Epsom and St Helier University Hospitals NHS Trust

Evidence appendix

St Helier Hospital
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Date of inspection visit:
09 January to 06 February 2018

Date of publication:
14 May 2018

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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

Epsom and St Helier University Hospitals NHS Trust has approximately 870 beds located across two acute locations; Epsom General Hospital which is located in Epsom and St Helier Hospital and Queen Mary’s Hospital for Children which is located in Sutton.

The trust has a further five locations registered with the CQC: Frimley Park Hospital Renal Unit, Kingston Satellite Dialysis Unit; Leatherhead; Mayday Satellite Unit and Sutton Hospital. In addition to these registered locations, Epsom and St Helier University Hospitals NHS Trust is the host for the South West London Elective Orthopaedic Centre (SWLEOC) which is located on the Epsom General Hospital campus. SWLEOC is run in partnership with a number of local trusts and is the largest hip and knee replacement centre in the United Kingdom and is one of the largest in Europe.

Additionally, St Helier Hospital is home to the Southwest Thames Renal and Transplantation Unit which provides acute renal care and dialysis and is integrated with the St George’s University Hospital NHS Foundation Trust renal transplantation programme.

Epsom and St Helier University Hospitals NHS Trust provides district general hospital services to a population of approximately 497,000 people living across south west London and Northeast Surrey as well as more specialist services in particular renal and level two neonatal intensive care to a wider catchment area covering parts of Sussex and Hampshire.

The trust services are commissioned by Sutton Clinical Commissioning Group, Merton Clinical Commissioning Group and Surrey Downs Clinical Commissioning Group.
The trust was previously inspected in November 2015 where it was found to require improvements in a number of areas. As a result we took regulatory action, which included serving the trust with eleven requirement notices.

Is this organisation well-led?

Leadership

Since the inspection of 2015, the trust more or less had a stable executive team. The chair, chief executive, joint medical directors and chief nurse were all in post at the last inspection. The chief financial officer and chief operating officer were relatively new in post. We largely received positive comments from staff and the executive team about the leadership culture within the organisation. Senior leadership was viewed by staff we spoke with as visible and accessible. Most were well respected by staff.

We heard positive comments from non-executive directors (NEDs), about the manner in which the trust was led and managed and that it was moving in the right direction.

The trust had developed a leadership and management matrix that mapped leadership and management interventions and opportunities across five levels of management. The matrix and interventions have been shared with managers and throughout the year specific programmes coming up are shared. The interventions are a mixture of national programmes, apprenticeship schemes and academic programmes, as well as bespoke programmes.

Local leadership in the core services we inspected was variable. Children and young people, medicine, critical care and surgery and maternity on the Epsom site had good leadership. However, leadership in the emergency departments, surgery and maternity on the St Helier site required improvement. There were some areas which we identified at the previous inspection which were yet to be resolved. Examples of these were the perception by black midwives in maternity at St Helier Hospital that they were not being treated fairly and the continued disappearance of surgical equipment during the sterilisation process.

We found the trust had a senior leadership team with the appropriate range of skills, knowledge and experience. Our checks included formal documentation for the fit and proper person requirement, recruitment processes and subsequent appointments. Everyone with ‘director’ in their title was checked for the fit and proper requirement. The checklist was carried out on appointment and then every five years.

Staff supported patients with mental health needs through the psychiatric liaison service and by hiring bank and agency mental health nurses. A mental health nurse was available at both main hospital sites through a psychiatric liaison service between 9am and 11pm, seven days a week.

All board members undertook the 15 steps programme. This involved board members visiting clinical areas for 30 minutes. The clinician then went back with the executive team and fed back to the board about the experience.

The trust was a member of NHS Elect, which was used to deliver coaching based programmes at Levels 3 and 4 to senior staff. The trust had also recently developed an in-house mentorship
register and also had a training program for middle level managers to equip them with the necessary skills to make them more effective. There were opportunities for career development for staff including a programme for BAME nurses wishing to progress.

Succession planning took place in the trust and assessed the readiness of junior staff to take over the role of their line managers, or at least act up for a limited time, without risk to the organisation's performance.

**Vision and strategy**

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust’s current strategy (2015-2020) was called ‘Patients First. Great Care. Every Patient, Every Day. This strategy included the commitment for both its main hospitals to continue to provide consultant-led, 24/7 A&E, maternity and paediatric services; and working with GPs to provide more care in community settings, so that people only care to hospitals when it was absolutely necessary. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services.

The trust’s planned strategy for 2020-2030, was based on securing a sustainable future for its hospitals. Future will be to combine six acute services on one site with community outreach. Outpatient activity will continue on both sites. The local community were widely consulted and around 25,000 people were involved. Over 1,000 questionnaires were completed and 37 stakeholders were in favour of its plans. 80% of respondents agreed to having a single acute site, as opposed to the two that the trust currently had.

Frontline staff understanding of the trust’s strategy and vision varied. Some were able to tell to tell us what it was, whilst other were not. In some areas, we observed the trust’s set of core values displayed. Each core service had a separate vision which included areas such as continuous quality improvement, delivering excellent experience and outcomes for patients, and reducing staff vacancy rate and staff turnover.

The trust’s strategy of aligning to the sustainability and transformation partnership (STP) was described as ‘complicated’. There are two STPs across two regions (South London and Surrey) (the only trust in England with this). The trust was aiming for a single site new build hospital and this idea had a programme board. The commissioners were aligned to this idea but other providers were not always happy with this decision. The STP was involved in canvassing views of the public. Whilst the STP work was to give advice, ultimately it was still the trust’s decision to make. The chairman met with other chairs of local STPs regularly and there was a South West London collaborative (chairs) operating, but needs ‘reinvigoration’.

Operational and clinical management were appropriately supported by financial colleagues, including embedded finance managers. Both operational staff and board members agreed that patient safety and clinical quality would not be compromised by financial restrictions.

The trust was expected to report a budget deficit for 2017/18 of £17,832. The trust had carried out work as part of the long-term strategy development to understand the causes of its underlying deficit. This showed that approximately two-thirds of the deficit related to the service configuration, but that the other half could be tackled through operational efficiencies. The trust
had a robust process which started in the autumn to develop cost improvement plans for 2018/19 based on both executive and divisional-level views of the required activity levels, cost pressures and opportunities for efficiencies.

Culture

The trust had two key findings that exceeded the average for similar trusts in the 2016 NHS Staff Survey:

- Quality of non-mandatory training, learning or development
- Percentage of staff agreeing that their role makes a difference to patients

The trust had five key findings worse than the average for similar trusts in the 2016 NHS Staff Survey:

- Quality of appraisals
- Recognition and value of staff by managers and the organisation
- Support from immediate managers
- % of staff satisfied with the opportunities for flexible working patterns
- % of staff believing that the trust provides equal opportunities for career progression or promotion

With regards to the Staff Survey questions related to the Workforce Race Equality Standard (WRES) indicators, two showed a statistically significant difference in score between White and BME staff:

- Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.
- In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader” or other colleagues”.

Disciplinary was still high for BME staff, which we were told the trust was looking to address. Examples of disciplinary action being more punitive towards BME staff and more about how to improve for non-BME staff was given by frontline staff. We held a focus group BME staff during the Well-led inspection. We were told that a BME leadership programme was available but this needed to be publicised more. A trustwide BME network was launched the week before our inspection. Some staff stated that a similar group was launched in the past and it had no lasting impact. Staff expressed some lack of clarity around WRES and its purpose.

Black midwives in the maternity service expressed concern about staff leaving, disciplinary/ performance being inconsistently managed, progression, bullying and equality of treatment. They had submitted a collective grievance to the trust. An internal investigation was carried out and the report submitted during our inspection. Recommendations to improve the situation were made.

The trust scored similar to the England average for recommending the trust as a place to receive care from September 2016 to August 2017. Board members described the trust culture as open, committed and passionate. Staff were honest when errors were made and we found that the majority of staff were able to raise issues with the CEO.
There was a freedom to speak up guardian (FTSUG) in post since September 2016. Training was provided by the National Guardian’s Office and the FTGUG also attended listening and learning events. The trust recently appointed another FTSUG for a further one day/week.

The trust had an equality and diversity (E&D) manager, toolkit and strategy. The manager started in September 2017 and although they had no team or members or staff working with them, they worked closely with the FTSUG. There was no trust assessment of EDS2 and no equality and diversity objectives before the E&D manager’s appointment. These were still yet to be developed.

Some black midwives said they had seen improvements since the current chief nurse started in 2015, but many of the issues were longstanding. Staff had raised concerns with the FTSUG freedom to speak up guardian. One senior executive recognised that one of the trust’s main equality and diversity challenges was the BME representation amongst senior nurses. To help address this, a lead nurse for nurse retention had begun running programmes and offering career development support for BAME nurses wishing to progress.

Most staff training was now online, so more flexible to access; however, getting staff to have time/access to computers can be difficult. Challenge was also in getting staff released, especially for nurses and healthcare assistants, often due to staff shortages.

The workforce culture included areas for development which were being reviewed by leaders within the organisation and actions planned to improve this. There had been no external review of workforce culture in areas of concern, however, external support was being arranged to deliver actions.

We reviewed evidence of the trust’s adherence to the Duty of candour requirement. There were clear audit trails within the clinical case notes of the methods used for verbal and written communication, with accountable trust staff identified with dates recorded of when the Duty of candour actions were undertaken.

Multidisciplinary team working was well embedded in most areas and there was a strong sense of commitment to doing what was right for patients. Significant improvement had been made in the culture on critical care at St Helier Hospital, since the last inspection.

**Governance**

The board had eight sub-committees; trust executive committee, patient safety and quality, performance assurance and risk, audit, people and operational development, finance and investment, renumeration and charitable funds. These were chaired by a board member and reported to their outputs to the board.

We met with the divisional management team for surgery. We were told that this division was too big and too complex to have one clinical director (CD), so now had three. CDs met weekly with the divisional manager. There was clinical input into the management team and there was easy
access to the executive team. The management team felt that the current system was functional and robust.

Staff knew how to report medicines errors and some gave examples of learning. Staff felt that the pharmacy team was responsive to their needs in terms of advice provision and chart screening. Staff felt that medicines supply from pharmacy to wards, happened in a timely manner. We saw and were told by staff on two wards (one at St Helier Hospital, one at Epsom General Hospital) that waste medicines were not always collected for return to pharmacy in a timely manner.

There was a weekly workforce meeting where doctors’ capability, conduct and competence were discussed and challenged where necessary. The chief nurse attended the governance committee meetings and worked closely with the medical directors who are responsible for governance and quality. There were also senior nurses represented on the governance committee.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. Non-executive and executive directors were clear about their areas of responsibility. There were appropriate governance arrangements in place in relation to Mental Health Act administration and compliance; and there were partnership arrangements with local NHS trusts for the provision of psychiatric liaison services with appropriate governance arrangements.

Governance and risk management processes were variable in the areas we visited. They were well structured in some areas, but not as strong or effective in others. For example, in some areas, incidents were not always reported, which limited the opportunities to review and learn from them.

Management of risk, issues and performance

The trust had a complaints procedure and the complaint process was simple and straightforward for patient and relatives to follow. The chief nurse, chief operating officer, general managers, clinical directors and heads of nursing received copies of all new complaints, so there was senior clinical and management knowledge of them. We were told the CEO read all the complaint responses and the divisions triumvirate signed off all complaints.

When written complaints were received, they were all acknowledged within the KPI of three working days. The complaint response timescale targets were 25 working days for minor, straightforward complaints, 35 days for more complex complaints and 45 days for very complex cases. The trust had a performance target of 75% to meet all complaint timescales, but was performing a lot lower at 30%. Not all complaints were risk assessed and there was no evidence of complaint outcomes making any difference to the service on some of the complaints we reviewed.

Innovation and continuous improvement was evident through examples such as the transformation team and use of the PERFORM methodology. This was a bespoke performance improvement methodology and was supported by a large service improvement team, staffed with substantive trust employees rather than relying on consultancy support. There was a focus of continuous
improvement on important areas such as Accident and Emergency and this had an impact. The trust was using the ‘Model Hospital’ as one source of ideas for its cost improvement programme.

The audit process had improved following recommendations from internal audit. New internal auditors were recently appointed.

The risk register had been re-written since the last inspection and the performance assurance and risk committee (PARC) was formed. We reviewed the risk management process and it was explained to us. Risks were identified, reported to the divisional management team (DMT), then to the performance committee and then to the trust executive committee (TEC), where corporate risks were discussed. All board members recognised that the trust’s top three risks were inadequate staffing, poor quality estate and finance. There was also universal recognition that inefficiencies were caused by running two full service district general hospitals, across a relatively small geography.

In 2015, governance and risk from ward to board was not managed; however, clear action had been taken to improve this. Trustwide risks and service risks were now better understood. Risks were identified in three categories with short term and long term actions. Risk register was dynamic and reviewed regularly in the senior leadership team (SLT) and risk committee. This was all in the public domain and part of the performance report. We saw some risks that were visible on both the divisional and organisational risk registers.

We reviewed the trust’s Board Assurance Framework (BAF) for quarter three 2017/18. The document outlined the trust’s performance against the 25 corporate objectives. It was not clear which sub-committee of the board was responsible for which of the trust’s 25 corporate objective. Timescales were described in quarters rather than by exact date. The BAF did not describe links to the risk register. Risks to the delivery of care were not outlined and therefore not rated. Primary, secondary or tertiary controls were not described, neither were assurances or assurances gaps. The BAF was not used to define the agenda of the board and its sub-committees and should have been.

**Information management**

There had an under investment in IT over several years. For example, the trust was still using the ISOFT3 data management system, which was an outdated PAS system which took a lot of manual processing. However, capital investment in IT had trebled as part of the trust’s digital strategy. Poor data quality was on the corporate risk register as a significant risk.

The trust had invested in a number of core systems to maintain availability of existing infrastructure (such as PACS digital storage), a rolling PC replacement programme, network infrastructure replacement, better mobile working, electronic prescriptions and medicines administration, and deployed new tools to improve clinical care and management of the trust.
Most data validation occurred daily, including waiting time data. For example, A&E datasets were validated by the emergency department team and the urgent care service leads daily and signed off by the director of urgent care. RTT data was reviewed by the trust operational performance group (consists of service managers from all divisions) twice every week. Cancer datasets were reviewed by the cancer services team. These were signed off by the director of planned care.

Most safety data were reviewed on a case by case basis. This included mortality review and infection control. The trust information team provided a series of reports that supported this review and validation process.

One senior executive told us that the trust data could not produce theatre efficiency. They also said that information throughout the local health economy needed to be better in order to alleviate some challenges around information sharing.

SITREP was collated by hand on an Excel spreadsheet daily. This risk was being managed until the new hospital build. The trust was putting a lot of effort into making the data right. Manually tracking of 18 week RTT had meant good quality data. A&E data was scrupulously tracked and so correct.

Information governance (IG) training was lower than were it should be. The trust spent £2.5k on face to face training, but there was still 20% of staff who were yet to complete it before April 2018.

The trust provided information to NHS Improvement and to its board on its financial position. Some executives told us that sometimes systems within the trust did not provide consistent information (e.g. between HR records and finance), but the trust has provided additional funding for analysts to work with divisions to ensure the information used by operational and clinical staff was as accurate as possible.

Performance measures were clearly collected and documented and information and data validated. There was work to be done to establish further information management and IT systems to improve data processes, whilst also considering the impact of the current estates.

**Engagement**

The trust was in the process of strengthening its engagement with staff. It introduced a major involvement event for all staff and formed a staff engagement group. There was a “Breakfast with the Boss”, where staff were able to speak with CEO and raise concerns.

The trust had struggled with obtaining exit interviews. Attempts to improve this had not been successful. Feedback was more frequently received informally. The CEO’s weekly message was well received for those who had regular access to computers. Matrons delivered messages for those staff who did not have access to computers.
The trust undertook internal engagement with both clinical and non-clinical staff regarding service design and change. As part of the development of the long-term plans for the organisation, the trust had also engaged extensively with local stakeholders including MPs, local authorities and the public. As the programme moves forward, the next stage was a formal public consultation led by its host CCGs.

The trust straddles two STPs (in two NHS regions) and the trust CEO took a lead role with engaging with these, supported by the director of strategy, corporate affairs and ICT. The chair also engaged with the STPs, and with the chairs of the other trusts in the area.

The trust was involved in an integrated provider alliance (with GP practices) around the Epsom area (Epsom Health and Care Alliance @home service) which delivered care for older people. This has resulted in better flow for example, zero 12 hour trolley waits in A&E and no corridor queues. At the time of the inspection, the trust was waiting to hear whether it was the preferred provider to deliver a similar service from the St. Helier Hospital site.

We were told that there were good relationships with the local CCGs. The focus was on what the trust was meant to deliver and the aim was to keep to a block contract.

In the Friends and Family Test, the trust scored similar to the England average for recommending the trust as a place to receive care from September 2016 to August 2017. Response rates were lower than national average. The results of the test were displayed in most areas.

In the NHS staff survey, the response rate was 56%. This was above the national average and the best ever for the trust. The trust’s engagement score in the staff survey was 3.8. This was average compared to the national average. The top three top 20% scores sit within the ‘Appraisal & support for development’, ‘Errors & incidents’ and ‘Patient Care and experience’ categories. Worse scores sit primarily with ‘equality and diversity’, ‘working patterns’ and ‘managers’. A high number of staff stated that do not always feel valued and recognised for the job that they do.

The trust held a ‘Shaping the Future Engagement Event with 200 staff to discuss and agree key success factors, improve staff experience and deliver our objectives. This led to each division reviewing the staff survey results with their staff and producing local action plans.

The trust re-instated a long service awards in the past year, to recognise our staff’s contributions.

Learning, continuous improvement and innovation

We saw an example where the radiology department changed its practice to ensure a named clinician was documented and followed through with investigations. This was following a route cause analysis (RCA), following an investigation of a missed diagnosis where the Duty of candour should have been applied and was not. This learning was presented to the quality meeting and discussed with the clinician responsible.

The trust had a policy for mortality reporting and mortality peer review process. The purpose of this policy was to state how the trust would implement the requirements of the Learning from Deaths Framework as part of the organisation’s existing procedures in order to learn and improve the quality of care for all patients.

