable but included members of the specialist palliative care team as well as the trust chair. There were also representatives from other specialties including elderly, respiratory and critical care, as well as chaplaincy, dietetics and speech and language therapy were present at meetings. There were also lay members and representatives from the local clinical commissioning group at meetings. Attendance at these meetings was variable.

We asked the trust to submit any evidence of strategic planning already in place to follow on from the current end of life care strategy 2016-19. However, we were told the EoLC steering group would undertake a review of the strategy and an updated strategy agreed and launched in April 2019. We were not assured that this was achievable in six months from the time of this inspection since there was no evidence of any planning already underway to launch a new strategy.

**Culture**

We reported after our last inspection we did not find a well-coordinated or coherent end of life care team and there was little contact information posted on wards about how staff could contact either the trust team or GBCH. At this inspection we noted this had improved. We saw screensavers on ward computer screens with ‘care for the dying patient’ information including how to contact the SPCT. The SPCT and the allied healthcare professionals (AHP) such as occupational health and speech and language therapists had printed contact stickers which they placed in the patients’ medical records to highlight their input into the patient’s care. The chaplaincy also had stickers. As previously mentioned staff appeared to be much more aware of the whole concept of the dying patient.

However, we did see and hear evidence of medical staff ‘not giving up’ on patients by continuing active treatment despite nursing staff and on one occasion relatives believing patients to be approaching the end of their life. We found no evidence of this for those patients referred to the SPCT.

**Governance**

The governance reporting structure of end of life care had changed since the previous CQC inspection and there was direct reporting to the trust management board as required. End of life care had a clear governance framework that ensured responsibilities for end of life care could be identified from the trust board of directors through to key members of staff. The chief nurse was the board member with end of life care responsibilities and members of the SPCT were aware of who this was. The chair attended end of life care group meetings and had end of life care responsibility.

The SPCT at the hospital are provided by the Greenwich and Bexley Community Hospice under a contract commissioned directly by the Greenwich and Bexley clinical commissioning groups (CCG).

**Management of risk, issues and performance**
We noted at the last CQC inspection in September 2017 there was no dedicated risk register for end of life or palliative care. Since then such a risk register has been introduced which had 11 current risks on it. Three of the risks related to the University Hospital Lewisham (UHL) site and seven related to either trust wide or community concerns. The one item specifically relating to this hospital was the lack of a seven-day SPCT service. The register had been updated in September 2018 recording that a business case had been submitted to the Greenwich and Bexley CCGs for consideration of funding. We had expected to see the clinical waste storage in the mortuary on the risk register if for no other reason than a potential health and safety issue.

The highest rated risk on the register was the very slow progress which had been made with the end of life care programme both within acute and community pathways since our last inspection report. This was something the chief nurse spoke to us about during our inspection. The risk is recorded as ongoing but we noted it was added to the register only after the chief nurse had been appointed. This reflects to our comments on leadership above.

Another risk was the early recognition of the dying patient which was also noted in the previous inspection. A treatment escalation plan (TEP) was introduced across the trust at the beginning of September 2018 and identified treatment options which medical and nursing staff discussed with patients and their family. The greater awareness by staff of the principles of care for dying patients should also increase early recognition.

Mortality and Morbidity (M&M) meetings took place to review deaths as part of professional learning and used to monitor the quality of care delivered to patients. Twenty five percent of all deaths had a structured judgement review (SJR) at this group. There was a discussion in the August 2018 minutes about the inclusion of a core set of measures to be added to the end of life care section of the SJR forms.

M&M meetings provide an opportunity for reflection and education about high quality end of life care. We noted that members of the palliative care team were not consistently represented at these meetings. Whilst the lead cancer nurse was at three of these meetings, there was no consultant palliative care consultant presence at any meeting between April and September 2018. There were no apologies recorded therefore we were unclear whether they were part of the M&M meetings or were on the circulation list to receive minutes.

Information management

Staff we spoke with told us they could access the information they needed to provide safe and effective care. Patient records were mostly in paper form although the trust is moving towards an electronic record system.

Staff stored paper medical records securely when not in use in areas with restricted access. We saw staff locked computer screens when not in use, which helped to prevent unauthorised access to confidential information.

SPCT staff completed records on their own GBCH electronic system as well as the hospital’s paper record.

Engagement

The trust has an annual staff awards ceremony to highlight and congratulate staff for their dedication and commitment. There was an excellence in end of life care award; which was
awarded last year to a healthcare assistant at UHL. Staff are nominated by colleagues and members of the public via the trust’s website.

In May 2018, the trust participated in ‘Dying Matters’ week which gave them a chance to meet with members of different faiths as well as the board member with end of life care responsibility. This attracted many members of the public and feedback we saw was very positive.

The trust’s website gave details of the bereavement services available at the hospital including details of the Coroner, how to register a death and how to obtain the required death certificate. The website also explained how to contact the trust to complain or compliment staff or services.

Learning, continuous improvement and innovation

The chief nurse told us she planned to continue to raise the profile of end of life care across the trust. They were proposing to invite nursing staff from local care homes to take part in end of life training with the aim of preventing unnecessary movement of residents into hospital towards the end of their life.
This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

There are two sites at Lewisham and Greenwich NHS Trust with urgent and emergency care departments. These are:

- Queen Elizabeth Hospital
- University Hospital Lewisham

(Source: Routine Provider Information Request (RPIR) – Sites tab)

University Hospital Lewisham (UHL) provides urgent and emergency care services which are open 24 hours a day, 365 days per year. UHL is a trauma receiving unit and emergency surgery is undertaken at the Hospital. The hospital receives emergency adult, paediatric and maternity patients.

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. All adult patients walking into the emergency department (ED) were initially seen by a nurse who carried out an initial assessment (streaming). Patients identified who require a further clinical assessment are then triaged using
the Manchester triage system'. This is a recognised assessment tool used in ED's. Patients were prioritised to be seen in the urgent care centre (UCC), to be seen by a GP or offered a GP appointment, directed to ambulatory care if referred by the GP and accepted by the ambulatory care team. Once streamed patients were then sent to the receptionist to register. If a patient required urgent assistance and couldn’t wait to be triaged the patient would be taken directly to the ED.

The paediatric ED was separate from the adult ED with its own waiting area. There were 31,513 paediatric attendances during the period April 2017 to March 2018.

During this inspection we spoke with 19 staff from a range of clinical and non-clinical roles and of varying grades. We spoke with seven patients and relatives. We reviewed 10 patient records. We made observations and looked at documentary information accessible within the department and provided by the trust.

**Activity and patient throughput**

The total number of attendances for urgent and emergency care services at the trust is provided in the table below. From April 2016 to March 2017 there were 277,294 attendances at the trust’s urgent and emergency care services as indicated in the chart above. This figure included children.

**Urgent and emergency care attendances at Lewisham and Greenwich NHS Trust compared to all acute trusts in England, April 2016 to March 2017.**

(Source: NHS England)
Urgent and emergency care attendances resulting in an admission

The percentage of attendances in urgent and emergency care that resulted in an admission, increased in 2016/17 compared to the previous year (2015/16). In both years, the proportion was lower than the England average for that year.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from March 2017 to February 2018

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

Of all attendances, the majority (143,644) were discharged, with 39,309 being admitted to hospital. Additionally, 6,786 attendees left the department either before treatment or having refused treatment.

(Source: Hospital Episode Statistics)
Is the service safe?

Mandatory training

The trusts mandatory and statutory training policy identified the legislative and trust specific training that staff are required to attend and the frequency that specific training modules should be refreshed. The policy identifies the core subjects, skills and knowledge specific to the clinical and non-clinical directorates, which also includes staff on the trusts bank. Temporary staff employed via agencies and contractors statutory and mandatory training requirements must be met by their employer.

Mandatory training was monitored through the trusts corporate training register with training provided as part of an annual programme throughout the year. Staff we spoke with told us that their training was mostly up to date.

Training completed by nursing staff since July 2018 demonstrated compliance had improved in three of the mandatory training modules. These were fire safety, patient manual handling and basic life support which were all 96% compliant.

Sepsis training was part of the trust induction programme, all new staff received training.

Mental health training was provided to nursing staff by members of the mental health liaison team (MHLT). However, this training was not regularly available. The MHLT were in the process of developing a mental health training schedule for the ED staff. The MHLT attended the emergency department (ED) away days every two months to provide them with a talk and discussion on supporting patients with mental health needs.

Staff received training in breakaway and de-escalation techniques. Security staff were further trained in managing violence and aggression, which include restraint. In addition, the security lead had provided security staff with mental health awareness training in February 2017.

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the adult urgent and emergency care department at University Hospital Lewisham is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution enhanced</td>
<td>111</td>
<td>112</td>
<td>99.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>113</td>
<td>119</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>109</td>
<td>119</td>
<td>91.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>107</td>
<td>119</td>
<td>89.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>105</td>
<td>119</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>105</td>
<td>119</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>103</td>
<td>119</td>
<td>86.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>94</td>
<td>119</td>
<td>79.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - HLS</td>
<td>88</td>
<td>116</td>
<td>75.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>84</td>
<td>119</td>
<td>70.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>60</td>
<td>119</td>
<td>50.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>58</td>
<td>119</td>
<td>48.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
At University Hospital Lewisham’s urgent and emergency department, the 85% target was met for seven of the 14 mandatory training courses made available to them.

In the paediatric ED the trust advised that all staff are trained in paediatric life support, and were 100% compliant over the past 6 months with every shift having at least two staff trained and up to date in paediatric life support on duty.

### Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>29</td>
<td>42</td>
<td>69.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>29</td>
<td>42</td>
<td>69.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>27</td>
<td>42</td>
<td>64.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>24</td>
<td>42</td>
<td>57.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>17</td>
<td>42</td>
<td>40.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>16</td>
<td>42</td>
<td>38.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>13</td>
<td>42</td>
<td>31.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>11</td>
<td>42</td>
<td>26.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>7</td>
<td>42</td>
<td>16.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in University Hospital Lewisham’s adult urgent and emergency care department did not meet the target for any of the 10 mandatory training courses made available to them. The highest completion rate within this staff group was 69% for information governance training and infection control clinical training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Senior medical staff acknowledged that mandatory training levels were below the trust target and that medical staff levels made it difficult to release people to attend training. Mandatory training was not linked to the trust appraisal process. Senior medical staff told us they were considering setting up specific days for medical staff to attend their mandatory training.

### Safeguarding

Staff we spoke with were aware of their responsibility to protect vulnerable children and adults. They understood how to access the trust safeguarding policy and understood how to report concerns.

*Safeguarding supervision was provided by the safeguarding team.*

Weekly paediatric ED safeguarding meetings took place chaired by a consultant paediatrician, attended by a paediatric nurse, doctor and an emergency nurse practitioner (ENP), a representative from the local social work team and a representative from the adult ED if patients between 16 to 18 years of age were being discussed. Staff told us referrals to local authority children’s services
were made as and when required, including on an urgent basis, and are not ‘held back’ for the weekly meeting.

Both adults and children safeguarding leads were managed by the associate director of nursing.

Adults and children safeguarding had a separate Safeguarding Assurance Group (SAG) meetings which are chaired by the associate director of nursing which reported into the trusts safeguarding committee which met quarterly.

All children using the ED were checked on the child protection information sharing programme (CP-IS). The Child Protection Information Sharing (CP-IS) programme is an NHS England sponsored nationwide initiative that helps clinicians in unscheduled care settings identify vulnerable children. Data relating to children (including unborn children) with a Child Protection Plan (CPP) or with Looked After Status (LAS) is securely transmitted to and stored in CP-IS on the NHS Spine and is presented as a flag indicating the patient is a vulnerable child.

The trust set a target of 85% for completion of safeguarding training.

**University Hospital Lewisham**

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 for staff in the adult urgent and emergency care department at University Hospital Lewisham is shown below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children &amp; Young People Level 3 - Specialist</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Young People Level 2</td>
<td>114</td>
<td>116</td>
<td>98.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Clinical Level 2</td>
<td>111</td>
<td>119</td>
<td>93.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff at University Hospital Lewisham’s adult urgent and emergency care department met the 85% training target for all three of the safeguarding courses made available to them.

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Clinical Level 2</td>
<td>29</td>
<td>42</td>
<td>69.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Young People Level 2</td>
<td>2</td>
<td>3</td>
<td>67.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Young People Level 3 - Core</td>
<td>24</td>
<td>39</td>
<td>62.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At University Hospital Lewisham’s adult urgent and emergency care department, medical staff did not meet the training target for any of the safeguarding courses made available to them.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Cleanliness, infection control and hygiene

During inspection, we found the ED and the paediatric ED appeared visibly clean and tidy. Cleaning staff could be seen in different parts of the ED during the day. ‘I am clean’ stickers had been dated and were visible to indicate that the equipment had been cleaned and was ready for use. In the paediatric ED one parent commented that staff washed their hands, and department has always been clean on their visits.

Staff were bare below the elbow and used personal protective equipment (PPE) such as gloves and aprons. We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Patients and visitors were asked to use sanitising gel and gel dispensers were clearly visible at the entrance to the different areas within the ED. We were not made aware of any patients in the department requiring isolation during the inspection.

We found that sharps management complied with Health and Safety (sharps instruments in healthcare) Regulation 2013. Sharps bins were dated when opened and were not over filled. Disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharps instrument containers. The ED had designated bins and colour coded bags for clinical waste.

Chairs in the adult ED, paediatric ED and waiting area were plastic so that they could be cleaned easily. Disposable curtains were checked and labels indicated when they came into use and when they were due to be renewed.

The trust had an infection prevention and control team (IPCT) that worked across the trust and in addition had a lead clinician for infection control at UHL. The infection prevention and control team monitored compliance with all relevant guidance and standards from the Department of Health and other organisations.

In the paediatric ED for the six month period April 2018 to September 2018 audits were undertaken monthly except in June 2018 when no data was provided. Over the five months that were reported compliance for hand hygiene before patient contact and after patient contact was 100%. In clinical areas we observed that staff complied with the trust policy of bare below elbows.

In the adult ED for the six month period April 2018 to September 2018 audits were undertaken monthly except in May 2018 when no data was provided. Over the five months reported compliance for hand hygiene before patient contact and after patient contact was not consistent. Compliance varied from between 85% in July, August and September 2018, 90% in April 2018 and 95% June 2018. In clinical areas we observed that staff complied with the trust policy of bare below elbows.

Saving lives cleaning and decontamination audits were undertaken monthly in the adult ED. This showed compliance was below the trust target of 96%. Compliance in April 2018 was 91% June 2018 80%, July 2018 73%, August 89% and September 2018 80%.

Joint infection prevention control, contractor and estates audits were undertaken in May 2018. These audits showed that the adult ED was 87% compliant and the paediatric ED was 96% compliant. Action plans were in place.
Environment and equipment

The nurse in charge of majors had oversight of the department which had 19 cubicles which includes 4 recently reconfigured cubicles which enables the department to accommodate mental health patients awaiting admission. The department had recently changed one of the cubicles to a ‘fit to treat area’ which had six chairs. The resuscitation area had five trolley bays plus two monitored cubicles which included a bay designated for children which was in easy access of the ambulance arrive area. The ED had two rooms with ensuite toilets to afford greater privacy or for infection control purposes. In addition there is a negative pressure room for highly infectious patients.

The clinical decisions unit (CDU) had spaces for 11 beds and a small waiting area with four chairs; there were no trolleys or beds. The urgent care centre (UCC) which had nine consulting rooms and two treatment rooms. The ambulatory care could accommodate 18 patients on 14 chairs and 4 trolleys. In additional the unit has 3 consultation rooms for patients to be seen.

The waiting area was clean with sufficient seating and was mostly used by patients waiting to be seen by GP’s or Emergency nurse practitioners in the UCC.

The majority of patients requiring a mental health assessment go to the psychiatric assessment room following any medical assessment or investigations. The room is in the emergency department and can be seen clearly from the staff base. The room meets the standard for mental health assessment rooms in emergency departments. (Quality standards for liaison and psychiatry service, Psychiatric Liaison Accreditation Network (PLAN), 2017) the mental health liaison team has a dedicated room in the ED for them to use as an office after they have assessed a patient.

Patients requiring further medical or mental health assessments sometimes went into one of the four cubicles in the major’s area of the department. These bays were used when it became busy or a patient had to wait longer for a bed to become available on a mental health inpatient unit.’ Usually this is in newly configured cubicles which allow lights to be turned off enabling patients to sleep when they are waiting for a mental health bed for over 24 hours. Some of the cubicles are not in sight of the nursing station in majors. This does not reduce the potential risks patients could present to themselves or others. A toilet is located next to the cubicles that have been recently fitted with ligature free equipment to reduce risks to patients.’

The paediatric ED was separate from the adult ED, access to the department was via an intercom which was overseen from reception. The department had a large play area for children, two triage rooms, a majors area which had 4 beds and two cots, isolation rooms and short stay unit for children who require admission for up to 24 hours.

Resuscitation trolleys were located in different areas of the ED readily available and within easy access for staff. We found there were gaps in the daily checking of resuscitation equipment in the adult ED. In the paediatric ED paediatric appropriate equipment was available.

Assessing and responding to patient risk

Patients presented to the department either by walking into the reception area or arrived by ambulance via a dedicated ambulance-only entrance. Those requiring immediate treatment were taken to the resuscitation area. The ambulance service telephoned the department to alert them of
the arrival of a patient needing immediate treatment; this would ensure a team was waiting for them on arrival.

All adult patients walking into the emergency department are initially seen by a nurse who carries out an initial assessment (streaming). Patients who require a further clinical assessment are then triaged using the Manchester triage system. This is a recognised assessment tool used in ED. Patients were prioritised to be seen in the urgent care centre (UCC), to be seen by a GP or booked an appointment with their GP or directed to ambulatory care if referred by their GP. Once streamlined, patients were then sent to the receptionist to register. If a patient required urgent assistance and couldn’t wait to be triaged the patient would be taken directly to the ED. The trust had a draft standard operating procedure in place to support the streaming to the ACU or to GP’s.

Between September 2017 and August 2018, the adult ED triaged and saw an average 43% of adults within 15 minutes of arrival.

Children walking into the ED were registered at reception and would be directed to the paediatric ED where they would be triaged by a paediatric nurse.

Between October 2017 and September 2018, the paediatric ED triaged an average of 65% of children within 15 minutes of arrival.

The records reviewed showed the ED used the National Early Warning Score (NEWS) system to detect deterioration in adult patients. Nine of the ten records we looked at had completed NEWS sections.

As part of the quality assurance in the ED the nurse in charge of majors checked all patients every four hours. This included checking NEWS that risk for pressure areas, continence and safeguarding had been identified. If patients had been waiting longer than four hours to be placed in a hospital bed the quality checks also monitored if patients had been offered food and drink.

We saw evidence of the quality assurance tool being completed each day every four hours for the last 25 days prior to the inspection.

There were sepsis care bundles for adults and within the paediatric ED which were age appropriate. Between April and June 2018 90.7% of all adult admissions across the trust who presented with suspected sepsis to the EDs were administered intravenous antibiotics within 1 hour of arrival in line with National Institute for Health and Care Excellence (NICE) guidance.

The service included round the clock access to the MHLT (covering the age range of the ward/clinic) and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health. Emergency department staff completed a brief assessment of mental health at triage and referred these patients to the mental health liaison team so they could be assessed as quickly as possible.

Patients had a mental health assessment as soon as possible when they had taken an overdose, harmed themselves, or may have been a risk to others. The mental health psychiatric liaison team aim to assess patients within one hour of referral. Emergency department staff booked a registered mental health nurse to carry out constant observations on patients who are high risk or placed under mental health act section to reduce the risk to staff and patients. Patients also had the opportunity to leave the emergency department before a mental health assessment.

The trust had an enhanced care policy in place. This outlined the when staff should carry out constant observations on a patient that had been deemed high risk. For example, if a patient was a harm to themselves or others and at risk of absconding.
Security staff had developed a risk profile handover sheet with the MHLT. This included the patients’ risk factors, what they were wearing and whether they displayed any aggressive or violent behaviour. Security staff used this when they needed to observe a patient that was a high risk of suicide, harm to themselves or others in the ED.

Staff had developed a joint protocol between the ED staff and mental health liaison staff for observing patients at high risk of suicide and self-harm. This stated that a patient at high risk of harm to themselves should be placed under constant observation from the point of assessment. This protocol was last reviewed in April 2016. This did not reduce the risk to patients at high risk as this protocol may not have been used by staff. The trust had devised a joint escalation protocol with the mental health liaison team for ED staff to follow when requesting a mental health assessment.

The staff nurse reported that rapid tranquilisation was rarely administered to mental health patients in the ED department. Staff did not know if the trust had a rapid tranquilisation policy. However, the trust provided us with a draft copy of their rapid tranquilisation policy after the inspection. The policy followed best practice and referred to carrying out physical health observations on patients every 10 minutes for the first hour to safely monitor the patient. Rapid tranquilisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need.

The trust scored “worse than” other trusts for two of the five Emergency Department Survey 2016 questions relevant to safety and “about the same” as other trusts for the remaining three questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>8.1</td>
<td>About the same as other</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.4</td>
<td>About the same as other</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait</td>
<td>5.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>before being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>7.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel</td>
<td>9.3</td>
<td>About the same as other</td>
</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td>trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The trust’s median time from arrival to initial assessment for emergency ambulance cases was consistently worse than the overall England median in each month over the 12 month period, from June 2017 to May 2018.
In May 2018 the median time to initial assessment was 14 minutes compared to the England average of 8 minutes.

Ambulance – Time to initial assessment from June 2017 to May 2018 at Lewisham and Greenwich NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

The trust provided information up to September 2018 which showed a similar pattern.

From July 2017 to June 2018, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at University Hospital Lewisham. During this 12-month period the value fluctuated between 60% and 68%.

Ambulance: Number of journeys with turnaround times over 30 minutes - University Hospital Lewisham

Ambulance: Percentage of journeys with turnaround times over 30 minutes - University Hospital Lewisham

Over the reporting period, the monthly percentage of ambulance journeys with turnaround times over 30 minutes at University Hospital Lewisham was consistently higher than Queen Elizabeth Hospital.

(Source: National Ambulance Information Group)
During the inspection we observed ambulance crews were greeted by the nurse in charge of majors on arrival, the triage was completed within 15 minutes. The handovers from the ambulance crews were appropriate and the patients were given information concerning the next steps in their treatment. Patients were then allocated to the areas within the ED that was appropriate to their clinical condition.

Display screens for monitoring crews arriving and time waiting were displayed so staff were aware of incoming crews so they could plan ahead. We observed good interaction between clinical and ambulance staff.

There was a floating member of nursing staff daily which could be allocated to care for patients if ambulance crews had to wait to hand over patients and had to queue in the corridor.

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From July 2017 to June 2018 the trust reported 467 “black breaches”, with a distinct peak being witnessed in the winter months. This is especially prevalent in December 2017 (99) and January 2018 (119).

![Graph showing black breaches over time]

Please note, the trust did not submit data for May 2018, therefore we are unable to comment on performance for this month.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Between October 2017 and September 2018, a total of 205 black breaches were reported at UHL. The winter months between December 2017 and March 2018 saw the largest number of black breaches which saw 79% (162) black breach occurring during this period.
Nurse staffing

The trust reported the following qualified nursing staff numbers as of March 2018 and June 2018 for adult urgent and emergency care:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
<th>Fill rate</th>
<th>March 2018</th>
<th>June 2018</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>106.6</td>
<td>134.6</td>
<td>79.2 %</td>
<td>115.6</td>
<td>140.7</td>
<td>82.1 %</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The adult ED staffing establishment consisted of the following: 1.6 whole-time equivalent (WTE) Band 8a matrons (job share), 3 WTE Band 8a emergency nurse practitioners, 13 WTE Band 7 nurses, 45.5 WTE Band 6 nurses, 45.5 WTE Band 5 nurses, 12 WTE health care assistants (HCA).

Nursing recruitment was an issue in the adult ED; the department had 1 WTE Band 7 vacancy, 3 WTE Band 6 and 15 WTE Band 5 nursing vacancies. Senior staff told us that 3 Band 5 nurses had recently been recruited. The department had used bank and agency staff to cover shifts. Staff told us that the agency staff were regular staff and they had the required skills to work in the department.

The trust had an ongoing nurse recruitment programme which included, rolling recruitment adverts, attendance at recruitment fairs and offering student nurses interviews after they had completed their training.

Mental health liaison nurses were available to assess patients throughout the day and night in the emergency department. The mental health service was hoping to meet the ‘core 24’ standard. Due to the smaller size of the ED the mental health liaison team did not meet the standard.

The emergency department also booked an agency registered nurse for each shift when needed. These nurses provided care for patients with mental health problems, including enhanced levels of visual observation, where required.

We observed a nursing handover from night to day staff. Each patient was discussed with an overview of their conditions and treatment plan. All nursing staff were allocated to bays and different areas within the ED. A new starter nurse was placed with a ‘buddy’ nurse for the shift.

The Royal College of Paediatrics and Children’s Health (RCPCH) mandate that staffing levels within paediatric ED, should be staffed by having a minimum of two registered childrens nurses (RCN) in the ED 24 hours a day seven days per week. The trust advised that all shifts in the last year had at least two RCNs on duty.

The paediatric ED was part of the childrens and young people division which had a head of nursing that worked across hospital sites and in the community. The paediatric ED’s staffing establishment comprised of 2 WTE band 7 RCNs, 8 WTE band 6 RCNs, 15 WTE band 5 RCNs, 5 WTE HCA’s and a 0.8 WTE play specialist.

Senior staff advised that the department had more HCA’s due to the difficulty recruiting band 5 nurses. There were currently 10 WTE Band 5 vacancies within the paediatric ED. To ensure that rota was covered the department used their own staff to cover bank shifts at an enhanced rate; a
rotation programme had been put in place to help retain and develop staff. The paediatric ward RCN's would also provide cover. Experienced HCA's had been trained in cannulation and taking observations.

Nursing staff in the paediatric ED told us there were occasional issues with staffing problems with staffing. The staffing rota had two triage nurses, one nurse in charge, one in majors, and one nurse in the short stay unit. However, when there were only three nurses present on shift the short stay unit stopped accepting patients, and they were admitted to the paediatric ward.

An induction process was in place for new starters, bank and agency staffing the ED. The ED had an induction folder and we saw evident of last years inductions having taken place. We also observed an induction of an agency nurse in the adult ED. It covered all relevant information such as incident reporting, how to use equipment, what to escalate and to whom, and the national early warning score (NEWS).

From July 2017 to June 2018, the trust reported a vacancy rate of 20.4% for qualified nursing staff in urgent and emergency care. This was worse than the trust target of 14%.

The breakdown of vacancy rate by site is provided below:

- University Hospital Lewisham: 18.8%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From July 2017 to June 2018, the trust reported a turnover rate of 12.0% for qualified nursing staff in urgent and emergency care. This was the same as the trust target of 12%.

A breakdown of turnover by site is provided below:

- University Hospital Lewisham: 3.8%

Nursing staff at Queen Elizabeth Hospital performed worse than the trust's target for turnover.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From July 2017 to June 2018, the trust reported a sickness rate of 3.8% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 3.5%.

A breakdown of sickness rate by site is provided below:

- University Hospital Lewisham: 3.7%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
From July 2017 to June 2018, the trust reported 11,371 shifts were covered by bank and agency staff. Of these, 48.1% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 31.1% of shifts were filled by agency staff. In addition 6.7% of shifts were not filled by bank and agency staff to cover staff absence.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Bank shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital Lewisham</td>
<td>2,704</td>
<td>1,407</td>
<td>439</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

Medical staffing

The ED was not meeting the Royal College of Emergency Medicine (RCEM) recommendations that consultants should provide 16 hours of emergency cover seven days per week. This was similar to what we found at the last inspection.

The department was providing a minimum of 15 hours of consultant presence 7 days per week. University Hospital Lewisham had eight WTE consultants in post, however had funding for 12 WTE emergency medicine consultants. Senior staff told us that the consultant team were covering a lot of bank shifts and this had been the case for the last five years. The department had recently recruited to two consultant posts who were due to start shortly.

Senior staff told us their main concerns were linked to the skills mix of middle grade doctors and the department should have 12 middle grade doctors to have two registrars on at night and during the day. The department had two specialist trainee year four (ST4) posts and one was currently vacant. Middle grade doctors were doing extra bank shifts, however senior staff advised the pan London agreement for bank shifts had impacted on the number of shifts being covered by bank staff. The department had dedicated rota coordinator, and saw the introduction of e-rostering as positive to help identify gaps.

The paediatric ED was meeting the Royal College of Paediatrics and Child Health care standards for emergency care settings seeing more than 16,000 children per annum employ a consultant with sub-specialty training in paediatric emergency medicine. The paediatric ED had four paediatric emergency medicine (PEM) consultants. A consultant told us there was consultant cover approximately 80% of the time. PEM consultants cover was from 09.00 am to 05.00 pm with a PEM consultant present until 10pm three nights per week. Where there was no dedicated PEM consultant cover, paediatric consultants from the childrens and young people wards would cross cover. The paediatric ED also shared middle grade doctors with the ward usually one on ward, one in the paediatric ED.

