Lewisham and Greenwich NHS Trust

University Hospital Lewisham

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook an unannounced focussed inspection at University Hospital Lewisham in response to concerns from patients, their relatives and staff about discharge arrangements for patients, staffing levels and poor care of patients. We inspected medicine (including older people's care) on 22 and 23 May 2018.

As this inspection is focused on specific areas of concern, we have not re-rated this service.

University Hospital Lewisham (UHL) is part of Lewisham and Greenwich NHS Trust. The trust was formed in October 2013 by the merger of Lewisham Healthcare Trust and the Queen Elizabeth Hospital Greenwich (following the dissolution of the South London Healthcare Trust by the Trust Special Administrator). The trust provides acute and community services.

Prior to this inspection the hospital has had two planned comprehensive inspections in February 2014 and March 2017 and was rated requires improvement at both of these inspections.

Our key findings were as follows:

- We found a significant shortage of nursing staff which was impacting on the continuity of patient care. Nursing staff told us they often felt they did not have sufficient time to spend with patients.
- Discharge arrangements were working reasonably well but, the complexity of the requirements of some patients had increased and staff were having to manage more complex discharge plans while working under pressure.
- The reliance on agency staff meant it was difficult to share learning from complaints and incidents with staff. It also impacted on permanent nursing staff being able to attend mandatory training.
- Information about the quality and safety of care displayed on wards was not always up to date.
- Patients told us staff kept them involved in decisions about their care but, relatives felt nurses were too busy to talk to them.
- Staff had a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- We observed nurses and allied health professionals treating patients with kindness and patients were positive about the care they received.
- There was good multidisciplinary working with senior nursing staff recognising and appreciating the support they had received from allied health professionals.
- Staff spoke highly of their local managers who were aware of the challenges and were working hard to address the shortages while providing support to staff.

Areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Take action to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed.

In addition the trust should:

- The hospital should ensure that all staff adhere to advanced PPE protocols when treating patients in isolation.
- Display latest infection control and safety thermometer information.
- The hospital should ensure that learning from incidents is shared appropriately with all staff, including agency staff.
- The hospital should work to ensure that discharge plans are effectively communicated to patients' relatives, in advance of their discharge.

Summary of findings

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)		We have not re-rated this service as we have only focussed on specific areas of concern. Significant nursing vacancies meant staff had less time to spend with patients and provide relatives with up to date information. Staffing shortages were also making it difficulty for permanent staff to attend mandatory training. It also impacted on learning from incidents and complaints. Discharge planning was sometimes complicated due to the complex needs of patients and staff working under pressure. Patients were positive about the care they received and we observed compassionate interactions between staff and patients. We found good multidisciplinary working with allied health professionals supporting nurses where they could. Staff were positive about their local managers who they felt supported them.

University Hospital Lewisham

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Medical care (including older people's care)

Detailed findings

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Background to University Hospital Lewisham

Lewisham is the fifth largest inner London borough and the 2018 Joint Strategic Needs Assessment the estimated the population of the borough was 301,300. It is one of the 20% most deprived local authority areas in England with 26% of children defined as living in poverty. Ten out of 29 indicators for health and deprivation are worse than the England average in the borough. Life expectancy in Lewisham is below that of London and England, for both males and females.

University Hospital Lewisham (UHL) is a district general hospital providing a full range of services including emergency department, medical, surgery, critical care, maternity and gynaecology, services for children and young people, outpatients and diagnostic imaging and end of life care. We inspected medical care (including older people's services).

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

Our inspection team

Our inspection team was led by Margaret McGlynn Inspection Manager and overseen by Helen Rawlings Head of Hospital Inspection South London.

The team included CQC inspectors, assistant inspectors, inspection planners and a nursing specialist advisor.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held including inpatient and staff surveys, contacts from patients, relatives and staff, national audit and performance data.

During the inspection we spoke with 31 staff, which included senior and other staff who had responsibilities for the frontline service areas we inspected, as well as those who supported behind the scene services. We requested documentation in support of information provided.