One of the joint medical directors was the board lead responsible for learning from deaths. One of the associate medical directors was responsible for the implementation of the policy. Both the medical director and associate medical directors were trained investigators for RCA.

The trust was an early adaptor for learning from deaths and had three trained investigators who also trained others within the trust. The trust approach: Stage 1- all clinicians could undertake the
investigation; Stage 2- Structured Judgement Review (SJR), undertaken by trained clinicians only. Anyone who had a psychosis or learning disability automatically had an SJR. Mental health and learning disability deaths were reviewed and learning was shared locally and beyond. The safeguarding committee was involved where there were. Part of this review included going out to talk to the family in their own home. There was a template for all junior doctors to complete for deaths in parallel with SJRs; this was then reviewed by senior staff.

We found the mortality review process was embedded into existing systems. Systems the trust found beneficial were RADAR (Reducing Avoidable Death Action Review) and simulation courses.

Mortality reviews were the responsibility of associate medical directors. The trust’s mortality rate had been reducing and was currently lower than the national average at 3.5%. Mortality and morbidity meetings were part of audit committee meetings. If death was felt to be avoidable, it was raised at the audit committee meeting.

The trust had invested in system of electronic whiteboards on ward areas. This was a plasma screen near the nurses’ station and included data including the patient’s name, whether venous thromboembolism was completed, National Early Warning Score, and dementia screen. The whiteboards gave a snapshot of what was happening with each patient on the ward.

Innovation and continuous improvement was evident through examples such as the transformation team and use of the PERFORM methodology. This was a bespoke performance improvement methodology and was supported by a large service improvement team, staffed with substantive trust employees rather than relying on consultancy support. There was a focus of continuous improvement on important areas such as Accident and Emergency and this had an impact. The trust was using the ‘Model Hospital’ as one source of ideas for its cost improvement programme.

Following refurbishment of St Helier Hospital, every surgical patient would be within 100 meters of each other. This will help with medical follow up. There were virtual clinics in general surgery that enabled a wider access and attendance.

One executive told us that there was a lack of capacity for some staff to complete mandatory training due to the trust ‘running hot’. They said that it was easier for non-operational staff to complete mandatory training.

One example of an educational development was the “Governance Grand Round”. This was where teaching and learning sessions were shared with all medical staff, who then developed a teaching program and shared with all staff. An example was the development of the hypoglycaemic training session program that the diabetic team developed on hypoglycaemic prevention and management.
Acute services

Urgent and emergency care

And data Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

St Helier provides urgent and emergency care services which are open 24 hours a day, 365 days per year. The hospital provides services to the local populations within areas of North East Surrey and the London Boroughs of Sutton and Merton.

St Helier ED is a trauma receiving unit and all emergency surgery is undertaken at St Helier Hospital. The hospital received emergency adult, paediatric and maternity patients.

In 2016/2017 152,843 patients were treated by Epsom and St Helier University Hospitals NHS Trust. Of these 24,617 (25%) were aged 17 years or under. During the same period St Helier ED had 87,913 attendances and admitted 21,978 patients.

During 2016/2017 Epsom and St Helier University Hospitals NHS Trust were in the top ten performing trusts nationally for the Accident and Emergency standard of 95% of patients being treated and admitted or discharged in under four hours.

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department booked into reception before being seen by the triage nurse. (The triage nurse will evaluate the patient's condition, as well as any changes, and will determine their priority for treatment).

The ED had different areas where patients were treated depending on their acuity including majors, resuscitation area, clinical decision unit (CDU), observation bay, and the urgent care centre (UCC). There was a separated paediatric ED with its own waiting area.

During the inspection the ED was under additional pressure due to the increased volume of patients. We were careful in our approach to interviewing staff and gathering of observational evidence so as not to disrupt the work of the department.

During this inspection we spoke with 16 staff from a range of clinical and non-clinical roles and of varying grades. We spoke with 19 patients and three relatives. We reviewed 14 patient records, including four related to children and young people. We made observations and looked at documentary information accessible within the department and provided by the trust

(Source: Trust Routine Provider Information Request)

Activity and patient throughput

Total number of urgent and emergency care attendances at Epsom and St Helier University Hospitals NHS Trust compared to all acute trusts in England.
There were 151,887 attendances from April 2016 to March 2017 at Epsom and St Helier University Hospitals NHS Trust as indicated in the chart above. 
(Source: NHS England)

Urgent and Emergency Care attendances resulting in an admission

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Trust</td>
<td>24.7%</td>
<td>23.8%</td>
</tr>
<tr>
<td>England Average</td>
<td>21.6%</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

The percentage of A&E attendances at this trust that resulted in an admission slightly increased from 2015/16 to 2016/17. In 2016/17, rates were higher than the England average. 
(Source: NHS England)

Urgent and Emergency Care attendances by disposal method
<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>38,689</td>
</tr>
<tr>
<td>Discharged*</td>
<td>84,8</td>
</tr>
<tr>
<td>Referred^</td>
<td>15,918</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>910</td>
</tr>
<tr>
<td>Died in department</td>
<td>85</td>
</tr>
<tr>
<td>Left department#</td>
<td>6,620</td>
</tr>
<tr>
<td>Other</td>
<td>5,937</td>
</tr>
<tr>
<td>Not known</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

(Source: Hospital Episode Statistics)
Is the service safe?

Our rating of safe stayed the same. We rated it as requires improvement.

**Mandatory training**

The trusts Statutory and Mandatory Training Policy details the legislative, as identified by the NHS Litigation Authority (NHSLA), and trust specific training, staff are required to attend to fulfil the requirements of their role. Subjects are identified along with the frequency of completion. For some this is once only at induction such as complaints handling and death and bereavement, whilst other subjects are to be completed yearly or every three years.

Mandatory training was monitored through the trusts corporate training register (WIRED) with training provided as part of a rolling programme throughout the year. Staff we spoke with told us that their training was mostly up to date.

Senior staff told us that WIRED did not reflect the true level of compliance within the ED; however the senior staff were not aware of any plans to resolve this. This meant that senior staff could not be assured that staff working within the ED had the appropriate skills and knowledge.

We were shown certificates of training completed by nursing and health care assistance (HCA) but the system did not show that the training had been completed for example, Information governance. Figures seen during the inspection were as follows: Safeguarding level 1 was 100%, Safeguarding level 2 was 89.5%, Safeguarding was 79%, Infection control was 100%, Equality and diversity was 100%, Major incident training was 85%, Fire was 81% Conflict resolution was 98% and MCA and DoLS was 48%. Senior staff explained that the MCA and DoLS training was run three times per year which made it difficult for staff to access.

Information governance was below the trust target of 95% Senior managers advised that Information governance had to be completed annually in line with financial year and anticipated this would meet the trust target by the end of March 2018.

The trust set a target of 95% for completion of mandatory training. The trust’s target of 95% was a self-imposed target that it aspired to meet.

A breakdown of compliance for mandatory courses as of October 2017 for medical/dental and nursing/midwifery staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Medical and Dental staff</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>69%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>64%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>56%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>55%</td>
</tr>
<tr>
<td>Manual Handling · People</td>
<td>95%</td>
<td>49%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>44%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>44%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>40%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>36%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>29%</td>
</tr>
</tbody>
</table>
The 95% target was met for none of the 10 selected mandatory training modules shown above for medical staff.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>97%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>82%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>81%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>77%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>64%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>44%</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the ten selected mandatory training modules shown above for registered nursing staff.

A breakdown of compliance for mandatory courses as of October 2017 for medical and nursing staff in St Helier Hospital is shown below:

<table>
<thead>
<tr>
<th>St Helier</th>
<th>Trust Target (%)</th>
<th>Percentage number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>87%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>74%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>72%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>70%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>69%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>69%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>67%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>51%</td>
</tr>
</tbody>
</table>

A breakdown of compliance for mandatory courses as of October 2017 for medical and nursing staff in St Helier Urgent Care Centre is shown below:
St Helier Urgent Care Centre | Trust Target (%) | Percentage number of staff trained (YTD)
---|---|---
Blood Transfusion | 95% | 100%
Manual Handling - People | 95% | 100%
Information Governance | 95% | 100%
Conflict Resolution | 95% | 100%
Resuscitation | 95% | 100%
Infection Prevention (Level 1) | 95% | 100%
Infection Prevention (Level 2) | 95% | 100%
Other (Please specify in next column) | 95% | 78%
Equality and Diversity | 95% | 67%
Information Governance | 95% | 23%

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

Staff we spoke with were aware of their responsibly to protect vulnerable children and adults. They understood how to access the trust safeguarding policy and understood how to report concerns. Between 1 October 2016 and 30 September 2017 there were 166 safeguarding referrals made from the ED at St Helier.

Safeguarding supervision was provided by the safeguarding team. We noted from the annual report that there had been 2224 consultations in 2016/17. This was a 56% increase from 2015/16 data and averaged 185 formal referrals to the team a month.

The safeguarding children team is led by the Named Nurse for Safeguarding Children. They report directly to the Safeguarding Lead with professional support from the Head of Nursing – Paediatrics and Neonatology and through to the Chief Nurse, who is the executive lead for both adult and children safeguarding. Staff we spoke with in the paediatric ED were aware of this.

The trust had a safeguarding hub covering both hospital sites, which coordinates the efforts of staff in safeguarding, child protection, maternity, independent domestic violence and learning disabilities. The safeguarding hub had monthly meetings which include community leads in agencies supporting people in these different areas.

Children using the paediatric ED who were known to Sutton and Merton Social Services department were identified on the patient record. There was a weekly multiagency paediatric safeguarding meeting review all cases where concerns had been raised. There were six missed safeguarding referrals for November and December 2017, reported formally to the weekly safeguarding meeting.

At the last inspection we had concerns that the children’s at risk register had not been updated. On this inspection staff reported that from February 2018 they would have access to 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 produced separate Safeguarding Children and Adults Annual Reports for 2016 – 2017. Information therein details the data related to attendance at the ED for mental health and suicidal reasons, or assault, along with data on referrals to children’s social care.

Staff had access to safeguarding training as part of mandatory programme. Safeguarding Adults, the Mental Capacity Act, Deprivation of Liberty Safeguards, and Caring for People with Complex Needs, such as learning disabilities formed part of this. There were various levels of training available, from level 1 to 5. Safeguarding Adults and Learning Disabilities continue to be part of the induction for all nurses and midwives.

Safeguarding with Prevent awareness was to be completed every three years. Similarly Safeguarding Adults, the Mental Capacity Act 2005 and Deprivation of Liberty (DoLS) training was to be completed three yearly.

Senior staff told us that wired does not reflect the true level of compliance within the ED, Figures seen during the inspection for nursing and HCA’s were as follows: safeguarding adults level 1 was 100%, safeguarding adults level 2 was 89.5%, safeguarding 3 children was 79%.

Figures provided by senior staff within the paediatric ED during the inspection showed that nursing and HCA’s had completed safeguarding adults level 1 was 100%, safeguarding children level 2 was 87%, safeguarding 3 children was 87%.

### Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training. The trust provided their training for all staff within the urgent and emergency core service.

The trust is not meeting any of the three safeguarding modules the lowest with 37% Safeguarding Adults (Level 2).

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>70%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>67%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>37%</td>
</tr>
</tbody>
</table>

The 95% target was met for none of the two safeguarding training modules for which medical staffs in urgent and emergency care were eligible.

The 95% target was met for one of the three safeguarding training modules for which qualified nursing staffs in urgent and emergency care were eligible.

A breakdown of compliance for safeguarding training courses as of October 2017 for medical and nursing staff in St Helier Hospital is 72%
A breakdown of compliance for safeguarding training courses as of October 2017 for medical and nursing staff in St Helier Urgent Care Centre is 52%.

Cleanliness, infection control and hygiene

The ED monitored staff hand hygiene monthly however we noted that between October 2016 and October 2017 there were four months when the department did not submit any data. The trust’s target was 80% and his was a low target. In the adult ED, compliance with good practice with hand hygiene averaged 51%, and in the paediatric ED compliance with good practice averaged
67%. This meant that 29% of staff in the adult ED and 13% of staff in the paediatric ED did not comply with the trust’s target of 80%.

In clinical areas we observed that eight out of ten clinical staff did not consistently adhere to infection control measures with washing hands between patients and after patient contact. We also noted that some medical staff had jewelled rings, were wearing watches and had long sleeve tops on which is in breach of the trusts policy of bare below elbows. We found similar practises on the last inspection.

The ED was visibly clean, and tidy. We saw domestic staff cleaning the department throughout the day. The monthly cleaning audit for December 2017 showed that the department was 99% compliant. The service level agreement (SLA) January 2017 for cleaning services set out the daily and weekly cleaning schedules for the department. In the UCC waiting area the toilets were clean with a cleaning schedule on display which was up to date.

Clinical staff cleaned clinical items and recorded in the cleaning folder for equipment and commodes. Evidence of last five days checks were seen and fully completed.

Chairs in the department had plastic seats or plastic coverings so that they could be cleaned easily.

We observed that there was adequate personal protective equipment available (PPE) available such as apron and disposable gloves. Hand washing facilities were available and sanitizing hand gel was available in most areas although in the UCC one dispenser was empty.

Five sets of disposable curtains were checked and found to be. The labels indicated when they came into use and when they were due to be renewed.

Sharps management complied with Health and Safety (sharps instruments in healthcare) regulation 2013. Three sharps boxes were observed to be dated and assembled properly.

A full programme of infection control training was offered in 2016-17, including induction and mandatory update training for all clinical staff that has direct contact with patients and for non-clinical staff who work regularly in the clinical environment, e.g. domestic and portering staff, in addition bespoke training was also delivered for specific groups. The vascular clinical nurse specialist (CNS) commenced Aseptic Non-Touch Techniques (ANTT) training delivery on induction.

The ED reported to the infection control committee through the medicine division. From January 2018 there were proposals for the ED to report separately and develop an A&E IPC improvement plan and strategy which was to be overseen by the divisional head of nursing for A&E.

Environment and equipment

The physical environment of the ED did not enhance patient safety; the layout of the department did not appear to be designed for ease of us which meant patient safety could be compromised. During the inspection at one time there was 10 patients waiting to be admitted to the hospital, the resuscitation area had all four bays full and in majors all the cubicles were full. There were six patients waiting to be admitted into the ED who were queuing in the corridor area which blocked access to majors and the resuscitation area. Priority calls were being dealt with just inside the resuscitation area as there was no clinical space to deal with a surge of patients arriving at the hospital by ambulance.
Senior staff told us that the CEO had done a walkabout and it had been agreed that the majors and the resuscitation area needed to be reconfigured. They were unable to give any time frame for this to be undertaken.

The rapid assessment and treatment (RAT) was accessed from the ambulance area and had 3 cubicles with seating which lead to the resuscitation area and majors. In total there were 10 majors’ cubicles including four side rooms that could be used to isolate patients. All bays had suction and oxygen.

The nurse in charge of the whole ED did not have sight of all the bays in majors from where they were stationed or other areas of department and was reliant on staff to update them. A senior nurse told us it was difficult for the nurse in charge to have an oversight RAT, majors and resuscitation because of the geography of the department.

The resuscitation area had four trolley bays which included a bay designated for children. At the last inspection we had concerns that daily checks of resuscitation equipment was not in place. On this inspection we saw evidence that resuscitation trolleys were tamper evident; medicines and equipment within them were within their expiry dates. Checks were on trolleys were completed daily.

The UCC which had four consulting rooms and two treatment rooms; the waiting area was clean with sufficient seating. The clinical decisions unit (CDU) had spaces for seven chairs; there were no trolleys or beds. The ED had a specific room for women with en-suite shower and toilet for privacy if they had gynaecology concerns. The observation bay had four beds where patients could be admitted for up to 24 hours with shower and toilet facilities.

The ED also had a mental health assessment room for patients who presented with psychiatric needs. This room could be secured to protect the patient and staff from harm. The room had two exit doors which were alarmed and no ligature points.

The ED had a separate paediatric ED which had five trolley bays, one cubicle, two isolation rooms and waiting room. The waiting room was also a children’s play area with toys and visual stimulus appropriate for young children.

We saw that Electrical Medical Equipment (EME) had a registration label and Portable Appliance Testing (PAT) labels were attached to electrical systems showing that it had been inspected. Six items of electrical equipment were checked and found to be safety tested and serviced appropriately.

**Assessing and responding to patient risk**

Patients present to the department either by walking into the reception area or arrive 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. Children arriving at the ED by ambulance were taken straight to the resuscitation unit for assessment.

All patients walking into the ED were initially registered at reception. Reception staff asks presenting symptoms and if they have concerns they would call for medical assistance. Reception staff told us they had not received any specific training to ensure that high risk patients were seen more quickly and rely on their experience and knowing triggers for example chest pain.
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. Adult patients would be seen by a nurse who carried out an initial assessment (streaming) using the Manchester triage system. This is a recognised assessment tool used in ED’s. Patients prioritised to be seen in the UCC by an emergency nurse practitioner or GP that provided a front door rapid assessment and treat (RAT) for admission into the ED. The streaming nurse also took bloods if they had time.

The records reviewed showed the ED used the National Early Warning Score (NEWS) system to detect deterioration in adult patients. Eight of the 10 records we looked at had completed NEWS sections. An audit of NEWS and pain scores in December showed that the 95% of records in the ED had NEWs and pain scores completed correctly. The paediatric ED used an age appropriate paediatric early warning score, a local audit in undertaken between February and April 2017 findings show an overall improvement in areas highlighted in training including the assessment of respiratory effort, monitoring of blood pressure and highlighting nurse/doctor/parent concern.

Sepsis leads have been identified in each clinical directorate. Their remit was to promote good clinical practice at a local level. We observed that a patient who had been diagnosed with sepsis had been given IV antibiotics within the one hour in line with NICE guidance.

Resuscitation was below the trust target of 95%. Information provided by the trust showed that 70% medical and nursing staff within the ED and 100% of staff working in the UCC had completed the training.

The trust scored “about the same as” other trusts for all five of the Emergency Department Survey questions relevant to safety.

<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>8.8</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>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a 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?</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.8</td>
<td>About the same as 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>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

Patients who are at risk as a result of their mental health receive a mental health assessment within ED or the assessment unit by a qualified mental health professional and their suicidal risk will be managed by the provision of one to one nursing where indicated following risk assessment.