Medical staff in the paediatric ED told us the majority of locum shifts were covered internally by existing staff, or by staff their bank who had worked in the department before. However, a clinical staff member told us the junior doctors rota was not compliant with the new junior doctor contract; there were some weeks when junior doctors worked more than 72 hours. This had been flagged up to the consultant who writes the rota.
The trust reported the following medical staffing numbers as of March 2018 and June 2018 for urgent and emergency care by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>37.3</td>
<td>49.4</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From July 2017 to June 2018, the trust reported a vacancy rate of 35.3% for medical staff in urgent and emergency care. This was worse than the trust target of 14%.

A breakdown of vacancy by site is provided below:

- University Hospital Lewisham: 31.1%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From July 2017 to June 2018, the trust reported a turnover rate of 42% for medical staff in urgent and emergency care. This was worse than the trust target of 12%.

A breakdown of turnover by site is provided below:

- University Hospital Lewisham: 35.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From July 2017 to June 2018, the trust reported a sickness rate of 0.5% for medical staff in urgent and emergency care. This was better than the trust target of 3.5%.

A breakdown of sickness by site is provided below:

- University Hospital Lewisham: 1.1%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From July 2017 to June 2018, the trust reported the following bank and agency staff usage at UHL in urgent and emergency care services. The following tables show a breakdown by site;
University Hospital Lewisham

<table>
<thead>
<tr>
<th>Location</th>
<th>Locum shifts</th>
<th>Agency shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>91</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>Middle grade</td>
<td>1,037</td>
<td>0</td>
<td>127</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>1,019</td>
<td>2</td>
<td>241</td>
</tr>
<tr>
<td>Total</td>
<td>2,147</td>
<td>2</td>
<td>410</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In December 2017, 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.

Staffing skill mix for the 68 whole time equivalent staff working in urgent and emergency care at Lewisham and Greenwich NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>39%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>32%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

We looked at eight sets of clinical records in the adult ED, two clinical records in the paediatric ED and three clinical records of patients admitted to the ED with mental health needs. We saw that patient records were held securely.

We found good practice in terms of recording allergies, NEWS and pain assessments. Plans of treatment were documented and entries were signed, dated and timed. However, we found that assessments for venous thromboembolism (VTE) and pressure areas using a national risk assessment tool were not always completed.
Patient medications records were clear in respect to what they were prescribed and frequency of medications.

Vulnerable patients who were known to have a learning disability, special plans, a re-attender, or had a history of violence were flagged on the IT system and senior staff were able to add flags if one was required. Patient living with dementia were documented in the ED records. The four hourly quality assurance checks by the nurse in charge also picked up if patients were vulnerable because of their needs.

A paper record was generated by reception staff (known as a ‘CAS’ card) registering the patient’s arrival in the department to record the patient’s personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document. The ED was in the process of moving to becoming ‘paper lite’. Patient records were scanning on to the system.

**Medicines**

Medicines were stored securely within locked clinical treatment rooms which were accessible via digilocks.

We saw controlled drugs were recorded and handled appropriately with two nurses signing when controlled drugs were being administered. However, in the CD register in paediatric ED, there was an incomplete record, for example, with only one staff member signing and patient details were not completed.

Staff had access to medicines out of hours. Pre-label labelled medicines packs (analgesia and antibiotics) were available for nurses to give out supplies labelled with appropriate instructions for patients to take home. However, an outsourced pharmacy was now operating within the hospital; use of medicines to take out (TTO) had decreased.

Appropriate records were kept of pre-label labelled medicines packs that staff could access. Whilst we saw a list of all the staff who had been trained to give out these medicines, the names were out of date. Staff were advised to update the list of names.

In the adult FP10 prescriptions were not managed appropriately. We did not see records kept for the FP10s in stock. In paediatric ED, staff told us that they were exempt from keeping records of FP10s used due to the level of activity there. FP10 prescriptions were stored in a safe.

Fridge and room temperatures were taken each day to ensure medicines were stored at the correct temperature. In the adult ED we saw that daily fridge checks and room temperatures were undertaken the majority of time, however we found some gaps in the daily checks. We also noted that no action was documented when fridge temperature were recorded out of range. In the paediatric accident and emergency department, staff took appropriate actions when temperatures were out of range.

We observed three nursing staff administer medicines in the resuscitation area. All the medicines were checked and administered safely using appropriate infection control measures such as gloves. Drug charts were completed and allergy checks were documented.

Patient group directives were in place to cover nurses giving medications. We saw that staff had received adequate training.

Pharmacists are available and visit adult and paediatric ED’s regularly. For adult ED a designated pharmacist is in ED and UCC daily to provide assistant to staff.
Emergency department staff could access an intravenous medicine guide and a BNF online.

**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.

From June 2017 to May 2018, the trust reported no incidents classified as never events for urgent and emergency care.

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type and location was as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>University Hospital Lewisham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>0</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Disruptive/ aggressive/ violent behaviour meeting SI criteria</td>
<td>0</td>
</tr>
<tr>
<td>Major incident/ emergency preparedness, resilience and response/suspension of services</td>
<td>0</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>0</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

(Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)

Serious incidents (SIs) and incidents were discussed as part of the ED clinical governance meetings. Four SIs were reported on STEIS between September 2017 and September 2018. One of these SI was de-escalated following further review by the ED multidisciplinary team and another was currently under investigation. SIs was investigated and lesson learnt identified. In one SI we reviewed, the duty of candour arrangements were detailed which included feed back to the patient the results of the investigation when the report had been finalised.

From November 2014, NHS providers were required to comply with the duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

The trust used an electronic incident reporting system widely used in the NHS to report incidents including near misses. Staff we spoke with were aware of how to report incidents. Staff told us that learning from incidents was shared. Information board had details of the top five themes of reported incidents, these were pressure ulcers, slips, trips and falls, medication incidents,
infrastructure (staffing, IT, facilitates, patient waiting in the ED for a mental health bed) and treatment and procedures. A list of learning points from the five themes was displayed for staff.

There had been an increase in incidents of violence and aggression in the ED over the last 12 months. A dedicated security officer stayed in the ED 24 hours a day and this had been in place for three months. The matron had undertaken a review of security in the ED and had finalised a business case at the time of the inspection to have permanent full time security cover. Following the inspection the trust has told us the business case had been approved.

There had been four incidents in the ED of patients attempting suicide whilst in the ED in 2018. The management of mental health patients in the ED was identified on the acute and emergency medicine directorate risk register.

The adult ED reported a total of 1627 incidents in the period 1st September 2017 to September 2018. Of which 1407 were graded as no harm, 193 were low harm, 23 were near misses, and two were moderate harm and two serious harm / death.

The trust provided morbidity surveillance group (MSG) meetings for January, March and May. The MSG reviewed deaths from across the trust. The minutes were not clear if lessons learnt had been identified and had been acted upon. In hospital mortality was discussed monthly at the NHNN All deaths in the ED were reviewed and recorded on the morbidity and mortality record and were discussed as part of the ED Governance meetings. Trust wide mortality review meetings were held monthly. The agenda included the review and monitoring of divisional mortality plans which were presented. Action points were identified and reviewed at the following meeting.

Major incident awareness

The trust had a major incident plan which had been issued in June 2018 and was due to be reviewed in May 2019.

Staff working in the ED received specific training on dealing with major incidents. Chemical, biological, radiological and nuclear (CBRN) training was being provided. Training data seen during the inspection showed that 95% of nursing staff had completed the in-house training course.

Safety thermometer

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 collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from May 2017 to May 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

Staff working in the emergency department (ED) had access to professional policies and procedures. Policies, procedures and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines. Policies, procedures and guidelines were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. Where relevant, these referred to the Royal College of Emergency Medicine (RCEM), and other guidelines.

Guidelines were easy to find. As well as being available on the trust's intranet, they were available in hard copy at in case of intranet downtime. Staff told us they were reviewed by consultants to ensure that review dates were adhered to. We saw the guidelines were in date, with appropriate review dates.

The trust provided details of the RCEM audits undertaken by the adult and paediatric ED’s in 2017/2018 these included the RCEM procedural sedation audit, pain in children audit, and fractured neck and femur audit. The trust was also participating in the national commissioning for quality and innovation (CQUIN); improving services for people with mental health needs who present to A&E to reduce attendances by frequent attenders. UHL had selected 28 patients to be part of the CQUIN.

The trust had an operational policy with the local mental health trust detailing the service provision and staffing of the mental health liaison team (MHLT) which was available within the ED 24 hours a day 365 days per year.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff from the MHLT attended the handovers.

Staff referred for a mental health assessment for patient’s suspected to be experiencing depression.

The ED had a link nurse for sickle cell patients. The sickle cell pathway was in line with NICE guidance and included a proforma for analgesia to be administered within 30 mins, and a clear treatment plan. The link nurse carried out quarterly audits to monitor to ensure the proforma was being used correctly and undertook refresher training with doctors and nurses.

Nutrition and hydration

The nutritional and hydration status of patients who were brought into the resuscitation or major’s area was considered. Intravenous fluids were prescribed and given where indicated and was noted in patient records.

Nursing records showed staff regularly offered patients food and drink to meet their nutrition and hydration needs.

In the CQC Emergency Department Survey 2016, the trust scored 5.5 out of 10 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
Pain relief

Patient group directives (PGD’s) were in place for nursing staff to administer pain relief. The department held a list of nursing staff trained to give medicines under PGD’s.

We saw evidence in patient records that pain tools were used to assess patients pain and records demonstrated that pain relief was administered. One patient we spoke with told us they had been offered adequate pain relief.

In the CQC Emergency Department Survey 2016, the trust scored 6.4 out of 10 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was the same as other trusts.

The trust scored 7.3 out of 10 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>5.5</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Patient outcomes

The trust provided action plans for three of the Royal College of Emergency Medicine (RCEM) audits for moderate and acute severe asthma, consultant sign off and sepsis and septic shock undertaken in 2016/2017.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, University Hospital Lewisham failed to meet any of the standards. The department was in the upper UK quartile for two of the seven standards reviewed:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 41.2%; UK: 26%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
  - This department: 72.7%; UK: 52%.

The department was in the lower UK quartile for three standards:

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. This department: 11.8%; UK: 19%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 0%; UK: 19%.
- Standard 5b (fundamental): within 4 hours (moderate). This department: 0%; UK: 28%.

The department’s results for the remaining two standards were all within the middle 50% of UK emergency departments.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, University Hospital Lewisham - Paediatric A&E failed to meet any of the standards. The department was in the upper UK quartile for three of the seven standards reviewed:

- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  
  Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 35.7%; UK: 19%.
- Standard 5b (fundamental): within 4 hours (moderate). This department: 52.9%; UK: 28%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  
  Adults 16 years and over: 40-50mg prednisolone for 5 days
  Children 6-15 years: 30-40mg prednisolone for 3 days
  Children 2-5 years: 20mg prednisolone for 3 days
  This department: 76.9%; UK: 52%.

The department was in the lower UK quartile for one standard:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 4%; UK: 26%.

The department’s results for the remaining three standards were all within the middle 50% of UK emergency departments.

(Source: Royal College of Emergency Medicine)

A re-audit of the RCEM moderate and acute severe asthma audit was undertaken by the trust in November 2017 information provided by the trust indicated that progress had made in all parameters, except the use of a proforma. The re-audit showed that the trust had performed against national standards in 3 parameters, recording of vital signs, chest X-ray performed in life-threatening asthma and oral prednisolone administered on discharge if indicated.

A new proforma and patient discharge information letter incorporating all recommendations were ratified at ED clinical governance meeting on 21st of June 2017 and introduced into practice. Asthma teaching sessions were held for junior doctors and nurses.

In the 2016/17 RCEM consultant sign-off audit, University Hospital Lewisham failed to meet any of the standards.

The department’s results for all standards were within the middle 50% of UK emergency departments.
The department was not in either the upper UK quartile or the lower UK quartile for any of the four standards reviewed.

(Source: Royal College of Emergency Medicine)

The trust provided details of a self-assessment checklist and action plan following the 2016 RCEM consultant sign-off audit. This indicated the difficulty of recruitment for consultants and the current consultant staffing levels impacted on performance against the standards.

In the 2016/17 RCEM Severe sepsis and septic shock audit, University Hospital Lewisham was in the upper UK quartile for three of the eight standards reviewed:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 100%; UK: 69.1%.

  For this metric, University Hospital Lewisham achieved the national standard of 100%.

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 68.0%; UK: 43.2%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 38.0%; UK: 18.4%.

The department was in the lower UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 42.0%; UK: 64.6%.

The department’s results for the remaining four standards were all within the middle 50% of UK emergency departments.

(Source: Royal College of Emergency Medicine)

The trust advised the sepsis audit is carried out every four to six months and has been benchmarked against RCEM standards.

The RCEM standards on lactate measurements and antibiotic prescribing (100% each) and achieved close to golden standard on fluid resuscitation (95%), vital signs recording (95%) and blood culture (89%) have been met. Areas of improvement included oxygen prescribing, urine output measurement, and senior doctor review. Teaching sessions with nurses and doctors are in place.

The paediatric ED is also involved with each round of RCEM audits. Staff told us they had recently completed the RCEM audit of management of pain in children and are currently involved in the ‘Mermaid’ trial, looking at best practice for treatment of sepsis in children, and the ‘CAPIT’ trial investigating ideal antibiotic duration in community acquired pneumonia.

From June 2017 to May 2018, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5% and also the England average.
Over this 12-month period, the trend in the trust’s performance was stable and limited to a narrow range from 9.8% up to 10.5%.

Unplanned re-attendance rate within seven days - Lewisham and Greenwich NHS Trust

(Source: NHS Digital - A&E quality)

Competent staff

The trust had a comprehensive emergency department education strategy for nurses and advance practitioners which set out the additional training requirements for nurses, emergency nurse practitioners (ENP) and advances clinical practitioners (ACP). This included:

- Foundations of Emergency Care course aimed at band 5 nurses and preceptorship into the ED.
- Emergency Nursing course for Band 5 nurses in both the adult and paediatric ED’s
- Trauma modules required for UHL trauma unit status within SELKaM trauma network
- Enhanced Clinical Assessment Skills for Band 6 and 7 nurses.

The ED had a practice development nurse (PDN). Their role was to support and develop nursing staff within the ED with regards to training and core competence. Emergency department staff were also trained in triage which is part of the foundations in emergency care which is made up of nine study days which is signed off by the PDN as part of their clinical supervision.

Nursing staff revalidation was discussed as part of the annual appraisal process, most staff we spoke with confirmed they received an annual appraisal.

A newly qualified nurse reported they were well supported and had monthly meetings for first three months with her supervisor, and then every three months thereafter. All their initial triages were double-checked, and they also completed the intravenous medication administration course

All band 7 nurses working in the ED had advance life support training as part of their training and development.

Trust had a corporate induction for new employees which consisted of three days training. The first two days are mandatory for all staff and the third day is mandatory for all clinical staff.
In the paediatric ED consultants told us that consultant appraisals were linked to their compliance with mandatory training for revalidation. Consultants used an e-portfolio to gather data including 360 degree feedback for revalidation. Junior doctors had allocated educational supervisor. They meet with their educational supervisor within a few weeks of starting in post.

Medical staff told us they had good working relationships with the nursing staff. Medical staff in the paediatric ED told us they had a good working relationship with adult ED and had excellent support in cases of for example trauma calls and cardiac arrest. Medical staff in the paediatric ED told us they had never been asked to cover the adult ED patients, or to work beyond their scope of practice.

From April 2017 to March 2018, 78.1% of required staff within urgent and emergency care at the trust received an appraisal compared to the trust target of 90%.

**University Hospital Lewisham**

From April 2017 to March 2018, 64.8% of required staff within the emergency department at University Hospital Lewisham received an appraisal compared to the trust target of 90%.

The breakdown by staff group is in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>(other qualified ST&amp;T)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified allied health professionals (qualified AHPs)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (qualified nurses)</td>
<td>122</td>
<td>87</td>
<td>71.3%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>1</td>
<td>50.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>34</td>
<td>13</td>
<td>38.2%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>105</td>
<td>64.8%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

**Multidisciplinary working**

There was effective multidisciplinary working in the ED, nursing staff we spoke with told us there was good multidisciplinary working across the EDs and with the medical specialities this was confirmed by medical staff. Acute medicine consultants were visible in the ED and the other specialities such as gynaecology were available via bleep.

In the urgent care centre (UCC) physiotherapists provided a musculoskeletal service five days per week.

In the paediatric ED senior staff told us that multidisciplinary meetings with allied health professionals are in the process of being re-implemented. Weekly safeguarding meeting were attended by a consultant paediatrician, social worker (if available), nurses, junior doctors, emergency nurse practitioners (ENP), a clinical staff member from the adult ED if a patient between 16-18 years was being discussed.
Emergency department staff and managers described their relationship with the mental health liaison team as good. The ED staff and mental health liaison team met most months for a joint operational meeting. The minutes of the joint mental health liaison staff and ED staff showed that staff discussed the increase in mental health patients attending the ED and the need for continuing communication between both trusts. Staff discussed case studies. For example, for the May meeting, staff looked at a patient who had been in the ED for several days waiting for a mental health bed and security staff stayed with them.

The joint operational meetings were also attended by the local clinical commissioning group and the police.

The trust agreed a service level agreement with the neighbouring mental health trust to undertake all Mental Health Act administration and ensure that detained patients had their Section 132 rights read.

The paediatric ED were able to access the child and adolescent mental health services (CAMHS) for young people.

Ambulance crews reported that they had good working relationships with ED staff.

**Seven-day services**

The department was open and provided care to adults and children 24 hours a day, 365 days a year. Consultants were available seven days a week in the both departments and on-call if required. There were middle grade doctors available 24 hour a day seven days a week. All on call consultants were required to be within 30 minutes of the hospital.

The GP service was available seven days per week from 8.00am to 11.00pm. Lewisham patients were also able to access extend appointments so they could be seen the same day.

The MHLT were available seven days a week and 24 hours a day to people aged 17 (out of hours) and above. Out of hours the MHLT also provided mental health assessments of young people under 17 years who presented at the ED. The child and adolescent mental health services (CAMHS) would see the patient the next morning or the Monday morning if the weekend. The CAMHS were available from 9.00am to 5.00pm Monday to Friday.

Diagnostic imaging was available 24 hours a day with access to X ray and a CT scanner.

Pharmacy services were available Monday to Friday 9.00am to 5.30pm; on a Saturday from 11.00am to 3.00pm and Sunday from 11.00am to 1.30pm. The pharmacy department also provided an out of hours on call service. The trust also had an outsourced pharmacy operating at UHL Monday to Friday 8.00am to 7.00pm, on a Saturday from 9.00am to 5.00pm and on a Sunday from Sunday 12 noon to 4.00pm.

**Health promotion**

In the paediatric ED a range of information leaflets for various conditions such as ankle injuries, wound closure strips, plaster casters, eczema, and headaches in children and young people were available for patients. There was also information about domestic violence which signposted patients and their relatives to specialist organisations. The electronic display in the paediatric ED waiting room also displayed public safety information which included promoting the use of home smoke alarms, breast feeding, choking and sepsis.
Information leaflets were also available in the urgent care centre (UCC) and there was an information board in the waiting room for patients to access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a consent to examination or treatment policy detailed what staff needed to do when seeking consent from adults, children and young people, and from people where they may not have the capacity to consent.

We saw staff obtaining consent from patients appropriately in relation to care and treatment. They explained what they were going to do and why, and we observed explanations being given. Staff told us that consent was mainly obtained verbally and we saw that this was recorded inpatient notes.

Staff in the ED worked closely with the MHLT. Clinical staff we spoke with showed an understanding of mental capacity and consent. They were also aware of the decision making requirements under the Mental Capacity Act 2005.

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the urgent and emergency care department at University Hospital Lewisham is shown below:

### Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Consent to Examination/Treatment</td>
<td>111</td>
<td>119</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Consent to Examination/Treatment</td>
<td>15</td>
<td>42</td>
<td>36%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Is the service caring?

Compassionate care

Staff provided treatment and care in a kind and compassionate way and treated people with respect. Staff were seen to be empathetic and considerate to patients. We observed positive interactions between staff, patients and relatives and found them to be polite and caring.

Privacy and dignity was maintained; curtains and screens were used in majors and resus areas. We spoke to a parent of a patient who attended the adult ED. They told us ED staff treated their relative with dignity and respect. However, we observed patients queuing to be streamed at the entrance of the ED could be overheard when discussing their health issues with the streaming nurse which compromised patients dignity and respect.
We spoke with seven patients and relatives. They told us the staff were very friendly and helpful. All the patients we spoke with were happy with their care and raised no concerns. In the paediatric ED one parent told us the treatment of their child is ‘always very impressive’.

Friend and family post cards were displayed in the ED for patient to complete and leave feedback. Senior staff advised the adult ED was achieving the 30% response rate target. We observed staff were being updated during the morning handover about the response rate from patients.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently better than the England average from May 2017 to April 2018.

Between October 2017 (96% recommend) and March 2018 (92.6% recommend) the trend in the trust’s performance deteriorated. In April 2018 the trust’s performance was 95.3% compared to the England performance of 86.7%.

**A&E Friends and Family Test performance - Lewisham and Greenwich NHS Trust**

![Graph showing A&E Friends and Family Test performance](source: NHS England Friends and Family Test)

In the adult ED the friend and family performance was consistently better than the England average between September 2017 (95.8% recommend) and August 2018 (96% recommend). A total 7829 patients responded which was 10% of patients who had been discharged.

In the paediatric ED the friend and family performance was variable between September 2017 and August 2018. In October 2017 the paediatric ED score for recommending was 98.8% and in January 2018 the score was 78%. A total 1966 patients responded which was 7.6% of patients who had been discharged.

**Emotional support**

We observed staff providing emotional support to patients and their relatives. Staff answered questions to explain what was going to happen next in order to provide reassurance. This was done in a kind and considerate manner.

Patients and their relatives who spoke with us told us they were kept informed in the majority of cases. In the paediatric ED one parent commented that they never had to wait long to be seen.
Staff referred patients for a mental health assessment they suspected to be experiencing depression.

There was a hospital chaplaincy service to support relatives of patients who died in the department, staff were aware of how to contact spiritual advisers to meet the emotional needs of patients and their families.

**Understanding and involvement of patients and those close to them**

We saw staff took time to ensure patients and their families understood the treatment. We observed doctors speaking respectfully and professionally about next steps. One patient told us “the doctor made me feel a lot better, they explained things”. In the paediatric ED one parent told us they were “Always given opportunity to ask questions and information is given in a clear and helpful manner”.

The trust scored “about the same” as other trusts for all 24 Emergency Department Survey 2016 questions relevant to the caring domain:

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>2.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people

Patients attending the emergency department (ED) were streamed to GP services which were available seven days per week from 8am to 11pm. Patients from Lewisham would be offered GP appointments which were appropriate for that day, this meant they did not have to wait to be seen. The urgent care centre (UCC) operated 24 hours per day, 365 days per year. Physiotherapy services were available in the UCC Monday to Friday 9.00am to 5.00pm.

The Adult ED has 19 cubicles which include 4 recently reconfigured cubicles which enables the department to accommodate mental health patients. The department also has a psychiatric room for patients requiring a mental health assessment. Registered mental health (RMN) nurses provided 460 one to one’s to support patients who had complex needs in the period April 2018 to September 2018. The trust advised this figure did not include the one to ones provided by HCA’s in the department.

The ED had a relative’s room where families could go to discuss issues with medical staff or amongst themselves relating to care or emotional support. It also provided a private space where distressed patients could spend time.

In the adult ED waiting area waiting times were not displayed, there was no screen available to display this information. This meant that patients did not know how long their wait would be. In the paediatric ED waiting times were displayed along with public health information.
The local mental health trust had just received funding to open a ‘crisis café’. This would operate from the hours of 3.00pm to 1.00 am with the aim to hopefully reduce the attendance of patients at the ED suffering from a mental health crisis.

**Meeting people’s individual needs**

The ED did not have specific arrangements to meet the needs of patients with dementia or means of identifying people with dementia by means of an identity band or special sticker. This meant that nursing staff, porters and x-ray staff had no easy way to recognise a dementia patient when caring for them.

Patients had access to a link nurse for sickle cell patients and a nurse who was the falls champion in the department.

The trust was participating in the RCEM 2017/18 QUIN to reduce attendance frequent attenders and mental health attendances.

The paediatric department treated children and young people up to the age of 16 years unless they were under a paediatric consultant. The adult ED would see patients from 16 years of age if they were not known.

In the paediatric ED a play leader was available to support children whilst they were undergoing treatment. Children were encouraged to participate in a range of activities including colouring and board games. The department had a range of tablets with games that children could play whilst waiting to be seen by clinical staff. There was also a range of age appropriate DVD’s that could be played through computer screens that could be taken to a child bedside whilst they were undergoing treatment.

In the clinical decision unit (CDU) patients were offered a choice of meals, sandwiches and drinks. In majors were saw patients were offered food and drink at different times of the day. In the ED waiting area vending machines were available so that people could access food and drink whilst they were waiting to be seen. On the short stay unit in the paediatric ED, there was a kitchenette that staff and parents could access to make hot drinks and food for children and young people.

Following the inspection, the trust told us that patients were offered hot food at different times of the day.

Face to face translation, telephone or sign language interpreting services, including deaf relay interpreters and British sign language (BSL) lip speakers, were provided by an external provider and were available 24 hours per day 7 days. Staff were able to access the services for patients where English was not their first language. During the six month period March 2018 to August 2018 telephone interpreting services were use 168 time, and four face to face translation services were provided, and this included a sign language interpreting service.

The trust scored “about the same” in the Emergency Department Survey 2016 as other trusts for each of the three Emergency Department Survey questions relevant to the responsive domain:

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Access and flow

The ED had an internal flow and escalation policy and we observed that full capacity issues were managed safely. On the second day of the inspection we observed the resuscitation area was full and two patients were due to arrive by ambulance. This was escalated to the site manager so that bed spaces could be found for two patients waiting to be moved out the department on to wards. We observed the ED consultant and matron undertake a risk assessment to move patients from the resuscitation to majors to create space for the new arrivals.

The ED was operational 24 hours per day 365 days per year and patients could self refer, be referred by their GP or the 111 service or arrive via ambulance. Most walk in patients were streamed into the GP services or into the UCC which was open 7 days per week 365 days per year. A navigator working at reception with the streaming nurse helps book appointments for patients with their own GP when appropriate and at the direction of clinical staff. (A navigator helps to facilitate the patient's journey by re-directing patients to the most appropriate healthcare provider, assist patients to find, and register with a GP surgery or book a GP appointment).

The ambulatory care service operated five days per week from 8.00am to 8.00pm with medical specialities providing the medical staffing. The nursing team was part of the emergency department staffing establishment. GP's were able to refer patients, send or make telephone referrals for patients to be seen in for different clinic such as chest pain, gastroenterology, falls, pain, deep vein thrombosis (DVT) and vascular clinics. Senior staff reported there were plans to extend the service and range of conditions of the unit to help divert patients away from the ED.

The clinical decision unit (CDU) was open 24 hours per day 365 days per year. There was a clear admissions criteria for CDU and which was managed by a Band 7 nurse and overseen by the ED matrons.

The ED was able to refer patients directly to the acute admissions unit (AMU) which had 30 beds and the frailty unit which had 24 beds which meant patients did not need to be assessed medicine consultant prior to admission.

Safety huddles were held at regular points throughout the day attended by the Nurse in charge, Matron, Consultant and service manager. Patients in each area of the ED were reviewed, with actions identified to either discharge or admit. This is also flagged where pressure points were within the department with regards the four hour target to admitted, transferred or discharged.

Children attending the paediatric ED could access the department via the reception area in the adult ED before they were directed to the paediatric ED to be triaged. Clinical staff told us that they had noticed a change in the flow of patients through department with surges in attendance at mid-morning and in in the early evening after parents had finished work. Staff also commented that parents will bring children at about midnight as they ‘know it will be quieter then’.

We attended a morning site meeting which reviewed the flow of patients across the hospital. Site meetings were held at three times a day so that the flow of patients could be monitored across the site. Nursing staff updated the meeting about potential discharges across the hospital. A white board was manually updated.

Patients’ attending the ED with mental health symptoms received an assessment within one hour of triage by the mental health liaison team (MHLT). The mental health team had assessed 72% of
patients within one hour in June 2018, 62% of patients in July 2018 and 71.4% of patients in August 2018.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard in each month over the 12 month period from June 2017 to May 2018, and was consistently better than the England average over the same time period.

From June 2017 to May 2018, the trend in the trust’s performance was stable and limited to a narrow range between 17 minutes and 23 minutes.

Median time from arrival to treatment from June 2017 to May 2018 at Lewisham and Greenwich NHS Trust

(Source: NHS Digital - A&E quality indicators)

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 emergency department. From July 2017 to June 2018 the trust consistently failed to meet the standard. In the same 12 month time period, the trust’s performance has fluctuated around the England average: from July 2017 up to December 2017, the trust’s performance was better than the England average; and between March 2018 and June 2018, the trust’s performance was worse than the England average.

Across the 12 months from July 2017 to June 2018, the trust’s performance showed a strong seasonal variation. Performance was best in July 2017 (92%) and stable up to October 2017 (92%); but after consistently deteriorated up to January 2018 (83%), when performance was worst. From March 2018 (84%) performance consistently improved up to the end of the 12-month period in June 2018 (89%).
Four hour target performance - Lewisham and Greenwich NHS Trust

Between September 2017 and August 2018, the adult ED at University Hospital Lewisham did not meet the target for 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. The ED achieved 90% or more for eight months, with their best performance in October 2017 (94.5%). During the winter months December 2017 to March 2018 the departments performance was 86.8% in December 2017, 86.7% in January 2018, 89% in February 2018 and 87% in March 2018.