We spoke with 14 patients and relatives and reviewed a range of documentation submitted before, during and

following the inspection. We made observations of staff interactions with each other and with patients and other people using the service. The environment and the provision and access to equipment were assessed.

Facts and data about University Hospital Lewisham

University Hospital Lewisham has 450 inpatient beds and mainly serves the people of Lewisham and other parts of South East London.

The hospital provides a range of medical specialties, including older people's medicine, stroke care, endocrinology, diabetes care, oncology, haematology, gastroenterology, respiratory, and HIV care. It has 333 medical beds.

Results from the 2017 inpatient survey showed an improvement compared to the 2016 inpatient survey, however, less responses were received in the 2017 inpatient survey. Areas that had improved included the length of time patients had to wait to get a bed on a ward and confidence and trust in medical staff. Some areas had deteriorated included nurses acknowledging patients and their answers to questions. Patients' confidence and trust in nurses, sufficient nurses on duty remained about the same.

In the NHS Staff Survey 2017 the top five questions for the trust including staff feeling their role made a difference, quality of appraisals and training. The bottom five questions included percentage of staff having an appraisal, staff satisfaction with resourcing and support, percentage of staff working extra hours and organisation's interest an action on health and wellbeing.

We undertook an unannounced focussed inspection at UHL in response to concerns from patients, relatives and staff about discharge arrangements for patients, staffing levels and poor care of patients. We inspected medicine (including older people's care) on 22 and 23 May 2018.

As this inspection is focused on specific areas of concern, we have not re-rated the service.

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

University Hospital Lewisham is part of the Lewisham and Greenwich NHS Trust. Medical care is provided in thirteen inpatient wards, a coronary care unit, an endoscopy day unit, a discharge lounge and an ambulatory care unit. Patients have access to a range of specialties, including older people's medicine, stroke care, endocrinology, diabetes care, oncology, haematology, gastroenterology, respiratory, and HIV care. University Hospital Lewisham has 333 medical beds.

We carried out an unannounced visit and focused on areas of concern identified through information sent to us by patients and their relatives. At our last inspection on 7 to 9 March 2017, Medical Care was rated requires improvement overall, with safe, responsive and well led rated requires improvement and caring rated good. This was a focused inspection of medical care in response to concerns that they had been raised with us. These related to the level of care provided to patients, poor communication between the service, patients and their families, the cleanliness of the wards and the discharge arrangements for patients. Our inspection focussed directly on these areas and those areas likely to have a direct impact on the issues highlighted to us. As this inspection is focused on specific areas of concern, we have not re-rated this service

During our inspection we visited all of the medical care wards and the discharge lounge. We spoke with 14 patients and their families and 32 members of staff, including nursing and medical staff, members of the senior leadership team, housekeeping and cleaning staff, allied healthcare professionals, including physiotherapists, occupational therapists and speech and language therapists and healthcare assistants (HCAs). We observed how people were being cared for and reviewed ten care records of people who were using the service at the time. We reviewed documents relating to performance and quality data.

Medical care (including older people's care)

Summary of findings

We found

- There was a significant shortage of nursing staff in the directorate. This directly impacted on the care staff were able to provide in a number of ways. In particular, staff said that had less time to spend with each patient. Senior staff and allied health professionals were supporting the nursing team to ensure that all their duties were performed, which then impacted on their ability to complete their own work in a timely manner.
- The reliance on agency staff impacted on the continuity of care and the ability of senior staff to share learning with their teams.
- Whilst the discharge process was reasonably effective, staff told us there was a good working relationship with most of the authorities and improved working with other local authorities would reduce some of the delays in addition to greater availability of care packages within some of the local authority areas. Further, the acuity of a substantial number of patients meant that staff were required to deal with highly complex discharge arrangements while under significant pressure.