Staff in the emergency department referred patients to psychiatric liaison team 1801 times in the period April 2016 to March 2017. Staff said that the team responded to their referrals within an hour, which is the trust target time.

We spoke to five staff members who were able to say how they would refer patients to the psychiatric liaison team if they needed further support for their mental health needs. A mental health nurse was available at through the psychiatric liaison service between seven days a week.
St Helier Hospital emergency department (ED) is not a legally “designated place of safety”. However, if ED staff agreed, then the ED can temporarily become a “place of safety” for a specific patient detained on Section 136 who is in need of immediate treatment for physical illness or injury such as self-harm. St Helier Hospital patients who present to ED under Section 136 are escorted to an available 136 suite, or if one is not available at the time of the request, once the patient was medically cleared. A total of 6 patients were detained under section 5(2) of the Mental Health Act in the last 12 months.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for 12 months over the 12 month period from November 2016 to October 2017.

Performance against this standard showed a trend of decline. In October 2017 the median time to treatment was 88 minutes compared to the England average of 59 minutes.

At St Helier hospital the average performance against this standard for the 12 month period from November 2016 to October 2017 was 82 minutes. (DR142)

**Ambulance – Time to treatment from November 2016 to October 2017 at Epsom and St Helier University Hospitals NHS Trust**

![Graph showing median time from arrival to initial assessment](Source: NHS Digital - A&E quality indicators)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was better than the overall England median in 12 months over the 12 month period from November 2016 to October 2017.

In each month from November 2016 to October 2017 the median time to initial assessment was one minute compared to the England average of eight minutes.

At St Helier hospital the average performance against this standard for the 12 month period from November 2016 to October 2017 was 8 minutes. (DR143)

**Ambulance – Time to initial assessment from November 2016 and October 2017 at Epsom and St Helier University Hospitals NHS Trust**
On inspection we saw delays in the UCC where patients were waiting more than 15 minutes to be triaged. The longest wait to be triaged was 73 minutes with 5 people waiting.

**Percentage of ambulance journeys with turnaround times over 30 minutes for this hospital**

From December 2016 to November 2017 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at St Helier Hospital.

In November 2017, 62% of ambulance journeys had a turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - St Helier Hospital**

![Graph showing the number of journeys with turnaround times over 30 minutes for St Helier Hospital.]

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - St Helier Hospital**

![Graph showing the percentage of journeys with turnaround times over 30 minutes for St Helier Hospital.]

On inspection we saw delays in the handover of patients. The longest we observed was 120 minutes from ambulance crew to nursing staff. During this time two ambulance crews black breached as ambulance staff had to wait more than an hour to handover. At one time there were six patients and ambulance crews waiting. Staff triaged all the patients within 15 minutes of arrival and deemed they were safe to wait. Any delays in handovers were reportable.

**Number of black breaches for this trust**

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.
October 2016 to September 2017 the trust reported 169 (Epsom – 50; St Helier – 119) “black breaches”.

![Black Breaches Graph](Image)

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

Nurse staffing

Across both EDs, there were 136 whole time equivalent (WTE) qualified nursing staff, including 12 emergency nurse practitioners. According to provider information there were no vacancies within the nursing staff. However, we noted from data provided by the trust that the number of shifts filled by healthcare assistant bank or agency staff was 629 and by qualified nurses, 3,568 during the previous year up to 18 October 2017.

The trust reported their registered nursing staff numbers as below as of October 2017.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>141.3</td>
<td>122.8</td>
</tr>
</tbody>
</table>

There were 18.4 less WTE nursing staff than the trust had planned to provide safe care within the urgent and emergency care core service.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

We asked for nursing staffing levels by site and were provided with the following as of October 2017: The compliment in ED was 81 whole-time equivalent (WTE) and consisted of the following: 10 healthcare assistants at Band 2, three associate practitioner at Band 4, 33 nurses at Band 5, and 21 nurses at Band 6. There were 13 Band 7 nurses (including emergency nurse practitioner), and a Nurse Manager at Band 8a. The number of nursing staff working cross both ED sites was one nurse at Band 8a, a deputy head of nursing Band 8b, and the divisional head of nursing, Band 8c. Senior staff advised us that that there were currently no vacancies for nursing staff within the ED. (DR 144).

During the inspection we observed that not all the areas within the ED were fully staff. At handover it was reported that the department was well staff for the day, but the ED was 3 nurses down. Band 7 staff reported that when the ED was busy they did not always get their protected
management time. We observed that senior nursing staff would cover on the floor when demand was high.

The paediatric ED, staffing levels complied with the Royal College of Paediatrics and Children’s Health (RCPCH) by having a minimum of two children’s nurses in the ED 24 hours a day seven days per week. All nursing staff were registered children’s nurses.

Vacancy rates

As at October 2017, the trust reported a vacancy rate of 26.5% in urgent and emergency care.

- St Helier Hospital: 21%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

As at October 2017, the trust reported turnover rate of 29% in urgent and emergency care.

- St Helier Hospital: 20%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

As at October 2017, the trust reported a sickness rate of 5.1% in urgent and emergency care.

- St Helier Hospital: 6.2%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

As at October 2017, the trust reported a bank and agency usage in urgent and emergency care; The trust used 4,880 bank staff to cover shifts, a further 1,650 shifts were covered by agency staff (of which 57% were at the Epsom Hospital site) and a total of 2,453 (62% were at the Epsom Hospital site) were unfilled for this core service.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Nursing handovers took place at the beginning of each shift. We observed one handover. All nurses coming on shift attended and were allocated to specific area although there was flexibility to move staff as needed during the shift. Staff departed to receive patient specific handovers from the night staff who were going off shift. No information was shared about the level of activity of the previous shift or the numbers in ED. At the time, there were four patients who had waiting to be admitted (DTA) onto the wards. A more detailed handover was observed between the night and day nurse in charge which included an overview of breaches, staffing and patients.

Medical staffing
At the last inspection, the ED was not meeting the Royal College of Emergency Medicine recommendations, that A&E consultants should provide 16 hours of cover per day, seven days per week. The trust was still not meeting this recommendation; however, there was a minimum of 14.75 hours of consultant presence on weekdays, and a minimum of 12 hours at the weekend. This weekend cover had increased from eight to 12 hours. Overall, consultant cover represented 87% of the RCEM’s recommendation. The trust had 12 WTE A&E consultants and was aiming to increase that to 16 WTE, in order to strengthen their staffing. Senior staff told us that funding was in place and there was an agreement to fund additional consultant hours if they were needed.

During weekdays, there was a consultant on site for a minimum of 8am-10:45pm, then on-call overnight providing cross-site cover. At weekends there was consultant on-site for a minimum of 10am-6pm at St Helier Hospital, then on-call providing cross-site cover afterwards.

At present there was an additional consultant on both sites from 2pm -10pm Friday to Tuesday.

Data provided by the trust indicated that 203 shifts at consultant level had been covered by locum, 544 by a doctor in training and 1,029 by a middle grade doctor during the year up to 18 October 2017.

We asked for medical staffing levels by site and were provided with the following information as of October 2017. The ED had 13 consultants who worked across both hospital sites, two foundation year 1 doctors, six foundation year 2 doctors, 12 speciality registrars, eight speciality doctors, two associate specialists and three physician associates.

This was complemented by a further eight acute paediatric consultants who provided a paediatric on-site presence in the ED until 10pm everyday.

The paediatric ED had a separate emergency paediatric consultant cover from 8am until 10pm Monday to Friday, 1pm until 10pm Saturday and Sunday. There was registrar and senior house officer (SHO) cover from 8am to 10pm seven days per week. There was a paediatric consultant on call across site. Medical staff advised that a paediatric A&E consultant had recently left and they were seeking to recruit.

The trust reported their staffing numbers below as of October 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>73.0</td>
<td>79.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

As at October 2017, the trust reported a vacancy rate of 37.7% in urgent and emergency care.

- St Helier Hospital: 53.7%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

As at October 2017, the trust reported turnover rate of 29% in urgent and emergency care.

- St Helier Hospital: 15%
Sickness rates

As at October 2017, the trust reported a sickness rate of 5.1% in urgent and emergency care.

- St Helier Hospital: 2.3%

Bank and locum staff usage

As at October 2017, the trust reported a bank and locum usage in urgent and emergency care. The trust used 2,900 bank staff to cover shifts, a further 136 shifts were covered by agency staff (of which 61% were at the Epsom Hospital site) and a total of 327 (46% were at the Epsom Hospital site) were unfilled for this core service.

Staffing skill mix

During August 2017, the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 54 whole time equivalent staff working in Urgent and Emergency Care at Epsom and St Helier University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>19%</td>
<td>28%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>30%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Junior*</td>
<td>26%</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

There were consultant led board rounds four times per day at 8am, 12 noon, 4pm and 10pm. We observed one handover. Patient management plans and treatment options were discussed in clinical priority. There was no hand over about the state of the department overnight, of seven hour waits, waiting times to DTA’s, The SWOOP team (a multidisciplinary service to support admission avoidance and early discharge) and nurse in charge (NIC) also attended the doctor’s board round. There was no joint handover with nursing and medical staff.
Records

We looked at 14 sets of medical records and seven care records patients admitted to the emergency department with mental health needs. The medical records were not completed consistently with gaps in documentation.

We found good practice in terms of recording allergies, NEWS and vital signs. However we found inconsistent documentation on pain scores, plans of care from ED doctors, no nursing notes for patients who had been in the ED a long time. We also saw that documentation lacked Waterlow and safeguarding assessments. We found one set of the notes that were illegible and some of the ED records did not have any patient details, which mean staff would be uncertain as to whether they belonged to a particular patient. One patient was known to be confused but this was not recorded on the front of their record this meant that porters or x-ray staff were not aware of this. In another set of records where an electrocardiogram (ECG) had been done there was no evidence of a medical signature to reflect that it had been reviewed, an hour after being done which was not best practice. (An electrocardiogram (ECG) is a simple test that can be used to check your heart's rhythm and electrical activity. Sensors attached to the skin are used to detect the electrical signals produced by your heart each time it beats).

Care records of patients with mental health needs showed that staff assessed patients within one hour, and completed consent to share information so that they could liaise with community teams and patients’ GPs. Staff referred patients to safeguarding when appropriate.

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. Paper records related to patients were kept at the nurse stations in the majors, minor and paediatric areas. In resuscitation where there was no nurse station, they were managed by the staff at each bay.

Patients were also registered on to an electronic system which tracked the patient’s journey through the department and flagged the time patients spent in the department to ensure that most patients met the four hour target to admit, discharge or transfer. The patients records detailed the time when the patient was first registered on the system, when patients were triaged, seen by a clinician, diagnosed and when a decision was taken to admit.

Vulnerable patients who were known to have dementia, a learning disability, special plans, a re-attender, has a history of violence were flagged on the system. We saw evidence that two patients had been flagged because of the needs.

A discharge summary was sent electronically to the patient’s GP for those that were discharged directly from the department. Medical staff told us that letters were generally turned round within 24 hours of a patient being discharged.

Medicines

Medicines were stored securely and were within their expiry dates. Daily fridge checks were undertaken and recorded as within the correct range. However, temperature records for medicines requiring refrigeration were incomplete. This meant that the trust could not be sure they were fit for use.
A fridge audit was undertaken in October 2017, with the UCC scoring 100% compliance against the five areas inspected. A&E resus, minor (which included majors) scored 80% and the paediatric A&E score 60%. No action plan was in place to address areas of non-compliance.

Controlled drugs were stored and managed appropriately. A controlled drug audit was undertaken in October 2017. A cross site action plan had been put in place which highlighted three areas to be addressed, as there was no target date for completion the trust could not be assured that the action points had been addressed.

In the paediatric ED we observed two cracked vials in the clean utility area where the medicines were stored that had not be disposed of correctly.

A trolley containing medicines commonly prescribed for discharge was stored securely in the ED. These medicines were given to people at the point of discharge to avoid delays in waiting for prescriptions to be dispensed. Staff told us this had reduced the time people had to wait for discharge.

Staff were aware how to report medicines errors and some gave examples of learning.

The trust had a medicines optimisation strategy, which set out its aims to improve the safety and outcomes achieved from the investment in and use of medicines by ensuring their utilisation in the most effective way.

On the staff notice board we saw a ‘medicines matters’ newsletter which was used to inform and reduce risk, improve prescribing and promote safer use of medicines.

**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 November 2016 to October 2017, the trust reported no incidents classified as never events for urgent and emergency care.

*(Source: NHS Improvement - STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with five (83% of total incidents)
- Pending review (a category must be selected before incident is closed) with one (17% of total incidents)
Three serious incidents related to St Helier ED all related to treatment delay meeting the SI criteria. Two of which resulted in the patients unexpected death. Both SI’s had been investigated and lesson learnt identified. A duty of candour lead for the investigation was identified to maintain contact with the patient’s families.

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 had a Duty of Candour and Being Open Policy and an identified Duty of Candour Lead

The trust had applied the principles of duty of candour 19 times in relation to ED services since October 2016 and September 2017

All clinical staff received an overview of Duty of Candour during trust induction. All clinically qualified staff; staff providing direct patient care and all non-clinical staff at Band 7 and above are required to complete on line training on joining the trust and thereafter update their training every three years.

The trust used an electronic incident reporting system widely used in the NHS to report incidents including near misses. Staff we spoke were aware of how to report incidents.

There were 196 incidents reported at the ED at St Helier between the 1st November and 31st December 2017. The highest number of incidents reported was pressure ulcers (66), care and treatment (16), staffing (14). The majority of incidents reported had been graded as no harm. Action taken at the taken at the time of the incident was also recorded.

Senior staff from the ED told us about the work they had undertaken to design and deploy a competency passport in response to previous incidents. This was designed to help embed learning, and reduce the risk of future incidents. We saw an example of this passport, which many staff on the department had already completed.

Staff told us that learning from incidents was shared. Staff had access to a folder which had details of incidents review and learning. A signatory page was in place for staff to evidence that that had read the reviews and the learning. Signatures seen were for 2017.
Medical staff provided and incident summary and learning sheet that had been emailed which detailed 13 incidents across site. None of incidents were dated and did not demonstrate what processes had been used to review. There were three issues still to be resolved. The document did not demonstrate a robust approach to reviewing and learning from incidents. Medical staff in the paediatric ED told us that following an incident of a missed fracture that a new system had been implemented to ensure all X – rays were reviewed by a radiologist.

Medical staff told us that there was no formal meetings for mortality and morbidity review within the ED. Mortality clinical reviews have been completed on all deaths within the ED’s across site. We saw that since November 2016 a total of 91 reviews had been completed. Senior medical staff advised that if the review identified poor quality care or learning they would be discussed as part of a mortality and morbidity review and if there was an incident it would be reported and investigated.

The trust had a new Reducing Avoidable Death and Harm (RADAH) Committee to oversee and co-ordinate work in this area. Meetings were held monthly with the purpose of receiving and reviewing reports to seek assurance from a number of sub groups with the purpose of identifying and providing recommendations on specific initiatives to improve service transformation, improving recognition and treatment of the deteriorating patient working towards the elimination of all avoidable in hospital mortality and ensuring transformational change meets clinical best practice. The trust provided minutes of RADAH meetings from 2017 which demonstrated the mortality dashboard was discussed as part of these meetings.

Major incident awareness

The trust had a major incident plan and major incident action card that had been reviewed in August 2017.

Staff working in the ED received specific training on dealing with major incidents; the programme was relevant and covered all aspects required. The re-training of ED staff was included as a control in place on the medicines risk register in October 2017 which indicated that the trust had employed 2 members of staff who are Chemical, Biological, radiological and nuclear (CBRN) trained and were taking the lead on training and exercises. A band 7 nursing team day in October focused on CBRN training and competency so that all senior staff were up to date.

The major incident cupboard within the ED stored emergency equipment, including decontamination equipment.

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 no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from October 2016 to October 2017 within urgent and emergency care.
Is the service effective?

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

Staff working in the ED had access to professional policies and procedures. Where relevant, these made reference to the Royal College of Emergency Medicine (RCEM), and other guidelines. Medical staff told us they were able to access these on the trusts intranet.

The trust had policies and procedures in place to meet the needs of people with mental health needs. The trust had a Service Level Agreement with the local mental health trust to help, to support staff in treating patients with a mental health illness, to train staff and administer the documentation of patients detained under the MHA.

The trust participated in the national reducing the impact of serious infections CQUIN for 2017/18 which was focused on sepsis. Data for quarters one 2017/18 indicated 150 ED patient records reviewed confirmed the individuals had sepsis. Of these, 124 were recognised and recorded as sepsis by the clinicians giving a percentage compliance of 83%. Data for quarter two 164 ED records were reviewed and 150 confirmed as Sepsis by the auditors. Of these 150 cases, 134 were recognised and recorded as Sepsis by the clinicians giving a percentage compliance of 89%.

Nutrition and hydration

In the ED we did not observe comfort rounds (a recommended approach in acute care for nurses to carry out regular check of a patient’s needs at regular intervals) and this included offering refreshments. However, following the inspection the trust advised that healthcare assistants provided refreshments to patients on a regular basis.

One set of notes we saw recorded that a person had been offered food and drink. One person we spoke old us they were gluten free so unable to have breakfast as they had no options form gluten free food so just had a cup of tea.

In the UCC, drinking water and vending machines were available so that people could access food and drink whilst they were waiting to be seen.

In the CQC Emergency Department Survey 2016, the trust scored 6.4 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey – September 2016)

Pain relief

At the last inspection we had concerns that pain scores were not routinely recorded and pain relief was not always being administered when prescribed. On this inspection we saw evidence that in patient records were found that pain scores tools were available but not always completed. Some of the patients we spoke with told us that they had been offered pain relief. One patient told us the
“nurse brought in painkiller to reception” however one patient told us they waited over an hour after it was prescribed before it was administered. The patient’s record confirmed this.

Patient group directives (PGD’s) were in place in the paediatric ED for pain relief to be given at the time of triage. The department held a list of nursing staff that had been trained to give medicines administered under the PGD’s and this audited regularly. PGD’s for pain relief, eye drops and anti-histamine were also given in the UCC by the streaming nurse. X-rays for limbs could also be requested.