From July 2017 to June 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was variable compared to the England average. From July 2017 to October 2017, the trust’s performance was consistently better; but from November 2017 to March 2018 it was worse; and then improved / was better than the England average from April 2018.

Across the 12 months from July 2017 to June 2018, the trust’s performance had a strong seasonal variation. However, after January 2018, performance consistently improved up to May 2018.

(Source: NHS England - A&E Waiting times)
Percentage of patients waiting more than four hours from the decision to admit until being admitted - Lewisham and Greenwich NHS Trust


Between September 2017 and August 2018, the number of patient waiting between four and 12 hours was less than 1% in October 2017, April, May, June July and August 2018. January 2018 saw the highest (3.48%) number of patients waiting to be admitted.

Over the 12 months from July 2017 to June 2018, 41 patients waited across the trust more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2018 (19 patients) and March 2018 (21 patients).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-17</td>
<td>219</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>275</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>394</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>302</td>
<td>1</td>
</tr>
<tr>
<td>Nov-17</td>
<td>614</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>793</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1,306</td>
<td>19</td>
</tr>
<tr>
<td>Feb-18</td>
<td>834</td>
<td>0</td>
</tr>
<tr>
<td>Mar-18</td>
<td>920</td>
<td>21</td>
</tr>
<tr>
<td>Apr-18</td>
<td>468</td>
<td>0</td>
</tr>
<tr>
<td>May-18</td>
<td>337</td>
<td>0</td>
</tr>
<tr>
<td>Jun-18</td>
<td>374</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

From June 2017 to May 2018 the monthly median percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was worse than the England
average in the first five months (June 2017 to October 2017) and then better than the England average for the remaining seven months (November 2017 to May 2018). For the last five months of the 12-month reporting period (January 2018 to May 2018), the monthly value was very low.

From June 2017 (5.5%) to September 2017 (5.5%), the trust’s performance was stable (between 5.0% and 5.8%). From September 2017 (5.5%) to November 2017 (0.1%), there was a consistent improvement to very low numbers, which was sustained up to the end of the 12-month period in May 2018 (0.0%).

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - Lewisham and Greenwich NHS Trust**

![Graph showing percentage of patients leaving without being seen from June 2017 to May 2018](image)

*Source: NHS Digital - A&E quality indicators*

From June 2017 to May 2018 the trust’s monthly median total time in A&E per patient (for all patients) was consistently higher than the England average.

From June 2017 (194 minutes) to March 2018 (232 minutes), the trend in the trust’s performance for this metric has deteriorated. In the last two months of the time period, there was an improvement (around 149 minutes).
Learning from complaints and concerns

From April 2017 to March 2018, there were 111 complaints about urgent and emergency care services. The trust took an average of 33.8 working days to investigate and close complaints for this service. The trust responded to 38.7% of complaints within the target period of 25 working days specified in the trust complaints policy.

The breakdown of complaints about urgent and emergency care services by subject and location is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>University Hospital Lewisham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>12</td>
</tr>
<tr>
<td>Communications</td>
<td>6</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>8</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>6</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Waiting times</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
</tr>
<tr>
<td>Admin/policies/procedures (inc patient record)</td>
<td>3</td>
</tr>
<tr>
<td>Transport (ambulances)</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td></td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>
From April 2017 to March 2018 there were 24 compliments in urgent and emergency care.

The trust had a complaints policy and procedure. Information on the trust’s complaints policy and procedure was available on the trust’s internet website. Most staff were aware of the trust’s complaints policy and of their responsibilities within the complaints process.

The ED had received 51 complaints in the last year, the top three themes for complaints were medical/surgical treatment 27.5% (14), nursing care 15.5% (8), and missed diagnosis 11.7% (6). The trust advised the ED took an average of 15 working days to investigate and close the complaints. This was less than the target period of 25 working days specified in the trust complaints policy.

In ED governance meeting minutes, we saw that complaints and compliments received in the department were discussed.

**Is the service well-led?**

**Leadership**

The emergency departments came under different directorates. The adult emergency department was part of the acute and emergency medicine (AEM) division and the paediatric emergency department part of the children and young persons (CYP) division. The AEM division also included community services. Each site had a divisional general manager and divisional director. The directories worked across both hospital sites in the trust. The adult emergency department (ED) was led by the clinical director. Senior managers told us this structure was currently in consultation with a proposal to move to site based directorates.

The ED had monthly operational meetings these included clinical director, consultants, and ED matrons. We looked at minutes of three meetings these demonstrated there was a standing agenda which looked included the ED performance, recruitment within the department and mental health.

Staff we spoke with told us that senior staff were supportive. Senior nursing staff were visible on easily assessable for support and help and consultants were available daily. There was a clear clinical leadership presence in the department and it was easy for staff to access/locate the consultant in charge of the shift. Their visibility was maintained throughout the inspection.

The trust sat on the mental health oversight board, which included two mental health trusts that worked across south London and the borough clinical commissioning groups for Lewisham, Greenwich and Bexley. The AEM divisional management team were aware of the challenges and barriers in the ED and of the issues related to the safety and quality of care for patients with known or who were experiencing mental health problems.
Vision and strategy

The AEM had an operating plan for 2018 which linked to the trusts strategic objectives. The operating plan set out a clear vision for the ED at University Hospital Lewisham (UHL) which included development and service improvements, increasing opportunities for the workforce and flow through the department.

Staff we spoke with were aware of the increase in opportunities with the nurses skills being expanded into for example advanced nurse practitioners (ANP) and emergency nurse practitioners (ENP) roles.

To support patients experiencing mental health problems the trust with other mental health partners were opening a ‘crisis café’ by the end of the year that would provide a safe place for people.

The trust had a service level agreement with the local mental health trust for mental health liaison and Mental Health Act management

The trust was part of the mental health oversight board which included representation from two mental health trusts and the borough clinical commissioning groups for Lewisham, Greenwich and Bexley.

Culture

There was a culture of honesty, openness and transparency. Staff felt valued, supported and spoke highly of their job; there was good team work and peer support. Staff were committed to delivering a good service. Staff said felt comfortable about reporting incidents and there was learning from mistakes.

There was emergency department education strategy for all nursing grades which set out the opportunities for further learning and development. Nursing staff told us there were opportunities for them to progress.

Medical staff felt supported and had no hesitation in asking questions about patients care. Junior medical staff were aware who the guardian of safe working was at the hospital. There had been four exception reports in the emergency department related to lack of senior staff which meant junior medical staff had to work above their hours. Exception Reporting can be helpful in highlighting any missed educational opportunities, breaks or working beyond what work schedule states for junior doctors.

Due to the increase of violence and aggression in the ED over the last 12 months there was dedicated security presence in the department 24 hours a day. This had been in place for the last three months. The department had submitted a bid to have permanent full time security presence. Senior nursing staff told that the security teams presence reassured their staff and patients.

Governance

The ED had had monthly clinical governance meetings. We looked at three sets of minutes which demonstrated they included a review the clinical and serious incidents within the department, updates on National Institute for Health and Care Excellence (NICE) guidelines and from the Royal College of Emergency Medicine (RCEM. The meetings also covered a review of patients experience which included patient feedback and complaints, mortality reviews and the departments risk register. Action and follow up from the meetings were identified.
The hospital had a standard operational policy for the management of patients awaiting a bed in a mental health unit in UHL. This policy was jointly agreed and devised by the mental health liaison team (MHLT) and the ED staff.

Staff had developed a joint protocol between the ED staff and mental health liaison staff for observing patients at high risk of suicide and self-harm. However, this protocol was last updated in April 2016. This meant it was over two years old and therefore staff may not still be using it.

The joint operational meetings between ED staff and the MHLT discussed developing a monthly monitoring tool to allow information, like referrals, from the MHLT to be shared. The MHLT had developed a new triage tool for ED staff to use when assessing patients who were high risk of harming themselves. This tool was in line with national guidance and was a simple triage tool for ED staff. The MHLT had passed this tool onto senior trust staff four months prior but it had not yet been implemented.

The trust had a Commissioning for Quality and Innovation (CQUIN) goal for patients who frequently attended the ED

Management of risk, issues and performance

The ED risks were incorporated into the AEM risk register. There were 39 risk identified on the risk register which covered both sites within the trust. Four of the risks on the risk register related to the adult ED at UHL. Two risks that were trust wide reflected the issues of the recruitment of medical and nursing staff in the ED that had been raised during the inspection. Each risk had been reviewed within the last month and detailed the actions taken to mitigate the risks. There were named individuals responsible for overseeing the risks.

Risks related to the paediatric ED were incorporated in the risk registered for the CYP service within the trust. There were 25 risk identified on the risk register which covered both sites within the trust and were applicable to the paediatric ED such as staffing and workforce retention. We saw there was one risk referred to the paediatric ED at UHL. For each item on the risk register there were details of the actions taken to mitigate the risks, that they were being reviewed and updated and there named individuals responsible for each risk.

Both risk registers identified risks regarding the safety of mental health patients. There were measures in place to mitigate the risks whilst in the departments.

The ED’s performance was part of the AEM dashboard was used to monitor the ED flow in relation to the key performance indicators. Issues and risk were highlighted and actions were identified which looked at specific issues for the ED which fed into the ED operational and governance meetings.

The paediatric ED performance was included in the CYP service dashboard which included monitoring performance against the four hours waiting time.

Information management

The department monitored performance of accident and emergency and performance against the four hour target on a daily basis through a computer based programme which staff were able to access across the ED.

Patient records were completed on paper and were scanned following their discharge from the department onto a patient data base before destruction. They were stored and managed in
accordance with data protection. Children’s records were retained in paper form until they reached 18 years of age.

Staff had secure access to the trust intranet which gave them access to trust news, policies and procedures and their training and personal development records.

**Engagement**

The trust provided an action plan of the improvements made across the ED following the national patient survey in 2016, these included increasing the capacity in majors from 15 to 19 cubicles to increase capacity and ED Matrons now managing Ambulatory care unit (ACU).

There was little information for patients attending the emergency department about quality and performance.

In the paediatric ED feedback from patients and relatives was also on display using ‘tops and pants’ to rate the service provided. In July we saw that 20 patients rated the department as tops, this related to the staff and games available on the tablets and three patients rated the department pants due to the waiting times and games available on the tablets in the department.

In the ED waiting area posters were on display asking patients to be considerate when using their mobile phones. The posters were the result of the ‘you said we did’ initiative across the hospital where patients had fed back concerns in the urgent care centre (UCC) and ambulatory care unit.

Following the last NHS 2017 staff survey the trust provided details of the actions taken in the department to address issues raised by staff this included having permanent security officer based within ED.

**Learning, continuous improvement and innovation**

The emergency department (ED) were training Band 7 nursing staff and some paramedics to become advance nurse practitioners so they extended their skills so they could see treat and discharge patients with certain conditions. The advance nurse practitioners were Band 7 whilst training and become substantive Band 8a’s when their training was complete. This demonstrated that the ED was seeking to develop and future proof the workforce.
Surgery

Facts and data about this service

The surgery core service at Lewisham and Greenwich NHS Trust operates from two locations; Queen Elizabeth Hospital and University Hospital Lewisham.

University Hospital Lewisham has 92 surgical inpatient beds located across four wards and units:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-colorectal and general surgery</td>
<td>26</td>
</tr>
<tr>
<td>ENT</td>
<td>26</td>
</tr>
<tr>
<td>Female surgery</td>
<td>20</td>
</tr>
<tr>
<td>Elective orthopaedic and trauma</td>
<td>20</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust had 21,262 surgical admissions from March 2017 to February 2018. Of these, 6,606 (31.1%) were emergency admissions, 12,282 (57.7%) were day case admissions, and the remaining 2,374 (11.2%) were elective admissions.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the surgery department at University Hospital Lewisham is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>22</td>
<td>23</td>
<td>95.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>141</td>
<td>160</td>
<td>88.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>139</td>
<td>160</td>
<td>86.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>138</td>
<td>160</td>
<td>86.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>136</td>
<td>160</td>
<td>85.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>134</td>
<td>160</td>
<td>83.8%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
At University Hospital Lewisham surgery department the 85% target was met for five of the 14 mandatory training modules for which qualified nursing staff were eligible.

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>106</td>
<td>116</td>
<td>91.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>98</td>
<td>116</td>
<td>84.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>90</td>
<td>116</td>
<td>77.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>81</td>
<td>116</td>
<td>69.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>78</td>
<td>116</td>
<td>67.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>74</td>
<td>116</td>
<td>63.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>73</td>
<td>116</td>
<td>62.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>69</td>
<td>116</td>
<td>59.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>68</td>
<td>116</td>
<td>58.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>55</td>
<td>116</td>
<td>47.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At University Hospital Lewisham surgery department the 85% target was met for one of the 10 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff told us that mandatory training was not measured on a yearly basis across the entire workforce, or for individual staff groups, but for individual staff, based on when they had started at the trust and completed their induction. They said the data the trust had on mandatory training did not give a clear picture of the training rates for each module at a given time in the year as this was different for each member of staff.

Staff told us mandatory training was generally provided by e-learning. Where mandatory training required face to face sessions these were usually available in a timely manner.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 for staff in the surgery department at University Hospital Lewisham is shown below:
At University Hospital Lewisham surgery department the 85% target was met for each of the two safeguarding training modules for which qualified nursing staff were eligible.

### Medical staff

- **Safeguarding Children & Young People Level 2**
  - Number trained: 87
  - Number eligible: 94
  - Completion rate YTD: 93%
  - Target: 85%
  - Met: Yes

- **Safeguarding Adults Clinical Level 2**
  - Number trained: 98
  - Number eligible: 116
  - Completion rate YTD: 84%
  - Target: 85%
  - Met: No

- **Safeguarding Children & Young People Level 3 - Core**
  - Number trained: 14
  - Number eligible: 22
  - Completion rate YTD: 64%
  - Target: 85%
  - Met: No

At University Hospital Lewisham surgery department the 85% target was met for one of the three safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Due to the differing training cycles for individual staff, the data provided was not sufficient to indicate whether the division had or had not met the target for safeguarding training compliance.

However, there were appropriate systems and processes in use by staff to safeguard vulnerable patients from avoidable harm or abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.

There was a safeguarding team within the hospital who provided advise, support and training to staff in respect of safeguarding matters. Staff we spoke with were aware of the safeguarding team and how to contact them. A number of nursing staff were able to give examples of safeguarding concerns they had raised and all of the staff we spoke with were confident in explaining how they would recognise and escalate safeguarding concerns. 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. Staff had also completed PREVENT training as part of their safeguarding training. PREVENT is a government scheme to safeguarding people and communities from the threat of terrorism.

### Cleanliness, infection control and hygiene

The environment in both theatres and the wards was generally visibly clean and clutter free. We observed cleaning staff carrying out regular ward rounds. Cleaning staff had access to appropriate cleaning equipment and had been made aware of the required standards for cleanliness.

At our last comprehensive inspection of surgery, we observed poor adherence to trust hand hygiene policy and national guidance, with staff not routinely sanitising their hands between

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Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children &amp; Young People Level 2</td>
<td>142</td>
<td>160</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Clinical Level 2</td>
<td>139</td>
<td>160</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At our last comprehensive inspection of surgery, we observed poor adherence to trust hand hygiene policy and national guidance, with staff not routinely sanitising their hands between
patients and on entering and leaving wards. There had been a significant improvement in this respect. All the staff we observed were bare below the elbow, washed their hands prior to and following contact with patients and made use of the hand hygiene gels provided throughout the hospital.

Hand hygiene audits were carried out on each of the wards and the results were displayed as part of the monthly dashboard. For the period March to August 2018, all four of the surgical wards met or surpassed the trust target for an 85% compliance rate. Only one occasion, March 2018 on Larch Ward was the target compliance rate met rather than surpassed. The IPC team told us that, where a ward scored lower than the target compliance rate, an action plan would be put in place and the frequency of audits increased.

A number of patients were in isolation to prevent the spread of infection. Staff made use of appropriate advanced personal protective equipment (PPE) when entering the rooms of these patients, and their doors were kept shut at all times.

At our last comprehensive inspection, we observed anaesthetists and surgeons taking their outdoor bags and briefcases into the anaesthetic rooms and theatres on three occasions, presenting an infection risk. At this inspection theatre staff informed us this poor practice no longer occurred and they would feel confident to challenge anyone not following best IPC practice. We observed all outdoor coats and bags were appropriately stored in the changing rooms.

Yellow sharps boxes were in use throughout the service, and were appropriately signed and dated. Ward staff used “I am clean” labels to indicate that an item of equipment was clean and ready for use.

We saw minutes of a quarterly surgery division’s IPC meeting, which took place at trust level. This meant IPC learning could be shared across both hospital sites. There were IPC policies in place, which we had sight of.

Nursing staff used a sepsis screening tool for all non-pregnant adults with a fever. The sepsis screening tool was included in the nursing notes and the majority of staff had a sepsis pathway card attached to their lanyard. Staff we spoke with demonstrated knowledge of identifying and managing sepsis. However, there were no specific sepsis care kits on the wards, meaning staff were required to obtain the necessary equipment and medicine from the store room, potentially causing a delay to treatment.

Environment and equipment

The environment in theatres and on the wards, was visibly clean and clutter free. However, the corridor leading into the Vanguard theatre suite was not kept clear and was cluttered. The corridor was cluttered with large theatre equipment and trolleys containing stacks of sterile surgical kits for the days’ surgery. At one point during our visit, a rack of lead apron for protection against x-rays was placed across the corridor, blocking access from the theatre and anaesthetic room to the fire escape. This presented a significant fire safety risk as the corridor was one of the fire exits from the theatre and, therefore the equipment was blocking the exit.

The service manager for theatres informed us the sterile theatre kits for the day’s operations were routinely brought over from the main theatre store room and stored in the corridor outside the theatre. This presented a significant risk of cross infection, as all the patients from the list were brought along the corridor, past the sterile kits both before and after their operations. This had the potential to compromise the sterility of the kits. We asked the service manager to remove the clutter from the corridor and were informed this would be done by converting an empty room in the corridor to a storage cupboard. When we returned to the hospital for an unannounced follow-up
inspection on 3 October 2018, this had been done. The corridor was no longer cluttered or used for storage. Surgical kits were stored in a large storage cupboard. Surgical kits needed for immediate use for the surgical list were stored in a small locked cupboard which had been appropriately fitted in the corridor.

Used surgical kits from all theatres were sent to QEH for sterilisation. Theatre staff told us generally all of the kits were available when necessary. They told us kits needed urgently could be marked for fast track through the sterilisation process and were usually available within 24 hours. The theatre manager told us they had a positive relationship with the decontamination team. Most of the theatre staff told us kits were usually fully complete and the consumables store in theatres was kept adequately stocked. However, during our inspection, some staff contacted us to say kits were not always complete, and they had frequently reported this via the online incident reporting system. They were concerned that this was an ongoing issue. We were told the directorate was seeking to employ a full time equipment officer, with responsibility for ensuring disposable stocks were at the right level and to act as a liaison with the decontamination team.

Surgical equipment for the Riverside and Ravensbourne theatre suites were appropriately stored in the surgery equipment stores.

Resuscitation trolleys were available in all both theatre suites, all of the wards, pre-assessment and the discharge lounge. At the last comprehensive inspection we identified a concern relating to different types of trolley were being used as resuscitation trolleys. This had been rectified and all of the trolleys were uniform in design and were appropriately stocked with necessary equipment and medicine. Each of the trolleys had been checked on a daily basis and signed for by the nursing staff.

During our inspection, the fire doors in the approach to the Vanguard theatre suite were not closing properly. We raised this as a concern to the service manager for theatres. When we returned on 3 October 2018, this had been addressed. In addition, the fire doors between theatres and recovery in the Ravensbourne Theatre suite was not closing properly. We raised this as a concern, and were told it would be addressed by the facilities team. When we returned on 3 October 2018, this had not been adequately addressed. However, the matron explained that the doors required work by the company which had installed them and they had contacted the company to arrange this.

Assessing and responding to patient risk

Staff on the wards made use of the National Early Warning Scores (NEWS) system, to monitor patients to identify deterioration in their condition. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. Of the 10 records we checked, the NEWS scores were appropriately completed and calculated. Ward staff had a good understanding of the system and of when and how to escalate a deteriorating patient. However, in theatre recovery, staff used the trust’s own anaesthetic record instead of the NEWS scorecard for all but the most at risk patients. The anaesthetic record was designed for use by anaesthetists and anaesthetic staff and, in addition, was not standardised like the NEWS scorecard and, therefore had the potential to lead to inconsistencies in care.

We observed the World Health Organisation’s (WHO) five steps to safer surgery being used during the surgical procedures. The WHO Surgical Safety Checklist is a checklist that was developed to decrease errors and adverse events, and increase teamwork and communication in
surgery. The WHO checklist was carried out appropriately, with opportunity for all of the staff present in the theatre to speak where appropriate.

We attended the directorate’s morning “safety huddle” at which all patients at particular risk were discussed. Ward matrons had an opportunity to raise concerns or request additional support in caring for individual patients in the discussion. We observed a safety huddle on one of the wards, where the nurse in charge discussed each of the patients, and any changes in their condition or the level of care or observation they required with the nurses on the shift.

### Nurse staffing

The trust reported the following qualified nursing staff numbers as of March 2018 and June 2018 for surgery by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital Woolwich</td>
<td>175.9</td>
<td>196.9</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>162.2</td>
<td>210.9</td>
</tr>
<tr>
<td><strong>Trust total</strong></td>
<td><strong>338.1</strong></td>
<td><strong>407.7</strong></td>
</tr>
</tbody>
</table>

Please note, the trust total may not equal the sum of the site totals as some nursing staff work cross-site.

*(Source: Routine Provider Information Request (RPIR) – Total staff tab)*

Whilst the directorate’s fill rate of 73% in June 2018 was significantly below the numbers for planned whole time equivalent (WTE) nursing staffing for the period, this was an increase on the number of actual WTE staff working in the directorate since the comprehensive inspection in March 2017 where there were 115.92 WTE staff working in surgery.

Ward and theatre managers told us they ensured safe staffing levels through the use of an acuity tool. Staff told us they were often moved to work on another ward with a higher acuity.

The head of nursing acknowledged the staff shortage. She described ongoing efforts to recruit nursing staff. She said the trust had held an open day in theatres at the hospital, with staff from both sides attending, to make the public aware of the work carried out at the hospital, and of the opportunities to work within it. As a direct result of the open day, 10 theatre support workers had been recruited. This formed part of the trust’s vision of using nursing apprenticeships to develop its own nurses as a way of addressing the staff shortage in the long term.

Similarly, the hospital had introduced career clinics, which staff could attend to meet the heads of other departments and directorates, to see if working within them better suited their skillset, career ambitions and personal circumstances. Where there was a vacancy available for which the staff
member met the criteria they could do a direct swap into the role, without the need to apply. We spoke to a member of nursing staff who had swapped in this way who told us that doing so had enabled them to remain working within the directorate without having to seek employment at another trust.

The trust was part of the Capital Nurse Project, with a number of trusts across London where senior leaders are able to pool resources for recruitment drives, for example the cost of advertising.

In addition, the head of nursing told us the directorate had undertaken two successful recruitment drives in the Philippines, from which the nurses had now started at the trust. The directorate was planning to undertake a further recruitment drive in the Philippines and in November 2018, was planning to visit India to recruit a further 40 nursing staff for theatres on both sites.

The majority of staff we spoke with told us they were aware of the action being taken by the directorate leadership to address the staffing shortfall. They said they believed the situation had improved, albeit only slightly, and would continue to do so.

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of 25.8% for qualified nursing staff in surgery. This was higher than the trust target of 14%.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

The vacancy rate for qualified nursing was significantly higher than the trust target and also than that at QEH, where the vacancy rate was 10.9%.

**Turnover rates**

From July 2017 to June 2018, the trust reported a turnover rate of 9% for qualified nursing staff in surgery. This was lower than the trust target of 12%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital Woolwich: 9.8%
- University Hospital Lewisham: 7.3%

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From July 2017 to June 2018, the trust reported a sickness rate of 5.3% for qualified nursing staff in surgery. This was higher than the trust target of 3.5%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital Woolwich: 5.6%
- University Hospital Lewisham: 5.0%

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and agency staff usage**
From July 2017 to June 2018, the trust reported that 34.5%% of qualified nursing shifts in surgery were filled by bank staff and 33.9% of shifts were filled by agency staff. In addition 3.9% of shifts were not filled by bank and agency staff to cover staff absence.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Bank shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
<th>Agency shifts</th>
<th>Agency shifts as a proportion of total shifts</th>
<th>Unfilled shifts</th>
<th>Unfilled shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital Woolwich</td>
<td>3852</td>
<td>18.4%</td>
<td>5081</td>
<td>24.2%</td>
<td>559</td>
<td>2.7%</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>3392</td>
<td>16.2%</td>
<td>2024</td>
<td>9.7%</td>
<td>260</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

In addition, the trust made extensive use of bank and agency staff. Senior staff told us they prioritised the use of bank staff, as they were already familiar with the hospital’s processes and systems and where possible they made use of the same agency staff. The agency staff we spoke with told us they had received a full induction onto the wards on which they were working and had been given smart card access to electronic systems and relevant areas of the ward, such as store cupboards. They told us they felt supported by their permanent nursing colleagues.

One of the allied health professional (AHP) staff we spoke with told us the significant reliance on bank and agency staff impacted on the ability to share learning and best practice with the nursing team.

Medical staffing

The trust reported the following medical staffing numbers as of March 2018 and June 2018 for surgery by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
<th>Fill rate</th>
<th>March 2018</th>
<th>June 2018</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital Woolwich</td>
<td>123.1</td>
<td>113.4</td>
<td>108.6%</td>
<td>126.0</td>
<td>123.6</td>
<td>101.9%</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>122.2</td>
<td>169.8</td>
<td>72.0%</td>
<td>131.1</td>
<td>180.4</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trust total*</td>
<td>245.3</td>
<td>283.1</td>
<td>86.7%</td>
<td>257.1</td>
<td>304.0</td>
<td>84.6%</td>
</tr>
</tbody>
</table>

Please note, the trust total may not equal the sum of the site totals due to some nursing staff working cross-site.
Vacancy rates
From July 2017 to June 2018, the trust reported a vacancy rate of 34.7% for medical staff in surgery. This was higher than the trust target of 14%.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Turnover rates
From July 2017 to June 2018, the trust reported a turnover rate of 40.4% for medical staff in surgery. This was higher than the trust target of 12%.

The breakdown by site was as follows:
- Queen Elizabeth Hospital Woolwich: 39.0%
- University Hospital Lewisham: 42.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From July 2017 to June 2018, the trust reported a sickness rate of 1.4% for medical staff in surgery. This was lower than the trust target of 3.5%.

The breakdown by site was as follows:
- Queen Elizabeth Hospital Woolwich: 2.5%
- University Hospital Lewisham: 0.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
From July 2017 to June 2018, the trust reported that 60% of medical shifts in surgery were filled by bank staff and 17.5% of shifts were filled by agency staff. In addition 7% of shifts were not filled by bank and locum staff to cover staff absence.

University Hospital Lewisham

<table>
<thead>
<tr>
<th>Location</th>
<th>Locum shifts</th>
<th>Locum shifts as a proportion of total shifts at trust</th>
<th>Agency shifts</th>
<th>Agency shifts as a proportion of total shifts at trust</th>
<th>Unfilled shifts</th>
<th>Unfilled shifts as a proportion of total shifts at trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>371</td>
<td>5.6%</td>
<td>7</td>
<td>0%</td>
<td>47</td>
<td>0.7%</td>
</tr>
<tr>
<td>Middle grade</td>
<td>656</td>
<td>9.9%</td>
<td>161</td>
<td>2%</td>
<td>95</td>
<td>1.4%</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>504</td>
<td>7.6%</td>
<td>187</td>
<td>3%</td>
<td>92</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
Staffing skill mix

In December 2017, 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 similar to the England average.

Staffing skill mix for the whole time equivalent staff working at Lewisham and Greenwich NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>35%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The directorate leadership recognised the vacancy rate of 34.7% for medical staff was a significant concern against a target vacancy rate of 14%. This was recorded on the divisional risk register. In order to mitigate against this, they were taking action to recruit new staff. By the beginning of April 2018, the trust had recruited six anaesthetic consultants (two who were previously locums).

There were three unfilled senior house officer (SHO) vacancies in April 2018, which were being advertised, however, the trust had been unable to fill the roles due to lack of suitable candidates. As of 24 April 2018, there were a further two SHO vacancies being advertised. As such, the division was considering introducing rotations for the SHO grade in order to stabilise fill rates across the specialties as well as giving doctors greater diversity of experience.

The hospital reported they had used the medical training initiative (MTI) to “some success” in obtaining more medical staff in urology and was considering using the programme in other specialties.

Records

The trust made use of both electronic and paper records, with nursing notes and observations being recorded on paper. Records were appropriately and securely stored in locked cabinets and trolleys. Staff made sure they locked computer screens before leaving them.
We checked 10 patients’ records. The records were generally well completed, with appropriate observations recorded and signatures indicating patients had received or refused medicines and had consented to treatment. However, three of the records we looked at had incomplete nutritional score cards. One of the matrons told us issues in completing nutritional score cards had been identified as a problem, and additional training had been introduced to address this.