However

- There was an experienced and effective safeguarding team in place, who supported staff in ensuring that safeguarding referrals were reported and progressed appropriately.
- Overall we observed good adherence to infection prevention and control techniques.
- Staff demonstrated a caring and compassionate attitude to their patients, and endeavoured to provide the best care, in spite of the impact of low staffing numbers.
- We observed a number of examples of compassionate care that went beyond what was expected.
- The leadership of the service had a clear understanding of the challenges they faced and were making efforts to address them.

Are medical care services safe?

Incidents

- We requested data from the trust regarding the number of incidents in medical care at UHL. However, this was not provided.
- A number of the nursing staff we spoke with told us that they did not always receive feedback on incidents they reported. Two of the ward sisters told us that it was difficult to ensure feedback was delivered to those staff who reported incidents on account of the number of agency nurses working on the wards which meant that the staff population was transient.
- All of the staff we spoke with had a clear understanding of the requirements of the duty of candour.

Never Events

- No never events had been reported in medicine by the trust in the last 12 months.

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 seven new pressure ulcers, five falls with harm and six new catheter urinary tract infections from February 2017 to February 2018 for medical services.
- There was a ward dashboard clearly displayed in each of the wards, which displayed the results of hand hygiene audits, the number of falls on the ward, the number of newly acquired pressure ulcers and hospital acquired infections over the previous three month period. On most wards, however, the information displayed on the dashboard was in arrears, following the inspection, the trust informed us that the data for the ward dashboards is always in arrears due to internal processes.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

- Prior to our inspection, there were concerns raised about the cleanliness and infection prevention and control (IPC) in the service.
- There were hand washing sinks on all wards, with appropriate signs advising staff and visitors of the 5 steps to hand hygiene. Sanitizing hand gel was also available for use by staff and visitors. We observed staff washing their hands between patients and when leaving and entering wards.
- We observed staff adhering to the bare below the elbow policy for preventing the spread of infection.
- On each of the wards there were side rooms which could be used to isolate patients suffering from or at increased risk of infection, this protected both the patient themselves as well as other patients on the ward. Generally, we observed staff using advanced personal protective equipment (PPE), such as aprons and gloves, when entering the rooms of patients in isolation and the doors were clearly signposted to remind staff and visitors of this. However, on one occasion on Cherry Ward we observed a member of staff entering and leaving a patient in an isolation room without using advanced PPE. We raised this with the nurse in charge on the ward at the time.
- There was a designated member of the housekeeping team for each ward, and we observed them cleaning the wards thoroughly. Some of the housekeeping staff said that they felt that some of the wards were so large that it was difficult for one cleaner to clean the ward alone.
- There was a hospital wide IPC nursing team who advised staff about IPC, carried out IPC and hand hygiene audits and spot checks of wards. We observed a ward visit taking place. The IPC nursing team said that overall the medical service adhered to IPC policies effectively.
- In addition there were inter-ward hand hygiene audits, with staff from one ward auditing the hand hygiene of another ward and vice versa. Where a ward fell below the trust's required compliance rate of 90%, additional audits would be carried out to ensure improvement in compliance.