In the CQC Emergency Department Survey, the trust scored 5.7 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.5 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<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>5.7</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>7.5</td>
<td>About the same as other trusts</td>
</tr>
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<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey – September 2016)

Patient outcomes

RCEM Audit: Moderate and Acute Severe Asthma 2016/17

In the 2016/17 Moderate and Acute Severe Asthma report, the trust met two of the standards for St Helier Hospital.

The trust was in the upper UK quartile for two standards:
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Trust: 80%; UK: 77%.
- Standard 5: If not already given before arrival to the ED, 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
    - 5b: Within four hours (moderate) Trust: 31%; UK: 26%.

The trust was in the lower UK quartile for three standards:
- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. Trust: 6.9%; UK: 19.3%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust: 35.3%; UK: 25%.
- 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
    Trust: 51%; UK: 52%. 
The trust’s results for the remaining two metrics were all between the upper and lower UK quartiles.

- **Standard 2a** (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Trust: 16.7%; UK: 26%.
- **Standard 5**: If not already given before arrival to the ED, 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
  - 5a: Within one hour of arrival (acute severe) Trust: 15.4%; UK: 19%.

*(Source: Royal College of Emergency Medicine)*

**RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 Consultant sign-off audit, the trust failed to meet any of the standards for St Helier Hospital.

The trust was in the lower UK quartile for one standard:
Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age. Trust: 33.3%; UK: 8%.

The trust’s results for the remaining one standard were all between the upper and lower UK quartiles.

Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Trust: 19%; England: 11%.

Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Trust: 0%; UK: 12%.

Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Trust: 5%; UK: 10%.

*(Source: Royal College of Emergency Medicine)*

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 severe sepsis and septic shock audit, the trust was in the upper UK quartile for none of the standards for St Helier Hospital

The trust was in the lower UK quartile for two standards:
- **Standard 2**: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Trust: 24%; UK: 64.6%.
- **Standard 5**: Blood cultures obtained within one hour of arrival. Trust: 2%; UK: 44.9%.
- The trust’s results for the remaining six metrics were all between the upper and lower UK quartiles.
• 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. Trust: 81%; UK: 69.1%.

• Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Trust: 36.5%; UK: 30.4%.

• Standard 4: Serum lactate measured within one hour of arrival. Trust: 64%; UK: 60.0%.

• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Trust: 56.6%; UK: 43.2%.

• Standard 7: Antibiotics administered: Within one hour of arrival. Trust: 53%; UK: 44.4%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Trust: 6.1%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

We asked for an explanation of the results and any factors which may have contributed to the ED at St Helier’s performance in relation to the RCEM audits in 2016/17. There was no real awareness of this data at senior nurse level and when we discussed with senior managers they too were not certain of the reasons. They suggested this was possibly as a result of data quality issue and data having been submitted mid-point. There was no formal process in place to review data before was submitted.

Unplanned re-attendance rate within 7 days

We asked for the unplanned re-attendance rate within seven days by site. For the period November 2016 to October 2017, St Helier’s re- attendance rate to the ED within seven days was 4.5 % which was similar to the to the national standard of 5%.

From November 2016 and October 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average in latest period, October 2017. Trust performance was 7.6% compared to an England average of 9.1%.

Unplanned re-attendance rate within 7 days - Epsom and St Helier University Hospitals NHS Trust

(Source: NHS Digital - A&E quality)
The unplanned re-attendance rate for St Helier ED within 7 days was 4,353 (4.63%) for the period November 2016 and October 2017.

Competent staff

The trust had appointed two practice development nurses (PDN); they had been in post for about three months. One PDN was allocated to each site but it anticipated that they would work closely. The roles had been developed to support and develop staff within the ED with regards to training, core competence and extending roles of nurses. It was planned that training would be provided in house so that staff could access this more easily and ensure that staff were fully compliance by spring 2018.

An induction process was in place for new starters and students in the ED. We saw new staff were completing induction books which were signed by senior staff.

The trust trained staff in the MHA and supporting patients with mental health needs. This training was delivered by the psychiatric liaison service which targeted staff in the emergency department as a priority. The trust did not provide data on how many staff members attended this training.

Appraisal rates

As of October 2017 28% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 80%.

The trust runs their appraisal period in quarter 4 of every year. This data was for quarter 4, 2016/17.

A split by staff group can be seen in the graph below:

Epsom Hospital had a 10% appraisal completion rate whereas St Helier Hospital had a 32.3% appraisal completion rate.
The hospital provided up to date details of medical staff appraisals for the period January to December 2017. Out of 38 doctors which included 2 who are on sabbaticals, 81.5% (31) doctors had completed appraisals. This met the trust target of 80%. Two doctors had permission to defer due to illness and five doctors were late in completing their appraisals. Two of the 5 should have had their appraisal in December 2016. However, it did not take place so carried over in to 2017. Medical staff we spoke with told us they had an annual appraisal.

Senior staff told us that WIRED IT system does not show true reflection of compliance within the ED. We were told that that out of 67 staff appraisals 45% (31) were still outstanding. This was below the trust target of 80%. Nursing staff we spoke with told us they had annual appraisals.

**Multidisciplinary working**

There was effective multidisciplinary working in the ED, nursing staff we spoke with told us there was good multidisciplinary working across the ED and this was confirmed by medical staff.

The SWOOP team (a multidisciplinary service to support admission avoidance and early discharge) supported the ED and attended the doctor’s board round to for referral to help facilitate potential early discharges.

Staff worked closely with the psychiatric liaison service, a mental health nurse was available at St Helier hospital through the psychiatric liaison service.

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 department and on-call if required. There was a middle grade doctor available 24 hour a day seven days a week.

Doctors were able to access diagnostic scanning. Imaging was available 24 hours a day, including portable x-ray. Images could be shared across sites. The trust used the Picture Archiving and Communications Systems (PACS)

A mental health nurse was available at St Helier hospital through the psychiatric liaison service between 9am and 11pm, seven days a week. An on call psychiatrist is available between 4.45pm to 8.30pm weekdays. The night doctor then takes the calls until 9am.

Pharmacy services are available 9am to 5.30pm Monday to Friday; 9am to 12pm on a Saturday; 10am to 12pm on bank holidays, and are closed on a Sunday. Outside of the pharmacy opening hours there is a pharmacist’s on-call covering the St Helier’s. On-call pharmacists were available out of hours for all requests for advice and supply of medicines that were not available in the emergency cupboard and for discharge medication. To facilitate discharge out of hour’s pre-packs of commonly prescribed medicines were available in the ED.

**Health promotion**
In the UCC there were three health promotion boards in place with information for patients which signposted them to other services. There was a range of leaflets about common illness and injury on display in waiting areas in the department but we did not see these given to patients.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust had a consent policy detailing what staff needed when seeking which obtaining 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.

In four of the records we reviewed we saw that evidence that mental capacity assessments had been undertaken and best interest decisions had been recorded as the people did not have the capacity to consent.

Senior staff told us that wired does not reflect the true level of compliance within the ED. Figures seen during the inspection for nursing and HCA’s were as follows: safeguarding adult’s level 2 was 89.5%, MCA and DoLS was 48%. Senior staff explained that the MCA and DoLS training was ran three times per year which made it difficult for staff to access.

The trust reported as of October 2017, that both Mental Capacity Act (MCA) and deprivation of liberty training (part of the Safeguarding Adults (Level 2) training module) has been completed by 37.3% of staff in within urgent and emergency care.

*(Source: Trust Provider Information Return P14/P49)*

At the last inspection, the trust was recommended to make sure that all relevant staff were clear on how a Deprivation of Liberty Safeguard authorisation (DoLS) should be used. During this inspection, we found that staff were able to state when a DoLS authorisation should be used and we found that DoLS authorisation documentation well filled out. Four out of six DoLS authorisations had a mental capacity assessment within the application.

Staff at St Helier Hospital spoke to the local authority DoLS lead every week concerning patients who are under a DoLS authorisation, to make sure that safeguards are in place to ensure patients who lack capacity are held under the appropriate legal procedure. The local authority DoLS lead visits the St Helier Hospital every two weeks to review patients who are waiting for a standard authorisation to be completed and to support staff to understand the procedure if necessary.

The trust applied for 238 Deprivation of Liberties Safeguard authorisations from the local authorities for the financial year 2016 to 2017. The trust did not provide information regarding the number of DoLS applications for St Helier hospital.

The trust trained staff in the Mental Capacity Act, Deprivation of Liberty Safeguards and caring for people with complex needs including learning disabilities. Trust wide compliance with this training was 96% as of 10 March 2017.

The trust had a safeguarding hub covering both hospital sites, which coordinated the efforts of staff in safeguarding, child protection, maternity, independent domestic violence and learning disabilities. The safeguarding hub had monthly meetings which include community leads in
agencies supporting people in these different areas. The hub supported staff to complete Level one and Level two safeguarding training which covered the Mental Capacity Act and DoLS. Mental Health training was delivered as a separate module and included suicide awareness.

There were two learning disability liaison nurses on site who support staff to deliver care to patients with learning disabilities. The learning disability liaison nurses support a referral management system to link with each GP in the local authority to make sure referrals of patients with learning disabilities have the appropriate care when they were admitted to the hospital.

Staff had links with autistic spectrum groups in the community to better support patients who have autism. The trust was currently developing a training module concerning autism so that staff have the skills they need to support patients.

**Mental Health**

From 1 December 2016 to 30 November 2017, the trust saw 8530 patients with a diagnosis relating to mental or behavioural disorders to St Helier hospital. Staff supported patients with mental health needs through the psychiatric liaison service and by hiring bank and agency mental health nurses. A mental health nurse was available at St Helier hospital through the psychiatric liaison service between 9am and 11pm, seven days a week.

The trust trained staff in the MHA and supporting patients with mental health needs. This training was delivered by the psychiatric liaison service which targeted staff in the emergency department as a priority. The trust did not provide data on how many staff members attended this training.

The trust ensured that when staff detained patients under the Mental Health Act (MHA), they filled out the correct paperwork and ensured that patients had their rights explained to them. We looked at three records of patients who had been detained under the MHA during the previous year. These were appropriately filled out and indicated that staff had to seek consent from patients before giving medication or treatment for physical health illnesses. The site administrator faxed over mental health documentation to the Mental Health Act office at the mental health trust and kept the originals.

The trust had policies and procedures in place to meet the needs of people with mental health needs. The trust had a Service Level Agreement with the local mental health trust to help administer the documentation of patients detained under the MHA, to support staff in treating patients with a mental health illness, and to train staff. Staff supported women with mental health needs through triaging them in the ante natal department and using a multi-agency approach to meet their needs. The total number of referrals to mental health services of women at any stage in their pathway was 517 for both hospitals.

**Restraint and restrictive practices**

Security and staff restrained patients if they posed a risk to themselves or others. The security staff covered Epson and St Helier hospitals. Security staff attended awareness training for Mental Health, Mental Capacity, Safeguarding and other courses provided by the trust. Security staff were trained in how to safely restrain patients who are vulnerable. The head of security attends regular
meetings with other departments in the trust and cascaded learning through security team meetings.

Before restraint was used on any patient, the responsible clinician filled out documentation to state under which legal framework the restraint is being used. The responsible clinician stated whether restraint was carried out under the Mental Capacity Act, the Mental Health Act, or under common law.

Security staff did not monitor or audit the use of restraint. Staff told us that restraints were logged as incidents on the incident reporting framework, Datix. However, when we looked at the Datix entries for the last year in the emergency, maternity, surgery, and ITU, it mentioned use of restraint four times. The forms from the security office showed that security were called to restrain patients 75 times during the past year. The trust did not formally monitor the use of restraint in the hospitals.

Senior staff at the hospital told us that rapid tranquilisation had not been used at the trust for the last three years; however, Datix entries for the previous year showed that staff recorded the use of rapid tranquilisation five times in the surgery and ITU. The Datix entries did not state whether staff safely monitored the patients after the rapid tranquilisation medication. The trust did not formally monitor the use of rapid tranquilisation or the staff compliance with NICE guidelines with regards to taking physical observations of patients after administering rapid tranquilisation. This meant that the trust was not monitoring whether patients were kept safe after the use of rapid tranquilisation medication.

Staff said that the trust did not use the security staff for monitoring or observing vulnerable patients, except for short periods of time (under two hours), while the trust located a mental health nurse to support patients, or while the patient awaited transport to another facility. However, the use of security staff for monitoring patients was not monitored by the trust.

Mental health nurses (RMN) on the wards supported patients with mental health needs where necessary. The trust did not hire mental health nurses and relied on NHS bank or agency RMNs. The trust gave inductions to RMNs coming to the hospital, and each ward supported the RMNs on the necessary procedures and policies. The psychiatric liaison team also provided a RMN to support patients in St Helier hospital.

**Is the service caring?**

Our rating of caring stayed the same. We rated it as good.

**Compassionate care**

Staff provided treatment and care in a kind and compassionate way and treated people with respect. Staff were seen to be very considerate and empathetic towards patients. However, we did observe that two patient’s privacy and dignity was being compromised with the patients having
their bloods and assessments undertaken in the resuscitation walk way due to lack of space in the resuscitation area.

We spoke with 19 patients and relatives, most of whose experience was very positive. Patients told us the “staff are all very nice, helpful and do a great job under tough conditions”, “staff are nice but staff generally very busy so difficult to get their attention” “staff in A&E are terrific” “very happy with service” “I have been here before with my partner before and they are very good” “staff very good and very friendly” and “the staff are excellent”.

Friends and Family test performance

The ED had Friend and Family Test (FFT) feedback forms and boxes located throughout the department. Results November 2017 were displayed in the department. A total of 918 patients had responded with 84% indicating they would recommend the service.

The trust’s urgent and emergency care friends and family test performance (% recommended) was generally worse than the England average from November 2016 to October 2017.

A&E Friends and Family Test Performance - Epsom and St Helier University Hospitals NHS Trust

(Source: NHS England Friends and Family Test)

For the period November 2016 to October 2017 a total of 7,973 patients responded with 86% of patients indicating they would recommend the service.

Emotional support

Staff showed a provided emotional support emotional support to patients and their families in addition to health care or treatment. They answered patient’s questions and provided reassurance when as possible. One patient we spoke with told us the “triage nurse was good, kind and knowledgeable”.

The ED had a relatives and viewing 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 with their loved one.

There was a hospital chaplaincy service, staff were aware of how to contact spiritual advisers to meet the spiritual 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 treatment. We observed doctors speaking respectfully and professionally about next steps. One patient we spoke with told us the “Nurse spoke to me and my daughter and she was very helpful”.

Emergency Department Survey 2016

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 23 of the 24 questions relevant to caring. The remaining question scored worse than other trusts, which was “Q39. Did a member of staff tell you about medication side effects to watch out for?”

<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>3.8</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>8.5</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>8.1</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>9.0</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>9.0</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>7.7</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>8.8</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>7.7</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</td>
<td>9.0</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>
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<td>----------</td>
</tr>
<tr>
<td>department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.8</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>9.0</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>6.0</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>8.3</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>8.5</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>8.9</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>9.2</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>4.1</td>
<td>Worse than 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>5.8</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>5.1</td>
<td>About the same as 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>6.0</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>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Is the service responsive?

Our rating of responsive improved. We rated it as good.

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

The hospital provides services to the local populations within areas of North East Surrey and the London Boroughs of Sutton and Merton. Services were planned working with the clinical commissioning groups, external providers and the local authority.

In meeting minutes we saw that there were plans expand the liaison psychiatry service with additional funding for an alcohol liaison nurse and band 8 psychologists.

Face to face translation and telephone interpreting services were available to staff where English was not their first language. Between the period 1st June to 30th November telephone interpreting services were used 17 times at St Helier Hospital.

**Meeting people’s individual needs**

In the UCC, patient waiting times were displayed every 10 minutes as part of a patient information presentation. However we found that the waiting times displayed were not correct. For example, at one time it stated there was a nine hour wait when there was a 5 hour wait. Waiting times were reliant on being updated manually every hour.

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 means that nursing staff, porters and x-ray staff have no easy way to recognise a dementia patient when caring for them. Whilst on inspection we observed a patient with confusion who had been placed in a side room. The patient was calling out. The patient was not visible to staff, had no nursing call bell, no identification to inform staff of his confusion. The trusts Dementia strategy 2015 – 2020 set out plans to extend dementia champion roles in the ED, however staff we spoke with were not aware of this.

The ED was not meeting the nation standard for all patients awaiting hospital admission should be placed on a hospital bed at 6 hours. We observed that five patients whose decision to admit (DTA) was for over 6 hours and they had not been placed on a hospital bed for comfort and skin integrity.

We raised this with senior staff at the time but they were unable to explain why this occurred.

On display within cubicles was an ED flow pathway which gave information about the patient’s journey through the ED. The picture flow chart detailed what care and tests a patient may need. The guide had pictures and was easy to read.

The ED had access to two learning disability liaison nurses on site who support staff to deliver care to patients with learning disabilities. The learning disability liaison nurses support a referral management system which link with each GP in the local authority to make sure referrals of

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*(Source: Emergency Department Survey September 2016)*
patients with learning disabilities have the appropriate care when they were admitted to the hospital.

From 1 December 2016 to 30 November 2017, the trust saw 8530 patients with a diagnosis relating to mental or behavioural disorders to St Helier hospital. Psychiatric support was available via the psychiatric liaison team and there was a designated room for patients with psychiatric needs in the ED.

The ED participated in the Sutton Vanguard scheme which gave vulnerable patients who are regularly admitted to the trust a red bag. This red bag contains all health information, the carers’ details, and current information from nursing homes or supported accommodation where appropriate. Sutton Vanguard held monthly meetings from different agencies, including the trust, to learn from incidents where the red bag did not contain current relevant information, or went missing. If staff noticed that patients had information missing in the red bag, they were able to phone a helpline which resolved the situation within the day. The Vanguard approach supported staff to ensure that delay in treatment and discharge was minimised.

Vending machines containing drinks, snacks and drinking water were available in the UCC reception area.

Emergency Department Survey 2016

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

<table>
<thead>
<tr>
<th>Question</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>7.4</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>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey September 2016)

Access and flow

The ED was operational 24/7 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 UCC. In the five week period from 30th November to 3rd January 2018, attendance at both services UCC and ED between 240 and 265 patients a day with between 56 and 63 ambulance arrivals.