**Medicines**

Medicines (including controlled drugs) were stored securely. Access to clinical areas and medicines cabinets was limited to specific staff using digital locks.

At the comprehensive inspection of March 2017 we identified concerns about the storage and management of medicines in theatres and issued a requirement notice to the effect that the hospital “must address and improve issues of medicines management in surgery”. However, at this inspection, the issues with poor medicines management continued, in particular in theatres.

Staff monitored temperatures of medicines storage areas. When temperatures were found to be outside of the required range, staff did not always take appropriate actions to safeguard the medicines. Controlled drugs (CD) registers were not managed appropriately. We noted a lack of consistency with regards to where CD balance checks were recorded. We saw missing counter signatures, which was not in line with the trust CD policy. In the CD registers, words had been scrubbed out, which is a breach of the Misuse of Drugs Regulations 2001. Staff were not aware of trust procedures to follow with regards to the completion of an incident report when a controlled drug vial was damaged.

We saw poor practice in theatres with regards to the drawing up of medicines into syringes in advance of administration. We saw three syringes with medicines drawn up that were labelled as suxamethonium, atracurium, and atropine. They were dated ‘14 September 2018’, therefore staff were advised to discard of them immediately. In addition, a vial of insulin that had expired due to the date it was first used was found in the fridge. Staff were also advised to dispose of it immediately.

We saw irrigation fluids being stored in a warming cabinet for use in theatres. The products were not labelled appropriately with the date they had been placed inside the cabinets as per the manufacturer’s instructions. It was not clear if staff had a trust policy to adhere to in this area.

**Incidents**

**Never Events**

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.

From June 2017 to May 2018, the trust reported no incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type and location was as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Queen Elizabeth Hospital Woolwich</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Environmental incident meeting SI criteria</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>4</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff told us they reported incidents through the electronic system. Learning from moderate to serious incidents was shared at handover meetings and ward meetings. Quarterly governance meetings had a set agenda for serious incidents from both sites to be discussed during the meeting.

Staff had a good understanding of the reporting of incidents of all levels.

Ward staff could describe actions taken and lessons learnt from a recent serious incident. This demonstrated information had been shared through surgical services, and we saw the new processes that had been put in place for each ward as well as extensive training for staff.

During our inspection we saw changes had been made with the assessment tools being used, but they were not fully embedded and some staff were still getting used to using the tools correctly.

The trust investigated serious incidents by conducting root cause analysis investigations and we saw duty of candour had been initiated for each serious incident we reviewed. Duty of candour is a process of open and honest practice when something goes wrong.

Safety thermometer

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 collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.
Data from the Patient Safety Thermometer showed the trust reported two new pressure ulcers, no falls with harm and three new catheter urinary tract infections from May 2017 to May 2018 for surgery.

### Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Lewisham and Greenwich NHS Trust

![Graph showing prevalence rates](graph.png)

1 Pressure ulcers levels 2, 3 and 4  
2 Falls with harm levels 3 to 6  
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Information from the safety thermometer was displayed on each of the wards. Staff told us that since the last inspection, significant efforts had been made on all surgical wards in respect of falls reduction. This was evident in the “take five” folders on the wards.

### Is the service effective?

**Evidence-based care and treatment**

Policies, procedures and guidelines were easily accessible to staff through the intranet. We reviewed a number of policies and procedures. These had been developed in line with relevant national guidance and best practice information from bodies including the National Institute for Health And Care Excellence (NICE) the Royal College of Nursing (RCN) and the Royal College of Surgeons (RCS). However, there was a lack of vital policies, such as specimen management and correct site surgery, whilst other policies had not been reviewed in line with their review dates. This was recorded as a high risk on the surgical division risk register. Delays due to staff absence, meant the hospital had not progressed any further in ensuring the vital policies were developed and updated. As a result staff may not always have had the correct guidance to follow for certain treatment and procedures.

Agency staff were provided with temporary log-ins which gave them access to the policies and procedures. Hard copies were also available on each of the wards. In addition, there was a “take five” folder in each of the nurses’ stations for nurses to read during quiet times in their shifts. This included “bite-sized” updates in respect of best practice from nursing journals as well as detailing changes to practice arising from learning from incidents.

The directorate carried out regular audits to ensure that staff were following best practice, these included audits of the use of the World Health Service (WHO) safety checklist in theatres, which indicated a 100% compliance rate for the period January to May 2018.
Nutrition and hydration

Nursing staff completed Malnutrition Universal Screening Tool (MUST) forms to monitor patients’ nutrition. One of the MUST forms we looked had different heights recorded for the patients, whilst another two had incomplete entries, as such these patients were not being appropriately assessed. When we raised this with one of the matrons, they acknowledged this was an ongoing concern and told us additional training had been planned to address the matter.

Fluid balance charts to measure a patient’s hydration were also in use. These had been completed appropriately.

There were protected mealtimes on each of the wards, during which visiting was restricted. There were signs at the entrance to each of the wards setting out when protected mealtimes were. Patients with dementia and those who needed additional support when eating were served their food on a red tray, in order to help staff identify and support them. We observed a patient being assisted to eat by a healthcare assistant. Dietary plans were included in patients’ care plans and were kept up to date.

Nursing staff told us there were speech and language therapists and dietitians within the hospital and they could refer patients for swallow assessments and for the development of a special diet. Where patients required a special diet, catering staff were notified of this directly, and again checked the patient’s dietary requirements before serving.

Patients who were ‘nil by mouth’ prior to operations were identified by signs above their bed, as well as in their nursing notes. There were protocols to ensure that where an operation was cancelled or delayed, the patient was not kept without food for too long a period.

Pain relief

There was a hospital-wide pain team who visited each of the surgical wards on a daily basis to assess patients who complained of significant pain. In addition, the pain team provided support and training to staff.

The majority of patients we spoke with told us they were always provided with pain relief in a timely manner when they requested it. One patient, however, complained that staff were not always responsive to their requests for pain relief. In addition, we observed a number of patients who had been prescribed patient controlled analgesia (PCA) to self-administer pain relief medicine by pressing a button. The use of PCA was appropriately monitored by pharmacists and medical staff.

Staff used a range of pain assessment tools for patients. We saw pain scores had been appropriately documented in patients’ notes. For patients who had difficulty expressing themselves verbally, the hospital made use of the Wong-Baker faces scale.
Patient outcomes

Relative risk of readmission

Elective admissions:

From February 2017 to January 2018, all patients at University Hospital Lewisham had a higher than expected risk of readmission for elective admissions when compared to the England average.

For the same comparator:

- Patients in ENT and in general surgery had a higher than expected risk of readmission for elective admissions
- Patients in trauma & orthopaedics had a similar expected risk of readmission for elective admissions.

Elective Admissions - University Hospital Lewisham

Non-elective admissions:

From February 2017 to January 2018, all patients at University Hospital Lewisham had an expected risk of readmission for non-elective admissions similar to the England average.

For the same comparator:

- Patients in general surgery and in ENT had a lower than expected risk of readmission for non-elective admissions
- Patients in trauma & orthopaedics had a higher expected risk of readmission for non-elective admissions

Non-Elective Admissions - University Hospital Lewisham

(Source: Hospital Episode Statistics)
The trust contributed to relevant national audits. Audit results were discussed at the surgical divisional quality meeting and action plans developed to address areas for improvement. A range of local audits were in use, including those for WHO five steps to safer surgery checklist compliance, venous thromboembolism (VTE) assessments, monitoring of recording of patient observations and nursing staff presence on general surgery ward rounds.

**National Hip Fracture Audit**

University Hospital Lewisham participated in the 2017 National Hip Fracture Audit.

- The risk-adjusted 30-day mortality rate was 7.4% which was within the expected range. The 2016 figure was 7.1%.

- The crude proportion of patients having surgery on the day or the day after admission was 75.0%. This result was below the national aspirational standard of 85% and put University Hospital Lewisham in the middle 50% of hospitals. The 2016 figure was 54.7%.

- The crude perioperative medical assessment rate was 99.3%. This result was about the same as the national aspirational standard of 100% and placed University Hospital Lewisham in the top 25% of hospitals. The 2016 figure was 93.1%.

- The crude proportion of patients documented as not developing a pressure ulcer was 98.6%. This result was similar to the national aspirational standard of 100% and placed University Hospital Lewisham in the top 50% of hospitals. The 2016 figure was 96.5%.

- The crude overall hospital length of stay was 26.9 days. This result placed University Hospital Lewisham in the bottom 25% of hospitals. The 2016 figure was 23.9 days.

*(Source: National Hip Fracture Database 2017)*

Although the hospital did not meet the national aspirational standard of 85% for hip fracture patients having surgery on the day of or day after admission, there had been a significant improvement in the percentage of patients who were receiving treatment within the timeframe from 2016. Staff in pre-assessment told us they had been working additional shifts and the nurse in charge told us pre-assessment had been opening on Sundays in order to increase the flow of patients through theatre, thereby supporting theatre colleagues to treat more patients in a more timely manner.

The hospital was performing poorly against the crude overall length of stay for hip fracture patients. However, nursing staff told us that in many cases this was the result of the age of the patients, their co-morbidities and the challenges in finding appropriate care in the community to allow the patients to be discharged safely.

**Bowel Cancer Audit**

The trust participated in the 2017 Bowel Cancer Audit.

- 64.5% of patients undergoing a major resection had a post-operative length of stay of greater than five days. This result was better than the national aggregate for England and Wales (69.5%). The 2016 figure was 71%.

- The risk-adjusted 90-day post-operative mortality rate was 5.6% which was within the expected range. The 2016 figure was 1.5%.

- The risk-adjusted 2-year post-operative mortality rate was 14.3% which was within the
expected range. The 2016 figure was 13.8%.

- The risk-adjusted 30-day unplanned readmission rate was 12.0% which was within the expected range. The 2016 figure was not reported.

- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 45.3% which was within the expected range. The 2016 figure was 42.3%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not participate in the 2017 National Vascular Registry audit.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

The trust participated in the 2016 National Oesophago-Gastric Cancer Audit.

- Poor quality data was provided by the trust on age and sex adjusted proportion of patients diagnosed after an emergency admission. Poor data quality means that over 15% of records had the referral source missing. In 2015 no figure was reported because of poor data quality.

- A value for the risk-adjusted 90-day post-operative mortality rate was not calculated because the trust was not eligible for this audit metric. In 2015 no figure was reported for the same reason.

- The crude proportion of patients treated with curative intent in the Strategic Clinical Network was 42.2%. This result was assessed as significantly higher than the national aggregate (37.6%). This metric is defined at strategic clinical network level. The network can represent several cancer units and specialist centres. The result can be used as an indicator for the effectiveness of care at network level. Better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

The National Emergency Laparotomy Audit (NELA) allocates three ratings for each audit metric used to assess a process of care:

- A green rating (a positive finding) indicates performance above 80%
- An amber rating (neither a positive or negative finding) indicates performance between 50% and 80%
- A red rating (a negative finding) indicates performance under 50%

University Hospital Lewisham participated in the 2016 NELA.

The hospital case ascertainment rate for the 2016 NELA was 48% (a red rating), and the audit results reported below for University Hospital Lewisham should be interpreted in the context of this.

The hospital received a green rating for each of the four audit metrics used to assess a process of care:
• The crude proportion of cases with pre-operative documentation of risk of death (96%). This result was based on 48 cases.

• The crude proportion of cases with access to theatres within clinically appropriate time frames (85%). This result was based on 40 cases.

• The crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with a consultant surgeon and an anaesthetist present in the theatre (94%). This result was based on 31 cases.

• The crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (95%). This result was based on 19 cases.

The risk-adjusted 30-day mortality for University Hospital Lewisham was 12.6%. This result was within the expected range and based on 48 cases.

(Source: National Emergency Laparotomy Audit)

University Hospital Lewisham participated in the 2016 TARN. The risk-adjusted in-hospital survival rate following injury was assessed to be similar to expected compared to other hospitals. This result was based on 168 cases.

National Joint Registry

University Hospital Lewisham participated in the 2017 National Joint Registry.

No data was available to calculate a case ascertainment rate for the 2017 National Joint Registry, and the audit results reported below for University Hospital Lewisham should be interpreted in the context of this.

The hospital was within the expected range for each of the four audit metrics used to assess care:

• The risk-adjusted five-year revision ratio for hips, excluding tumours and neck of femur fractures. This result was based on 19 cases.

• The risk-adjusted 90-day mortality ratio for hips, excluding tumours and neck of femur fractures. This result was based on 17 cases.

• The risk-adjusted five-year revision ratio for knees excluding tumours. This result was based on 47 cases.

• The risk-adjusted 90-day mortality ratio for knees excluding tumours. This result was based on 47 cases.

National Prostrate Cancer Audit

No analysis is available for the trust or its hospitals for each of the three audit metrics reported on at a site level.
Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

The proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, and the proportions of patients who reported a worsening can be viewed on the left.

In 2016/17 performance for the procedure of groin hernia was:

- Worse compared to the England average based on the EQ VAS; but
- Better compared to the England average based on the EQ-5D Index.

In 2016/17 performance for the procedure of hip replacement was:

- Better compared to the England average based on the EQ VAS; and
- Similar to the England average based on the EQ-5D Index and Oxford Hip Score.

In 2016/17 performance for the procedure of knee replacement was:

- Worse compared to the England average based on the EQ VAS and EQ-5D Index; and
- Similar to the England average based on the Oxford Knee Score

In 2016/17 performance for the procedure of varicose vein was:

- Better compared to the England average based on the Aberdeen Varicose Vein Questionnaire and EQ-5D Index; but
- Worse compared to the England average based on the EQ VAS

(Source: NHS Digital)
Competent staff

Appraisal rates

From April 2017 to March 2018, 67.4% of required staff within surgery at University Hospital Lewisham received an appraisal compared to the trust target of 90%.

The breakdown by staff group is in the table below:

The trust target of 90% was not met for either qualified nursing staff or for medical staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>189</td>
<td>166</td>
<td>87.8%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>124</td>
<td>82</td>
<td>66.1%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>71</td>
<td>29</td>
<td>40.8%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>387</td>
<td>277</td>
<td>71.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

A number of nursing staff in the day surgery unit told us they did not feel appraisals were meaningful. They said training or development goals they asked for in their appraisals were routinely not provided. When we raised this with the head of nursing, she told us she had arranged to speak with staff in the day surgery unit and “career clinics” which had been introduced for nurses could be of assistance to those seeking development options.

Multidisciplinary working

During our inspection, we observed good multidisciplinary team (MDT) working. Allied health professionals (AHP)s told us they had a positive working relationship with medical and nursing staff. They said they were included in decisions about patient care and their opinions listened to.

We observed effective MDT working between a consultant and a member of the orthotics team assessing a patient.

There were regular MDT meetings on each of the surgical wards. In addition, the theatre users group included members of a range of professional backgrounds.
Seven-day services

The hospital took surgical emergency admissions with consultant surgeons attending all out of hours (OOH) theatre cases. The trust had consultant led on-call rotas for general surgery, trauma and orthopaedics and urology. All of the consultants were within 30 minutes of the Hospital. However, since the comprehensive inspection in March 2017, there had been a decline in the number of consultants available for shifts overall.

There was out of hours pharmacy support in the hospital as well as diagnostic imaging cover.

Health promotion

There were posters throughout the hospital offering support and advice to stop smoking and reduce alcohol intake. On wards and in waiting rooms there were leaflets available offering advice and encouragement to patients to eat healthily and undertake exercise.

Staff in pre-assessment told us they were proactive in health promotion. They said where a patient had necessarily made a lifestyle change in advance of an operation, they directed them to support networks both inside and outside of the trust to continue that change.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with had a clear understanding of consent. They were able to explain their responsibility under the Mental Capacity Act (MCA) and had a clear understanding of the Deprivation of Liberty Safeguards (DoLS).

All of the consent to treatment records we saw had been completed appropriately. We had sight of a completed MCA assessment, which had been appropriately documented.

Patients told us the staff took the time to explain their treatment and options for treatment to them. They said staff explained treatment options and risks in a way they could understand.
Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 85% for completion of mandatory training.

Nursing staff

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for qualified nursing staff in the surgery department at University Hospital Lewisham is shown below:

### Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Consent to Examination/Treatment</td>
<td>138</td>
<td>159</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Consent to Examination/Treatment</td>
<td>69</td>
<td>116</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At university Hospital Lewisham, the completion rate target of 85% was met by nursing staff but not by medical staff who had a rate of 59%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Whilst medical staff had not met the trust’s target completion rate for MCA training at this point, it is important to note the percentage completed rate refers to the year to date. Therefore, the division still had the opportunity to ensure the target was met within the year.

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Is the service caring?

Compassionate care

Friends and Family test performance

From May 2017 to April 2018 the Friends and Family Test (FFT) response rate for surgery at the University Hospital Lewisham was 12%. This was based on 2,395 responses.

A breakdown of FFT performance by ward for surgical wards at this hospital with total responses over 100 is below. All the wards scored 91% or above over the whole 12-month period.

The lowest monthly score was reported by Juniper Ward with a score of 86% in June 2017.
Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

The response rate for the FFT was significantly lower than the England average of 28%.

The majority of patients and family members we spoke with told us staff demonstrated compassion and were caring and attentive. One patient, however, told us the staff had not always listened to their concerns. They said that following an informal complaint to the ward sister, the situation had improved.

Emotional support

The chaplaincy and pastoral care service was available to provide spiritual, emotional, and religious support to all patients.

In addition, at the safety huddle, we observed a patient’s emotional wellbeing being discussed.

The clinical nurse specialists (CNS)s were able to offer emotional support for patients diagnosed with specific conditions or undergoing life-changing surgical interventions.

Understanding and involvement of patients and those close to them

The majority of patients told us they had been involved in all aspects of their care and kept up-to-date regarding changes to their care plans.

Patients that we spoke with told us that staff had helped them to maintain their dignity during their stay in hospital.

One patient’s family member who we spoke with told us that although the nurses were often very busy, they were kept “reasonably well” informed regarding the care their relatives were receiving. Another family member expressed concern at the lack of clarity of discharge date for their relative.

Is the service responsive?

Service delivery to meet the needs of local people

Average length of stay

University Hospital Lewisham

Elective patients:

From March 2017 to February 2018, the average length of stay for all elective patients at
University Hospital Lewisham was 4.3 days, which is longer than the England average of 3.9 days.

- Average length of stay for elective patients in urology was shorter than the England average.
- Average lengths of stay for elective patients in trauma & orthopaedics and general surgery were longer than the England average.

Elective Average Length of Stay - University Hospital Lewisham

![Elective Average Length of Stay Chart]

Note: Top three specialties for specific site based on count of activity.

University Hospital Lewisham

Non-elective patients:

From March 2017 to February 2018, the average length of stay for all non-elective patients at the University Hospital Lewisham was 4.1 days, which is shorter than the England average of 4.9 days.

- Average length of stay for non-elective patients in trauma & orthopaedics was shorter than the England average.
- Average length of stay for non-elective patients in general surgery was longer than the England average.
- Average length of stay for non-elective patients in ENT was similar to the England average.

Non-Elective Average Length of Stay - University Hospital Lewisham

![Non-Elective Average Length of Stay Chart]

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)
Meeting people’s individual needs

Staff made use of a telephone translation service for patients who did not speak English. They understood the need to use an independent translator rather than a relative of the patient for obtaining consent to treatment.

The hospital’s chaplaincy service included community leaders from a number of faiths and had the contact details for representatives of other faiths in the local area, should they be required.

There was a dementia link nurse within the hospital, who provided guidance, support and training to staff caring for patients living with dementia. Patients living with dementia needs were identified on the notice board in the nurses’ station on each ward as requiring a “red tray”, this was also noted in their nursing notes.

There was a learning disabilities link nurse, who provided support for patients with learning disabilities. We observed the learning disabilities link nurse assessing a patient and then working with ward staff to devise a specialist care plan for the patient.

One of the ward sisters told us that one of the healthcare assistants (HCA)s working on the ward was completing a course in British sign Language (BSL), supported by the hospital. They said this had been introduced in response to concerns raised by patients and their families.

Ward staff also told us they had links with local homeless charities. They said key workers from one of the charities would visit patients on a daily basis and work with staff to assist in their discharge to suitable accommodation.

There was a clinical nurse specialist (CNS) in colorectal and stoma care within the directorate. The CNS was involved in the pre-assessment for patients who were undergoing stoma surgery or were at risk of needing a stoma. Pre-assessment staff told us they had a good relationship with the stoma team. In addition, the stoma care team were involved in patients’ care on the ward, visiting the patient and advising the staff caring for them, as well as liaising with the community nursing team who would be providing follow up care prior to the patient’s discharge.

In the discharge lounge, specific chairs had been assessed and labelled by occupational therapists and physiotherapists as the most suitable for patients suffering from certain conditions or who had undergone certain types of surgery, for example hip surgery.

Patients could select their chosen meals from a menu at the beginning of each day. Where patients were required to wait in day surgery recovery for a prolonged period, they would be offered a hot meal.
Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

From May 2017 to April 2018, compared to the England average, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse in six months, better in five months and similar in one month.

Over this 12-month period there was a gradual improvement in the trust’s performance in terms of both the absolute value and also the value relative to the England average:

- In June 2017, 57% of the trust patients for surgery began treatment within 18 weeks compared to the England average of 70%.
- In April 2018, 69% of the trust patients for surgery began treatment within 18 weeks compared to the England average of 65%.

(Source: NHS England)

Referral to treatment (RTT) (percentage within 18 weeks) – by specialty

From May 2017 to April 2018 two specialties were above the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>84.2%</td>
<td>72.8%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>88.9%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.3%</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

Over the same period one specialty was below the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>31.6%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>25.0%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0.0%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>48.9%</td>
<td>60.7%</td>
</tr>
</tbody>
</table>

In response to the ongoing poor performance against the England average for RTTs in the ear nose and throat (ENT), ophthalmology, oral surgery and trauma and orthopaedic specialties, the division had introduced a cross-site RTT recovery action plan. This detailed specific barriers to meeting the RTT targets and included actions against each of these to address or mitigate their impact. For the majority of the identified barriers there was both a short and long term plan to address the issue.
In addition, extra clinics had been scheduled in these specialties for elective surgery on weekends in order to reduce the backlog. The pre-assessment team were running additional weekend clinics to help process patients in a more timely manner.

Cancelled operations

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.

Over the two-year period up to quarter 4 of 2017/18, after the first three months (quarter 1 2016/17), there were no patients who were not treated within 28 days after a cancelled operation at the trust. Over the same period the England performance for this metric varied between 6% and 11%.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Lewisham and Greenwich NHS Trust

Over the same two-year period, the percentage of cancelled operations at the trust was better than the England average in seven out of the eight quarters. For the remaining quarter (quarter 2 of 2017/18) the trust was similar to the England average.

From quarter 3 of 2016/17 up to quarter 2 of 2017/18, the trust performance compared with itself deteriorated. After this the trust performance improved: in quarter 4 of 2017/18, the percentage of cancelled operations was half the England average.
Cancelled Operations as a percentage of elective admissions - Lewisham and Greenwich NHS Trust

Staff reported a significant reduction in the number of outlying patients since our inspections in March 2017 and our unannounced follow-up inspection in May 2018. They said this was in part due to improvements in the bed management process and, in addition, due to the reduced demand for beds following the winter pressures period. Bed meetings were held daily within the surgical directorate, with representatives of each ward attending. We attended a bed meeting and observed it was conducted in an open and fair way. Staff were able to give challenge, and efforts were made to ensure patients were cared for in the most appropriate environment for their needs.

Discharge for the majority of patients was arranged by named nurses and AHPs. Patients were primarily discharged to the surrounding London Boroughs of Lewisham, Greenwich, Bexley and Southwark. Staff told us the primary delay to discharge was in ensuring there were suitable care packages in place. This was said to be more of an issue with some boroughs than others, on account of the complexity of the local authority’s processes for requesting a package of care. Patients being discharged to boroughs a significant distance from the hospital, as well as overseas patients and those with complex needs were dealt with by the complex discharge team.

Staff in the day surgery unit said the challenges in discharging patients identified at the March 2017 inspection continued. In particular, the on-site commercial pharmacy continued to close at 19:00, whilst patients could be discharged from day surgery up to 21:00. Staff explained that, due to commissioning and funding rules, patients were restricted to collecting their prescriptions from the on-site pharmacy and, therefore had to return the next day to collect their prescription. This was not only inconvenient to these patients, but also had the potential to impact on their health by delaying them starting a course of medication.

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were 49 complaints about surgery services.

The trust took an average of 46 working days to investigate and close complaints for this service.
The trust responded to 18.4% of complaints within the target period of 25 working days specified in the trust complaints policy.

The breakdown of complaints about surgery services by subject and location is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Queen Elizabeth Hospital Woolwich</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Appointments</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Transport (ambulances)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>End of life care</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>22</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From April 2017 to March 2018, were four compliments within surgery at UHL.

Unfortunately we are unable to provide commentary on themes.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff were able to describe changes in practice arising out of learning from complaints and concerns. For example, a member of ward staff learning British Sign Language (BSL) in response to a complaint from a patient regarding the lack of staff with BSL training.

**Is the service well-led?**

**Leadership**

On the whole, staff spoke highly of local, divisional and trust-wide leadership. The majority of staff told us their local leadership was supportive, and some staff expressed confidence that the divisional leadership would address the issues within the core service. However, staff within the day surgery unit lacked confidence in the divisional leadership to provide meaningful change and felt they had been “forgotten” by senior leadership. In addition, they expressed concern at the lack of local leadership on the unit and a number of staff told us they were not aware of the local leadership structure or the names of senior staff within the unit.
Overall, the divisional leadership had a clear understanding of the challenges they faced, in particular in respect of nursing and medical staffing and the impact of low staffing levels on morale. However, from the comments of the day surgery staff, it was apparent there was still work to do in recognising the issues on the unit. In addition, whilst the leadership recognised the challenges faced, progress in addressing the staffing issues had been slow and there was a failure to meet the requirement notice issued by the CQC at the March 2017 inspection to address the concerns around medicines management.

A number of staff spoke highly of the trust’s new chief executive and saw their appointment as an opportunity for change. Some of the staff we spoke with had met the chief executive on visits to clinical areas.

**Vision and strategy**

Upon its formation 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 multidisciplinary 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”.

There was no specific vision outlined for the surgical division. The majority of the staff we spoke with were aware of the vision for the trust.

**Culture**

The senior leadership team recognised there were issues with morale among medical and nursing staff on account of the high vacancy rate. Staff reflected this lack of morale. However, a significant minority of staff told us they were optimistic the recruitment drives would improve morale.

A number of staff in the day surgery unit described the relationship with the endoscopy team, who were part of a different directorate, with whom they shared space in the unit. In particular, there were challenges over the use of space in the unit on given days when there were high numbers of patients for both services. During our inspection, we observed a disagreement taking place between a number of staff from both services. This took place in the main corridor in the unit, and therefore could have been visible to patients and their relatives. In addition, we were told there were sometimes disagreements in the unit regarding nurses from one or other of the services being asked to assist patients under the care of the other service. This had the potential to impact on the continuity of patient care as well as having a significant impact on the confidence of patients in the professionalism of those caring for them.

**Governance**

The governance structure for the surgical division was integrated across the two sites of the trust, to ensure consistency.

There were governance structures in place to ensure oversight of care. This included cross-site monthly clinical governance meetings, which were held alternately on each site. We were provided with minutes from the meetings. The meetings were well attended, with representation of staff from across the professions. At each meeting there were standing agenda items, including patient safety, patient experience and clinical effectiveness, policies and protocols and information exchange. The minutes included action points for individually named staff members or staff
groups, with clear deadlines for completion and for reporting back on progress at subsequent meetings.

Staff told us they received regular updates of learning or changes to protocols arising from clinical governance meetings. They said these were shared in governance newsletters as well as at team meetings.

In addition to the divisional level clinical governance meetings there were localised governance meetings for each of the surgical specialities and for the ward managers. We also had sight of the minutes of those meetings, which similarly were well attended and included standardised agenda items. We saw evidence of concerns identified at these meetings being escalated for consideration at a divisional level.

Each of the theatre suites had a monthly theatre users’ group meeting. The meeting had good MDT representation.

In addition, there were monthly mortality meetings held at a divisional level for which a mortality review report was prepared which discussed all deaths within the division and sought to identify key themes and introduce actions to reduce the overall mortality rate.

Management of risk, issues and performance

There was a cross-site risk register for the surgical division. The risk register included a risk of identified risks to care and continuity of care, a score for the seriousness of each risk and also set out proposed mitigating actions. The risk register was reviewed on a two weekly basis, and progress against the mitigation actions were updated.

The most serious risk identified on the register for 24 April 2018 was delayed discharges from surgical wards. In order to mitigate this risk, the division had introduced a surgical flow project lead, with dedicated clinical nursing staff managing beds on UHL. In addition, efforts had been made to prioritise the preparation of to take out (TTO) medication for patients to take home with them to be prepared by the pharmacy a day in advance of the planned discharge date and a “Home for lunch” project had been introduced. The risk register indicated the mitigation project was still being consolidated, with the surgical flow leads having taken up their post, but awaiting training to become nurse prescribers to better assist with the preparation with TTO medicines. However, it was evident the risk was being managed proactively, with a reduction in risk score from 20 to 16 between 4 and 24 April 2018.