Safeguarding

- In the months prior to our inspection, there was a high number of safeguarding concerns raised in respect of patients within the medical service. However, we were told that, in a clear majority of cases, the issues that led to the safeguarding occurred prior to admission. In addition, we saw evidence that safeguarding cases were appropriately escalated and managed by staff, with the support of the safeguarding team and local authority colleagues.
- There was an in-house safeguarding team, based within the hospital who supported staff in meeting their safeguarding responsibilities. Clinical staff we spoke with described the safeguarding team as approachable and supportive. The team was responsible for training and advising staff regarding safeguarding matters, as well as liaising with external organisations such as local authority safeguarding teams. The safeguarding team were also responsible for implementing the government's 'Prevent strategy' within the hospital to safeguard individuals and communities at risk of terrorism.
- A safeguarding advisor within the team told us that they had effective working relationships with, local authority safeguarding teams that they frequently worked with, particularly the London Borough of Lewisham.
- The safeguarding advisor said, however, that they faced a very high workload. There was currently a vacancy for another safeguarding advisor role. They said that whilst there was a high number of safeguarding referrals made from the hospital, the vast majority of these were appropriate. They said that there had been an increase in the number of safeguarding referrals within the medical service as, since the start of the year there had been an increase in the number of patients presenting with signs of self-neglect and, further, because following training, staff had become more adept at recognising self-neglect as a safeguarding issue.
- All of the staff we spoke with had a clear understanding of safeguarding. The majority of nursing and allied health professional (AHP) staff were able to describe safeguarding concerns they had raised, and the process for doing so. Staff said that they could seek advice from the in-house safeguarding team, who were based within the hospital.
- Safeguarding policies were detailed and up to date. Staff had access to these policies via the intranet.
- Safeguarding team noticeboards were visible throughout the service. Photographs and names of the safeguarding team were displayed, meaning staff could easily contact the safeguarding team in the event of a safeguarding concern.
- The safeguarding team were supported by an health independent domestic violence advocate (IDVA),

commissioned by the London Borough of Lewisham from a local charity and working full time within the hospital. The post had been created in response to the prevalence of domestic abuse within the borough of Lewisham. The IDVA was able to provide specialised advice and support in respect of safeguarding issues relating to domestic abuse.

Assessing and responding to patient risk

- The concerns we received prior to our inspection suggested that the service did not always respond adequately to patient risk. During our inspection, however, we observed good practices in place to assess and respond to patient risk. However, nursing staff accepted that the significant shortage of permanent nursing staff meant that there were sometimes delays in responding to patients when risks increased. This was reflected in the inpatient survey, in which the trust performed worse than the English average for the question 'When you had important questions to ask a nurse, did you get answers that you could understand?'
- The reliance on agency nurses had increased the difficulty in knowing patients, and therefore could impact on the ability to recognise patients' deteriorating wellbeing. In addition, during our inspection, it was evident that the service was providing care to a significant number of patients with a high level of acuity, as well as a high number of patients with co-morbidities such as dementia.
- Nursing staff made use of the National Early Warning Score (NEWS) system for the detection and response to clinical deterioration in adult patients and is a key element of patient safety. In addition, staff used a MUST score and stool chart to assess patient nutrition. We examined patient records across the wards and saw that they had been fully and appropriately completed. Nursing staff demonstrated a clear understanding of the early NEWS system and the escalation process for deteriorating patients to their medical team or the hospital's critical care outreach team.
- Nursing staff we spoke with said that the critical care outreach team were highly responsive.
- Patients assessed as having enhanced care needs were placed in cohort together on single sex bays. There was always one member of the nursing team present in a cohort bay, in addition to any other staff who were providing care in that bay. We observed this to be the case during our inspection. In order to ensure that the cohort bay was attended at all time there was a system whereby the named cohort nurse or healthcare assistant wore a badge and lanyard indicating their role, if they needed to leave the bay they could only do so once the cohort badge had been passed to another member of staff who would then provide the cohort nursing cover for the bay.
- There was a poster outside the cohort bay explaining its purpose to patients, visitors and staff and stating the purpose for which the patients had been placed in the cohort. At the time of our inspection, the majority of the patients in cohort were suffering dementia or were at increased risk of falls.
- Family members we spoke with told us that they found the constant presence of a member of the nursing team in the cohort bays to be reassuring.
- We spoke with a number of HCAs carrying out cohort nursing duties. They said that they felt the system was effective in responding to patient risk, and allowed them to deal with or escalate concerns as they arose.
- We observed a cohort HCA in a bay for patients at increased risk of falls reassuring a patient who had become restless and therefore was at increased risk of falling attempting to leave their bed without assistance.