The ED did have an escalation protocol in place to manage flow into the ED when the resuscitation and majors areas were full. Nursing staff we spoke with told us they always escalated to the site manager and executive team but they had to wait for beds. During the inspection on the 10th January we were advised there were no beds in the hospital and ambulance crews were queuing in the corridors to handover patients. In the morning on the 11th January we were advised by nursing staff that five patients had been bedded overnight in the UCC. Staff told us that this was the first time had happened. This affected the functioning of the UCC.
The UCC was short staff for two days over the course of the inspection with one nurse streaming patients. The plan was for two streamers during the day from 10am to 10pm. The longest wait we observed was for one hour which was longer than the 15 minute triage target. This was a potential risk for patients awaiting assessment and pain relief.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

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 ED.

The trust met the standard eight times from December 2016 to November 2017.

The trust breached the standard four times from December 2016 to November 2017.

From December 2016 to November 2017 performance against this metric showed a trend of stability compared to the national standard and better than the England average for the full period.

**Four hour target performance - Epsom and St Helier University Hospitals NHS Trust**

![Graph showing four hour target performance](image)

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

We asked for information on the number of breaches within the St Helier ED and were told that out of 94,064 attendances for the period November 2016 and October 2017 there were 4,768 breaches. This represented a performance of 94.9% overall.

Following morning handover on 10 January, we were told that there had been 32 breached before midnight and four breaches after midnight. There were four patients waiting to be admitted to the wards. There was a seven hour waiting time over night and at handover this was seven and a half hours. The site manager and on-call consultant had been informed. As the department had been deemed safe the on-call consultant did not come in.

We were informed after our site visit that the trust achieved just over 90% for ED for the whole of the week during which we undertook our inspection. This was one of the best in London and 5% better than the England average.
Whilst we were in the department 10 January at 2.30pm, we saw six patients waiting with ambulance crews; staff triaged all the patients within 15 minutes of arrival and deemed they were safe to wait. There were 10 patients the ED waiting for beds on the wards.

The trust’s operational plan for 2017-18 indicated that during the first six months of 2016/17 there had been a 4% increase in non-elective demand through the emergency departments on both hospital sites. To deal with this they implemented a patient flow transformation programme aimed at streamlining existing systems and processes to mitigate an increase in activity and effectively manage non-elective demand.

The trust’s bed management policy purpose was to produce consistent and widely understood trust wide approach in the effective utilisation of the trust’s bed stock. This included the national target of 95% of ED (Emergency Department) patients spending less than four hours in the department from arrival to admission. A separate target for stroke patients being admitted to a stroke unit with four hours of their admission was set at 90%.

We attended a morning site meeting which reviewed the flow of patients across the hospital. Nursing staff updated the meeting about potential discharges across the hospital. A white board was manually updated. We found that whilst staff were aware of the issues in the ED with four patients waiting to be admitted to wards, no plans were put in place to address this. This meant that patients waiting in ED had would have to wait in the department until beds on the wards could be found.

Senior staff reported that due to bed blocks on the wards they were frequently unable to move patients out of the ED.

Medical staff in the paediatric ED advised that they frequently had difficulty moving children from the ED to the paediatric assessment unit which meant that children who required admission to the hospital were delayed.

The site manager was responsible for assisting ED and assessment unit staff to access support services for patients who do not require hospital admission for clinical reasons but did require support to ensure immediate and safe discharge. They also updated the web-based Capacity Management Systems (CMS) used by the Emergency Bed Service (EBS), London Ambulance Service (LAS) and South East Coast Ambulance Service (SECAMB). In addition they monitored ED activity and supported the ED staff in anticipating admission activity throughout the day and night. They attended the ED huddles with the purpose of sharing information; however we did not see this during the inspection.

There was a service model for the paediatric ED which set out the pathway for children going through the department leading to admission or discharge. The model also set out details of the consultant cover within the department.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

From December 2016 to November 2017, Epsom and St Helier University Hospitals NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average. Performance against this metric showed a trend of stability over the period.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Epsom and St Helier University Hospitals NHS Trust**
Number of patients waiting more than 12 hours from the decision to admit until being admitted

No patients waited more than 12 hours from the decision to admit at St Helier’s ED in the period November 2016 to October 2017.

Over the 12 months from December 2016 and November 2017, one patient waited more than 12 hours from the decision to admit until being admitted in March 2017.

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-16</td>
<td>101</td>
<td>0</td>
</tr>
<tr>
<td>Jan-17</td>
<td>80</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>43</td>
<td>1</td>
</tr>
<tr>
<td>Apr-17</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>63</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>78</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>38</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From November 2016 to October 2017, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse to the England average.

From July 2017 to September 2017 performance against this metric showed a trend of improvement and then declined in performance. In October 2017 the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 4.8%, compared to the England average which was 2.9%.

Percentage of patient that left the trust without being seen - Epsom and St Helier University Hospitals NHS Trust

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

At St Helier’s ED 5.11% of patients left before they were seen for treatment for the period November 2016 to October 2017. This was higher than the England average of 2.9%.

Median total time in A&E per patient (all patients)

From November 2016 to October 2017, the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Performance against this metric showed a trend of decline. In October 2017 the trust’s monthly median total time in A&E for all patients was 174, which is worse than that of the England average which was 148.

Median total time in A&E per patient - Epsom and St Helier University Hospitals NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)
Learning from complaints and concerns

From November 2016 to October 2017 there were 129 complaints about urgent and emergency care services. The trust took an average of 88 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 35 days or 45 days for more complex ones.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

There were 76 complaints received concerning the ED at St Helier, 44 had the subject as all aspects of clinical treatment and a further 11 were reported about staff attitude.

Senior staff were aware that complaints needed better management and could provide an opportunity for learning. They advised that three people have been invited to attend training days in the ED. They consist of a mixture of complainants and relatives. Two of them have not taken up the offer. The relative of a patient will be attending a joint Acute Medical Unit and Emergency Department training day for nursing staff in February 2018.

Is the service well-led?

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

There was a clear senior management structure across Epsom and St Helier University Hospitals NHS Trust emergency departments. The leadership team worked across both sites. The ED’s were led by the clinical director and director of unplanned care. The ED was part of the medicine directorate and was supported by clinical leads, and the divisional head of nursing.

The paediatric ED came under the woman’s and children’s directorate, however the nursing staff were under the responsibility of the divisional head of nursing for the ED.
Staff we spoke with told us that senior staff were supportive. Senior nursing staff were visible on easily assessable for support and help. We observed that when the department became very busy that members of the executive team assisted in the ED.

Medical staff told us they felt supported and had access to study days.

The trust undertook exit interviews for staff leaving the trust. Between 1st January and 31st December 2017, three clinical and one non clinical staff from St Helier hospital responded. Leaving reasons were listed as retirement (2) and voluntary resignation (2).

The trust board’s ‘15 Steps Challenge’ walkabouts were monthly prior to board meetings. Both clinical and non-clinical areas within the trust were visited by executives and non-executives, and feedback from the visit was received as either part of the public board meeting or the public briefing. Any issues that were identified as requiring resolution were recorded in a tracker. Nine walkabouts had taken place between November 2016 and October 2017 covering different wards/areas within the hospital. The ED at St Helier had not been visited.

**Vision and strategy**

Plans to restructure ED to increase capacity been agreed, however senior staff were unable to give any time frame for this. Staff working in the ED appeared to be unaware of any potential changes to the ED department. Staff described the geography of the department problematic as they did not have to have an oversight of the department (majors, resuscitation area, CDU, observation bay, UCC and streaming).

**Culture**

Staff told us that they were starting to feel the effects as the ED had been extremely busy. Both medical and nursing staff described good team and peer support, and a commitment to delivering a service which met the patient needs. It appeared that staff had got used to having a full ED.

We saw multidisciplinary working which involved patients, therapists and community nursing staff working together to achieve good outcomes.

There were opportunities for further learning and development. Staff told us there was access to training and professional development. Band 6 emergency nurse practitioner posts were used as band 7 training posts. Some staff we spoke with had mentors and were mentees to junior staff and enjoyed that aspect of their role.

Minutes of band 6 and band 7 nurses meetings demonstrated that they were involved in how the department operated and defining their roles and responsibilities.

**Governance**

The ED was part of the medicine division which meant that the ED governance meeting was managed as part of the medicine division governance meeting. Urgent issues were raised to the Medicine Division Cross Site Clinical Governance Meeting in order to strengthen the overall divisional management of quality and governance.

We reviewed minutes from the Medicine Senior Divisional Management Team Meeting and the Medicine Division Cross Site Clinical Governance meeting these demonstrated that for example incidents, root-cause analysis, the risk register, complaints and shared learning were discussed.
Management of risk, issues and performance

The senior management team were aware of the challenges within the ED. They acknowledged that the sharing of information was not robust and could be better in particular the sharing of learning from incidents. There were plans to recruit a quality lead to take this forward.

The ED had recently introduced weekly performance meeting which looked at specific issues for the ED. A dash board had been developed which enabled the ED leadership team to monitor trends across the ED’s to help with the planning the flow through the department.

The ED risks were incorporated into the medicine divisions risk register. Five of the seven risks were identified related to St Helier which mostly identified what we found, however did not include the training IT system WIRED or the physical environment of the ED. Each risk was rated, had a review date and a named manager responsible for overseeing the risk. For each item on the risk register there were details of the actions taken to mitigate the risks. However, we saw that not all the risks had been reviewed within the last three months October 2017.

Risks related to the paediatric ED were incorporated in the risk registered for the children and young people’s service within the trust. We saw that there were at least three risks which made reference to the paediatric ED. We noted that whilst there was an initial and current risk rating assigned and the mitigations, there was no named person responsible for overseeing the mitigations or actions.

We found that not all the issues identified in the last inspection had been addressed for example ensuring that consultant hours in the ED were below the RCEM recommendations.

Information management

The department was able to monitor performance of accident and emergency and performance against the four hour target on a daily basis through and electronic white board.

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 then access to trust news, policies and procedures and their training and personal development records.

We were told that WIRED IT training system does not reflect the true level of compliance within the ED; however the senior staff were not aware of any plans to resolve this.

Engagement

There was little information for patients attending the emergency department about quality and performance.

Patients participated in the friend and family test to provide feedback on their experience whilst in the ED.

The trust runs a Patient First programme which had a mixture of 420 patients and local people signed up to offer their views and share their thoughts about the services the trust provides from a patients perspective.
In July 2017 the trust launched an involvement conversation: Epsom and St Helier 2020-2030. Based on previous estates engagement activities, it focused on gaining support for investment within the trust, including building a membership database to assist with further engagement activities.

**Learning, continuous improvement and innovation**

Frailty pathways were being developed with a view to in-reach to the Emergency Department at the St Helier site, through liaison between the Older Persons Assessment and Liaison Service and Care of the Elderly consultant teams.

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**Medical care (including older people’s care)- St Helier Hospital**

**Facts and data about this service**

Acute medicine – There are 38 beds at St Helier. The unit has rapid assessment hubs where admissions are managed. St Helier has a short-stay ward managed by acute medicine. Through capital investment the trust is expanding its medical ambulatory care services at both sites.

General inpatient medicine - Three wards at St Helier Hospital provided inpatient acute medicine services. The on-call rota is covered by 13 consultants at the hospital.

Elderly care - Four dedicated wards at St Helier, including a nurse/GP-led closer-to-home ward. There is a frailty assessment service on AMU.

Gastrointestinal - Specialist gastroenterology and endoscopy services was provided at the hospital.

Stroke – St Helier Hospital provided stroke units however, there were no 24/7 hyper-acute service.

Other key medical services:
Cardiology/Respiratory - St Helier has a ward that is 50% respiratory and 50% CCU. The Respiratory Team in-reach to the acute medical wards.

Haematology/Oncology – Inpatient services at St Helier. The hospital provided daily acute oncology services jointly with the Royal Marsden.

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**Is the service safe?**

**Mandatory training**

Subjects covered by all staff included child and adult safeguarding, information governance, infection prevention and control, fire safety, health and safety and trust values. Clinical and scientific staff had additional role specific mandatory training which included higher level
safeguarding training, responding to deteriorating patients, record keeping and more detailed infection prevention and control training.

As part of the hospital process for new starters, mandatory training was provided in different formats including face to face classroom training and e-learning, which offered the flexibility of access from any computer connected to the internet. This meant staff could complete certain topics after hours or at home if desired, however, other topics required attendance at a classroom session. Staff told us training was easy to access, via ward or library computers. Nursing and allied health professionals we spoke with said senior staff would ensure they were given the time to carry out the necessary training.

Medical staff mandatory training was below the hospital target of 90%. When we discussed mandatory training with staff, some staff were still waiting to complete their hospital induction and some said they found it hard to fit training in with their daily workloads as a result of staff shortages.

We were told that all new staff to the trust attended a corporate induction programme which included the majority of the mandatory modules and any outstanding mandatory training modules were expected to be completed by staff within two months of their employment.

Ward managers monitored staff compliance with mandatory training in different ways. Some wards had dedicated staff members to make sure staff had carried out training; other wards displayed a reminder to staff about outstanding training in the staff room.

Staff were aware of the mandatory training they were required to undertake. Bank nurses said they were provided with training. Clinical managers we spoke with showed us the systems they used locally to monitor attendance of their staff at mandatory training, to ensure training was completed or refreshed when necessary.

**Mandatory training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of October 2017 for medical/dental and nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Medical staff Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>79%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>76%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>75%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>66%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>66%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>64%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>57%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>56%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>47%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>24%</td>
</tr>
</tbody>
</table>
The medical and dental staff only met one of the 11 training with a completion above the trust target of 95%; the lowest completion was for information governance with 24%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>97%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>91%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>84%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>82%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>77%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>74%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>73%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>39%</td>
</tr>
</tbody>
</table>

The nursing staff met two of the 11 training with a completion above the trust target of 95%; the lowest completion was for information governance with 39%.

St Helier Hospital had a 74% mandatory training completion rate, met the trust target of 95% for one of the 11 modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

Staff had access to the trust’s safeguarding policy and knew how to contact the safeguarding team for advice and guidance when required. Staff demonstrated an awareness of the trust’s safeguarding procedures and knew the escalation process to raise a safeguarding concern. Staff were also knowledgeable about what safeguarding meant in practice. Wards and departments had systems in place for the identification and management of adults and children at risk of abuse. Trust protocols and guidance on safeguarding were accessible to staff and staff told us they would speak with a manager if they needed to raise a concern.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust had systems and processes in place to help staff identify and report concerns to protect their patients. Staff we spoke with had safeguarding training at the correct levels for their roles and were alert to any potential issues with adults or children.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as at October 2017 for medical/dental and nursing staff in medicine is shown below:
<table>
<thead>
<tr>
<th>Medical Module</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>70.1%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>58.3%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

The medical and dental staff did not meet any of the three safeguarding training with a completion above the trust target of 95%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>52.3%</td>
</tr>
</tbody>
</table>

The nursing staff did not meet any of the two safeguarding training with a completion above the trust target of 95%.

St Helier Hospital had a 71% safeguarding training completion rate, no modules met the 95% trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

There was a safeguarding policy in place which accessible to staff. Staff we spoke with could explain what they would do if they had a concern about a patient or their family member and they understood the correct process to follow. The trust safeguarding team was available during office hours for staff to contact should they have any safeguarding queries or concerns. Outside of these hours we were advised staff could contact on call managers who could then provide advice if required. The trust had a safeguarding hub covering both hospital sites, which coordinates the efforts of staff in safeguarding, child protection, maternity, independent domestic violence and learning disabilities. The safeguarding hub had monthly meetings which include community leads in agencies supporting people in these different areas. The hub supported staff to complete Level one and Level two safeguarding training which covered the Mental Capacity Act and DoLS. Mental Health training was delivered as a separate module and included suicide awareness.

There were two learning disability liaison nurses on site who support staff to deliver care to patients with learning disabilities. The learning disability liaison nurses support a referral management system to link with each GP in the local authority to make sure referrals of patients with learning disabilities have the appropriate care when they were admitted to the hospital.

Staff have links with autistic spectrum groups in the community to better support patients who have autism. The trust is currently developing a training module concerning autism so that staff have the skills they need to support patients.
Cleanliness, infection control and hygiene

Medical services had infection prevention and control policies readily available for staff to access on the trust intranet. Staff were aware of the policies and knew how to access them. These included waste management policies, which were monitored through regular environmental audits.

The medical wards and other areas of the hospital we visited were visibly clean and tidy. Signed cleaning schedules were visible on most of the wards indicating when cleaning had been done and when it was due. Staff followed the trust’s infection control policy, for example by washing their hands in between attending to patients, using personal protective equipment such as gloves and aprons, and adhered to the trust’s ‘bare below the elbow’ policy. Each ward we visited had single occupancy rooms where patients with infections could be isolated to stop the spread of infection. We saw evidence that hand hygiene and cleaning regimes were audited regularly. The outcomes of audits were sent to ward managers, where audit fell below that required trust target, these were flagged up and action plan developed to improve outcome.

The trust used the national colour coding equipment scheme for hospital cleaning materials and equipment, this reduced the risk of cross infection. We observed that the disposal of sharps, such as needle sticks followed good practice guidance on the majority of wards and sharps containers were signed and dated on assembly. Waste and clinical specimens were managed and disposed of in a way that kept people safe, including storage, labelling and handling.

Personal protective equipment and hand sanitising gel was readily available throughout wards and departments we visited. We reviewed seven items of clinical equipment and noted these to be clean and labelled. Staff also used labels to provide assurance that equipment had been cleaned and was ready for use.

Environment and equipment

The wards we visited were clean and tidy. The building itself was noted to be old but efforts were being made to refresh and refurbish it where possible. There was lots of building work going on within the hospital and this had caused severe restriction on the hospital environment.

Resuscitation equipment on each of the medical wards had been checked at least daily and the stored items were secure. However, they were cluttered and untidy, which could have impacted on ease of access when needed in an emergency situation. We saw each resuscitation trolley had a log attached to it for staff to complete. Records indicated that the majority of daily checks of resuscitation equipment had taken place on the wards we visited.