The risk register also identified a risk presented by the difficulty in filling rotas for medical staff at all grades. At our inspection of March 2017, the risk register detailed a risk in respect of recruiting and retaining junior doctors, at that time this was the division’s number one risk. Whilst it was evident the risk had been mitigated overall, it was concerning that the issue had widened solely from junior doctors to include doctors of all grades.

The risk register included risks which were categorised as so serious as to require escalation to the trust’s overall risk register. There were two such risks identified by the surgery division, the first was: “Lack of morale among medical staff, leading to lack of engagement with the governance agenda, Safety and Quality Improvement Projects and leadership roles” resulting in a risk to maintaining quality services. Whilst the second risk concerned the “High vacancy factor within nursing establishment across UHL site was causing poor staff morale, resignations, challenges in
getting agency staff to work for fear of being moved and impacting the quality and safety of care. In particular on Mondays and Fridays a recurrent theme of RED FLAGS in AEM caused staff to be moved from surgical areas and critical care to support predominantly Chestnut.” Efforts to address the high nursing vacancy rate within surgery at UHL are detailed in the “Nurse Staffing” section of this report above.

Daily safety huddles on wards and staff handovers across the division meant patients risks were discussed at length and staff had a good understanding of mitigating actions to take to help support patients.

Safety performance was displayed on a notice board at ward entrances and the information was up to date and available for patient’s staff and visitors to see.

**Information management**

Information technology systems were used to monitor and improve patient care. Data was regularly submitted to external auditors in order to benchmark the standards of care provided and outcomes and the division was proactive in notifying the CQC and other relevant bodies of adverse incidents. Staff, including agency and bank staff had access to patients’ care records via electronic and paper-based records. Senior staff told us the hospital was planning to move towards solely electronic records in future.

**Engagement**

Patients and relatives views were taken into account to improve services. Patients were encouraged to comment through the NHS Friends and Family test, albeit the response rate for surgery was worse than the national average.

Posters inviting patients to provide feedback were displayed prominently in wards and feedback cards were readily available. The trusts board meetings were partially open to the public.

The directorate had held a theatres open day to engage more proactively with the public about the work they carried out.

Staff took part in the annual NHS staff survey. Following the 2017 results of the 2017 staff survey, the trust had put together a Staff Survey 2017 action plan, published in May 2018 to seek to address the key concerns identified by staff. Staff were kept updated on progress made against the action plan through the “improving together” updates provided by the senior leadership team. A number of staff in the Day Surgery Unit told us they did not believe the actions detailed in the action plan would be fully implemented, nor that they would impact on their situation.

**Learning, continuous improvement and innovation**

The governance and risk group received a monthly report outlining innovation within the directorate. Staff were invited to propose innovations to the Clinical Effectiveness Department (CED) for approval. Once innovations were approved by the CED, their progress was monitored at governance and risk group meetings. The report for the meeting of 14 August 2018 included nine active innovations and one innovation pending approval by the CED. All of the innovations listed in the report related to the introduction of new surgical processes.
One of the physiotherapists we spoke with told us that all Band 6 allied health professionals (AHP)s carried out projects during each of their rotations. This supported their continued learning and drove improvement and innovation within the area of practice in which they were working. For example, there was currently a project being undertaken for physiotherapists to work with the orthotics team to train nurses to assist patients to apply and remove braces. As part of their appraisal process, the Band 6 AHPs were responsible for assessing the impact of their project. Similarly, Band 5 AHPs were responsible for undertaking audits to measure efficiency within the directorate, identifying areas for improvement. For example, at the time of our inspection, one of the Band 5 physiotherapists was undertaking an assessment of the value to patients of physiotherapist input at pre-assessment.

The pre-assessment unit had worked with the trust’s art manager in order to improve the environment in the unit for patients.

### Maternity

#### Facts and data about this service

We inspected University Hospital Lewisham (UHL) maternity service during an announced visit on the 25 and 26 September 2018 and an unannounced visit on 1 October 2018.

The trust has 148 maternity beds across two sites:

- 73 beds at Queen Elizabeth Hospital
- 75 beds at University Hospital Lewisham

**University Hospital Lewisham**

The maternity service at University Hospital Lewisham mirrors that for Queen Elizabeth Hospital. The 75 maternity beds at University Hospital Lewisham are made up of:

- 42 beds on the maternity ward
- 17 beds on the Anderson obstetric delivery suite
- 5 beds on the midwife-led birth centre
- 5 beds on the day assessment unit
- 6 beds on the antenatal clinic

**Community-based midwifery services**

The community-based maternity service for the trust catchment area provides services to women living in the Greenwich, Bexley and Lewisham local authority areas. Antenatal and postnatal care is provided in children’s centres and GP surgeries, and also a woman’s home.

**Specialist maternity services**

The trust provides specialist antenatal services for diabetes, for women with raised BMI (‘Pregnancy Plus’) and for women with additional vulnerabilities including alcohol / drug misuse, homelessness and social care concerns from the obstetric-led units and also through a satellite clinic at Queen Mary’s Hospital, Sidcup.

Two consultant midwives, one based on each main hospital site, offer additional care to women
with complex conditions and women birthing outside of guidance.

(Source: Trust Provider Information Request – Acute sites; and Acute context)

**Deliveries**

From January 2017 to December 2017, there were 7,966 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

**Number of babies delivered at Lewisham and Greenwich NHS Trust – Comparison with other trusts in England**
A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

### Profile of all deliveries (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>Lewisham and Greenwich NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7,814</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>119</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>213</td>
<td>2.7%</td>
</tr>
<tr>
<td>20-34</td>
<td>5,557</td>
<td>70.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>1,765</td>
<td>22.2%</td>
</tr>
<tr>
<td>40+</td>
<td>398</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7,933</td>
<td></td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

### Gestation periods (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>LEWISHAM AND GREENWICH NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Gestation period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>10</td>
<td>0.1%</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>495</td>
<td>7.1%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>6,408</td>
<td>92.2%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>37</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,950</td>
<td></td>
</tr>
</tbody>
</table>

The trust has a higher number of older mothers at the trust compared to the England average, with 27.2% being 35 or over, compared to 22.1%.

*(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)*

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.
Over the two-year period from January 2016 to December 2017, there was a downward trend in the number of deliveries. The count of deliveries in each quarter of the last 12 month (2016/17 Q4 to 2017/18 Q3) is lower than the count of deliveries in the corresponding quarter of the first 12 months (2015/16 Q4 to 2016/17 Q3).

(Source: HES - Deliveries (January 2017 - December 2017))

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training was provided in various formats which included online e-learning and classroom based training.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 at trust level for staff in maternity is shown below:
Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>299</td>
<td>335</td>
<td>89.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>298</td>
<td>335</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>295</td>
<td>335</td>
<td>88.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>285</td>
<td>335</td>
<td>85.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>280</td>
<td>335</td>
<td>83.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>273</td>
<td>335</td>
<td>81.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>273</td>
<td>335</td>
<td>81.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>267</td>
<td>335</td>
<td>79.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>237</td>
<td>335</td>
<td>70.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus – HLS/NLS maternity</td>
<td>229</td>
<td>332</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>197</td>
<td>335</td>
<td>58.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and harassment</td>
<td>5</td>
<td>11</td>
<td>45.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for five of the 13 mandatory training modules for which qualified nursing staff were eligible.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>65</td>
<td>73</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>54</td>
<td>73</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>54</td>
<td>73</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>53</td>
<td>73</td>
<td>72.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>48</td>
<td>73</td>
<td>65.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>48</td>
<td>73</td>
<td>65.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>37</td>
<td>73</td>
<td>50.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>34</td>
<td>73</td>
<td>46.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>34</td>
<td>73</td>
<td>46.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>26</td>
<td>73</td>
<td>35.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for one of the 10 mandatory training modules for which medical staff were eligible.

University Hospital Lewisham

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the maternity department at University Hospital Lewisham is shown below:
Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>161</td>
<td>171</td>
<td>94.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>157</td>
<td>171</td>
<td>91.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>154</td>
<td>171</td>
<td>90.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>148</td>
<td>171</td>
<td>86.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>146</td>
<td>171</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>143</td>
<td>171</td>
<td>83.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>142</td>
<td>171</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>126</td>
<td>171</td>
<td>73.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>117</td>
<td>171</td>
<td>68.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus – HLS/NLS maternity</td>
<td>100</td>
<td>168</td>
<td>59.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>93</td>
<td>171</td>
<td>54.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and harassment</td>
<td>5</td>
<td>10</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At University Hospital Lewisham maternity department, the 85% target was met for six of the 13 mandatory training modules for which qualified nursing staff were eligible.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>38</td>
<td>40</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>37</td>
<td>40</td>
<td>92.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>34</td>
<td>40</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>33</td>
<td>40</td>
<td>82.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>30</td>
<td>40</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>24</td>
<td>40</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>23</td>
<td>40</td>
<td>57.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>23</td>
<td>40</td>
<td>57.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>21</td>
<td>40</td>
<td>52.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>16</td>
<td>40</td>
<td>40%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At University Hospital Lewisham maternity department, the 85% target was met for three of the 10 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff told us they had sufficient time to complete mandatory training. We saw evidence that staff had been allocated protected time to complete e-learning training. However, data submitted to us by the trust showed that mandatory training for staff in the maternity unit did not always meet the 85% target set by the trust.
The trust also submitted the below data that was correct at the time of this inspection.

<table>
<thead>
<tr>
<th>Training Type / Staff Type</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical Obstetric Multi-Professional Training (PROMPT)</td>
<td></td>
</tr>
<tr>
<td>Midwives (MWs)</td>
<td>91.0%</td>
</tr>
<tr>
<td>Maternity Support Workers (MSWs)</td>
<td>71.9%</td>
</tr>
<tr>
<td>MSWs (inpatient areas)</td>
<td>82.6%</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Young People Level 3 &amp; Perinatal Mental Health</td>
<td></td>
</tr>
<tr>
<td>Midwives (MWs)</td>
<td>97%</td>
</tr>
<tr>
<td>Hospital Life Support and Newborn Life Support and Resuscitation</td>
<td></td>
</tr>
<tr>
<td>Midwives (MWs)</td>
<td>90.3%</td>
</tr>
<tr>
<td>Basic Life Support (BLS) Maternity Support Workers (MSWs)</td>
<td>87.9%</td>
</tr>
<tr>
<td>Medicines Management E-learning</td>
<td>Midwives (MWs)</td>
</tr>
</tbody>
</table>

The data above does show an improvement in mandatory training figures. However, it does still show that service did not always meet its 85% target.

The issue of mandatory training compliance was identified at the last inspection and the trust had not ensured that targets were being met at the time of this inspection. This being said, the leads of the service recognised the importance of improving mandatory training compliance to meet the trust target.

Maternity leads told us the training year ended in March which meant staff had several months to complete their mandatory training and, therefore, compliance levels would improve by the end of the year. The maternity staff also told us it had been difficult to improve mandatory training rates due to the high number of staff currently on leave. To tackle this, staff told us the service was trying to enable staff to access the mandatory training system at home.

**Safeguarding**

Staff, both clinical and nursing, were able to define what a safeguarding incident was and were able to give examples of when they had escalated a safeguarding concern. All midwives we spoke with knew who their safeguarding lead was and how to access them for support.

All safeguarding concerns were documented on the trust’s incident reporting system and in women’s maternity care records. Electronic care records had a flashing alert function which alerted staff to safeguarding concerns such as mental health and domestic violence concerns.

The trusts policies on safeguarding were in date and easily accessible to staff on the trust’s intranet. The trust intranet also had contact details for staff requiring further advice or support with safeguarding referrals.

We saw evidence that staff had undertaken Female Genital Mutilation (FGM) training and had correctly identified and documented FGM concerns. We also saw that FGM, and how to escalate concerns around this, had recently been discussed in one of the daily handover ‘Just Take 5’ sessions. These sessions were included in all handovers, in both mornings and evenings, and
allowed a whole team to take time to discuss learning, risks and updates relevant to the maternity service, and the wider trust when appropriate.

The service undertook audits of women who had been victims of FGM. The most recent audit established that all of women were asked about FGM at the midwifery booking appointment and all of those identified as having had FGM were referred appropriately to the safeguarding team.

The maternity service had a ‘Best Beginnings’ team which included a dedicated safeguarding lead midwife. This lead was a point of contact for all other staff and provided safeguarding updates when appropriate.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 at trust level for staff in maternity is shown below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>291</td>
<td>335</td>
<td>86.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - core</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - specialist</td>
<td>230</td>
<td>324</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>57</td>
<td>73</td>
<td>78.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - core</td>
<td>50</td>
<td>73</td>
<td>68.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was not met for each of the two safeguarding training modules for which medical staff were eligible.

**University Hospital Lewisham**

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 for staff in the maternity department at University Hospital Lewisham is shown below:
Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>153</td>
<td>171</td>
<td>89.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - specialist</td>
<td>131</td>
<td>160</td>
<td>81.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 3 - core</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At University Hospital Lewisham maternity department the 85% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children &amp; young people level 3 - core</td>
<td>34</td>
<td>40</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>33</td>
<td>40</td>
<td>82.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At University Hospital Lewisham maternity department the 85% target was met for one of the two safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

All midwives were required to be trained to safeguarding adult's level two and safeguarding level three for children and young people. Staff told us that safeguarding training included issues such as trafficking, mental health and domestic violence issues.

Whilst the trust target compliance rate had not been met, maternity leads informed us the training year ended in March which would mean staff had several months to complete their safeguarding training and therefore, compliance levels would improve by the end of the year. The maternity staff also told us it had been difficult to improve mandatory training rates due to the high number of staff currently on leave. To tackle this, staff told us the service was trying to enable staff to access the mandatory training system at home.

The trust also submitted the following safeguarding training information that was correct at the time of this inspection.

<table>
<thead>
<tr>
<th>Training Type / Staff Type</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children &amp; Young People Level 3 &amp; Perinatal Mental Health</td>
<td>Midwives (MWs)</td>
</tr>
</tbody>
</table>

These new figures indicate a better compliance for safeguarding training than shown by the tables above. This gives us some assurance that the trust has improved its training compliance to above its target of 85%.
Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children’s services, adult services or the police should take place.

The trust submitted the following information on their safeguarding referrals within the maternity service at University Hospital Lewisham (UHL).

<table>
<thead>
<tr>
<th>Date</th>
<th>Total Bookings</th>
<th>Maternity Safeguarding Notifications</th>
<th>Multi-agency Safeguarding Hub (MaSH) Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2018</td>
<td>368</td>
<td>88 (24%)</td>
<td>16/88</td>
</tr>
<tr>
<td>August 2018</td>
<td>384</td>
<td>66 (17%)</td>
<td>19/66</td>
</tr>
<tr>
<td>September 2018</td>
<td>Figures not yet available</td>
<td>62</td>
<td>10/62</td>
</tr>
</tbody>
</table>

Cleanliness, infection control and hygiene

All of the environments and equipment we observed within the maternity service at UHL were visibly clean and we saw evidence that cleaning schedules were thorough and carried out at appropriate intervals. The environments we observed met all the criterions set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. Staff could easily access up to date policies on infection prevention and control (IPC) and hand hygiene on the trust intranet.

‘I am clean’ stickers were dated and attached to equipment once cleaned. All ‘I am clean’ stickers we observed were attached to visibly clean equipment. Staff could easily access cleaning products which were stored securely in a locked cupboard.

Personal protective equipment (PPE) was easily accessible to staff and was regularly replenished. PPE included gloves, aprons, face masks and longer gloves for surgical procedures. We saw staff using the PPE at appropriate times and disposing of it once it was no longer needed.

Staff adhered to good IPC and hand hygiene practices. The maternity service carried out regular IPC and hand hygiene audits in accordance with the National Institute for Health and Care Excellence (NICE) guidance on effective hand decontamination.

We saw evidence of IPC audits across the different clinical areas of the maternity service, all of which were complaint. For example, the maternity ward’s last 4 months of IPC audits, prior to the inspection, were 100% compliant with the trust’s guidelines based on the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

We saw evidence of monthly hand hygiene audits where staff were observed washing their hands after contact with patients and clinical environments. For example, the day assessment unit had
an IPC information board within the department which showed a 100% compliance rate for hand hygiene in the month prior to our inspection.

Women and partners told us they thought the environment was clean and they had seen staff regularly cleaning their hands when entering and leaving clinical areas.

The management of waste was carried out safely within the maternity service and products of conception were stored in line with the national guidelines. All the sharps boxes we observed were filled below the minimum level required, had their lids closed and were dated.

The dirty utility room within the labour ward had a separate exit to minimise the risk of contamination. However, it was not always securely locked which meant that anyone could gain access to a potentially infectious area.

Anti-bacterial hand sanitisers were available throughout the maternity service and at every entry and exit point to the clinical areas. We saw staff reminding people to use the sanitisers when they had forgotten. All toilets we visited were visibly clean and regularly checked and cleaned, as shown by the cleaning schedules which were clearly visible in each area.

Women were placed in isolation rooms if they were believed to have a potentially infectious disease, in order to minimise the risk to other people within the department. We observed good IPC practice when staff attended these isolation rooms, with appropriate use of PPE and regular and thorough hand washing. We checked an isolation trolley in the delivery suite which had an attached IPC checklist which was completed and signed appropriately.

Environment and equipment

The maternity ward, birth centre, delivery suite, daily assessment unit, anaesthetic rooms and theatres were all visibly clutter free and in a good general state of repair.

Equipment was stored in stock rooms in a tidy manner and staff were aware of their roles responsibilities in terms of the checking and tidying this equipment.

The appropriate equipment was readily available for staff to use, enabling them to carry out their roles effectively. The service had enough foetal monitoring systems to assess babies’ health; however, staff told us that there were some signalling issues with the wireless monitors which meant they could sometimes stop working. Staff told us that trust management were aware of the issue and were currently working with an external provider to resolve the problem. We observed that all equipment which required electrical safety testing had this completed within the appropriate timeframes. The trust had a central maintenance rota which allowed for a regular testing programme to be undertaken.

Theatre instrument trolleys were signed and check daily and after every procedure. Suction kits, nitrous oxide gas, suturing sets and other maternity items we checked were in date, sealed and stored correctly.

Staff used key cards to access the different areas within the maternity service. Staff were aware of the importance of security and we saw staff ask visitors who they were before granting them access to the department. We saw evidence on the trust’s incident reporting system that staff had reported breaches of security.

The maternity ward was accessed by visitors via a telecom system. The ward receptionist manned this telecom system and visitors would not be granted access without confirming their identity. All visitors signed in and out when entering or leaving the ward. The receptionist manned the door
during normal working hours and outside of this, the ward manager was responsible for ensuring the security of the ward. The ward manager had a camera monitor positioned in the nurses station which showed who was trying to enter the ward.

**Assessing and responding to patient risk**

All staff we spoke with were able to identify risks and knew where to escalate them. Maternity early obstetric warning scores (MEOWS) were used to assess deteriorating patients and ensure they were escalated urgently. The MEOWS we checked on inspection we all clearly recorded, accurately scored and escalated appropriately. We saw evidence of Newborn Early Warning Trigger and Track (NEWTT) scores being appropriately assessed and recorded within patient notes.

Regular risk assessments were undertaken throughout women’s pregnancies to ensure they were triaged to the most appropriate place of birth given their clinical needs. We checked risk assessments within electronic care records and found them to be thorough with plans of care that were appropriate based on clinical and social need. The screening team tested women who were at higher risk of infectious diseases which could be harmful to mother and baby, such as Human Immunodeficiency Virus (HIV), hepatitis B and syphilis.

The maternity service had regular meetings, including quarterly ward meetings, where risks were discussed and actions were identified to mitigate these risks. Risks discussed included medicines management, safeguarding and staff well-being. We saw evidence that, at the twice-daily handover ‘Just Take 5’ sessions, potential risks for the up-coming shift were discussed which included staffing and complex discharges.

The midwife-led birth centre was available to women who had low risk pregnancies and the consultant-led labour ward was accessed by women with pregnancies with higher risks attached. The trust had an up to date transfer policy which staff used in the event that a mother or baby deteriorated and needed to be transferred to a more specialist service.

Staff assessed the capacity of the unit on a daily basis, with regard to clinical acuity, activity and staffing. This information was sent to maternity leads who would act according to clinical need and rearrange staffing across both sites if required.

All obstetric staff adhered to the obstetric haemorrhage guidelines. Staff had access to post partem haemorrhage trolleys, which were checked and completed daily, in accordance with this guidance. The trust’s induction of labour of policy also included information and guidance on the management of a major haemorrhage.

A new ‘fresh eyes approach’ was used within the maternity service. The approach was created by the Royal College of Midwives who have provided guidance on reducing the misinterpretation of CTG readings. This approach introduced a buddy system which ensured a second member of staff also interpreted the CTG reading as a ‘sense check’. We observed women’s maternity care records where this had been correctly completed. Staff told us that an annual mandatory training session had just been introduced which tested staff’s ability to read a CTG recording.

Staff were trained to effectively identify and manage sepsis. The trust had an up to date sepsis recognition and management policy which was easily accessible on the trust intranet. This was in line with NICE guideline 51 (recognition, diagnosis and early management of sepsis). Staff we spoke with were able to give examples of when they had escalated patients who had been identified as potentially septic and describe how those patients had been managed.

Maternity care records included a maternal sepsis screening and action tools and a sepsis six pathway, as well as contact details for the appropriate staff members and teams to escalate
concerns to. We checked 13 maternity records which had the sepsis management tool clearly documented. We checked sepsis boxes in the postnatal ward, day assessment unit and in the delivery suite. All these were checked and signed for regularly, in accordance with national guidance.

Theatres were easily accessible from the labour ward. Emergency medications, obstetric and resuscitation, both adult and neonatal, equipment were all available and checked in line with national guidance. The maternity service audited the use of the World Health Organisation’s five steps to safer surgery checklist (WHO surgical safety checklist) in obstetrics. For the period January to May 2018 there was 100% compliance. We checked eight records which required a WHO surgical safety checklist and these were all completed correctly.

**Midwifery and nurse staffing**

On the days of inspection, we observed safe midwifery and nursing staffing levels in all areas of the maternity service which met the requirements set by the trust and were in line with the ‘safe midwifery staffing for maternity settings’ (NICE NG4) guidance.

Staff told us that shifts were covered by bank staff employed by the trust and agency staff were very rarely used. The rotas we assessed reflected this and, in addition, ward managers told us they would ‘step down’ to ensure safe staffing levels when required.

The maternity leads had weekly managers meetings to discuss any potential staffing issues and proactively manage them. Depending on need, staff could be moved between the two hospital sites to ensure both hospitals had safe staffing levels.

The maternity dashboard showed in August 2018 that 97.8% of women received one to one care from a midwife whilst in established labour.

The maternity service used the Birthrate Plus (BR+) tool for monitoring the midwifery staffing levels, in accordance with the recommendation of the Royal College of Midwives (RCM). The most recent (BR+) report from May 2018 indicated that there was a variance of -3.74 whole time equivalent midwives between the BR+ recommendations and the actual midwifery staffing levels.

The trust had recently employed a 0.5 WTE recruitment midwife to help new recruits through their whole recruitment process and initial introduction into the service. All staff we spoke with said they felt this role had been a very useful introduction and had helped the service.
Total staffing

The trust reported the following qualified nursing staff numbers as of March 2018 and June 2018 for maternity by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018 Actual WTE staff</th>
<th>March 2018 Planned WTE staff</th>
<th>March 2018 Fill rate</th>
<th>June 2018 Actual WTE staff</th>
<th>June 2018 Planned WTE staff</th>
<th>June 2018 Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>146.6</td>
<td>157.5</td>
<td>93.1%</td>
<td>147.3</td>
<td>160.3</td>
<td>91.9%</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>153.6</td>
<td>162.0</td>
<td>94.8%</td>
<td>154.3</td>
<td>162.4</td>
<td>95.0%</td>
</tr>
<tr>
<td><strong>Trust total</strong></td>
<td><strong>300.2</strong></td>
<td><strong>319.5</strong></td>
<td><strong>94.0%</strong></td>
<td><strong>301.6</strong></td>
<td><strong>322.7</strong></td>
<td><strong>93.4%</strong></td>
</tr>
</tbody>
</table>

Please note, the trust total may not equal the sum of the site totals because some nursing staff work cross-site.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From July 2017 to June 2018, the trust reported a vacancy rate of 6.3% for qualified nursing staff in maternity. This was better than the trust target of 14%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 6.9%
- University Hospital Lewisham: 5.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From July 2017 to June 2018, the trust reported a turnover rate of 11.8% for qualified nursing staff in maternity. This was similar to the trust target of 12%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 13.3%
- University Hospital Lewisham: 10.5%

Queen Elizabeth Hospital performed worse than the trust target for turnover, while University Hospital Lewisham was better.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 4.8% for qualified nursing staff in maternity. This was worse than the trust target of 3.5%.
The breakdown by site was as follows:

- Queen Elizabeth Hospital: 5.6%
- University Hospital Lewisham: 4.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From July 2017 to June 2018, the trust reported 9,001 shifts in maternity services. Of these, 78.9% maternity were filled by bank staff and 1.1% of shifts were filled by agency staff. In addition 11.2% of shifts were not filled by bank and agency staff to cover staff absence.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Bank shifts</th>
<th>Bank shifts as a proportion of total shifts at trust</th>
<th>Agency shifts</th>
<th>Agency shifts as a proportion of total shifts at trust</th>
<th>Unfilled shifts</th>
<th>Unfilled shifts as a proportion of total shifts at trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital Lewisham</td>
<td>3,115</td>
<td>34.6%</td>
<td>264</td>
<td>2.9%</td>
<td>402</td>
<td>4.5%</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>3,987</td>
<td>44.3%</td>
<td>95</td>
<td>1.1%</td>
<td>609</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Nursing bank agency)

Midwife to birth ratio

From January 2017 to December 2017, the trust had a ratio of one midwife to every 25.7 births. This was similar to the England average of one midwife to every 25.5 births, and an improvement on the ratio for the earlier time period from November 2015 to October 2016 of one midwife to every 29.9 births.

(Source: Electronic Staff Records – EST Data Warehouse)

Medical staffing

On the days of inspection, we observed safe medical staffing levels in all areas of the maternity service which met the requirements set by the trust and were in line with the Royal College of Obstetrics and Gynaecology (RCOG) recommendations. All medical staff we spoke with said they felt that staffing levels were safe.
Anaesthetic cover was appropriate to ensure emergency caesarean section surgery could be carried out. Staff also told us they had always been able to get an anaesthetist to administer a spinal block or epidural upon request.

Women told us they had sufficient contact with medical staff and felt, if requested, one would be available to speak with.

Junior doctors told us that more senior medical staff were supportive and approachable.

Medical turnover rates were high at 47.2%. However, we observed that medical staffing levels were safe throughout the inspection and for all the staffing rotas we assessed. Medical staff told us they were happy to work in the UHL maternity service and said it was a supportive environment to work in.

**Total staffing**

The trust reported the following medical staffing numbers as of March 2018 and June 2018 for maternity by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>June 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>30.3</td>
<td>40.5</td>
<td>75.0%</td>
<td>35.9</td>
<td>42.6</td>
</tr>
<tr>
<td>University Hospital Lewisham</td>
<td>36.2</td>
<td>44.3</td>
<td>81.7%</td>
<td>39.3</td>
<td>43.1</td>
</tr>
<tr>
<td>Trust total</td>
<td>66.5</td>
<td>84.7</td>
<td>78.5%</td>
<td>75.1</td>
<td>85.7</td>
</tr>
</tbody>
</table>

Please note, the trust total may not equal the sum of the site totals because some nursing staff work cross-site.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of 21.3% for medical staff in maternity. This was worse than the trust target of 14%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 24.2%
University Hospital Lewisham: 18.6%

Both sites did not meet the trust’s target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From July 2017 to June 2018, the trust reported a turnover rate of 41.2% for medical staff in maternity. This was worse than the trust target of 12%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 34.4%
- University Hospital Lewisham: 47.2%

Both sites were worse than the trust’s target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 1.8% for medical staff in maternity. This was better than the trust target of 3.5%.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 2.6%
- University Hospital Lewisham: 1.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From July 2017 to June 2018, the trust reported 523 shifts in maternity. Of those, 74.2% were filled by bank staff and 11.1% of shifts were filled by locum staff. In addition 8.4% of shifts were not filled by bank and locum staff to cover staff absence.

The trust did not provide data for University Hospital Lewisham, therefore the data in the table below for Queen Elizabeth Hospital only.

<table>
<thead>
<tr>
<th>Location</th>
<th>Locum shifts</th>
<th>Locum shifts as a proportion of total shifts at trust</th>
<th>Agency shifts</th>
<th>Agency shifts as a proportion of total shifts at trust</th>
<th>Unfilled shifts</th>
<th>Unfilled shifts as a proportion of total shifts at trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>169</td>
<td>32.3%</td>
<td>0</td>
<td>0.0%</td>
<td>16</td>
<td>3.1%</td>
</tr>
<tr>
<td>Middle grade</td>
<td>196</td>
<td>37.5%</td>
<td>57</td>
<td>10.9%</td>
<td>24</td>
<td>4.6%</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>23</td>
<td>4.4%</td>
<td>1</td>
<td>0.2%</td>
<td>4</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
Staffing skill mix

In December 2017, 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 about the same as the England average.