Nursing staffing

- The intelligence we received prior to our inspection indicated significant, ongoing concerns regarding nursing staffing levels. During our inspection, we found that there was a significant shortage of permanent nursing staff. Further, there was some evidence that this was impacting on nursing care.
- At the time of our unannounced inspection, the senior leadership team acknowledged that the vacancy rate for nurses in the service was very high. We requested the actual vacancy rate for nursing staff, in April 2018 there were 109.1 for medical care across the trust.
- All of the staff we spoke with, nursing, medical, managerial, AHP and non-clinical staff commented on the low nursing staffing levels. This was reflected by the comments of patients and their relatives, who told us that nurses were often too busy to respond to their requests in a timely manner.
- Nurses told us that they frequently had insufficient time to carry out all of the care they needed to carry out for patients, in particular personal care.
- On the majority of the wards we visited during our inspection, the ward sister was included in the numbers

for allocated nursing staff on the ward that day. This meant that they had limited time to carry out their supervisory and managerial roles as sisters alongside directly caring for patients.

- Ward sisters told us that the low numbers of permanent staff presented issues in respect of arranging mandatory and non-mandatory training packages for staff.
- Due to the severe shortage of staff the service relied heavily on agency staff and, to a lesser extent, bank staff. Due to the shortage of permanent nursing staff across not only the service but the whole hospital, there was not sufficient staff to provide bank cover. Even with the use of bank and agency staff not all nursing hours were filled for each shift. Following our inspection, the trust provided data that indicated that in May 2018 10.14% of nursing hours were unfilled.
- Senior nursing staff acknowledged the high staff shortage and reliance on agency staff usage and its impact on staff morale. They said that they were making efforts to recruit more permanent staff, but were having difficulty filling the posts.
- We spoke with two matrons, who told us that the high reliance on agency staff impacted on the consistency of care provided to patients, albeit that they tried to mitigate against this by using the same agency staff where possible. They said that one impact of the extensive use of agency staff was the difficulty in disseminating learning from incidents to staff who had been on the wards at the time that the incidents had occurred.
- Senior nursing staff used an acuity assessment tool to determine the establishment number of staff required on each ward at various times given the varying care needs of patients. Whilst they said that the tool was effective, they acknowledged that they were not always able to obtain the staff numbers they needed.
- All agency staff underwent inductions and orientation on each of the wards they worked on. We saw documentary evidence of these having been completed.
- The discharge lounge was always staffed by at least one nurse and one HCA. The nurse we spoke to in the discharge lounge told us that the shifts were arranged so that there was an overlap meaning that two nurses were working on the unit at its busiest time in the early afternoon.

Are medical care services effective?

Nutrition and hydration

- We observed water jugs and cups left close by patients' beds where they could reach them.
- Food record charts and MUST scores were generally well completed. We observed staff and volunteers supporting patients during mealtimes.
- We spoke with speech and language therapists (SALTS), who told us that they carried out swallow assessments for patients who may have difficulty swallowing food and worked with dieticians and the catering team to ensure that appropriate food was provided for these patients.

Multidisciplinary working

- All of the staff we spoke with described effective multidisciplinary (MDT) working. They said that their expert opinions were listened to and respected. Meeting minutes evidence good MDT attendance at ward meetings.
- The nursing staff described the extensive support they had received during the recent winter pressures from their AHP colleagues.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). In addition, they told us that advice on these areas was readily available from the hospital's safeguarding team.
- We examined two sets of patient notes which included a DoLS assessment which had been appropriately completed.

Are medical care services caring?

Compassionate care

- The Friends and Family Test response rate for medicine at the hospital was 51% which was better than the England average of 25% from March 2017 to February 2018.