Medical equipment within the medical directorate was managed by the trust electro-medical engineering department. They maintained a database of all equipment identified by individual asset numbers. Staff told us the medical devices department coordinated the monitoring of equipment and calibration checks where necessary. All equipment including endoscopy equipment we checked had safety-testing stickers in date. Senior ward staff told us that there were processes for reporting defective equipment; they felt the service worked well and there were no delays in replacing or repairing equipment. Staff had access to the equipment they needed to care for patients and maintained and used it in a way that helped keep people safe. Staff told us pressure relieving equipment was available when required.

Staff provided patients at risk of developing pressure sores with appropriate pressure relieving mattresses and cushions. For those patients who were admitted into hospital with pressure sores
or developed skin damage whilst in hospital, access to higher specification mattresses were available through Tissue Viability Nurses or equipment stores.

**Assessing and responding to patient risk**

An early warning score system was used throughout the hospital to alert staff if a patient’s condition was deteriorating. This was a standard set of clinical observations such as respiratory rate, temperature, blood pressure and pain score; these were used for early detection of any changes in a patient’s condition and were documented within the trust electronic health information system, and on the whiteboard.

Risk assessments associated with falls, pressure ulcers, venous thromboembolic assessments (VTE), catheter and urinary infections were collated. The nursing documentation supported the completion of these records, as they were loaded onto the electronic whiteboard to assist doctors ward round and huddle meetings on the ward.

We reviewed 25 patient records and all had full nursing assessment completed within four hours of arriving on the wards. These included assessment of falls risk, malnutrition universal screening tool (MUST), pressure area risk assessment (Waterlow) and bed rails needs. The majority of patients had full risk assessments completed and reviewed regularly from admission to discharge.

Staff monitored changes in patients’ conditions using nationally recognised systems. Wards used different techniques to minimise risk and ensure patients were kept safe. Some wards put their patients together so that patients at higher risk who needed closer observation were placed in bays closest to the nurse’s station. Other wards had dedicated nurses in each bay who were responsible for the care and supervision of patients in that area only. Each ward used an early warning score system to identify patients whose condition was deteriorating. This would trigger intervention from the medical team or the critical care outreach team.

Patients at risk of deterioration were discussed in daily safety huddles and ward rounds, where members of the multidisciplinary team (MDT) gathered to review individual patient treatment plans and conditions. We also witnessed comprehensive handovers between nursing staff that discussed risks to particular patients and appropriate actions that could be taken to mitigate these. There was evidence of the use of the sepsis care bundle for the management of patients with presumed or confirmed sepsis. The trust had recently launched a new sepsis box and sepsis assessment framework which all staff were aware of and confident in using.

Staff across the wards had access to mental health liaison and/or other specialist mental health support if they are concerned about risks associated with a patient’s mental health. This was available, 24 hours a day, seven days a week. For patients who were thought to be at risk of self-harm or suicide, psychosocial assessments and risk assessments were completed.

**Patient moves per admission**

From October 2016 to October 2017, 27% of individuals did not move wards during their admission, and 43% moved once or more.

(Source: Trust Routine Provider Information Return (RPIR) P51 Bed Moves)

The hospital managed the transfer of patients internally, through the ‘Internal transfer policy’. This clarified the needs of patients transferred between wards or departments and the role and
responsibilities of trust staff. The transfer of deteriorating patients or those requiring specialist care from a different directorate was managed within the policy. The transfer of patients between hospitals was defined within the ‘Intra-transfer between hospitals policy’. Nursing staff reported good responses from medical staff when a patient’s condition deteriorated.

Nurse staffing

Shortage of registered nurses was a concern raised by senior staff and managers and was included on the directorate risk register. The trust had taken action to address the shortfall in staffing such as recruiting overseas nurses. We were told another recruitment drive was in progress at the hospital. Managers stated that planned staffing was generally met, although bank and agency staff were often required. Managers encouraged use of Bank staff as they were familiar with the ward processes and environment. Where agency staff were used, we were told they were added to the rota and booked in advance in an attempt to provide the ward with safe staffing levels with staff who had been orientated to the ward. We saw examples of correctly completed agency orientation sheets which confirmed this.

Staffing was a concern at the time of our previous inspection in 2015. During this inspection, we found that staffing was still a concern with some of the medical wards having high vacancy rates.

Planned staffing levels at the time of our inspection were mostly appropriate for the acuity and dependency of patients. The hospital used a system that allocated staff in advance based on predetermined nursing demand. They also used the system on the day to enter actual patient acuity and get the numbers of staff required in real time. Where patient dependency meant more staff were required, this was provided for via the use of bank and agency staff.

Nurse staffing due to vacancies and sickness continued to be challenging across medical services with nurse staffing levels on many occasions below 90%. The service had a forward plan in place and had taken actions to address the issue, mitigate risk, and monitor service provision to maintain safe care on the wards.

Most of the wards had nursing staff vacancies and data provided showed that there were occasions when the nurse staffing fill rates were less than 90%. There was a high reliance of staff working extra shifts to fill gaps. Additional band 4 staff who had received training in taking vital signs, observing patients and completing fluid balance charts were used to support nursing staff when there was a shortage in nursing staff on duty or when patient’s required additional support.

During our inspection we reviewed staff rotas on the wards and saw that the majority of shifts were filled as planned although there were occasions when agency and bank nurses had been used to help fill shortfalls and managers were working on the wards when they should have been attending to managerial duties. The majority of managers we spoke with told us that they felt the staffing skill mix was safe. However, one matron had concerns regarding staffing skill mix on some wards which she had raised to senior managers. Senior managers told us that experienced staff had been moved to the ward concerned, which was continually monitored.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust has reported their staffing numbers below for as of September 2017 for medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
There are 77.8 less WTE staff in place at the trust compared to what they had planned to provide safe care.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, the trust reported a vacancy rate of 26.7% in medicine compare to a trust target of 10%.

- St Helier Hospital: 34.9%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From October 2016 to September 2017, the trust reported a turnover rate of 16% in medicine; compare to a trust target of 12%.

- St Helier Hospital: 23%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From October 2016 to September 2017, the trust reported a sickness rate of 4.5% in medicine; compare to a trust target of 3.8%.

- St Helier Hospital: 2.2%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

From October 2016 to September 2017, the trust reported a bank and agency usage rate of 21% in medicine.

- St Helier Hospital: 25% bank and agency usage with 5,486 shifts unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)
Medical staffing

Information provided by the trust indicated there were medical staff shortages. Medical staff we spoke with told us they felt the impact of staff shortages and sometimes felt stretched especially if they had to cover a number of wards. However, junior doctors told us they felt supported by consultants and senior staff.

All medical wards had a dedicated level of medical cover on a daily basis. In the majority of clinical areas, consultants reviewed patients on a daily basis from Monday to Friday and all new admissions were seen by a consultant at weekends. Newly admitted patients received a timely review by a medical consultant and we saw ward rounds taking place. A consultant on-call system operated in the hospital. Junior doctors we spoke with told us they could access advice from a consultant at any time, and that, when required, consultants medically reviewed patients. Junior doctors told us they generally had good support from senior doctors and could access advice as and when needed.

At weekends patients on the medical assessment wards were reviewed by a consultant who also provided urgent cover and discharges for other wards from 8am to 9pm. Outside these hours, a consultant was on call and was within 30 minutes travel time to the hospital.

Medical handovers at shift changes were timely and comprehensive with detailed and relevant information shared prior to ward rounds with the consultants. Although invited to attend, senior nurses did so intermittently due to pressures and workload on their respective wards.

Information provided by the trust showed there were a number of patients being cared for in non-speciality beds (outliers) which may not be best suited to meet their needs. There was a dedicated consultant who reviewed and provided care to all outlier patients and those on the escalation ward from Monday to Friday 8am to 4pm. At all other times the on call consultant provided medical cover.

The trust has reported their staffing numbers below as of September 2017 for medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>176.9</td>
<td>182.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From October 2016 to September 2017, the trust reported a vacancy rate of 26.7% in medicine compare to a trust target of 10%.

- St Helier Hospital: 10.8%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From October 2016 to September 2017, the trust reported a turnover rate of 16% in medicine; compare to a trust target of 12%.
• St Helier Hospital: 11%
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From October 2016 to September 2017, the trust reported a sickness rate of 4.5% in medicine; compare to a trust target of 3.8%.

• St Helier Hospital: 1.0%
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
From October 2016 to September 2017, the trust reported a bank and locum usage rate of 33% in medicine;

• St Helier Hospital: 32% bank and agency usage with 491 shifts unfilled.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix
In August 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 193 whole time equivalent staff working in medicine at Epsom and St Helier University Hospitals NHS Trust. We have asked the trust to provide us with a site specific data, but unfortunately there was none available.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</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 (01/08/2017 - 31/08/2017)
Staff kept good records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. We looked at 35 sets of patient records which were multidisciplinary and we saw doctors, nurses and therapists contributed to a single document. We found that patient records and risk assessments were completed appropriately. Pain scores were reliably recorded, as were food and nutrition, falls risk assessments and cannula assessment records. The records were well maintained and easy to navigate. We reviewed 12 do not attempt cardiac pulmonary resuscitation (DNACPR) forms when reviewing medical records on the elderly care wards. These were easily accessed by staff and were fully completed; however, some of the records did not include evidence of discussion with family members.

All of the records we reviewed were signed and dated by staff and were legible. They were compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. The records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received.

Patient records were both electronic and paper. Paper records including care plans, fluid balance charts and intentional rounds were stored in a file at the end of the patients’ bed.

Medical and nursing records were not stored securely in all of the areas we visited. We saw that records were stored in an unlocked medical records trolley by the nurses’ station, and the nurses station was not manned at all times, meaning records were not always secure.

**Medicines**

Medicines policies and procedures were available on the trust intranet and links were available through the electronic prescribing system to guidelines and reference sources, such as the intravenous drug guide.

We visited ward B5 at St Helier Hospital. We found that medicines were not managed safely. Although medicines were stored securely, we found that bags of different intravenous fluids were stored together, mixed up. Controlled drugs were not always stored appropriately. The controlled drugs register did not always match the contents of the cupboard. Staff had not noticed this, but had told us they would investigate it. Some records within the CD register (book) had also been partially obliterated. We found expired medicines in the treatment room. We also found a used syringe out on the medicines preparation bench. We looked at prescription and administration charts for three people. People’s allergies were documented appropriately and there were no missed doses.

We checked that medicines, including controlled drugs were stored safely and securely in most of the wards except B5 as above. We looked at the controlled drugs registers on seven of the wards and saw weekly checks were fully completed on all wards in line with policy and best practice. We looked at the trust’s audits of controlled drugs and found these were in line with our findings on inspection.

All wards had systems in place for the safe handling and disposal of medicines. Ward staff told us pharmacists regularly visited wards and were available when they were required. We also checked the medication fridges and saw daily minimum and maximum temperature checks were completed on all wards. We saw action was taken when temperatures were not within an acceptable range.

All treatment rooms were locked and suitable locked cupboards and cabinets were in place to store medicines. There were suitable arrangements to store and administer controlled drugs (medicines that are required to be stored and recorded separately). Stock balances of controlled
drugs and patients’ controlled drugs were correct and two nurses checked the doses and identified the patient before medicines were administered.

**Incidents**

Matrons and ward managers we spoke with had a good understanding of incidents in their respective areas. Each ward shared learning and improvement actions from incidents in a variety of ways to make sure all staff received feedback, these included team meetings, handovers and safety huddles. Staff gave us examples of learning from incidents such as making sure information on each incident was documented appropriately to make sure staff were aware of the incident and actions learned.

All staff we spoke with were aware of how to report an incident and were clearly able to articulate examples of the type of things they would report as incidents. Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses and were fully supported when they did so. When something went wrong, investigations were conducted and lessons learned were shared with all staff. During our inspection we saw that feedback was routinely given and staff could give us examples of learning from incidents.

We reviewed the documentation of five serious incidents. We noted that all the incidents were subjected to a root cause analysis, improvement plans created and lessons learnt were shared with the relevant ward and staff. We saw examples of these investigations and noted they were sufficiently thorough, identified lessons learnt and actions to be taken. Staff told us, and we saw from meeting minutes, information regarding serious incidents was shared with the matrons and sisters who then reported anything to staff on the wards via, handover or departmental meetings.

Managers we spoke with had a good understanding of duty of candour, and senior staff were fully aware of their responsibilities under the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All nursing and medical staff we spoke with knew what the duty of candour was and that it was about being open, honest and transparent when things go wrong.

**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 November 2016 to October 2017, the trust reported one incident classified as a never event for medicine.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with two (33% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (17% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (17% of total incidents).
- VTE meeting SI criteria with one (17% of total incidents).
- Slips/trips/falls meeting SI criteria with one (17% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

Each ward we visited had a noticeboard displayed in a public area showing performance against the trust’s own safety and patient satisfaction targets, which included some safety thermometer data.

The information on the safety thermometer included prevalence of pressure ulcers, falls, venous thromboembolism (VTE or blood clots) and catheter-acquired urinary tract infections. The safety and patient satisfaction information on the noticeboards we saw included pressure ulcers, falls, MRSA and Clostridium difficile (types of infection), medication incidents, complaints and ‘Friends and Family Test’ returns.
We were told safety thermometer data was discussed at the monthly matrons’ meetings and reports sent to the patient safety committee which met monthly to discuss trends and themes and agreed action plans.

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 39 new pressure ulcers, 19 falls with harm and 74 new catheter urinary tract infections from October 2016 to October 2017 for medical services.

### Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at St Helier University Hospitals NHS Trust

**Total Pressure ulcers**

- **Total** (39)

**Total Falls**

- **Total** (19)

**Total CUTIs**

- **Total** (74)

*Source: Safety thermometer - Safety Thermometer Data for St Helier*

### Is the service effective?

**Evidence-based care and treatment**

The medical directorate carried out a range of both internal and external audits.
The trust had appointed staff responsible for the daily management of National Institute of Health and Care Excellence (NICE) guidance. This included the communication of guidelines and monitoring their implementation across the trust.

Wards were also auditing compliance with NICE guidelines at local level. We saw records showing that medical wards took turns to audit one another’s local performance and compliance on a monthly basis, on subjects such as the Sentinel Stoke National Audit Programme (SSNAP) and venous thromboembolism (VTE) assessments. Results of these audits were documented and validated by the Matron or Head of Nursing. Learning and action plans from audits were shared with staff regularly through the Ward Manager. For example on C3, there was a monthly Stroke meeting and communication of information from SSNAP every following week. Key information could also be shared with staff in daily ‘huddles’.

Practice Development Nurses and Clinical Nurse Specialists played a role in ensuring staff were up to date with any changes or new national guidance. Advanced Nurse Practitioners and Matrons were also available to support junior doctors.

Staff were able to access advice from and make referrals to specialist teams such as neuro-rehabilitation.

Clinical guidelines were in place to guide patient care for specific procedures and interventions. We saw evidence that clinical guidelines were written in line with best practice and referenced national standards. For example, the protocol that all patients over 65 years old were subject to a falls risk assessment.

Policies and procedure were available on the trust’s intranet page and staff were able to show us how to access them.

Joint Advisory Group (JAG) accreditation is a formal recognition that an endoscopy service is fully competent to deliver against specific measures, as identified by the ‘Global Rating Scale’ standards. The endoscopy unit had JAG accreditation.

The trust had run a Sepsis recognition and management improvement programme from August 2016 – 2017. This led to the use of Sepsis boxes in clinical areas, based on NICE guidelines, with tools for staff to use to identifying both red flag and amber flag sepsis. We saw that these boxes were available in clinical rooms in wards we visited.

Junior doctors told us they were participating in audit programmes, but there was no clear avenue for them to present data or findings.

**Nutrition and hydration**

Patient nutrition and hydration was supported by dietitians within the hospital. Patients could be referred for dietetic review if there were concerns about their weight and calorie intake. Staff we spoke with displayed knowledge and understanding of the importance of patients receiving sufficient nutrition and hydration.

Patients who had difficulties with eating and drinking could be referred to speech and language therapy for relevant assistance. Food menus had various food options including soft food, high-energy food and food suitable for patients with type two diabetes.
 Fluid balance charts were used to monitor the fluid intake and output for most patients. We saw evidence that these charts were put in place, completed and reviewed by staff at regular intervals. Malnutrition Universal Screening Tool (MUST) were used to assess patients nutritional needs. MUST assessments were also included in patient records and we found that these had been completed for most patients. Staff told us that MUST assessments were audited weekly and they could refer a patient to a dietitian if the MUST assessment displayed concerning results.

We saw patients were provided with jugs of water at their bedside and could access hot drinks at intervals throughout the day. There was a protected mealtime policy in place.

Pain relief
We observed staff assessing patient’s pain levels and taking appropriate actions to ensure pain relief was administered in a timely way. Patients told us that they had received appropriate pain relief when necessary.

Patient’s pain was usually managed via oral medicines or intramuscular injections. When patients were in a lot of pain, staff could refer the patient to the hospital pain team. We observed referrals to the pain team being discussed in board rounds.

Assessments of patient’s pain were included in a routine set of observations and as part of a ‘Patient Centred Care’ record in patient’s notes.

Patient outcomes

Relative risk of readmission

Trust level

From July 2016 to June 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in General Medicine had a similar expected risk of readmission for elective admissions
- Patients in Clinical Haematology had a higher than expected risk of readmission for elective admissions
- Patients in Nephrology had a lower than expected risk of readmission for elective admissions
- Patients in General Medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in Geriatric Medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in Nephrology had a lower than expected risk of readmission for non-elective admissions

Elective Admissions – Trust Level
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 – Trust Level

St Helier Hospital

From July 2016 to June 2017, patients at St Helier Hospital had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in General Medicine had a higher than expected risk of readmission for elective admissions
- Patients in Nephrology had a lower than expected risk of readmission for elective admissions
- Patients in Clinical Haematology had a higher than expected risk of readmission for elective admissions
- Patients in General Medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in Nephrology had a lower than expected risk of readmission for non-elective admissions
- Patients in Clinical Haematology had a higher than expected risk of readmission for non-elective admissions

Elective Admissions - St Helier Hospital

(Source: HES - Readmissions (01/07/2016 - 30/06/2017))
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 - St Helier Hospital

Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade D grade in latest audit, April 2017 to July 2017 for St Helier Hospital.