Staffing skill mix for the 76.5 whole time equivalent staff working in maternity at Lewisham and Greenwich NHS Trust.

\[\begin{array}{c|c|c|c}
\text{This Trust} & \text{England average} \\
\hline
\text{Consultant} & 34\% & 40\% \\
\text{Middle career}\wedge & 19\% & 8\% \\
\text{Registrar group}\sim & 39\% & 45\% \\
\text{Junior}\ast & 8\% & 6\% \\
\hline
\end{array}\]

\wedge Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
\sim Registrar Group = Specialist Registrar (StR) 1-6  
\ast Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
Maternity records consisted of mix of paper and electronic patient notes. Staff told us it was easy to scan documents into the electronic record system and we saw this regularly took place to ensure a complete patient record.

Both electronic and paper records were concise and informative, with hand written records being clear and legible. Women’s preferences were well presented and medical histories including prescription medication, alcohol intake and allergies were completed. The electronic record system allowed staff to see patient interactions and appointments at other hospital sites within the trust and vice versa.

Electronic patient records were available on the trust’s computers and all the appropriate staff had access. Labour ward paper notes were securely stored in a trolley behind the nurse’s station.

We reviewed 16 maternity records for both mother and baby. They showed good continuity of care, clinical pathways and protocols were correctly followed and plans of care were clearly documented. All of the records we reviewed were completed in line with the records management code of practice for health and social care. Antenatal checks, scan and screening tests were included in the records.

We observed the SANDs (Stillbirth And Neonatal Deaths) stickers on the front of women’s’ notes to indicate to staff that the women had previous suffered the loss of a child.

Community midwifery staff told us maternity care records stayed at women’s at homes so they could be easily accessed. The staff said they uploaded information onto their electronic system promptly but that this could impact on their working hours.

**Medicines**

All medicines storage areas were securely locked, clean and tidy. We saw risk assessments in place for circumstances where medicines were not locked away to ensure staff could access them quickly in an emergency.

We saw medicines were prescribed and recorded appropriately. We observed good compliance for the checking of controlled drugs (CDs) in all areas of the maternity service and all registers we reviewed had accurate balance checks. However, in one instance we saw the crossing out of errors which is a breach of CD regulations.

Expiration dates were written on all medicines boxes clearly and were generally in date. However, we did observe one instance where a supply of Atropine injection that had expired. Emergency medicines trolleys were managed appropriately with short-dated items noted on the checklist and on the boxes of the medicines.

There was a system in place for monitoring stock levels of pre-packed medicines for discharge. All medicines for discharge were prescribed by the doctors and midwives supplied pre-packs against these prescriptions.

Medicines were disposed of safely once used into sharps boxes. If women bought their own medicines onto the ward, this could be stored securely in the ward medicines room or in the lockable cabinet next to women’s beds.

Staff were aware of the trust’s medicine management policy and could easily access medicines information and policies on the trust’s intranet page. We saw a copy of the up to date injectable medicines (Medusa) guidelines.
We saw evidence that medicines checks and top-ups were completed weekly by pharmacy staff and the pharmacy technician completed expiration checks every week. Pharmacy staff also completed a monthly walkabout and gave feedback to the maternity team so they could act upon any issues identified. Staff told us they had a good relationship with the trust’s pharmacy team. For example, staff at the birth centre told us the pharmacy attended the unit most days and were able to answer any queries staff might have.

We saw that all fridges which stored medicines were regularly temperature checked and fell within the stated minimum and maximum ranges. However, fridge resets were not always documented within daily temperature checklists.

Staff had recently started monitoring ambient room temperatures where medicines were stored. Records for September 2018 showed these checks of room temperatures had been taken every day.

Staff had access to a glucagon hydrochloride injection kit which was checked daily. However there was no documentation made of these checks, hence staff could not assure themselves that this was always being completed.

**Incidents**

All staff we spoke with were aware of how to report incidents using the trust’s electronic incident reporting system. Staff were encouraged to report incidents and felt supported by managers to do so. Staff told us said the culture of the service was open and they felt able to challenge poor practice.

Incidents were categorised based on severity and clinical harm and included near misses and non-clinical incidents as well. The head of maternity reviewed all incidents and identified reoccurring themes. Staff received individual feedback when they reported an incident. Action plans were created in response to incidents to reduce the risk of the incident reoccurring.

In the year prior to our inspection, the service had no maternal deaths within 42 days of labour. Similarly, in the year prior to our inspection, the service had no maternal deaths between 42 days post-labour and 1 year post-labour.

Learning from incidents was shared via email, in daily ward huddles, handovers, one to one meetings and ‘Just Take 5’ sessions. We reviewed four ‘Just Take 5’ meeting minutes which all included examples of lessons learned from incidents. For example, the day assessment unit had previously noticed an increase of inappropriate referrals due to a number of incidents reporting this. The minutes showed that staff had discussed what happened, why it happened, any contributory factors, root causes, recommendations and identified learning.

Staff told us lessons were learned from incidents and were able to give examples where practice has changed as a result of learning from an incident. The perinatal mental health (Indigo) team also had specific reflective practice sessions on a monthly basis to discuss learning from incidents.

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 DoC and senior staff were knowledgeable about their responsibilities in relation to this.
Never Events

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.

From June 2017 to May 2018, the trust reported one incident which was classified as a never event for maternity. The incident occurred in April 2018 at the Queen Elizabeth Hospital and related to a retained foreign object post procedure. At the time of inspection this incident had been downgraded and investigation continuing.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018.

The breakdown by incident type and location was as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Queen Elizabeth Hospital</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother only</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>9</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The trust used its own maternity dashboard which showed national comparison data against other NHS trusts. At the time of inspection, an information board in the birth centre displayed the August 2018 maternity dashboard. This started that the normal birth rate was 52.6%, the emergency C-section rate was 27.1%, the breastfeeding rate was 86.7% and the one to one care rate in labour was 97.8%.
Safety thermometer information was displayed in an open area in the birth centre which allowed staff and service users to see how the department compared when benchmarked against other hospital nationally. Staff were able to access the safety thermometer electronically on the trust computers.

Is the service effective?

Evidence-based care and treatment

Care and treatment provided by the maternity service was in line with and met national evidence-based guidance. Staff we spoke with were aware of clinical best practice and aware of current policies and legislations that were relevant to their roles. Staff accessed up to date policies on the trust intranet.

Staff told us they were regularly updated on the latest evidence-based guidance which was available via the trust email system, on the trust intranet, daily huddles including ‘Just Take 5 sessions’ and through notice boards throughout the maternity departments. We saw evidence in paper and electronic care records that the appropriate NICE guidance was being followed.

The service had a specialist foetal monitoring midwife who supported midwives, particularly with regard to CTG interpretation. There was a meeting every week to discuss CTGs in which staff were able to query any new guidance or best practices.

The perinatal mental health lead ensured that staff adhered to maternal mental health alliance guidelines through newsletters and one to one support. Staff told us they were able to access the perinatal mental health team directly to ask any queries regarding best practice.

Staff worked in line with the early pregnancy assessment unit (EPAU) guidelines which included guidance an emergency department (ED) early pregnancy pathway, management of eptopic pregnancy, management of miscarriage up to 14 weeks, and management of bleeding in pregnancy up to 14 weeks. We saw evidence that this had been followed within electronic patient records.

Nutrition and hydration

Midwives noted feeding choice discussions in women’s care records. Care records also included completed fluid balance charts, and associated guidelines, if a patient was identified to be at risk of dehydration.

Women told us they felt supported with feeding their baby in the way they chose. Trained staff offered this support on a one to one basis when required. The maternity unit was a UNICEF accredited level three baby friendly service which meant the unit had demonstrated it supported mothers, partners and babies with different infant feeding choices. The maternity service also provided a breastfeeding class to support new parents who wanted to try breastfeed their babies.

The maternity ward had a specific breastfeeding information board which displayed the benefits of breastfeeding and the different feeding options available to parents. In addition, the postnatal information pack provided to all new parents included thorough information regarding feeding babies and also had useful signposting information for other organisations parents could contact for support.
The birth centre and maternity ward had dedicated kitchens for parents to prepare milk for their babies. The unit did not supply milk but did have an emergency supply in case it was needed. The kitchens could also be used by mothers and visitors to make tea or coffee during they stay.

**Pain relief**

Women had a wide range of pain relief options available to them including epidurals, pethidine and aromatherapy. Women told us that they were regularly offered pain relief and it was administered in a timely manner.

These was an on-call anaesthetist who would attend to perform epidurals and spinal block procedures. They were scheduled from 8:30am to 5pm on the delivery suite, making them available for the emergency obstetric theatre as well as having 24 hour on-call cover. Staff told us the on-call anaesthetist was easily accessible upon request to perform procedures.

Anaesthetists would assess women’s pain and these assessments were clearly documented within women’s care plans and included discussions on the risks of these procedures. However, the service did not record information on the time taken between the anaesthetist being called and the women receiving pain relief. This meant the service could not ensure this was undertaken within 30 minutes as per AAGBI Obstetric Anaesthetic guidance.

Nitrous oxide gas was available in every room of the birth centre and on the maternity ward. Post-delivery pain relief was prescribed on an individual basis.

Pain management and scores were clearly recorded in notes, which allowed staff to proactively monitor any changes in patient pain levels. Staff used a graded system of zero to ten (zero being no pain and ten being the worst) to record pain measurements of women. Obstetric epidural analgesia records were completed when required.

Women with a history of using recreational opioids were not permitted the usage of opioids for pain relief. These women were assessed to determine alternative pain relief for them.

**Patient outcomes**

Patient outcome information was routinely collected and assessed. Audits were monitored over time to identify trends and to show how the trust performed against comparators nationally. The serviced carried out a number of audits including staffing levels, risk management, mortality, readmissions, complaints, breast feeding and safeguarding concerns.

Maternity leads told us they had noticed an increased percentage of unplanned caesarean sections due to local auditing. To tackle this, maternity leads reviewed records to understand see if they could identify any reason why this may have increased. Some of the initial findings suggested this increased rate could be due to a high failed induction rate. Maternity staff believed this could originate from the local community having a larger population of older mothers and a larger proportion of mothers with raised BMIs. This work was on-going at the time of the inspection.

Maternity leads used effective audit mechanisms to identify service improvement. We saw evidence that records, IPC and hand hygiene audits had been used to identify issues which were then acted upon. We saw evidence that any outliers were investigated and action plans were created to help tackle them.

Outcomes of audits were regularly discussed in ward meetings and daily huddles. We saw evidence that audits were regularly discussed in ‘Just Take 5’ meetings and similarly we saw that,
in recent newsletters, both breastfeeding and FGM audits were highlighted. Results of audits were also visible in the communal staff areas to make sure staff aware of how the unit was performing.

The maternity service had recently started the implementation of the Better births’ as part of the national ‘Five Year Forward View’ for maternity care with an aim to ‘improving outcomes of maternity services in England’. As part of the process, the trust invited staff to a discussion event in June 2018 to plan initial steps of implementation.

At the time of inspection, an information board in the birth centre displayed the August 2018 maternity dashboard. This stated that the normal birth rate was 52.6%, the emergency C-section rate was 27.1%, the breastfeeding rate was 86.7% and the one to one care rate in labour was 97.8%.

The maternity service at UHL contributed towards a number of national audit programmes seen below.

**National Neonatal Audit Programme**

**University Hospital Lewisham**

In the 2017 National Neonatal Audit, the results of University Hospital Lewisham for the two audit measures relevant to maternity services were:

**Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 108 eligible mothers identified for inclusion in this audit measure, 89.7% of whom were given a complete or incomplete course of antenatal steroids. This was within the expected range and compared to the national aggregate of 86.1%.

The hospital met the audit’s recommended standard of 85% for this measure.

**Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

There were 27 eligible mothers identified for inclusion in this audit measure, 55.6% of whom were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5%, and put the hospital in the top 25% of all units.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Standardised Caesarean section rates and modes of delivery**

From April 2017 to March 2018, the total number of caesarean sections was similar to expected. For the same time period;
the number of elective caesarean sections was lower than expected; and
The number of emergency caesarean sections was similar to expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>Lewisham and Greenwich NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>548</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>1,607</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>2,155</td>
</tr>
</tbody>
</table>

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery, the table below shows the proportions of deliveries recorded by method in comparison to the England averages from April 2017 to March 2018. The trust had a similar profile of deliveries when compared to the national averages.

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Lewisham and Greenwich NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>2,155</td>
<td>27.2%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>960</td>
<td>12.1%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>4,818</td>
<td>60.7%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>7,933</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.
4. Includes elective and emergency caesareans
5. Includes forceps and ventouse (vacuum) deliveries
6. Includes breech and normal (non-assisted) deliveries
(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of 5 July 2018, the trust had no active maternity outliers.
(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.02.

This is up to 10% higher than the average for the comparator group rate of 4,000 or more births per annum, at 24 weeks or later and was worse than expected.

(Source: MBRRACE UK)

Competent staff

The maternity service proactively supported staff to deliver effective care and treatment. Staff told us they had regular one to one meetings with their managers and felt well equipped to carry out their roles.

Staff told us they felt supported to request additional training and that these requests would be taken seriously. However, staff did mention that additional training courses were often rejected due to funding issues but, they recognised this issue was outside of the trust’s control.

Maternity leads organised and ran training sessions on specific areas to support staff. We saw evidence of diabetes awareness, healthy lifestyles and bereavement support training. Staff we spoke with found these training sessions useful and said they could also suggest training topics to maternity leads and felt they were likely to be considered seriously.

Midwives told us they were well supported with supervision and revalidation. They also told us the trust ensured they received four protected working days a year to complete their mandatory midwifery training update.

Junior doctors told us that they participated in observing ward rounds with consultants and registrars. They told us this was a friendly and supportive environment where they felt comfortable to ask questions and seek advice.

Maternity staff told us they received regular appraisals. We saw evidence that, during each appraisal, training needs were discussed with associated plans to support staff to meet these needs and further their skills. Staff told us these appraisals were beneficial and supportive.

Appraisal rates

From April 2017 to March 2018, 71.4% of required staff within maternity at the trust received an appraisal compared to the trust target of 90%.

University Hospital Lewisham

From April 2017 to March 2018, 73.9% of required staff within maternity at University Hospital Lewisham received an appraisal compared to the trust target of 90%.

The breakdown by staff group is in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate 2017/18</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust target of 90% was not met for either qualified nursing staff or for medical staff.
Medical staff | 4 | 17 | 23.5% | 90% | No  
Qualified nursing staff | 155 | 185 | 83.8% | 90% | No  
Qualified allied health professionals | 0 | 0 | - | 90% | -  
Scientific, therapeutic & technical staff | 0 | 0 | - | 90% | -  
Support staff | 53 | 85 | 62.4% | 90% | No  
Total | 212 | 287 | 73.9% | 90% | No  

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Updated information received from the trust showed that 86% of maternity staff at UHL had had an appraisal and this was part of the rolling annual programme. This was below the target but the trust recognised this and had action plans in place to increase this compliance to meet and exceed the target.

Multidisciplinary working

Throughout the inspection, we observed strong multi-disciplinary team (MDT) working and strong working relationships between different teams to achieve positive outcomes for women and their babies. We observed interactions between midwives, midwifery support workers, doctors, and theatre staff and among others which were all positive.

Staff told us that all staff respected one another and understood each other’s roles. Staff said that the open culture of the service allowed all staff members to challenge practice and raise concerns.

Electronic care records supported good MDT working which many different types of health care professionals contributed to. This created a holistic record and plan of care for service users.

During the inspection we observed a number of handovers which were multi-disciplinary. Midwives and consultants on the labour ward undertook combined handovers twice a day, at 8am and 8pm. These handovers were effective in identifying the needs of women and ensuring they received the most appropriate plan of care.

Many of the teams within the maternity service worked across both hospital sites and were able to demonstrate good examples of MDT working with different colleagues across both sites.

Health promotion

Staff proactively promoted lifestyle choices to support the health and wellbeing of women and their families. Women’s care records included discussions around health promotions and lifestyle choices. This included advice on smoking, alcohol consumption and diet.
The maternity service provided support to help women stop smoking. Smoking cessation mandatory training had been implemented recently by the trust. Staff we spoke with we aware that the local geographic area had a very high rate of mothers smoking during pregnancy at 11%. All midwives were trained to have a sensitive conversation with mothers who smoke during pregnancy at their 11 to 14 week scan. The service also ran a weekly clinic support women who smoke during pregnancy.

Many women told us they had attended classes which promoted different aspects of health and found them to be supportive and informative. Staff told us they enjoyed putting these workshops on because they felt it was very beneficial to women’s health. In many areas of the maternity service, information was displayed about the benefits of breastfeeding and the service also ran breastfeeding classes to promote the benefits and support new parents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

All staff we spoke with were aware of the Mental Capacity Act 2005 (MCA) and gave examples which demonstrated they could support women and partners to make decisions in their care and that of their baby.

We observed consent being appropriately taken, along with a discussion of the associated risks of their examination or treatment. Staff knew the importance of gaining consent for examinations and treatment and maternity care records reflected that staff had accurately documented the consent process, and included consent forms for an emergency caesarean sections.

Staff were able to identify capacity concerns and refer patients for mental health assessments when appropriate to do so. We saw evidence in care records that this had been done in line with guidance and referrals were appropriately made to mental health specialists.

We spoke with two women who had recently undergone surgical procedures within the maternity theatres. They both confirmed they had been asked for consent prior to the procedures which we were then able to confirm within their records.

Maternity staff showed awareness of the Deprivation of Liberty Safeguards (DoLS) and were able to give examples of when they would be appropriate to implement. Minutes from the ‘Just Take 5’ August 2018 meeting showed that DoLS processes had been highlighted as an area of learning and gave guidance information to further raise awareness to staff.

Staff undertook training on the MCA and consent to examination or treatment, with figures shown below.

Mental Capacity Act and Deprivation of Liberty Safeguards training

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 at trust level for staff in maternity is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Nursing staff in maternity met the target for MCA training with 91% completion.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>50</td>
<td>73</td>
<td>68.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in maternity did not meet the trust’s target for MCA training completion, with a rate of 68.5%.

University Hospital Lewisham

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for staff in the maternity department at University Hospital Lewisham is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>161</td>
<td>171</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff in maternity at University Hospital Lewisham met the trust’s target of 85% with 94.2% completion.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>27</td>
<td>40</td>
<td>67.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in maternity at University Hospital Lewisham did not meet the trust’s target, with a completion rate of 67.5%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care
Staff treated women and their partners with compassion throughout their maternity journey. We spoke with 15 women and partners across the UHL maternity service and all of them were positive about their experience within the service and described it as a ‘friendly and kind’ environment. Women told us they felt supported to make decisions and were able to make individualised choices on their care.

We observed staff offering women advice in a caring and professional manner. Staff provided individualised care specific to women’s medical and social needs. Expectant fathers told us they felt supported and involved in their partner’s care.

Staff respected women and their partners’ privacy and dignity throughout their maternity journey. Staff ensured that curtains were pulled around women during assessments and private discussions could not be overheard. We observed staff knock on doors or asking to enter a clinical environment before doing so.

At the time of the inspection, the maternity ward displayed recent feedback from mothers, their partners and relatives. One service user said “great after care... overall very positive experience”, another said “brilliant midwives and care” and another said “excellent care from midwives. Knowledgeable and quick to react”. Upon request, the maternity staff showed us the original comment cards these came from, enabling us to confirm these positive experiences.

We observed many thank you cards throughout the maternity areas which indicated patient gratitude for such “kind and compassionate care”.

In communal areas of the labour ward and birthing centre, there were toys available for young children visiting mothers and their babies.

**Friends and Family test performance**

Please note no data for any of the four maternity Friends and Family Tests was published by NHS England for November 2017 because of data quality concerns. For the same reason no data were published for the maternity (postnatal community) Friends and Family Test for July 2017.

Because November 2017 data is not included in the charts below, May 2017 has been included to provide 12 months of data. For postnatal community, because July 2017 and November 2017 are not included in the chart, April 2017 and May 2017 have been included to give 12 months of data.

**Friends and family test performance – antenatal**

From May 2017 to May 2018 the trust’s performance in the maternity Friends and Family Test for antenatal care was consistently 90% or higher, and overall the trend was neutral.

Performance compared with the England average has fluctuated: the trust is worse than the England average in six months, the same in one month and better than in the remaining five months.

In May 2018 the trust scored 93% (compared to the England average of 95%) and in May 2017 it scored 100% (England average 96%).
Friends and family test performance – birth

From May 2017 to May 2018 the trust’s performance in the maternity Friends and Family Test for birth was consistently 93% or higher, and overall the trend was neutral.

Performance compared with the England average has fluctuated: the trust is worse than the England average in eight months (and in four of these months the difference was equal to or less than 1%), the same in two months and better than in the remaining two months.

In May 2018 the trust scored 97% (compared to the England average of 97%) and in May 2017 it scored 93% (England average 97%).

Friends and family test performance – postnatal ward

From May 2017 to May 2018 the trust’s performance in the maternity Friends and Family Test for postnatal ward care was consistently 84% or higher. Performance was consistently worse than the England average.

In the first seven months of the time period, the trend was neutral but in the last five months of the time period, there was a downward trend. The trust scored 92% in December 2017 and 88% in May 2018.

In May 2018 the trust scored 88% (compared to the England average of 95%) and in May 2017 it scored 89% (England average 95%).
Friends and family test performance – postnatal community

From May 2017 to May 2018 the trust’s performance in the maternity Friends and Family Test for postnatal community care was consistently 97% or higher, and overall the trend is neutral.

The trust scored 100% in 6 of the 12 months in the time period and performance was better than the England average in 11 of the 12 months.

Friends and family test performance (postnatal community), Lewisham and Greenwich NHS Trust

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017

The trust performed similar to other trusts for each of the 19 questions in the CQC maternity survey 2017:

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.85</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most</td>
<td>7.75</td>
<td>About the same</td>
</tr>
<tr>
<td>Area</td>
<td>Question</td>
<td>Score</td>
<td>RAG</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------------</td>
</tr>
<tr>
<td>Comfort</td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.35</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.99</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.26</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.22</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.33</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a member of staff help you within a reasonable amount of time?</td>
<td>8.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.41</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.70</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.43</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.92</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>6.85</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Was your discharge from the hospital delayed?</td>
<td>4.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed after the birth, did a member of staff help you within a reasonable amount of time?</td>
<td>6.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.64</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.30</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Was your partner who was involved with your care able to stay with you as much as they wanted?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.47</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

**Emotional support**

Women, their partners and families were emotionally supported whilst they were under the care of the maternity service at UHL.
A bereavement midwife and bereavement counsellor sensitively supported bereaved women and their partners. The bereavement midwife was appropriately trained and had the right skills to support bereaved women, their partners and families.

There was a private bereavement suite on the maternity ward, sensitively named the ‘quiet little room’. The suite had a bed, sofa bed for families to stay on and small kitchen facilities for women and their families to use during their stay. The room was quiet and decorated in a non-clinical and sensitive manner. There was a process in place to ensure another private room could be available in the event that another bereavement suite was required.

There were cold cots available to allow bereaved parents to spend more time with their babies. There were also cooling mats and portable bassinets available to allow bereaved parents to take their baby out of the hospital if they wished to do so. This process was in line with the trust’s bereavement guidelines. We saw evidence of that bereaved family had used a cooling mat to take their baby out of the hospital which they said had allowed them to have a ‘special day out’ as a family and had helped to ease some of their grief.

There was a selection of memory boxes available to all women having babies at UHL. There were specific memory boxes available to bereaved families which were specialised for the different lengths of gestation at which the pregnancy ended. Families were also able to have hand and foot prints moulds from their babies created. Clothes which had been knitted by volunteers were available for bereaved parents to dress their babies who had passed away.

The unit had a refrigeration unit specifically for keeping placentas and babies who had passed away. This was locked and accessible by staff only; the refrigeration unit was kept in the bereavement office and was overseen by the bereavement midwife. We saw all items contained in the refrigeration unit were labelled correctly and were emptied daily to the main hospital mortuary.

The service ran a monthly peri-natal pregnancy loss support group which was led by an obstetrician and a midwife who emotionally supported bereaved women and their partners.

Mortuary staff visited the maternity ward to support bereaved families with funeral arrangements and there was a specific viewing area within the mortuary for bereaved families to visit their babies.

Chaplains of different faith groups were available on site and also had an on-call system, to ensure women’s religious needs were appropriately supported, particularly in times of grief.

The service ran a ‘fathers’ group’ for new fathers and partners to share experiences and aspirations. The group provided information relevant to expectant fathers and partners.

**Understanding and involvement of patients and those close to them**

Women said they felt supported to make informed decisions about their care. We observed staff explaining women’s care in a friendly manner which was easy to understand. We saw consultants and medical staff offer advice to women and their families and gave opportunities for them to ask questions.

Women and families who attended the service’s breastfeeding clinic praised the information they had received, with one commenting “all my questions have been answered”. We spoke with 15 women and partners who told us they had both been involved in their care and we able to discuss their choices and preferences throughout their pregnancy journey. Women told us they felt listened to and were empowered to make decisions that were suited to them, free of any judgement.
Partners told us they felt they had been involved in their partner’s pregnancy journey and had been offered classes which were specific to them. For example, service’s ‘fathers’ group’ was available to all new fathers and partners to share experiences and aspirations.

We saw information leaflets being given to women and their partners depending on their situations. A post-natal information pack was given to all parents who had lots of different useful information including signposting information for parents to use should they have any further questions.

The service ran a ‘Whose shoes’ workshop which allowed women and their families who had babies with Down’s syndrome to discuss their perspective and experiences for both during pregnancy and after birth. The workshop provided useful information to the families who attended.

Is the service responsive?

Service delivery to meet the needs of local people

Cross-site working between University Hospital Lewisham (UHL) and Queen Elizabeth Hospital meant that women’s care plans were always met. Staff told us of the importance care continuity and we observed support given to women as they progressed between the different stages of the maternity service. We saw evidence that women were given treatment choices which were fully explained to them.

Antenatal care was easily accessible and referrals into the service came from GPs and online self-referral. Women were seen in a timely manner from the time of referral to their first midwifery assessment.

Midwives were appropriately trained to deliver care to women with additional support needs, such as, women with disabilities, women with alcohol or drugs dependencies and women with raised BMIs. Stickers were used in women’s care records to highlight if a woman had any additional support needs.

The service had a specialist lead nurse for young persons who was part of the kaleidoscope team. The kaleidoscope team worked to support with vulnerable women and women suffering with mental health within the local community.

The perinatal mental health (Indigo) team worked in conjunction with local mental health trust and closely with mental health visiting teams to ensure service met the needs of the local community.

Private single room accommodation was available on the maternity ward which was purchased upon request. This facility provided an extra option to families to potentially better meet their needs.

The service had a high rate of bed occupancy at 86.1%. However, we saw evidence of risk assessments being undertaken to monitor the on-going situation at points of particularly high bed occupancy rate. Staff told us that, although bed occupancy rates were high, they did not feel the service was unable to cope with demand and it did not impact on safety. The service had contingencies in place in case the occupancy rates became too high and breached capacity.

Bed Occupancy

From October 2016 to March 2018 the bed occupancy levels for maternity were consistently higher than the England average.
Over quarter 4 of 2017/18 (January to March 2018) the trust bed occupancy rate for maternity was 86.1% compared to the England average of 58.5%.

The chart below shows the occupancy levels compared to the England average over the period:

**Bed occupancy levels at Lewisham and Greenwich NHS Trust compared to the England average.**

![Bed occupancy chart](chart.png)

(Source: NHS England)

**Meeting people’s individual needs**

Staff ensured that people’s individual needs were identified and met. All the care records we reviewed at the time of inspection included plans of care that met women’s individual needs.

The kaleidoscope team worked to support vulnerable women and women suffering with mental health. When appropriate, the team would link with local mental health trust staff to ensure those women’s needs were met.

The trust had a midwifery lead for perinatal mental health and staff told us they were supported to identify and proactively manage mental health concerns during a women’s pregnancy. The perinatal mental health (Indigo) team managed women with complex emotional needs, with a recent increase in the number of trafficked women. Staff were trained to identify needs of these women and ensure a plan of care was created to support those needs. We saw an example of this on inspection where the team assessed a woman’s needs and worked with the local family nursing partnership to enable the women to get 28 days of postnatal care.

The Pilot study Of midwifery Practice in Preterm birth Including women’s Experiences (POPPIE) team gave specialised support to women requesting a homebirth, had previously suffered a stillbirth or traumatic birth or had babies with learning difficulties or a disability. Women’s notes included stickers which alerted staff that a woman had suffered a still birth. This allowed staff to provide appropriate and sensitive care to that individual.
If a women’s first language was not English, staff had access to telephone interpretation service or could book an interpreter in advance of any appointments. Staff told us that language line was easy to access and that interpreters were easy to book, when organising in advance. The use of interpretation services was highlighted in the August 2018 to further raise staff awareness of how to access an interpretation service.

Women and partners told us they had been offered food and drink, with a meal being provided once a day. If women were hungry outside of the meal time they could request a snack box at any time of day.

**Access and flow**

Women accessed the trust’s maternity pathway via referrals from GPs and online self-referral. The pathway could, and usually did, span their full length of pregnancy but, depending on risk, women were able to differ from the norm and enter a more specialist pathway of care.