Medical care (including older people's care)

- Prior to our inspection, there were concerns raised to us by patients and their families about the quality of care provided. In many cases, this related to the level of communication provided by the hospital. Whilst we found that, overall, staff were caring, it was evident that the shortage of nursing staff had a significant impact on the amount of time that they were able to spend with each patient and the ability to provide up to date communication to their family.
- On the whole, nursing and other staff treated patients with kindness and compassion. Generally patients spoke highly of staff, praising their compassion and kindness. However, two patients' relatives told us that, whilst the nursing staff were not unkind, they could sometimes be rushed with patients and not spend enough time speaking with them.
- When discussing patients and their care, staff spoke with kindness and compassion.
- We observed a number of caring interactions with patients. In particular, we observed two physiotherapists assisting a patient to the window so that they could look at the ducks in Ladywell Park outside the hospital window. Nursing staff told us that they occasionally had couples in the hospital at the same time. They were able to provide examples of when they had used a lull in activity to bring one of the couple to visit the other in their ward. They said that this had a significant positive impact on the patients' wellbeing.
- Staff and patients told us about events that they had put on for patients, particularly those who were staying in the hospital long term. This included a royal wedding tea party and a party celebrating the diversity of staff backgrounds, with flags and other decorations. In addition, we saw signs advertising events for patients, including a therapy dog that was due to visit the ward, which patients could book time with.

Understanding and involvement of patients and those close to them

- Nursing staff told us that they endeavoured to keep patients and their families informed about their care. A number of patients we spoke with said that staff took the time to speak to them and explain their care and the potential impact of any decisions about their care.
- However, the majority of patients' relatives we spoke with said that they were not always kept informed about their relative's care. They said that nursing staff were often too busy to speak to them and that it was not always the same staff delivering care, meaning that they were not able to provide the family with an update. Poor communication was the primary concern raised to us both in the concerns leading to the inspection and during the inspection itself. This was also reflected in the most recent inpatients survey.
- Senior nursing staff acknowledged that staff shortages may have impacted on nurses' ability to communicate with patients' relatives. Further, they acknowledged that the heavy reliance on agency staff impacted on the ability to provide updates to family members.
- Two patients' relatives told us that when they telephoned the ward, no one answered. Ward clerks we spoke with informed us that there were a number of wards without full time administrative staff. They were not aware who answered the phones in their absence.
- Results from the 2017 inpatient survey showed an improvement compared to the 2016 inpatient survey, however, less responses were received in the 2017 inpatient survey. The 2017 survey looked at the experiences of 72,778 people who were discharged from an NHS acute hospital in July 2017. Between August 2017 and January 2018, a questionnaire was sent to 1,250 recent inpatients at each trust. Responses were received from 293 patients at Lewisham and Greenwich NHS Trust. Responses were received from 336 patients in the 2016 inpatient survey.

- Doctors answering questions, acknowledging patients, and confidence and trust had improved from 8.2/10 to 8.5/10. Nurses answers to questions and acknowledging patients had got worse. Confidence and trust in nurses, enough nurses on duty, and nurses in charge of care remained about the same. The overall care and treatment of patients had got better from 7.3/10 to 7.9/10, however, communication for not being told one thing by a member of staff and something quite different by another had got worse. Patients being told about any danger signals to watch for after going home had got worse and the overall leaving hospital experience remained about the same. Patient's views and information about complaints remained about the same with low scores of 2/10 and 2.5/10 respectively.

Emotional support

- Emotional support services were readily available for patients and their relatives. Staff demonstrated compassion and kindness in all of our observations, including when discussing difficult decisions about care.
- Patients had access to a multi-faith chaplaincy and spiritual services.
- Relatives and carers of those with dementia were allowed to visit outside visiting hours including overnight as part of the hospital's dementia strategy.
- There were clinical nurse specialists (CNS) based in the hospital, who could be called upon to provide additional advice and emotional support to patients suffering from specific conditions, such as cancer.
- Patients notes included observations of their wellbeing and emotional state. We observed records of assessments for anxiety and depression for patients.

Are medical care services responsive?