St Helier Hospital

This site does not routinely admit patients directly and as such there is a number of team centred performance domains are not applicable. There is a trend of decline over the two quarter period between January to March 2017 to April to July 2017 with a number of the domains moving down a performance rating.

<table>
<thead>
<tr>
<th>Patient centred Performance</th>
<th>Jan -Mar 17</th>
<th>Apr 17 -Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>E</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C</td>
<td>A</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team</td>
<td>C</td>
<td>D</td>
</tr>
</tbody>
</table>
Source: Royal College of Physicians London, SSNAP audit)

Overall Scores

<table>
<thead>
<tr>
<th></th>
<th>Jan -Mar 17</th>
<th>Apr 17 -Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

Source: Royal College of Physicians London, SSNAP audit)

**National Diabetes Inpatient Audit – St Helier**

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.
The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 67 inpatients with diabetes at St Helier Hospital, 84% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile two.

In St Helier Hospital, on average 0.31 diabetes specialist nursing hours per week were spent with each patient in 2016, which places this site in Quartile 1.

In St Helier Hospital, on average 0.30 consultant hours per week were spent with each patient in 2016, which places this site in Quartile 4.

In St Helier Hospital in 2016, 9.1 per cent of patients with diabetes received a diabetic foot risk assessment within 24 hours of admission, which places this site in Quartile 1. 9.1 per cent of patients received a diabetic foot risk assessment at some point during their hospital stay, which places St Helier Hospital in Quartile 1.

In St Helier Hospital in 2016, 66.7 per cent of patients with diabetes experienced one or more medication error, which places this site in Quartile 4. 40.0 per cent of patients with diabetes experienced at least one prescription error, which places this site in Quartile 4. 51.1 per cent of patients with diabetes experienced at least one medication management error, which places this site in Quartile 4. Of the patients on insulin, 48.9 per cent experienced one or more insulin (prescription or medication management) error, which places this site in Quartile 4.

In St Helier Hospital in 2016, 51.1 per cent of patients with diabetes experienced at least one medication management error, which places this site in Quartile 4. Of the patients on insulin, 48.9 per cent experienced one or more insulin (prescription or medication management) error, which places this site in Quartile 4.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2014 to March 2015, 91% of nSTEMI patients were admitted to a cardiac unit or ward at St Helier Hospital and 37% were seen by a cardiologist or member of the team compared to an England average of 95.1% and 55%.

The proportion of nSTEMI patients who were referred for or had angiography at St Helier Hospital was 69% compared to an England average of 79%.

<table>
<thead>
<tr>
<th>2014/15</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
</tr>
</thead>
</table>
Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 0%, which was worse than the audit minimum standard of 90%. The 2015 figure was not available.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 30%; this is not significantly different from the national level of 24%. The 2015 figure was not available.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 20%; this is significantly worse than the national level of 64%. The 2015 figure was not available.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 11%; this is significantly worse than the national level of 69%. The 2015 figure was not available.

The one year relative survival rate for the trust in 2016 is 34%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017 – St Helier

The trust have a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 10% this below the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 13% this below the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 53% this similar to the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 88% this better than the national aspirational standard of 100%.

(Source: Royal College of Physicians)

On ward B6 a ‘hub’ had been developed to assess medical patients. Staff told us this prompt access to a senior decision maker had resulted in a reduced number of admissions.

Competent staff
We observed clinical practice, attended staff handovers, MDT and bed meetings and saw that staff across all medical services were competent and knowledgeable within their chosen wards.

Staff were competent and trained to carry out their roles and meet the needs of patients. Staff were supported to undertake professional training to enhance their knowledge and skills. For example, specialist training on caring for patients living with dementia, and one healthcare assistant told us they had received training on venepuncture.

Junior doctors we spoke with said they could access consultants for help and to escalate concerns where necessary. Junior doctors told us they could access their educational supervisor for regular meetings, and were able to obtain study leave.

Newly recruited staff told us they received an induction. The induction programme included an introduction to the trust and the mandatory training required by the staff to undertake their roles.

Staff in medicine received a local induction in their area of work. Staff told us a similar introduction to the ward would be provided for bank and agency staff, and they could escalate any concerns about bank or agency staff competence to their respective managers.

**Appraisal rates**

As at September 2017, 34.2% of staff within medicine at the trust had received an appraisal compared to a trust target of 80%.

A split by location can be seen in the graph below:

*Source: Routine Provider Information Request (RPI R) P43 Appraisals*

Most staff we spoke with told us they received regular appraisals which involved setting and measuring of objectives, and this was useful. Although the figures for appraisal rates for St Helier above show that the hospital is below target, at the time of our inspection the financial year had not yet elapsed. Some staff told us that they were not up to date on their appraisals because the ward was busy, and due to short staffing they did not have time to undertake their yearly appraisals.
Multidisciplinary working

The service had a well-established multidisciplinary team (MDT) approach to care provision. Board rounds were held on a daily basis on the medical wards, and were attended by staff from a number of professions and departments. We attended two of these daily board rounds, and two weekly MDT meetings. We saw that there was good MDT working between doctors, nurses, therapists and members of the Service Improvement team.

All staff we spoke with said that MDT working was positive. Therapists worked closely with ward staff to implement rehabilitation plans for each patient. We saw there was good communication between different professions, and contributions from all staff to MDT discussions were respected and taken in to account.

Staff told us that they worked closely with local social services to help facilitate patient discharge in a safe and timely way, and arrange packages of care.

Most wards were visited by a pharmacist on a daily basis and members of the pharmacy team checked drugs stock.

Seven-day services

A seven day services summary report issued by the trust showed that diagnostic testing and reporting was available seven days per week. Acute internal medicine had the highest percentage of patients receiving a consultant review within 14 hours both at the weekend and during the week (78% weekday, 94% weekend). Consultant-directed interventions were available seven days per week, mostly through a mix of on and off site arrangements through formal agreement.

However, minutes from the Trust Executive Committee meeting from December 2017 showed that out of hour’s reviews of patients was raised on the corporate risk register. To mitigate this the trust were considering the implementation of electronic tools for handover.

There was a trust strategy for cardiology service which required consultant review of patients 7 days a week and which specific sub-specialties are appropriate. At the time of our inspection, a locum consultant was being sourced for additional support.

The trust was phasing in 12 hours a day, seven days a week services for physiotherapy at the time of our inspection.

Access to information

Clinical staff were able to access electronic clinical and patient records from across the hospital, which required a secured staff log in. Staff were able to access diagnostic results such as bloods and imaging report to support the care and treatment of patients. Agency staff were able to access these systems through a temporary login provided by the site manager, which permanent staff had to request.

Staff had access to policies and procedures via the trust’s intranet page.

During handovers and board meetings staff discussed each patient using an electronic whiteboard, which had recently been implemented. This contained key information such as what assessments had been conducted and estimated date of discharge. It also incorporated a section for ‘Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)’ so staff could check whether
patients had their DNACPR status recorded. This would then prompt staff if patients’ statuses were not recorded.

**Health promotion**

We saw a range of health promotion leaflets across medical wards including smoking cessation, support for patients with cancer, and advice on a healthy diet.

Medical services were supporting national priorities, such as smoking cessation, dementia and cancer by offering support and advice. For example, the pharmacy had increased the number of products which could be used to help patients stop smoking, and patients could be referred to community drug and alcohol support services. Staff could access dementia specialist services to support patients living with dementia.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that as of October 2017 their mental capacity act (MCA) and deprivation of liberty training (part of their Safeguarding Adults (Level 2) had been completed by 47% of staff within medicine.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Nursing staff and HCAs told us that if they had concerns about a patient’s ability to consent they would escalate this to the Ward Manager and seek appropriate assessment for the patient. Staff reported that they attended both internal study days and external training on MCA/DOLs. Staff were familiar with Deprivation of Liberty Safeguards (DOLs) and we saw evidence of DoLS assessments and applications in use on medical wards. On a ward designed for patients living with dementia, we saw that charts recording patient’s behaviour were fully completed and held in patient’s records.

We reviewed six DoLS paperwork for patients. Four of them had a mental capacity assessment completed by the clinician attached to the paperwork. We spoke to four staff members who were able to explain when DoLS authorisations were considered for patients and how they would apply for an authorisation. Staff members stated that any nurse or clinician could assess a patient’s capacity for different aspects of medical treatment.

We reviewed the care of two patients who had mental health needs. We found that there was good communication between the psychiatric liaison team and the staff on the ward. The patients’ notes reflected the assessments by the psychiatric liaison team and had clear risk assessments attached.

**Mental Capacity Act and Deprivation of Liberty Safeguards**

At the last inspection, the trust was recommended to make sure that all relevant staff were clear on how a Deprivation of Liberty Safeguard authorisation (DoLS) should be used. During this inspection, we found that staff were able to state when a DoLS authorisation should be used and we found that DoLS authorisation documentation well filled out. Four out of six DoLS authorisations had a mental capacity assessment within the application.
Staff at St Helier Hospital spoke to the local authority DoLS every week concerning patients who are under a DoLS authorisation, to make sure that safeguards are in place to ensure patients who lack capacity are held under the appropriate legal procedure. The local authority DoLS lead visits the St Helier Hospital every two weeks to review patients who are waiting for a standard authorisation to be completed and to support staff to understand the procedure if necessary.

The trust applied for 238 Deprivation of Liberties Safeguard authorisations from the local authorities for the financial year 2016 to 2017. The trust did not provide information regarding the number of DoLS applications for St Helier Hospital.

The trust trained staff in the Mental Capacity Act, Deprivation of Liberty Safeguards and caring for people with complex needs including learning disabilities. Trust wide compliance with this training was 96% as of 10 March 2017.

MHA

From 1 December 2016 to 30 November 2017, the trust saw 8530 patients with a diagnosis relating to mental or behavioural disorders to St Helier Hospital.

Staff supported patients with mental health needs through the psychiatric liaison service and by hiring bank and agency mental health nurses. A mental health nurse was available at St Helier Hospital through the psychiatric liaison service between 9am and 11pm, seven days a week.

The trust trained staff in the MHA and supporting patients with mental health needs. This training was delivered by the psychiatric liaison service which targeted staff in the emergency department as a priority. The trust did not provide data on how many staff members attended this training.

The trust ensured that when staff detained patients under the Mental Health Act (MHA), they filled out the correct paperwork and ensured that patients had their rights explained to them. We looked at three records of patients who had been detained under the MHA during the previous year. These were appropriately filled out and indicated that staff had to seek consent from patients before giving medication or treatment for physical health illnesses. The site administrator faxed over mental health documentation to the Mental Health Act office at the mental health trust and kept the originals.

The trust had policies and procedures in place to meet the needs of people with mental health needs. The trust had a Service Level Agreement with the local mental health trust to help administer the documentation of patients detained under the MHA, to support staff in treating patients with a mental health illness, and to train staff.

Staff supported women with mental health needs through triaging them in the ante natal department and using a multi-agency approach to meet their needs. The total number of referrals to mental health services of women at any stage in their pathway was 517 for both hospitals.

Restraint and restrictive practices

Security and staff restrained patients if they posed a risk to themselves or others. The security staff covered Epsom and St Helier Hospitals. Security staff attended awareness training for Mental Health, Mental Capacity, Safeguarding and other courses provided by the trust. Security staff were trained in how to safely restrain patients who are vulnerable. The head of security attends regular
meetings with other departments in the trust and cascaded learning through security team meetings.

Before restraint was used on any patient, the responsible clinician filled out documentation to state under which legal framework the restraint is being used. The responsible clinician stated whether restraint was carried out under the Mental Capacity Act, the Mental Health Act, or under common law.

Security staff did not monitor or audit the use of restraint. Staff told us that restraints were logged as incidents on the incident reporting framework, Datix. However, when we looked at the Datix entries for the last year in the emergency, maternity, surgery, and ITU, it mentioned use of restraint four times. The forms from the security office showed that security were called to restrain patients 75 times during the past year. The trust did not formally monitor the use of restraint in the hospitals.

Senior staff at the hospital told us that rapid tranquilisation had not been used at the trust for the last three years. The trust told us prior to the inspection that it did not formally monitor the use of rapid tranquilisation. This meant that the trust was not monitoring whether patients were kept safe after the use of rapid tranquilisation medication.

Staff said that the trust did not use the security staff for monitoring or observing vulnerable patients, except for short periods of time (under two hours), while the trust located a mental health nurse to support patients, or while the patient awaited transport to another facility. However, the use of security staff for monitoring patients was not monitored by the trust.

Mental health nurses (RMN) on the wards supported patients with mental health needs where necessary. The trust did not hire mental health nurses and relied on NHS bank or agency RMNs. The trust gave inductions to RMNs coming to the hospital, and each ward supported the RMNs on the necessary procedures and policies. The psychiatric liaison team also provided a RMN to support patients in St Helier Hospital.

Is the service caring?

Compassionate care

We observed nursing, medical, therapy and non-clinical staff interacting with patients in a genuine caring manner. This included addressing patients by name, actively listening, recognising each individual, and coming to the patient’s level when they were in beds and chairs. Patients described feeling safe and that they could always get assistance from a member of staff when needed. We observed patients using their buzzers and staff responded to these quickly.

We observed staff speaking gently with patients, giving them time and repeating the information patiently when patients were confused or anxious. This included all professions and job roles including porters and a phlebotomist.

Patients explained to us that staff maintained their privacy and dignity and always informed them of any care delivery or procedure in advance. The majority of the wards we visited had set visiting times to ensure meal times were protected. Staff authorised visiting outside these hours to assist in individual circumstances. Staff enjoyed telling us of positive feedback received from patients and family members and most wards we visited displayed ‘thank you’ cards.

We observed nursing staff being very attentive to patients and calling them by their preferred name. Patients told us call bells were answered promptly unless the ward was very busy and
under staffed. Staff were watchful of patients who wanted to move around independently but could be a falls risk.

Confidentiality was respected and maintained with curtains drawn during private conversations. Patients made comments about the kindness of staff such as, “From the minute I walked through the door, the staff have been very kind” and “I felt like a nuisance, wasting their time, but they never make you feel like it; they are so sweet and tender. They told me they had a bed for me and not to worry about anything.”

**Friends and Family Test performance**

The Friends and Family Test response rate for medicine at the trust was 26% which was similar to the England average of 25% from October 2016 to September 2017.

The number of responses to the Friends and Family Test was above the England average at 26% as compared to 25% nationally. The percentage of patients recommending all medical wards was above 90% in April 2016 for medical services. We noted on all the wards we visited that the Friends and Family Test response rates were low, however, responses were positive.

**Friends and Family Test – Response rate from October 2016 to September 2017 by site.**

![Bar chart showing Friends and Family Test response rates](chart.png)

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff empathised with patients who were frightened and concerned about their health and being hospitalised. We observed genuine warm and caring interactions. Staff explained to us, when caring for a patient they considered all aspects of their particular needs from physical deficit to emotional and social elements that may affect their holistic well-being.

Staff informed us patients received emotional support from a variety of sources including chaplains and volunteers. We observed staff at all levels recognising patients who required emotional support. We observed cleaning and housekeeping staff take time to spend with patients who wanted to talk.

We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care, and these staff offered appropriate support to patients and their families.
in relation to their emotional needs. We saw that staff took a holistic approach to their patients and in MDT meetings considered both their physical and psychological needs, seeking referral to the mental health team where appropriate.

Patients informed us staff tried their best to make the hospital environment as normal as possible and we observed a number of patients had their personal belongings with them. Staff offered patients and relatives private areas if they wanted time away from their bed area to discuss personal matters.

There was a non-denominational hospital chaplaincy service, which provided pastoral support for patients and their relatives, carers and staff. The chaplaincy were available 24 hours a day throughout the week and could be contacted by staff, relatives or carers through the hospital switchboard. The chaplaincy team visited wards and provided spiritual and emotional support to patients, staff and relatives.

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

Patients felt they had a good understanding of the plans for their care and treatment and they were kept informed of developments and changes to the plan. One person who did not feel they were initially kept informed said that after their family spoke to staff they had been fully informed.

Patients told us staff explained things fully, in a way they could understand. For example, a patient said the physiotherapist had explained the exercises they needed to do, and informed them they would check with them again before discharge. Another person told us they had received good information about a low potassium diet from the dietician.

Information boards on each of the wards provided families and visitors with details of protected mealtimes, visiting times and staff uniforms. Patients, families, carers and visitors said they were able to ask questions, and if staff did not know the answers they would find out or find someone with the information to talk with them.

All the patients we spoke with knew why they had been admitted and knew their treatment plan including when they would be discharged. One patient told us ‘they (doctors) ensure that he always understand what they were saying’. A few relatives told us they did not receive enough information and one patient felt their condition had not been diagnosed correctly. Otherwise, people we spoke with felt their treatment was explained in a way they could understand.

Ward rounds were appropriate with interaction between the doctors and the patient explaining what they had reviewed. Staff were introduced to the patient at the beginning. Most of the patient note review was done outside of the bay so it did not seem doctors were talking about the patient without involving them.

**Is the service responsive?**

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

**Average length of stay**

**Trust Level**

From August 2016 to July 2017 the average length of stay for medical elective patients at the trust was 5.9 days, which is higher than the England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.6 days, which is higher than the England
Average length of stay for elective specialties:

- Average length of stay for elective patients in Nephrology is lower than the England average
- Average length of stay for elective patients in General Medicine is higher than the England average
- Average length of stay for elective patients in Gastroenterology is lower than the England average

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in General Medicine is higher than the England average
- Average length of stay for non-elective patients in Nephrology is higher than the England average
- Average length of stay for non-elective patients in Geriatric Medicine is higher than the England average

**Elective Average Length of Stay – Trust Level**

![Bar chart showing the average length of stay for elective specialties across different trusts and England, with the top three specialties noted for each trust based on count of activity.]

**Non-Elective Average Length of Stay – Trust Level**

![Bar chart showing the average length of stay for non-elective specialties across different trusts and England, with the top three specialties noted for each trust based on count of activity.]