Clinic opening times usually ran from Monday to Friday and from 8am to 5pm, with a few clinics having later opening hours. Saturday clinics were sometimes held to ease the build-up of appointments. Staff told us this wasn’t a frequent occurrence.

The trust had a dedicated helpline to provide women and partners with easy and direct access to maternity information. The helpline also supported GPs and other health care professionals with any queries they might have. This service was available Monday to Friday from 10am to 6pm and staff told us it helped to ease pressures on maternity service.

The service monitored and proactively managed the number of expected deliveries. They used the number of referrals and subsequent information collected at periodic gestational scans to estimate the number of deliveries they could expect in a given week and month.

The service kept a record and carried audits of the number of transfer-out (when women were transferred to other areas of care) incidents. These transfers occurred if there were capacity issues within the service. Staff told us that they adhered to the trust’s policy of favouring women who were being induced over those who were already in labour. No women had been diverted outside of the trust since 2015 and we saw evidence that the service had received patients from another trust when they had closed their unit.

**Learning from complaints and concerns**

Staff treated complaints seriously and took active steps to improve practice as a result of people raising concerns. We observed posters throughout the maternity units with information on how to raise a complaint and this information was also easily accessible on the trust’s website. We saw evidence that complaints had been reviewed and learning points appropriately identified.

Learning from complaints was shared on the trust’s intranet, highlighted in ‘Just take 5’ newsletters and discussed in daily huddles and ward meetings. Staff gave examples of complaints that had been investigated and actions that had been implemented based on learning from those complaints.

Both staff and patients told us that complaints would often de-escalate as staff would initially informally discuss complaints with women and visitors to try to resolve an incident quickly. When this wasn’t possible, women and visitors were supported to escalate these up to become written formal complaints. Staff told us that there was a ‘no blame’ culture amongst maternity staff and felt open to challenge by others as a way of improving practice.
The maternity service had professional midwifery advocates who worked across both hospital sites and supported women who had experienced difficult births. The advocates told us they undertook debriefs with women and visitors to discuss any positive or negative feedback. Any feedback identified was taken back to the involved staff directly by the professional midwife advocate in face to face meetings. If any of the feedback had been negative, then the two colleagues would discuss learning and send feedback to the wider maternity team. Staff told us that this had been a supportive process and the service had seen a measurable reduction in complaints attributed to this method.

Complaints were monitored as part of the maternity dashboard; see below for figures submitted by the trust.

### Summary of complaints

From April 2017 to March 2018 there were 50 complaints about maternity services.

The trust took an average of 33.5 working days to investigate and close complaints for this service.

The trust responded to 36% of complaints within the target period of 25 working days specified in the trust complaints policy.

The breakdown of complaints about maternity services by subject and location is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Queen Elizabeth Hospital</th>
<th>University Hospital Lewisham</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>10</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Waiting times</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Appointments</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Transport (ambulances)</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Admin/policies/procedures (inc patient record)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
<td><strong>19</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

### Number of compliments made to the trust
From April 2017 to March 2018, there were 72 compliments within maternity at the trust.

A breakdown by site is provided below:

- Queen Elizabeth Hospital: 40
- University Hospital Lewisham: 32

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The service was led by a divisional director of nursing, a head of midwifery, a clinical director and deputy head of midwifery. Staff knew who these were, as well as the local managers of the maternity service.

The maternity service had a clear medical and nursing leadership structure and these maternity leads had the skills, knowledge and professional qualifications to carry out their roles. The management team had well defined roles and responsibilities and staff knew who to escalate concerns to.

Staff we spoke with told us their local managers were supportive, approachable and easily accessible if needed. Staff told us maternity leads acknowledged the challenges their teams faced and they worked together with all staff to resolve these issues.

Staff told us that the executive team were visible, approachable and supportive. Many staff gave us examples of when executive team members had visited their clinics and asked them questions about what worked well and what didn’t in their areas of work. Staff gave us examples of when they had raised concerns to the head of midwifery and other maternity managers and these had been acted upon.

We saw posters of the executive team, which included photographs, throughout the different maternity clinical areas to inform staff and visitors of who they were and their roles within the organisation.

Vision and strategy

Staff we spoke to were aware of the trust’s vision and purpose. We observed ‘key priorities’ posters displayed throughout the different maternity clinical areas to inform staff and visitors of the main aims of the service.

The midwifery strategy had 10 key objectives outlined as follows:

- Health Promotion
- Visible nursing and midwifery leadership
- Equipping patients and carers to help them to make informed choices and manage their own health
- High value care/ patient experience
- Work in partnership with our patients and families
- Listen and respond to our staff and colleagues
- Ensure that we use evidence to inform practice and increase our involvement in research
- Education, training and development
- Right staff, in the right places and at the right time
• Champion the use of technology and informatics

Staff we spoke with were aware of the objectives and how they were expected to meet them. Each objective had a clear divisional action plan linked to it which clearly outlined how the maternity service would achieve this.

The maternity leads, including the divisional director of nursing, head of midwifery, clinical director and the deputy head of midwifery, all spoke of vision for the service which aligned with these objectives.

The executive team had engaged with women, families and staff about the values and the behaviours expected from all staff via an online survey that was advertised on the trust’s intranet and external web page. This survey was closing at the end of the week after our inspection. Alongside this, maternity leads told us they were currently in the process of creating a new strategy for the service and staff we spoke with felt they had been included in and contributed to this process.

**Culture**

Staff told us that there was an open and honest culture within the maternity service. Staff were encouraged to report incidents and there was a no blame culture when incidents were reported.

Many staff we spoke with had worked for the trust for a long time and said they were happy and proud to work there. They told us they felt valued and felt that there were equal opportunities within the service.

Staff were complimentary of the local and executive leadership team and told us they promoted a positive culture that supported and valued staff.

Staff told us that they felt confident and comfortable to raise concerns to senior staff. Staff were also aware that the trust had ‘freedom to speak up guardians’. Guardians promote an open culture, allowing staff to speak up about concerns easily. We saw posters displayed throughout the different maternity clinical areas to remind staff about the guardians and how to access them.

**Governance**

The service had effective structures, systems and processes to ensure safe and high quality care was delivered to service users.

There were a monthly risk committee meeting which was attended by the clinical director, the head of midwifery, and the clinical governance manager amongst others. These meetings included discussions on patient outcomes, safeguarding concerns, complaints and medicines. We also saw evidence of senior staff and ward meetings where governance issues were discussed.

The service utilised several groups which aimed to improve governance. The WaSH (Women’s and Sexual Health) governance board discussed policies, audits, serious incidents and NICE guidance compliance. The service had a specialist risk and governance midwife and we saw evidence of divisional update reports that were sent to the monthly directorate meetings to be discussed. These updates included positive findings, areas for improvement and how the key issues to be discussed were related to the service’s strategic objectives.

There were clear processes in place for escalating and sharing information and to facilitate communication from front line staff to the maternity leads and the executive team. Maternity staff held regular handovers and team meetings where staff could escalate concerns to maternity leads.
Maternity staff knew about their department's governance arrangements and who the key leaders were within that department. They were clear about their own individual roles and responsibilities and that of their colleagues and the leads of the maternity service.

The service’s ‘Just Take 5’ newsletter included examples which related good governance practices including learning from incidents and updates to relevant guidelines.

The intranet was easily accessible to all staff and contained links to guidelines, policies and procedures. All guidelines we reviewed as part of this inspection were thorough and were in date. All staff had access to a trust email account and received relevant trust wide information on a regular basis including updates and changes to policy and procedures.

**Management of risk, issues and performance**

The maternity-specific risk register was reflective of the issues identified on inspection. We reviewed the trust wide maternity risk register which showed staffing issues as the service’s top risk. The trust had taken steps to tackle this risk by conducting a recruitment drive which had successfully encouraged people to apply for jobs with new staff due to start working in the service in the coming months.

On the risk register, each risk had mitigations to reduce their impact and a set of meaningful actions with timeframes attached to ensure risks were reduced and eliminated where possible. For example, one risk identified was a shortage of support for newly qualified midwives which had been mitigated with the introduction of a new preceptor midwife.

Staff recorded risks on the maternity risk register, which was reviewed on a weekly basis by the maternity leads. All staff we spoke with understood the importance of highlighting risks on the risk register and gave examples where actions had been taken to mitigate risks.

Maternity leads knew the top risks associated with the service. Risks were rated according to severity (using a red, amber, green ‘RAG’ rating system) and had clear actions, timescales for review and owners set against each risk.

Maternity leads monitored quality and safety outcomes and reported on these to the board. We reviewed three sets of meeting minutes for the monthly mortality review group which showed discussion of topics including incidents, risks and audits. The service used its maternity dashboard to benchmark its service against national comparators.

Board and maternity leads reviewed a range of quality and risk information about the service. This included staffing levels and information on quality outcomes. We saw evidence of maternity and risk governance meeting minutes being shared to staff and observed that the risk register, complaints, incidents and performance were discussed at these meetings.

**Information management**

The trust had safe and effective information management systems to record and monitor data and information. Information was treated confidentially, stored securely and in line with the trust’s information governance policy.

Staff had secure log in information to access patient records and we observed good practice with regard to information security during the inspection. We saw evidence of a ‘Just Take 5’ newsletter in August 2018 which reinforced the importance of confidentiality to staff and described the processes which staff had to follow in order to work in line with the information governance policy.
The service stored robust and granular information on mandatory training, appraisal and complaint response rates which enabled them to effectively monitor staff’s competence and identify themes from complaints.

The trust used information to effectively monitor and report on maternal outcomes. Board and divisional level staff reviewed a range of quality and risk information about the service which included staffing levels, referral times and on maternity-specific quality outcomes.

Maternity leads shared information with NHS England, clinical commissioning groups (CCGs) and other external bodies. They received comparative information from external comparators and used it to assess their own service. For example, the service’s annual screening report showed the number of women who screened positively for infectious diseases. This data was benchmarked against national comparators and was used inform the service of the challenges that were facing the trust’s demographic.

**Engagement**

Staff engaged with women and their families and used feedback to improve services. Women were encouraged to leave feedback about their experience via patient satisfaction surveys and the Friends and Family Test. We saw evidence that the service used this feedback to improve patient experience.

The maternity service ran a Lewisham Maternity Open Forum twice a month to encourage women and their partners to discuss their experiences in an open environment. The forum was led by maternity team leaders and patients told us they had been encouraged by staff to attend. The trust also provided information to patients through leaflets and posters in clinics.

The trust engaged with staff regularly using various types of communication including trust wide emails, newsletters and the intranet. Staff told us they were also kept up-to-date with key information through monthly team meetings and email communication from managers.

The trust held a staff achievement awards ceremony on an annual basis. This was to recognise the contribution of exceptional teams and individual staff who had been identified by other trust colleagues and members of the public as “going the extra mile”. Similarly, the maternity service also had its own staff recognition award called the ‘maternity star’ award where maternity staff were nominated by colleagues and patients for their contributions to the service. There were also ‘Midwifery Roll of Honour’ posters displayed throughout the service which listed the awards, accreditations and promotions that midwives had recently received across the service.

**Learning, continuous improvement and innovation**

The trust sought to participate in national improvement projects. For example, the maternity service had worked to become a UNICEF accredited level three baby friendly service and had started a weekly class to promote the benefits of breastfeeding and support new parents.

The trust was innovative in its approach to supporting its local community. The local demographic had a higher than average number of vulnerable women and women suffering with mental health. In order to meet the needs of these women, the service had a specialist kaleidoscope team to holistically support women in vulnerable circumstances.

The executive team was committed to continuous improvement, redefining models of care and trialling new ways of working. For example, after service user feedback, the service had refurbished its bereavement room and also implemented new practices to ensure bereaved parents were fully supported with their grief.
Staff in the maternity service worked hard to improve practice from continuous learning. Incidents and complaints were constantly monitored with themes being identified and acted upon. We saw that learning from both incidents and complaints was discussed regularly in meetings and the service had implemented changes in practice based on such learning.

End of life care

Facts and data about this service

The trust provides end of life care at one of its sites, University Hospital Lewisham (UHL). There are arrangements in place to provide end of life care at its other main site, Queen Elizabeth Hospital by staff not employed by the trust.

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

Specialist palliative care at the hospital is provided by the Lewisham Macmillan palliative care service, which delivers a service seven days a week between 9:00am and 5:00pm. There is on-site consultant presence between 9:00am and 5:00pm Monday to Friday. The on-call consultant rota operates after 5:00pm seven days a week and includes UHL palliative care consultant as well as consultants from Guy’s and St Thomas’ NHS Foundation Trust.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The trust had 1,766 deaths from March 2017 to February 2018.

(Source: Hospital Episode Statistics)
Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training.

The information in this section is based on very low numbers of staff, therefore should be considered as indicative only. It should also be noted that where a target was not met, this is often based on one or two members of staff not completing the course.

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 at trust level for staff in end of life care is shown below:

A breakdown of compliance for mandatory training courses from April 2018 to July 2018 for specialist palliative care staff at University Hospital Lewisham is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control clinical</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and harassment</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent WRAP level 3</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 85% target was met for eight of the 12 mandatory training modules for which qualified nursing staff were eligible.

Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent WRAP level 3</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient manual handling</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency planning</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - adult &amp; paediatric BLS</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety clinical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The 85% target was met for each of the 11 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

The trust set a target of 85% for completion of safeguarding training.

The information in this section is based on very low numbers of staff, therefore should be considered as indicative only. It should also be noted that where a target has not been met, this is often based on one or two members of staff not completing the course.

A breakdown of compliance for safeguarding training courses from April 2018 to July 2018 at trust level for staff in end of life care is shown below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 85% target was met for each of the two safeguarding training modules for which qualified nursing staff were eligible. All staff have completed this training.

**Medical staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults clinical level 2</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children &amp; young people level 2</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At University Hospital Lewisham end of life care department, the 85% target was met for each of the two safeguarding training modules for which medical staff were eligible. All staff have completed this training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

Medical and nursing staff followed trust policies on infection, prevention and control. For example, they were bare below the elbows in line with trust policy, used antibacterial hand gel when they moved between patients, washed their hands, wore personal protective equipment and disposed of waste correctly. This ensured that patients receiving end of life care were cared for as safely as possible.
Staff in the mortuary had a changing room, hand washing facilities and protective clothing. This included specialist clothing when handling bodies with highly infectious diseases. Mortuary staff told us ward staff informed them if a deceased patient had an infection and this was included in the records transferred with them. The patient was then isolated in the mortuary. This information was also recorded in the mortuary register to ensure staff were aware of any risk. Porters described to us how they ensured nurses placed these bodies in a body bag and labelled them correctly to denote infection.

The mortuary area was clean and we saw there were regular audits to check compliance with the infection protection and control processes. Post mortems were not carried out at UHL. Staff told us that all leakages were wiped up immediately and trays with bodies on were cleaned once the body was removed. Porters, mortuary staff, and undertakers were provided with personal protective equipment such as gloves or aprons.

We saw different coloured bags for different types of waste were used in line with trust policy; for example, for clinical and non-clinical waste on the wards and in the mortuary.

Environmental and equipment

Access to the mortuary was for authorised people only. There was closed circuit television and staff had to sign in. Porters accessed the mortuary at weekends when mortuary staff were not on duty. There was one set of mortuary keys that was held in the site office and logged in and out needed.

The mortuary fridges were in different sizes for storing bodies and included specialist fridges for babies and bariatric bodies. There was one super-bariatric fridge with space for four bodies; three bariatric fridges that each held six bodies and three regular fridges with space for six bodies in each. There was one fridge set aside for children and babies and a freezer for six bodies. There were arrangements with local undertakers in case of emergencies, who had capacity to store additional bodies. There were two additional temporary storage facilities on standby in the mortuary in the event of the number of bodies exceeding the availability of permanent storage. These came to temperature within 20 minutes when needed.

There was a well-established system for monitoring and recording fridge temperatures daily. Records we reviewed confirmed daily checks were made. The permanent fridges were connected to a fail-safe system that was operated by an external contractor. There was an automated temperature measurement system on each fridge, and an alarm rang if there was a fluctuation in temperature. If the alarm went off at the weekend when no member of mortuary staff was on site it went through to site management as well as the on-call member of mortuary staff. They responded and checked the fridge and escalated any problems to the manufacturer.

There was one concealment trolley used for transferring bodies from ward areas to the mortuary. This was in good condition, appeared hygienic and had no visible tears in the concealment cover. Porters told us that one trolley was frequently not enough, as there were many occasions when there was more than one body to move at any one time. This led to delays which nursing staff also told us about. They said whilst the removal of bodies from the ward was done in a respectful and safe manner; they confirmed there were often delays with transfers the mortuary when the concealment trolley was in use transferring another body.

The mortuary staff told us that whilst there was a second trolley in the mortuary, this was not fit for purpose. It was too narrow to transfer a body safely and respectfully. It had removable metal bars
framing it that could rattle off as porters transferred the body across the hospital grounds to the mortuary. There was a hydraulic trolley which was used to transfer bodies around the mortuary; it was placed on charge when not in use. In the event of a mechanical failure, there was a reserve manual trolley.

The viewing room where family members spent time with their relative’s body was well maintained by mortuary staff.

The trust used one brand of syringe driver across all wards which reduced the likelihood of confusion or error by staff, particularly bank or agency staff. A syringe driver is a small, portable, battery powered infusion device that is suitable for patient use in the hospital and at home and is used for delivering measured doses of pain medication. The type of syringe driver used by the trust conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia.

Nursing staff explained the process to report a faulty syringe driver. Syringe drivers were stored and delivered or collected from the equipment library. Staff told us this made sure they were clean, safe to use, serviced and maintained properly. They were kept in the equipment library where they were serviced and maintained. Nurses told us these were available on request without delay.

**Assessing and responding to patient risk**

The last CQC inspection commented that there was poor recognition of the dying patient. Doctors did not always recognise when to discontinue active treatment. In order to improve upon this, the trust launched a treatment escalation plan (TEP) at the beginning of September 2018 which included the patient’s expressed wish about resuscitation. The TEP identified treatment options which medical and nursing staff discussed with patients and their family.

Members of the leadership team told us recognition of the dying patient remained a challenge to address but the expectation was that doctors would feel more confident to act according to the TEP.

Some nurses described the process for identifying the dying patient. Patients referred to the specialist palliative care team were discussed at the weekly palliative care multidisciplinary meeting and those with a terminal diagnosis and not responding to treatment were usually placed on an end of life care plan.

Staff used a national early warning system (NEWS) to help identify if escalation of care was required. They used it to identify patients who were deteriorating and may require SPCT involvement when symptoms were more complex. All patients required risk assessments related to pressure ulcers (Waterlow), malnutrition (MUST) and moving and handling.

We reviewed patient notes and saw that evaluation of the patient was not always linked with the end of life care plan; we found there was inconsistent recognition of the dying patient in some patient records. We reviewed eight patient records and found significant recording omissions on two records. On one, deterioration over the course of three months was not evidenced in nursing notes; there was no review of assessments or care plan documentation. The patient was seen by the SPCT and ward staff delivered care in response to their needs during this time. However, there was no end of life care plan in place despite this patient being very close to death when seen on inspection.

The second record had poor documentation of a patient’s MUST score where, despite the patient’s very low body weight, the nursing note stated the patient was eating and drinking normally. This meant staff had not always fully assessed patients against these risks using the trust’s risk assessment tools. We escalated these concerns to the palliative care consultant as well
as the associate director of nursing (ADON) and they told us that both patients were reassessed immediately and appropriate actions taken.

We spoke with staff on the wards where these patients were being nursed. It was their view that nursing staff shortages affected good end of life patient care at times. There was high usage of agency staff, most of whom did not consistently work on the ward and therefore did not always understand the specific needs of the dying patient. We saw minutes of the April 2018 end of life steering committee which agreed to add staffing levels risk to the risk register and the impact cited lack of resources in wards to provide requisite palliative and end of life care. Minutes from June 2018 recorded that eight beds on Chestnut ward were closed in April in response to the staffing issues which remained shut and a further four to eight beds were flexed dependent on patient flow.

Other records we looked at had good documentation including the principles of care for the dying patient and evidence of multidisciplinary assessments. There was evidence these patients were regularly reviewed by nursing and medical staff. End of life patients were seen by medical staff every day. This ensured that patients increased needs were responded to; for example, a change of medicine for increased symptoms of pain.

We saw TEPs were in place on patient records and staff told us they felt more confident to consider different forms of treatment in the best interest of the patient. There was active promotion of the TEP; it was on trust screensavers and displayed as a poster in staff areas, as well as on trust social media.

Advance care planning is a process that enables individuals to make plans about their future health care. Advance care plans provide direction to healthcare professionals when a person may not be able to either make and/or communicate their own healthcare choices. The trust had a ‘Pro-active Elderly Advance Care’ (PEACE) plan for residential care home patients. They were initiated for patients with advanced, progressive, incurable conditions who were expected to die within 12 months or if they were at risk of dying from a sudden acute crisis in their condition. The PEACE plan was not in place for patients who lived in their own homes.

**Nurse staffing**

The trust has informed us that they are unable to separate total staffing due to the format of the data. Therefore, we are unable to report total nursing staffing at this time.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Following this inspection, the trust submitted data which showed there was one whole time equivalent (WTE) band 8A lead palliative care nurse and five WTE B7 specialist palliative care clinical nurse specialists.

From July 2017 to June 2018, the trust reported a vacancy rate of 13.2% for qualified nursing staff in the specialist palliative care team. This was similar to the trust target of 14%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From July 2017 to June 2018, the trust reported a turnover rate of 42.4% for qualified nursing staff in the end of life care department at University Hospital Lewisham. This was worse than the trust’s target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

We discussed this turnover rate with members of the SPCT who told us it reflected changes to
the service with posts moving to the new provider and additional posts being recruited to in the hospital team.

From July 2017 to June 2018, the trust reported a sickness rate of 1.7% for qualified nursing staff in the specialist palliative care team at University Hospital Lewisham. This was better than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From July 2017 to June 2018, the trust reported a total of 96 shifts in specialist palliative care team.

The breakdown of these shifts is provided in the table below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Bank shifts</th>
<th>Bank shifts as a proportion</th>
<th>Agency shifts</th>
<th>Agency shifts as a proportion</th>
<th>Unfilled shifts</th>
<th>Unfilled shifts as a proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital Lewisham</td>
<td>93</td>
<td>96.9%</td>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

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 specialist palliative care staff. We reported at the time of our last inspection that the trust received notice that community specialist palliative care would in future have one provider rather than three, as was the situation at that time and decided not to make a bid for the service.

The outcome of the competition meant that the specialist palliative care team based in UHL no longer provided community based services. The concerns raised at the time were that loss of community services would result in no SPCT in-reach to the hospital at weekends. This was recognised and the SPCT establishment was increased from 2.8 clinical nurse specialists to one whole time equivalent (WTE) band 8A and five WTE B7 clinical nurse specialists.

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. Link nurses for EoLC play a key role in supporting good practice and the implementation of guidelines, policies and procedures relating to EoLC.

Members of the SPCT told us this continued to be a work in progress as just 50% of wards currently had an end of life care link nurse. They said it was a challenge at times to attract nurses since support given to attend training and carry out the role in addition to their nursing tasks was variable.

A link nurse described their role to us, which included participation in the end of life steering committee. They said they discussed ways to improve end of life care at the committee and gave
feedback to their ward about any developments. They had protected time to promote their role and raise the profile of good end of care life. We confirmed that there were end of life link nurses in key areas including emergency department, critical care unit, high dependency unit and care of the elderly wards.

**Medical staffing**

The information in this section is based on a single consultant doctor in the palliative care team.

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

From July 2017 to June 2018, the trust reported a total vacancy rate of 0% for medical staff in specialist palliative care. This was better than the trust target of 14%.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

From July 2017 to June 2018, the trust reported a turnover rate of 0% for medical staff in specialist palliative care. This was better than the trust target of 12%.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

From July 2017 to June 2018, the trust reported a sickness rate of 0% for medical staff in end of life care. This was better than the trust target of 3.5%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

The trust did not provide bank and locum staff usage for medical staff in specialist palliative care, possibly due to the low number assigned to this core service.

*(Source: Routine Provider Information Request (RPIR) – Medical agency locum)*

We confirmed there was one full time palliative care consultant employed by the trust who worked Monday to Friday 9:00am to 5:00pm. They were part of the 24-hour consultant cover rota, which included telephone cover from Guys and St Thomas’ hospital. However, they told us there was no physical on-site day-to-day consultant cover for planned absence such as annual leave.

**Records**
Patient records were held electronically and in paper form, which were stored securely. We noted in the previous CQC inspection that patient notes were not filed in chronological order on some records. This meant it was difficult to track what the most recent assessment was. During this inspection we found that notes and assessments were filed in chronological order.

Members of the SPCT team acknowledged that further improvements needed to be made about how SPC records were held. They told us the hope was that palliative care documentation would be integrated into trust electronic records, in order to improve practice and the quality of patient care.

The trust submitted data following this inspection of a re-audit undertaken by the specialist palliative care team (SPCT) in January 2018 of a similar audit done in January 2017. This was to identify solutions to type written notes misfiled in other areas of the medical notes as well as to standardise the palliative care documentation.

The records of twenty-five patients assessed one or more times by the SPCT were included. The tables below show varied results in both hand written and typed entries, with greater improvements in the typed notes:

### Hand-written notes:

<table>
<thead>
<tr>
<th></th>
<th>2017 audit</th>
<th>2018 audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present in patient notes</td>
<td>96%</td>
<td>81%</td>
</tr>
<tr>
<td>Timed</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>Signed</td>
<td>92%</td>
<td>69%</td>
</tr>
<tr>
<td>SPCT sticker present to indicate SPCT involvement</td>
<td>8%</td>
<td>81%</td>
</tr>
<tr>
<td>SPCT typed entry referenced</td>
<td>88%</td>
<td>75%</td>
</tr>
<tr>
<td>Out of hours service referenced</td>
<td>12%</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Electronically typed notes:

<table>
<thead>
<tr>
<th></th>
<th>2017 audit</th>
<th>2018 audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present in patient notes</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>Correctly filed</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>Timed</td>
<td>17%</td>
<td>75%</td>
</tr>
<tr>
<td>Signed</td>
<td>86%</td>
<td>94%</td>
</tr>
<tr>
<td>Out of hours service referenced</td>
<td>21%</td>
<td>31%</td>
</tr>
</tbody>
</table>

The trust introduced a treatment escalation plan (TEP). This form ensured that every patient’s future care was considered and documented formally, in line with the national initiative. A TEP also provided information about limits for interventions that are likely to be unsuccessful or contrary to the patient's wishes, as well as basic nursing care and pain relief. We saw TEPs were completed correctly on records; nurses told us they gave them confidence when faced with certain decisions around care and treatment.

We saw records of chaplain’s visits to patients in the care plans. This demonstrated that patient’s spiritual needs were being met. When a person was identified as requiring end of life care, their GP was informed within 24 hours of discharge through the electronic discharge summary system.

Mortuary documentation was in place. Any movement of bodies by porters in or out of the mortuary was logged on a monitoring sheet and completed each time by them. We saw that these
sheets were completed and audited by the mortuary technician. We also saw there was a folder located in an accessible location within the mortuary, which contained guidance and correct procedures for porters to reference.

**Medicines**

During the previous CQC inspection, a symptom observation chart for patients who were dying was being piloted. This was to assess the efficacy of anticipatory drugs and whether the patient’s care should be escalated to the SPCT. The pilot did not involve a sufficient number of patients to demonstrate effectiveness and was abandoned due to lack of resources in the team. Members of the SPCT told us the observation chart would be implemented in November 2018. An audit of anticipatory medicines was being undertaken as a supplementary audit as part of the National Care of the Dying audit 2018 to be submitted in October 2018.

The trust used the same brand of syringe driver across all wards that reduced the likelihood of confusion or error by staff. Members of the specialist palliative care team provided syringe driver training as part of induction for all new nurses and more recently provided refresher training to critical care unit staff. We observed patients who were at the end of their life were prescribed anticipatory medicines in advance to manage any change in the patient’s pain or symptoms.

Non-Medical Prescribing is the prescribing of medicines, dressings and appliances by health professionals who are not doctors. None of the specialist palliative care nurses could prescribe medicines as they had not completed a non-medical prescribing course. This was not seen as an issue and the accepted view was that prescribing should be the general responsibility of medical teams.

**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.

From June 2017 to May 2018, the trust reported no incidents classified as never events within end of life care.

*Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)*

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care that met the reporting criteria set by NHS England from June 2017 to May 2018.

*Source: Strategic Executive Information System (STEIS))*

There were two incidents reported on the electronic incident reporting system between September 2017 and August 2018. Both of these were information technology related and reported on consecutive days. They were reporting palliative care team voicemail was not working. The problem was escalated to the IT helpdesk and voicemails were successfully retrieved.

Incidents reported by the mortuary incident were predominantly around patient identification. For example, one patient taken to the mortuary had two different name bands. Mortuary staff immediately noticed this and a nurse from the ward came and matched the correct name to the body. We discussed this and were told in order to reduce occurrences of this kind, red name bands are used for patients with similar names or age profiles to alert staff to be more vigilant.
In a more recent incident, two bodies were released on the same day with incorrect paperwork. Mortuary staff told us this occurred at a weekend when site management is responsible for releasing bodies to funeral directors. In response to this, mortuary staff planned training for site management staff who covered at the weekend.