Access and flow

- Concerns had been raised prior to our inspection on the discharge arrangements at the hospital. We had received a number of concerns relating to the lack of sufficient equipment as well as a lack of communication around the discharge process with patients' families.
- All of the staff we spoke with were able to describe the discharge process in detail.
- Patients had named key workers who were responsible for their coordinating discharge process, for example arranging assessments and speaking with GPs, the local authority, the patient's family and other stakeholders. Key workers were drawn from the AHP teams, including speech and language therapists (SALT)s, physiotherapists and occupational therapists (OT)s. One of the SALTs we spoke with told us that acting as a key worker added significantly to their workload, and occasionally took them away from their clinical duties. Further, a small number of AHPs expressed concern that they were acting as key workers not only for patients who were not under their care, but also patients who were not under the care of any of the staff within their speciality.
- Patients generally lived in the surrounding London Boroughs of Lewisham, Greenwich, Bexley and Bromley, with a minority of patients from other London Boroughs and Kent. The AHPs we spoke with said that they generally had positive working relationships with community nursing and social work colleagues in the surrounding boroughs. However, the majority of staff said they experienced difficulties or delays as of the two primary boroughs commissioning services, there were slightly different arrangement for packages of care and discharge in each. In addition, they said that discharging patients to those areas which they dealt with less frequently presented more difficulties.
- All of the staff said that, on the whole the discharge process was effective. They acknowledged, however, that there were challenges to the process. In particular in respect of the resources available within the community. They said that the acuity of patients and their co-morbidities meant that discharge arrangements were increasingly complicated. Further, staff acknowledged that the public health and lifestyle challenges in the local areas increased the complexity of the discharge process.
- Some staff said that patient's relatives' expectations exceeded the package of care that was agreed with the patient. They understood that relatives wanted the best possible care for their loved ones, but said that there were occasions where relatives did not understand the funding process for care provision within the local authority within which their relative resided.
- There was a complex discharge team within the hospital, who provided support with the arrangements for patients with complex discharge needs. Whilst the AHPs described the team as highly supportive, they said that there were occasions when certain patients did not meet the requirements for transfer to the complex discharge team, despite significant challenges in arranging their ongoing care, which could lead to delays for the patient and a significant increase in workload for the AHP concerned.
- We visited the discharge lounge. The lounge was clean and clutter free. We spoke with the discharge lounge staff who told us that the primary delay to discharge for patients in the lounge was transport issues. On the second day of our inspection there were three delayed discharges. We requested information relating to the number of delayed discharges for the month prior to the inspection, this was provided and set out the reasons for each delay and what actions the trust had taken to mitigate the delay and the learning from it.

Medical care (including older people's care)

- The inpatient survey 2017 showed that patients waiting to get a bed on a ward had improved from 6.2/10 in 2016 to 7/10 in 2017. This meant that more patients felt that they did not have to wait a long time to get to a bed on a ward.

Meeting people's individual needs

- During our inspection, there were a significant number of patients in the service with complex needs. Medical, nursing and AHP staff worked hard to ensure that these needs were met. Patients with complex needs were discussed at weekly multidisciplinary team meetings, to ensure that their care plans were up-to-date, appropriate and that all staff were made aware of them. Staff described a positive MDT working environment.
- Staff had access to a telephone translation service. We saw evidence of this having been used in patient notes. In addition, leaflets and other documentation were available in a variety of languages on request.
- Patients suffering from dementia were identified by the presence of a shell symbol on the whiteboard, which allowed staff to provide care in the appropriate manner for those patients, for example through help with eating. There was a dementia lead nurse in the service who provided support and training for staff caring for patients with dementia.
- We observed patients with dementia receiving their food on a red tray, as part of the red tray scheme for supported eating. There were also group activities, such as drawing, for patients with dementia on some of the wards.

Learning from complaints and concerns

- Prior to the inspection, there had been concerns raised about neglect of patients, and poor care, as well as poor communication. The majority of concerns raised with the hospital related to poor communication. We requested a copy of the service's complaints log, however, this was not provided. We had sight of a number of complaints that had been progressed, and saw that they had been adequately responded to, with an apology to the complainant and action plans had been put in place to prevent the reoccurrence of the issue.
- Senior staff told us that complaints and concerns were treated as learning opportunities, this was reflected in our conversations with staff on the wards. We saw examples of complaints that had been investigated and the learning from them. Some of the nursing staff we spoke with were able to describe learning they had received arising from complaints.

Are medical care services well-led?

Governance, risk management and quality measurement

- There were clear lines of governance within the service. Incidents, complaints and concerns were escalated for investigation to relevant individuals and the learning from incidents was then cascaded to staff, albeit that some senior nursing staff said that it was difficult to share learning with nursing staff in particular, as the reliance on agency staff meant that there was inconsistency in teams.
- There were monthly governance meetings at which risks were discussed and identified, as well as serious incidents and action plans, complaints and concerns. We had sight of the minutes from monthly governance meetings, which indicated that they were well attended by medical, nursing and AHP staff.
- There was a service risk register for the management of risk within the service. There were actions and updates for each of the risks on the register.
- The primary risk related to nurse staffing. This was recognised at all levels of leadership and the trust was attempting to mitigate the risk through recruitment drives locally and examining the package of benefits they could offer to staff. In addition, one senior nurse told us that they had travelled abroad to recruit nurses in cohort from training schools overseas.
- We had sight of the minutes of monthly morbidity and mortality meetings, which indicated that national best practice around death was discussed, alongside the learning from deaths within the service. The nurse staffing levels were identified as the most serious risk in the service.

Leadership of service

- At the time of our inspection, the head of nursing for medical services was returning from a period of absence. The deputy head of nursing had been acting

up to provide leadership for the service, and was due to hand over responsibility in the days following our inspection. She said that this was being done in a phased way to ensure continuity of leadership.
- Staff spoke highly of the leadership within the service. They said that the leadership acknowledged the challenges they faced and were working hard to address the issues with the resources available.
- Staff also spoke highly of the local leadership on the wards, who they described as supportive and proactive in helping to provide care to patients. We observed matrons and ward sisters providing direct care to patients to assist their team with their workload, as well as engaging in supportive interactions with their staff.
- Staff were aware of the Freedom to Speak Up guardians within the trust.

Culture within the service

- The nursing staff we spoke with said that the shortage of nursing staff impacted significantly on the culture of the service. They said that this not only impacted on their morale, but also that the reliance on agency staff meant that there was a lack of continuity within the service, and made it difficult to foster a team spirit.
- Conversely, however, some of the nurses we spoke with said that the shortage of nursing staff had positively impacted on multi-disciplinary working within the service, in as far as they had been compelled to work more closely with colleagues from other professions, such as doctors and AHPs to ensure that standards of care remained appropriate in the face of the staff shortage. Senior nursing staff were emphatic in their praise of the support they had received from AHP colleagues in meeting the challenges they had faced.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure medical and nursing staffing levels are in line with national standards in services for medicine at UHL to provide safe continuity of care for patients.

Action the hospital SHOULD take to improve

- The hospital should ensure that all staff adhere to advanced PPE protocols when treating patients in isolation.
- Display latest infection control and safety thermometer information.
- The hospital should ensure that learning from incidents is shared appropriately with all staff, including agency staff.
- Ensure processes are in place to prevent common themes of incidents and share learning from incidents and complaints with staff.
- The hospital should work to ensure that discharge plans are effectively communicated to patients' relatives, in advance of their discharge.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 Health and Social Care Act (RA) Regulations 2014 Staffing 18(1) • There was a significant shortage of nursing staff within the service. • The service relied heavily on agency staff, which impacted on the continuity of care and the ability for learning from incidents to be shared. • On the majority of wards the establishment staffing levels were not met, which impacted on the amount of time staff were able to spend with each patient. • The nursing staff shortages meant that senior nursing staff were counted in the staffing numbers to ensure that patients were cared for. This directly impacted on this staff groups' ability to carry out their managerial and clerical roles. The provider must take action to: • Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this PART. In particular at University Hospital Lewisham this relates to nursing staff. Regulation. 18 (1))