Mortuary staff told us they were not always clear about the governance around closing incidents. For example, some incidents were closed within their (pathology) division, even if the incident arose on a ward. This meant it was unclear whether any learning from the incident was focussed on the area where the incident occurred.

Is the service effective?

Evidence-based care and treatment

We found the policies, procedures and processes provided to staff complied with national guidelines and good practice recommendations; care and treatment provided was based on national guidance. The mortuary staff followed the Human Tissue Authority guidelines.

The trust relaunched the end of life care plan based on the ‘five priorities for care of the dying person’ set out by the priorities for care of the dying person from the Leadership Alliance for the Care of Dying People. The aim of the end of life care plan was to promote a stronger culture of compassion in the NHS and social care and put people and their families at the centre of decisions about their treatment and care.

Local audits included ‘Palliative Medicine Consultant On Call Audit 2018’ completed in August 2018. Findings of this audit confirmed University Hospital Lewisham (UHL) met the minimum recommended service levels for specialist palliative provision of face to face visiting between 9:00am and 5:00pm seven days a week and access to telephone advice twenty-four hours a day seven days a week.

A critical care consultant completed an audit of end of life decisions in critical care in July 2017. Twenty patient records were included and results showed that 75% (15) clearly documented the limitations of treatment; 100% (20) documented a formal decision to withdraw treatment and 80% (16) showed clear documentation of a family discussion where treatment was withdrawn. However, documentation of the method and process of withdrawal was not done in 40% (8) of cases and an end of life treatment document was not completed in 70% (14) of cases. The recommendation from these results was to issue reminders about the importance of paperwork to junior doctors in meetings and at handovers.

A member of the SPCT registered an audit to look at opiate prescribing for palliative care patients to identify any delays in the delivery and administration of the medication. This was expected to begin in September 2018.

The National Care at the End of life audit was due for completion at the end of October 2018. The focus of this audit was on the quality and outcomes of care experienced by those in their last admission in acute settings (as well as community and mental health hospitals throughout England and Wales). Members of the SPCT told us questions were added to capture additional information.
relevant to the local population. These included documentation, end of life care descriptors, care in the last hours of life and symptom control record of pain.

We attended nursing handovers on the wards and noted that where a patient was at end of life, there was special mention of any additional emotional support they or their relatives required. Information about where to seek emotional support was available in patient and relative information leaflets. It was also available from the palliative care team, medical staff and the chaplaincy. There was also a guide for carers supporting people with learning disabilities for palliative care, end of life care and bereavement.

**Nutrition and hydration**

Nurses used a nutritional screening tool to assess all patients on admission. A referral was made to dietetics depending on the score. The aim was that a dietitian saw all patients within 48 working hours of referral.

We spoke with a dietician who told us there was a proactive approach by clinicians and nursing staff to referring patients who were end of life. Ward staff identified at risk patients via a malnutrition screening tool and referred to a dietician.

They said that nurses who cared for patients identified as in the last twelve months of life encouraged them to take food and drink, and were able to offer alternatives to the usual hospital menu, for example, a cooked breakfast.

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. A speech and language therapist rapidly assessed patients where there were concerns about ‘risky feeding’.

**Pain relief**

The Hospital Specialist Palliative Care team (SPCT) aim was to ensure patients received correctly prescribed regular controlled drug analgesia on time in order to ensure pain and other symptoms were controlled. The trust submitted pilot study results following the inspection related to timely pain relief for hospital palliative care and end of life patients.

Thirty male and female cancer and non-cancer patients on controlled drug pain relieving medication were included. However, due to problems noted with prescribing which included timing of pump not documented, there was an inability to check that patients received the syringe driver controlled drug medication on time. Other results showed that 43% (13) of patients did not receive their medication on time; 10% (7) was on time and for 34% (10) it was not possible to read the prescription chart.

Recommendations from this study included: sharing findings with pharmacy and considering ways to improve prescribing and administration of medicines; findings were to be discussed in various meetings including end of life steering committee, practice development nurse and matron’s meetings; SPCT to contribute to the implementation of pathways to change practice to ensure patients receive controlled drug analgesia as prescribed.

During this inspection, we observed patients who were at the end of their life were prescribed medicines to manage any change in their pain or symptoms. These medicines are known as anticipatory medications for symptoms that may not be encountered very frequently and known to occur at end of life, or were predicted to occur. We saw examples in patient prescription records of pain control managed with anticipatory medication. Drugs were administered by a syringe driver
where the oral route had become inappropriate and symptoms were continuous. Nurses did not rely on the SPCT to set up the syringe drivers.

Records we reviewed showed that patients had medicines provided when needed. A doctor told us that they ensured anticipatory medicine was prescribed in a timely way, especially for deteriorating patients. However, these medicines were controlled drugs (Misuse of Drugs legislation) and as such, required two nurses to administer them. Nursing staff told us there were times when it was not always possible to administer medication at the time when the patient required it due to low staffing levels on the ward. On one of our inspection days we witnessed there was a delay of two and a half hours from the time a syringe driver was prescribed to when it was set up. A nurse apologised to the patient and explained that this delay was due to the general busyness of the ward.

Staff told us the use of anticipatory medicine was much improved and they demonstrated an awareness of symptom control and the use of anticipatory medication. We saw they 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). They used numeric pain scales for patients who could communicate their pain. For others unable to communicate, nurses told us they paid close attention to body language, including facial expressions.

Patient Outcomes

The SPCT 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 where there were no complex needs. In these cases, it was felt that the medical team should be competent and confident to prescribe and treat. The SPCT provided teaching to medical and nursing staff in order to reinforce this message. We were told that whilst not every patient nearing the end of life would be automatically seen by the team, all those specifically referred would be.

There was an audit completed in November 2017, ‘DNACPR decisions and Treatment Escalation Plans at UHL’ set out to review decision making with regards to ‘do not attempt resuscitation’ (DNACPR) orders and treatment escalation plans (TEPs). Ninety-eight inpatient notes were reviewed within a two-week period across the adult medical wards and TEPs were only reviewed where a DNACPR decision was in place. The audit considered whether decisions were timely and pre-emptive or in response to crisis; were senior clinicians involved in decision-making and were TEPs developed alongside DNACPR decisions.

A DNACPR decision was made for 34 patients (35%); 16 (47%) of which were made on admission and 18 (53%) after admission. It was assumed that all 16 DNACPR decisions made on admission were consultant led. Thirty (88%) of decisions were made on admission or during normal working hours and interpreted as being made in a non-crisis situation. There were TEPs on 12 (35%) records, of which five (42%) included the phrase ‘ward based ceiling of care’ without further definition of what that meant.

Of the 18 DNACPR decisions made after admission, four (22%) were made outside normal working hours (9:00am to 5:00pm Monday to Friday), six (33%) were consultant led decisions and all were confirmed with an ST3 doctor or above. Recommendations from this audit included development of a TEP proforma which we saw in place during this inspection and ‘ward based ceiling of care’ to be defined when included on a TEP.
When we spoke with ward staff it was clear they had an understanding that end of life care was for patients diagnosed with any life limiting condition and not solely related to patients with cancer related conditions.

We saw that referrals were regularly reviewed by the SPCT who then visited the patient and offered support to both patient and ward staff as required. 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.

Treatment escalation plans (TEPs) were introduced at the beginning of September 2018. The aim was to encourage the discussion and documentation of plans for treatment in case of expected or unexpected deterioration of clinical status. They encouraged forward planning and improved communication between medical and nursing staff, as well as between staff and patients. TEPs ensured that patients had access to appropriate treatment of their choosing which could mean escalation of care or withdrawal of treatments.

We saw they were in patient records with clear guidance for staff, including whether the patient wished to be resuscitated. There was no audit to review the impact on TEPs since they had been in use for just three weeks at the time of this inspection.

**Competent staff**

As with other sections, the numbers of staff presented in the following data are very small, therefore this information should be viewed as indicative only.

From April 2017 to March 2018, 57.7% of required staff within end of life care at the trust received an appraisal compared to the trust target of 90%.

The breakdown by staff group is in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nhs infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff (other qualified st&amp;t)</td>
<td>10</td>
<td>7</td>
<td>70.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>3</td>
<td>1</td>
<td>33.3%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (qualified nurses)</td>
<td>8</td>
<td>2</td>
<td>25.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>15</strong></td>
<td><strong>57.7%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, 30% of required staff within the end of life care department at University Hospital Lewisham received an appraisal compared to the trust target of 90%.

The breakdown by staff group is in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
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</thead>
<tbody>
<tr>
<td>Nhs infrastructure support</td>
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<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
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<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff (other qualified st&amp;t)</td>
<td>10</td>
<td>7</td>
<td>70.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>3</td>
<td>1</td>
<td>33.3%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (qualified nurses)</td>
<td>8</td>
<td>2</td>
<td>25.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>15</strong></td>
<td><strong>57.7%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>
We received data following this inspection that confirmed two appraisals were outstanding due to a change in line manager and a change to online appraisal. These were booked in for October 2018. The palliative care consultant told us they received regular clinical supervision and had an annual appraisal with a colleague in another specialism.

Members of the SPCT completed other training to enhance their skills. These included advanced pain and symptom management course; advanced communications skills course and NHSi end of life masterclass.

Teaching on end of life care was delivered to the band 5 nurse preceptorship programme as well as syringe driver training. The SPCT recently delivered syringe driver training to staff in the high dependency unit and intensive treatment unit.

We attended part of a health care assistant training session on care of patients at end of life. Training was delivered by members of the SPCT team to seven members of staff. This was a very interactive session and delivered information essential to good care in a good learning environment. We spoke later with some attendees who were very positive about the session and how much they learned.

Mortuary staff told us they trained porters on an annual basis. They no longer did a training session as part of the corporate induction but provided bespoke training for individual groups of staff as requested. Porters told us they found the training to be of great benefit. They learned about how to transfer a body to the mortuary safely and in a respectful manner. They also learned how to do the necessary paperwork to release a body into the care of the funeral director.

We saw that education and development of end of life care training for all staff groups was on the risk register. Members of the leadership team told us part of the challenge to this was the release of staff to attend training. Since the size of special palliative care team (SPCT) was recently increased, planning had begun to develop a ‘menu’ of bespoke training for different groups of staff. Training will be delivered on wards in ‘bite sized’ sessions to maximise coverage. It will be extended to all specialities and groups of staff. The practice development nurses delivered regular updates to ward staff and palliative care link nurses had four days training per year to support them in their role.

**Multidisciplinary working**

Relevant professionals were involved in the assessment, planning and delivery of patient care. We observed good working relationships between a range of health professionals within the trust. The weekly palliative care multidisciplinary meetings were attended by a range of professionals, including doctors, nurses, social workers, allied health professionals (AHP) and members of the chaplaincy.

Members of the SPCT acted as a point of reference for any ward staff that needed support or advice. They also attended meetings for the different specialties to anticipate any patients whom
they may need to support. Nursing and medical staff told us there was good communication with the SPCT and the seven-day service they provided was well utilised.

A member of staff from the dietetic service told there was a strong MDT approach to the safe and effective care of the dying patient as well as those who were receiving palliative care. The weekly ‘feedings options’ MDT meeting included members of the SPCT team, geriatrician, gastroenterologist and specialist nutrition nurse. Dietitian and speech and language therapist (SaLT) attended, as well as the treating specialty.

The focus of the meeting was to discuss complex feeding issues and create and advise on care plans. There was a general understanding that care of the patient was a shared responsibility. Rigorous assessment was applied when palliative care plans were discussed; this was to ensure the care plan was medical, ethical and within the best interests of the patient as defined by the Mental Capacity Act 2005.

Care records confirmed involvement from health professionals such as occupational therapists, physiotherapists and dietitians, where necessary. One AHP told us their care was all about making the patient’s last year, months or days as good an experience for them as possible.

Minutes of the end of life steering committee addressed concerns about poor MDT working and communication between the palliative care team and another specialty. The discussion was minuted and recommendations made around how communication could be enhanced.

We saw clear lines of communication and joint working between the mortuary staff, staff in the bereavement centre and the SPCT all of which focussed on easing the distress of the bereaved.

**Seven-day services**

At the time of the previous inspection, there was uncertainty about the provision of SPCT nurse cover at weekend. This situation was resolved and members of the specialist palliative care team (SPCT) were available between 9:00am to 5:00pm seven days a week and the consultant was available between 9:00am to 5:00pm Monday to Friday. There was on-call consultant cover after 5:00pm from local trust hospitals including Guys and St Thomas and Kings College hospital.

**We were told that the team reviewed all patients on a Friday afternoon in order to plan which patients needed to be seen and anticipate any potential deterioration or issues with the current patient list. Nurses across the wards we visited told us it gave them confidence to know that there was a member of the SPCT available to support them if required at weekends.**

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Please note, the following section is based on very low numbers of staff and should be viewed as indicative only.

**Trust level**

A breakdown of compliance for Mental Capacity Act (MCA) training courses from April 2018 to July 2018 at trust level for staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

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Nursing staff in end of life care had a 100% completion rate for MCA training.

### Medical staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate YTD</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act &amp; consent to examination/treatment</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical staff in end of life care at University hospital Lewisham had a 100% completion rate for MCA training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Members of the SPCT demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and consent and told us consent was to the forefront of their minds whenever they engaged in any care of the patient. They were able to show us where relevant documentation related to Mental Capacity Act, Deprivation of liberty Safeguards, mental health and dementia was stored on the intranet.

We reviewed five Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and found them all to be correctly completed and accurately reflected the information included in the patient’s mental capacity assessment.

Mortuary staff told us they ensured consent for tissue removal was clearly documented on post-mortem forms. The wishes of the parents must be known and recorded. They told us they occasionally found forms without appropriate information. Where the death took place in the maternity unit, they requested the bereavement midwife to follow up before the post mortem took place.

### Is the service caring?

#### Compassionate care

We observed several examples of staff interacting with patients and those close to them with kindness and dignity. Staff told us how important it was that their role extended to supporting the families of the dying and enabling them to spend as much time together as possible. Family members told us staff treated their relative with dignity and respect, explained what was happening and were caring at all times. One relative told us, “I can’t fault any of the staff; they are all marvellous right across the board.”
Mortuary staff spoke with compassion about the deceased and their family members. They explained to us how they tried to make the process of viewing the dead as simple as possible for the family. Viewing took place Monday to Friday between 9:00am and 5:00pm.

We saw the programme of a ‘forever and always’ remembrance service planned to take place in October 2018. The chaplaincy service arranged this in remembrance and commemoration of the staff and patients who died during the year. It was widely advertised in local newspapers, radio and public venues.

We spoke with staff about their support needs when a patient died. We were told that in most incidences, they accepted this as part of their role. However, there were times when a patient’s death affected them. At such times, they got support from colleagues and members of the chaplaincy.

**Emotional support**

Staff we spoke with understood the emotional and social impact that a patients’ care, treatment or condition had on their wellbeing and on those close to them. Members of the SPCT offered emotional support to patients and relatives.

Patients who received end of life care told us they received support that helped them to cope with their condition. The staff told us where possible; they always tried to provide a side room for patients for privacy and dignity. One relative told us nursing staff offered a side room for privacy when their relative was dying which they appreciated very much.

The trust had processes to support the family and relatives for patients who were identified as being at the end of life. For example, family members were enabled to stay overnight with their relative.

We observed nursing staff attending to an end of life patient who was highly distressed and shouting. They calmed the patient down by reassuring them and treated them with great kindness and compassion. They also offered assurances to relatives that this behaviour was part of the dying process and did not mean that the patient was experiencing pain and discomfort.

The chaplaincy supported patients and relatives spiritually. Chaplains visited patients on the wards and could arrange for other faith leaders to visit if required.

We read some cards sent to staff; comments included ‘thank you for making my [relative]’s last few days so happy; it helped us all accept their death’.

**Understanding and involvement of patients and those close to them**

The bereavement officer provided a compassionate and responsive service to bereaved families and provided further advice as required. They understood how certain religions required that their dead were buried as soon as possible after death. In such circumstances, they tried to ensure that all the relevant paperwork was completed as soon as possible in order to issue the medical certificate of causes of death that the registrar required in order to register the death.

The bereavement officer kept relatives updated of any delays with releasing the body; for example, where a post mortem was required. They also offered practical advice and sign posted relatives to other services as required.

Mortuary staff told us they encouraged relatives to bring in religious or spiritual artefacts when sitting with their deceased relative. Support and information was available in patient/relative information leaflets and from the palliative care team and the chaplaincy.
Is the service responsive?

Service delivery to meet the needs of local people

The trust had no designated palliative care ward or beds; palliative care patients or those at the end of life were nursed across all wards. Side rooms were allocated wherever possible; nurses told us not all patients wanted to be in a side room at the end of their life, preferring instead to be in a ward with others. Patients with an infection risk were prioritised for the side rooms to prevent cross infection with other patients.

All patients at end of life were identified and discussed at the daily patient flow meetings and daily huddles. Patient records demonstrated that the SPCT was responsive to all palliative care patients and not just those patients with a cancer.

There were 454 patient referrals to the specialist palliative care team between January and August 2018. Fifty-three per cent of which were cancer patients and 34% were non-cancer patients and diagnosis was not recorded for 13%.

Members of the chaplaincy team told us they were included in the multidisciplinary approach to palliative and end of life care throughout the hospital. They attended the end of life steering committee and felt their contributions were valued. They said there was increased commitment to palliative and end of life care from other parts of the hospital since the last inspection.

The chaplaincy recently organised a ‘dying matters’ day to raise public awareness about death and dying and ‘myth bust’. Over 70 members of the public as well as different faith groups attended it. Members of the special palliative care team and the trust non-executive director attended for the whole day.

Meeting people’s individual needs

At the last CQC inspection in March 2017, we reported that a significant number of patients were treated actively in their last days and hours of life. Members of the SPCT told us that this had improved; they provided increased training to doctors to give them confidence to recognise when to cease active treatment. They supported medical and nursing staff on how to recognise the dying patient and encouraged them to initiate an end of life care plan review.

A treatment escalation plan (TEP) was introduced in September 2018; this was an individualised care plan based on the five priorities of care of the dying patient and agreed with the patient and/or their next of kin. It supported staff to provide good quality of care for people who are dying.

The introduction of the TEP showed positive signs that nursing and medical staff were more confident to recognise the dying patient earlier and act according to their TEP. A nurse told us the TEP gave them ‘permission’ to treat patients according to their expressed wishes.

During the last inspection, we found that staff did not always consider patient’s spiritual needs. A member of the chaplaincy team told us this had improved significantly and nurses and doctors were more mindful of a patient’s spiritual needs. The trust submitted data following the inspection that showed there were 471 referrals made to the chaplaincy between September 2017 and August 2018.

We noted in the last inspection report that palliative care and end of life patients were sent to the discharge lounge waiting to return was not appropriate for most as they were often too ill to wait in this environment or required a bed to lie in.

This was no longer the case and a nurse told us they refused to admit any patient who was clearly at end of life. They said it was not safe for them to be in a busy discharge lounge where
appropriate levels of care may not always be available. Members of the SPCT told us the standard operating procedure for the discharge lounge identified the care needs of patients who could be safely looked after there and were not applicable to palliative care patients. They said this was significant progress in the recognition of the needs of palliative care patients.

Many staff told us how readily available the SPCT was. They frequently visited wards and responded quickly to requests for advice. We observed this when a ward nurse contacted them and requested advice on a rapidly deteriorating patient. A member of the SPCT attended and worked with the ward nurse to address the needs of the patient.

All staff had training in equality and diversity as part of their induction. Guidance was available on wards and on the intranet to support staff in providing care in accordance with peoples’ religious and cultural preferences. The multi-faith room provided a place of worship, quiet time and prayer for people of all faiths and none. Prayer mats and religious texts were available for Christians, Jewish, Hindu, Sikh, Buddhist and Muslim religions. There was an ablution area for people to wash themselves before prayer beside the multi faith room and a screen within the room for males and females to pray separately. 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. Mortuary staff told us they facilitated this practice by supporting the family and providing bowls of water if required.

Mortuary viewing facilities were appropriate and allowed relatives privacy. Viewing was usually arranged through the bereavement officer who accompanied relatives to the mortuary. Nurses were responsible for recording the deceased’s belongings and either handing them over to relatives or delivering them to the bereavement office for safekeeping. Any valuables were left in the cash office safe.

Whilst there were no facilities for relatives to wash the body of the dead according to their specific religious and cultural practice, mortuary staff told us that this had not been raised as an issue. Muslims transferred their dead to a mosque immediately after the body was released into their care. Mortuary viewing facilities were appropriate and allowed relatives privacy. Viewing was usually arranged through the bereavement officer who accompanied relatives to the mortuary.

**Access and flow**

We reported at the last CQC inspection in March 2017 that the trust did not have a rapid discharge pathway and did not routinely record hospital patient’s preferred place of death. We found this was still the case on this inspection.

Ward staff told us in most cases, they were able to get the patient home to die if this was their expressed wish. The hospital discharge team usually arranged this, with assistance from the SPCT when necessary. We observed a bed flow meeting where each ward gave an update on the patient status. This included identification of end of life patients and was information shared with the SPCT.

The trust submitted data that showed that there were 454 referrals made to the SPCT between January 2018 and August 2018. Of these, 72% of patients were seen within 24 hours of referral and 82% were seen within 48 hours of referral. Ward staff demonstrated they understood how to make a referral to the specialist palliative care team and reported that the team responded promptly, usually within one working day.

Following the death of a patient on the wards, relatives were given an appointment with the bereavement officer. The bereavement officer undertook the processes related to death, which included communication with funeral directors if that was what the relatives wished. In cases
where the deceased patient had no next of kin or friends, the hospital took responsibility for registering the death, arranging and paying for the funeral.

**Learning from complaints and concerns**

From April 2017 to March 2018, there was one complaint about end of life care services regarding facilities. The trust took 27 working days to investigate and close the complaint for this service. This response was not within the target period of 25 working days specified in the trust complaints policy.

*(Source: Routine Provider Information Request (RPIR) - Complaints tab)*

From April 2017 to March 2018, there was one compliment within end of life care.

We are unable to provide commentary on the themes of these compliments.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

We saw that complaints about the service were reviewed at the end of life steering committee. Emerging themes discussed included lack of accuracy of death certificates. Minutes recorded in response to this noted that the trust planned to introduce the Medical Examiner role before April 2019. The Medical Examiner would review all deaths daily and provide a review of the death certification to ensure that all deaths were accurately reported.

We found leaflets throughout each ward telling patients and relatives about how to access Patient Advice and Liaison Service (PALS) to make a formal complaint. None of the patients or relatives we spoke with felt they had cause to complain. The trust website had a section on how to make a complaint.

**Is the service well-led?**

**Leadership**

Specialist palliative care sat within the long-term conditions and cancer division. The local leadership of end of life care included the associate director of nursing, palliative care consultant and lead cancer nurse. There was a recently created role of chief nurse who chaired the EoLC steering committee and was the board member with end of life care responsibilities.

We noted at the last CQC inspection in March 2017 there was no non-executive director (NED) with lead responsibility for promoting end of life in the trust. This was no longer the case and the trust chair was now the non-executive lead for end of life care and frequently attended the end of life (EoLC) steering group meetings as well as taking an active interest in general end of life matters. For example, they attended the chaplaincy led ‘Dying Matters’ day earlier in the year.

The trust generic lead for EoLC was a consultant geriatrician who led on the National Care of the Dying audit. This gave a broader medical input to palliative care and helped to make end of life care more of a shared responsibility throughout the trust.

However, members of the SPCT told us there was no dedicated management or administrative support for this role to enact the decisions and changes required to improve the effectiveness and
leadership within EoLC. They also said senior nurses took on responsibilities with the EoLC steering group which were not part of their identified role and had to be managed alongside their established role. We noted this lack of additional support was on the risk register.

Vision and strategy

The End of Life Care (EoLC) steering committee was established to oversee the implementation of the end of life care strategy 2016-19. It had a wide-ranging brief that included reviewing the risk register, incidents and complaints. It also reviewed and ratified policies and recently signed of the treatment escalation plan (TEP) which incorporated the principles of care of the dying and the delayed bereavement survey. The steering committee discussed trust issues, which affected the safe care of those patients at the end of life such as staffing shortages on the wards.

Minutes we reviewed showed that attendance was variable but included members of the specialist palliative care team as well as the trust chair. There were also representatives from other specialties including elderly, respiratory and critical care, as well as chaplaincy, dietetics and speech and language therapy were present at meetings. There were also lay members and representatives from the local clinical commissioning group at meetings. Attendance at these meetings was variable.

We asked the trust to submit any evidence of strategic planning already in place to follow on from the current end of life care strategy 2016-19. However, we were told the EoLC steering group would undertake a review of the strategy and an updated strategy agreed and launched in April 2019. We were not assured that this was achievable in six months from the time of this inspection since there was no evidence of any planning already underway to launch a new strategy.

Culture

Staff told us they enjoyed and took great pride in caring for end of life patients. They said that end of life care was more integrated within the trust than at the time of the last CQC inspection and it felt more like it was every nurse and doctor’s responsibility.

Governance

The governance arrangements for end of life care changed since the previous CQC inspection in March 2017 and there was direct reporting to the trust management board as required. End of life care had a clear governance framework that ensured responsibilities for end of life care could be identified from the trust board of directors through to key members of staff. The chief nurse was the board member with end of life care responsibilities and members of the SPCT were aware of who this was. The chair attended end of life care group meetings and had end of life care responsibility.

Management of risk, issues and performance

We noted at the last CQC inspection in March 2017 that there was no dedicated risk register for end of life or palliative care. One was since introduced and was discussed at each end of life steering group. Patient safety incidents were collected by the electronic incident reporting system and from across all divisions. They were discussed and any learning from end of life care incidents was identified.

There were 11 current risks on the register, the highest of which was lack of dedicated project support to drive the EoLC service improvements required in response to the previous CQC report.
This was reviewed in September 2018 and mitigation was that the EoLC steering group met monthly to discuss and plan improvements. It was noted that progress was slow due to lack of capacity; a point made to inspectors by members of the SPCT.

Another risk was the early recognition of the dying patient which was also noted in the previous inspection. Members of the leadership team told us whilst this had improved, it still remained an issue. A treatment escalation plan (TEP) was introduced at the beginning of September 2018 and identified treatment options which medical and nursing staff discussed with patients and their family.

Education and development of end of life care training for all staff groups was also on the risk register. SPCT team members told us the recently increased size of the team meant that it would be possible to deliver more comprehensive training on end of life care matters.

Mortality and Morbidity (M&M) meetings took place to review deaths as part of professional learning and used to monitor the quality of care delivered to patients. Twenty five percent of all deaths had a structured judgement review (SJR) at this group. There was a discussion in the August 2018 minutes about the inclusion of a core set of measures to be added to the end of life care section of the SJR forms.

The lead cancer nurse who was at the meeting explained that this process would allow the trust to check that all end of life patients had an individualised care plan. Patients were likely to have a more positive outcome when discussions around their care had taken place. The focus was not only on quality of care but also on the importance of documentation surrounding patient care to evidence that decisions have or are being made. Some concerns were raised by members of the M&M group that end of life care might only be considered as good when the patient was referred to the SPCT.

The meeting agreed that a subgroup would be set up to discuss updating the trust SJR form with additional palliative care related questions. This subgroup included a range of speciality consultants as well as the specialist palliative care consultant. We noted in the September minutes that updates were deferred to the October meeting.

M&M meetings provide an opportunity for reflection and education about high quality end of life care. We noted that members of the palliative care team were not consistently represented at these meetings. Whilst the lead cancer nurse was at three of these meetings, there was no consultant palliative care consultant presence at any meeting between April and September 2018. There were no apologies recorded therefore we were unclear whether they were part of the M&M meetings or were on the circulation list to receive minutes.

The mortuary had an action card that outlined actions to take in the event of a major disaster such as mass loss of life and incidents that involved the release of chemical, biological or radioactive materials.

Information management

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. At the last CQC inspection, we reported that an objective of year two of the end of life strategy was to ensure improved access to CMC. However, members of the SPCT told us there was no significant improvement, largely because there was over-reliance on the SPCT to enter the patient details. Not all GP surgeries engaged with CMC so there was a gap in community-based information.
The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

**Engagement**

In the last CQC inspection in March 2017, we said the trust did not carry out a bereavement survey to capture and understand the experiences of the bereaved. The survey had not been carried out at the time of this inspection.

Following this inspection, the trust confirmed that the survey questions were agreed in accordance with NICE quality guideline in 2017. The launch was delayed due to lack of capacity within the SPCT but was planned for November. The method by which relatives would receive the form was not yet finalised but this was likely to be when they returned to the registrar’s office to collect the death certificate.

The trust introduced a new end of life care award for compassionate care demonstrated by members of staff. Members of the SPCT told us this encouraged all members of staff to consider the care and support offered to this patient group.

The trust participated in ‘Dying Matters’ week which gave them a chance to meet with members of different faiths as well as the board member with end of life care responsibility. This attracted a number of members of the public and feedback we saw was very positive.

**Learning, continuous improvement and innovation**

Members of the SPCT told us they were determined to continue to improve standards and quality of care for end of life patients. We were told there was no current innovation underway since the SPCT was focused on managing the transition of their team into a hospital based only team.