**St Helier Hospital**
From August 2016 to July 2017 the average length of stay for medical elective patients at St Helier Hospital was 6.3 days, which is higher than England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.0 days, which is higher than England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in Nephrology is lower than the England average
- Average length of stay for elective patients in General Medicine is higher than the England average
• Average length of stay for elective patients in Gastroenterology is lower than the England average

Average length of stay for non-elective specialties:

• Average length of stay for non-elective patients in General Medicine is higher than the England average
• Average length of stay for non-elective patients in Nephrology is higher than the England average
• Average length of stay for non-elective patients in Clinical Haematology is lower than the England average

**Elective Average Length of Stay - St Helier Hospital**

![Elective Average Length of Stay - St Helier Hospital](chart1.png)

*Note: Top three specialties for specific trust based on count of activity.*

**Non-Elective Average Length of Stay - St Helier Hospital**

![Non-Elective Average Length of Stay - St Helier Hospital](chart2.png)

*Note: Top three specialties for specific trust based on count of activity.*

Senior leaders had acknowledged that a high number of their admissions were for older people; therefore there was an increased need for elderly care consultants within the hospital. This led to new care of the elderly consultants being recruited to develop the service for frail older people.

Our inspection visit and ongoing engagement with the trust showed better cross-site working than was described in our previous inspection report. The trust had aligned clinical directors to medical specialties that were provided at both sites to enable cross site interaction to take place.

Between October 2016 and September 2017 the trust reported no mixed sex accommodation breaches. A mixed sex breach occurs when a male and female patient were cared for in the same clinical area. During the inspection we saw no mixed sex breaches.
There were relatives’ rooms and quiet rooms available on medical wards for relatives and patients to use. Visiting times on medical wards were generally between 2pm and 8pm, with protected times scheduled for meals.

We visited the recently refurbished Ambulatory Care Unit. Ambulatory care is a patient focused service in which treatment can occur without the need for an overnight stay on the wards. Patients were risk assessed and were able to start their treatment using this unit. This also helped to improve bed access on the wards.

Meeting people’s individual needs

At the time of our inspection, the hospital was undergoing significant building work, in an effort to improve the ageing estate of the hospital site. Although not fully accessible in all areas, the hospital was mostly accessible to wheelchair users via paved surfaces, ramps and lifts. The trust was liaising with stakeholders throughout estates work to drive towards achieving the Disability Discrimination Act 2010 fully accessible building requirements. There were blue badge parking spaces available in several places in the hospital car parks.

Staff were able to access telephone and face to face interpreter services for patients whose first language was not English. We observed posters which clearly showed that information was available in different formats or languages as required. The trust told us that deaf patients were provided with British Sign Language interpreting services (and braille material) at consultations or discussions around care.

Across the wards we saw there was a ‘Carers Charter’ in place which enabled carers to produce a card to identify themselves as a patient’s carer and visit during a wider range of hours.

Patients living with dementia were identified using the ‘Forget me not’ symbols, and ‘This is Me’ documents in patient notes, to ensure staff had access to a patient’s biographical history, likes and dislikes. We saw that ‘This is Me’ documents were in use on wards, although not all of these had been completed (by family members).

There was an Older People’s Assessment and Liaison (OPAL) team, and staff were able to refer to the OPAL team if they required support for patients living with dementia.

However, not all care of the elderly wards were dementia friendly. For example C2 was meant to be a ward for the care of patients living with dementia. However, there were plans for it to be turned in to an escalation ward once all patients had been discharged, although they were still accepting admissions.

There was a learning disability CNS within the trust who staff could access if required. Patients were flagged as having a learning disability through the presentation of their Health Passport, used by local patients with a learning disability. The Learning Disability team would be informed and the CNS would visit the patient on the ward daily.

Relatives and patients had access to a multi-faith chaplaincy service and we saw information on how to access this was displayed in medical wards. We saw that various services were available for different religious beliefs.

On C3 we saw that there were some groups and activities available for patients and their relatives, such as a lunch club for those who enjoyed eating their meals in a social environment, visits from a Pets as Therapy (PAT) dog, and a stroke education group for friends and family.
Patients were mostly happy with the ward environments but some patients told us that they felt they were not able to access activities and social interaction. For example one patient said “I seem to be spending too much time in bed rather than walking around or doing things.” Another patient told us “it is a shame there is no community on the ward.”

Most patients we spoke with were happy with their food choices on the ward. We reviewed patient menus and saw a range of options for specialist diets including vegetarian, low salt, gluten free, cultural and softer options. Catering staff were knowledgeable about special diets and could explain the use of different coloured trays to identify patients who required support with eating.

**Access and flow**

Patients accessed medical services after becoming unwell at home and being admitted via the emergency department or through booked admissions for planned treatment.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From October 2016 to September 2017 the trust’s referral to treatment time (RTT) for admitted pathways for medicine patients treated within 18 weeks showed a similar trend versus the England average.

![Graph showing referral to treatment times](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

One specialty was 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>Rheumatology</td>
<td>96.1%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

Three specialties were 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>Geriatric Medicine</td>
<td>95.6%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.9%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>93.8%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

At the time of our inspection, the hospital was experiencing increased winter time demand for medical services. Staff worked hard to meet this demand through the use of escalation wards.
Medical outliers, where a patient was not placed on the appropriate speciality ward, were tracked throughout the hospital. Staff told us daily safety huddles and shift handovers discussed outliers to ensure appropriate actions were followed up. We observed a handover and saw that this was the case.

Staff told us that planning for a patient’s discharge commenced on admission. We saw discharge was discussed in handovers, board rounds and MDT meetings. Staff could seek advice from the discharge team who carried a bleep.

On some wards non-clinical staff worked in a support role to the lead nurse to help allocate beds. Staff said this helped to ensure clinical staff could better assist patients during periods of short staffing.

Patients who required a mental health assessment were referred to the psychiatric liaison service.

Learning from complaints and concerns

Summary of complaints

From November 2016 to October 2017 there were 166 complaints about medical care out of 577 trustwide. The trust took an average of 115 days to investigate and close complaints, this is not with their complaints policy, which states complaints should be 35 days or 45 days for more complex complaints.

- St Helier: There were 102 complaints, the main themes relate to all aspects of clinical treatment with 44 complaints followed by 20 related to admissions, discharge and transfer arrangements.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We saw information and leaflets on how to make a complaint and the Patients Advice and Liaison Services (PALS) service available across medical wards. Staff told us that if a patient or relative was unhappy they would try to resolve the problem at ward level. If this was not possible they would refer the complainant to PALS or to the relevant Consultant if it was a clinical issue. Senior medical staff reported that the PALS service was very supportive in facilitating meetings between patients, relatives and Doctors.

We saw evidence that complaints were shared with staff and learning opportunities were considered. We saw that there had been changes made following learning from complaints where trends and recurring themes were examined and that learning implemented. Staff were aware of the hospitals complaints process and said they were confident informing patient about the complaints process if approached.

Is the service well-led?

Leadership

We saw examples of strong local ward and department leadership. The trust had managers with the right skills and abilities to run a service providing high-quality and sustainable care. We found nursing leadership was generally good at ward manager and matron level, and when concerns had been identified additional support had been put into place. Staff said their ward managers were approachable and they were able to raise issues and concerns. Ward managers told us they felt listened to and supported.
All staff we asked were aware of how to access the whistleblowing policy. During our inspection we observed positive working relationships within all teams. Some staff commented that the hospital was going from strength to strength; that it was supportive and democratic. The majority of junior doctors reported they were supported by senior staff.

Nursing staff told us they felt well supported, valued and that that their opinions counted. At a local level, we saw that nurses in charge were clearly identified, which helped ensure local leaders were visible to staff and visitors.

Staff told us the leadership of the hospital were very visible. This included the chief executive and the lead nurse. Staff spoke of a noticeable change in the culture since 2016 and senior leadership were more accessible and visible on the wards.

All staff were aware of who the executive team and senior managers were and felt they were visible around the hospital. Senior managers told us that there was an open door approach and that they had a good working relationship with all staff across the trust including the executive team.

Vision and strategy

We noted that staff were engaged with the broader issues of the trust. For instance, they were aware of the trust 2020 - 2030 strategy and its relevance across services. There was a clear vision for the service. This was evident when speaking to staff at various levels of the service. The vision included continuous quality improvement, delivering excellent experience and outcomes for patients, reducing staff vacancy rate and staff turnover, increasing staff retention, and sustainability. All staff we asked were aware of the vision and mission and we saw these were displayed on the notice boards on the wards we visited.

The trust had strategies to achieve the above mentioned vision in medical services. The trust’s quality strategy plan “looking to our future 2020 – 2030”, set out how they would work to continuously improve the quality of the services provided by the trust. The strategy (2020-2030) set out how the trust would deliver excellent patient experience and outcomes in a sustainable way, including how they would recruit and retain staff to deliver great care to the people using the services.

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. We saw poster displays and other publications about the vision and values as we visited the wards. These were readily available for staff, patients and the public to view. In addition to information published for staff on the trust intranet, the trust published information about its mission, values and vision on its public website. Moreover, the trust had undertaken various public engagement exercises to inform service users and the public about their vision for the future.

Culture

Staff understood the need for openness and transparency and were knowledgeable about duty of candour. Staff felt they were fully supported by their peers and managers when errors had occurred and demonstrated that duty of candour had been applied. Staff described the culture within the medicine services as open and transparent. Staff could raise concerns and felt listened to by their managers, and they were visible and approachable.
Staff at all levels said they were encouraged to report incidents. Staff described a ‘no blame culture’ which encouraged the reporting of incidents and near misses. Across medical wards, we spoke with very passionate staff that were proud to work for the trust.

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with confirmed this and described how they felt appreciated and supported by the management. Staff spoke in positive terms about the team working with medical and specialist support to provide care.

Staff said they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an ‘open culture’ in which staff could raise concerns without fear.

**Governance**

The service had governance, risk management and quality measures to improve patient care, safety and outcomes. There was a clear governance structure in medical services. Senior staff from the medical division attended key governance meetings both divisional and trust wide.

The governance structure was led by the quality committee, which reported to the board (chaired by non-executive directors, with the chief nurse as the executive lead, supported by a medical director). Within the division, there were divisional clinical governance boards. These were chaired by divisional medical directors supported by the clinical governance team. The framework monitored quality performance and risk; including serious incidents, complaints and investigations.

Each division held its own risk register. These risks were documented and a record was maintained of the action being taken to mitigate the level of risk. We found that each risk had clearly defined mitigating factors and the date by which action was to take place was clearly stated. We found that senior staff were aware of the risks on the risk register and the service’s plans to mitigate risks.

Quality dashboards were maintained and these provided a range of key management and quality metrics that could be benchmarked against key performance indicators, for example, the rate of mandatory staff training in the medical directorate. We noted that performance information was displayed in ward areas on ‘How we are doing’ displays. These displays were accessible to staff, patients and their families. Some ward managers displayed additional performance data. Staff we spoke with were aware of this data and took an interest in their team’s performance.

Handover meetings, team meetings and managers’ meetings fed into the medicines governance meetings. These meetings were held monthly where local audits, performance indicators, serious incidents and complaints were discussed and action plans and implementation arrangements agreed.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The divisional risk register identified the risks for medical services, for example growth in non-elective demand, nurse recruitment and retention, and low medical staff numbers at night. The risk register had clear actions to mitigate risks and there were clear timelines for completion of actions. Risks were discussed at divisional governance and quality boards and changes in risk levels were highlighted in the register. Risks
recorded in the risk register for the service reflected the risks staff told us about during the inspection, showing that senior leaders were aware of the risks within their service.

There was a systemic programme of national and local audits to monitor quality and operational performance. For example, the service carried out local audits such as hand hygiene, and national early warning scores (NEWS). National audits included the heart failure audit, national audit of inpatients falls, and the Sentinel Stroke National Audit Programme (SSNAP).

There were displays on each ward providing details of the ward’s performance in relation to MRSA, Clostridium difficile, pressure ulcers and falls. A divisional scorecard was in place that reviewed key performance indicators such as length of stay, readmissions, activity, patient harm and referral to treatment targets. These were reviewed on a monthly basis; we saw evidence of actions to improve areas of poor performance. There were also ward specific dashboards on equipment, hand hygiene, catheters, cannulas, MRSA, pressure ulcers, medicines, NEWS, nutrition, resus trolleys, CDs, blood sugar, complaints, patient feedback and falls.

We were informed by the management team how governance and risk issues were cascaded to frontline staff through ward meetings, safety huddles and peer review. The service used quality measurement outcomes from such activity to identify areas for improvements in future initiatives. The medicine leadership team confirmed plans to develop future nursing leaders, reduce falls and review incident reporting via an improvement group looking at risk ratings and root cause analysis.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust’s website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.

Policies and protocols were available on the hospital’s intranet, which meant all staff had access to guidance when required. Clear and robust service performance measures including incidents, deaths and complaints were reported and monitored by senior managers. There were systems in place to manage data and maintain confidentiality, and staff had their own username and password to access hospital information system including NHS.net email system. During our inspection we observed staff logging on and off systems following inputting or reviewing data.

Board meeting minutes were also available on the trust’s website, along with dates of future public trust board meetings.

**Engagement**

The trust encouraged public engagement and offered a range of ways for the public to feed back their comments and help improve services. For example; the Friends and Family Test.

During our inspection and at focus groups we were told about and met with patients, their carers and the public who were actively involved in influencing trust strategy making sure the patient voice was heard. We were also told about patient’s stories, which is where patients write about the hospital experiences from their perspective. We were told how these stories were used for teaching and training purposes and to shape patient services.
The trust produced a newsletter and chief executive blog to update staff on current and future plans. We were told by staff on some of the medical care wards we visited, that senior staff produced a local ward newsletter which gave them information in their specialist area.

The trust took part in PLACE (Patient-led assessment of care environment) assessments. These are annual appraisals involving local people called patient assessors who visit hospitals to assess how the environment supports the provision of care. Areas looked at include cleanliness, food and hydration, privacy, dignity and wellbeing, environment appearance and maintenance, dementia, and disability. Results from this assessment are published by the NHS Digital and on the trust webpage and used to help drive improvements in the trust. The results from the 2016 survey saw results above the national average in all areas.

The trust engaged the public by using the Friends and Family Test. Results from November 2017 were displayed on information boards at the entrance of all wards. Visitors were encouraged to contribute to the FFT.

The 2016 staff survey showed that in comparison with other acute trusts on an overall indicator of staff engagement the trust's score was worse than the national average when compared with trusts of a similar type.

**Learning, continuous improvement and innovation**

Since the last inspection, the hospital had introduced an electronic whiteboard system enabling clinicians to capture patient’s vital signs electronically in association with the NEWS score, improving accuracy and aiding better patient care.

The division has rolled out the implementation of ‘safety huddles’. These real-time MDT meetings prioritised patient safety issues. The huddles promoted awareness of key themes such as falls and highlighted particular individual patient needs concerns surrounding safety risks. The forum shared lessons learnt from incident feedback.

Hospital patient deaths were reviewed at speciality level meetings. These meetings were overseen by a mortality lead for each specialty. Action relating to any issues in care, trends or notable learning was driven through divisional mortality review groups and the trust wide mortality surveillance group. The trust actively identified learning from both expected and unexpected deaths and used the process to improve outcomes where death was unexpected, and to improve care and services to patients where death was expected.

Electronic patient monitoring was being introduced to assist staff to recognise and promptly respond to deteriorating patients. Since the last inspection the hospital had launched a new sepsis box and sepsis screening tool to help staff diagnose and monitor suspected and actual cases of sepsis.

The hospital had set up a SWOOP team, made up of nurses, social workers and therapists, designed to speed up discharges without admission. The stroke ward held a number of initiatives such as communication group and a lunch group. Ward managers discussed with us the areas they wanted to improve and the aims they had set for the next quarter.

*Surgery- St Helier Hospital*

**Facts and data about this service**
The hospital has eight main operating theatres, covering colonoscopy, upper GI and endoscopy, laparoscopic, thyroidectomy, vascular and orthopaedic surgery.

There are five surgical wards at St Helier Hospital. Services provided across the wards include; endoscopy procedures, non-elective general, hip fracture, non-elective and trauma and orthopaedic surgery as well as a surgical assessment unit.

St Helier Hospital has 22 day case and 75 inpatient beds.

The trust had 31,173 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 3,860 (12 %), 19,742 (63 %) were day case, and the remaining 7,482 (25%) were elective. This data was not available for St Helier Hospital specifically.

Is the service safe?

Mandatory training

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of October 2017 for medical/dental and nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Medical staff Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>84%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>82%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>68%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>55%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>54%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>53%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>53%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>42%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>31%</td>
</tr>
</tbody>
</table>

The medical and dental staff only met one of the 11 training with a completion above the trust target of 95%, the lowest completion was for information governance with 31%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>96%</td>
</tr>
</tbody>
</table>
The nursing staff met three of the 11 training with a completion above the trust target of 95%, the lowest completion was for information governance with 60%.

Overall, St Helier Hospital had a 76% mandatory training completion rate, met the trust target of 95% for one of the 11 modules.

At the last inspection, the CQC requested that the trust should improve attendance at mandatory training.

However, senior staff explained that the mandatory training year was measured from April to April, on the electronic system for recording training completion. This meant that whilst a number of staff groups had not met the training targets in all modules, they still had a number of months to do so before the completion rate could be considered against the trust target.

Two ward managers expressed concern that the electronic system for recording mandatory training completion figures was not always accurate. One nurse told us that whilst they had recently completed a number of mandatory training modules, this had not yet been updated on the system. The potential inaccuracy of the data recording system was of concern as it meant senior staff could not be fully assured of training completion rates.

On the hip fracture ward (A3), the ward manager had recently introduced a system of teams, whereby each of the Band 6 nurses on the ward were responsible for ensuring the mandatory training for their team of Band 5 nurses and Healthcare Assistants (HCAs) was completed. Staff on the ward said that as this had only been recently introduced, they had not yet noticed an impact.

Nursing staff told us that they were given protected time to complete mandatory training. They said that they were not eligible to undertake bank shifts anywhere within the trust unless their mandatory training was up to date. They said that this worked as a positive incentive to ensure their training was completed. However, this had not had any real effect of the mandatory training completion records across the surgical directive as a whole within the hospital.

**Safeguarding**

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as at October 2017 for medical/dental and nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Medical Module</th>
<th>Average of Trust</th>
<th>Average of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>91%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>87%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>84%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>83%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>82%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>60%</td>
</tr>
<tr>
<td>Target (%)</td>
<td>Number of staff trained (YTD)</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>83%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

The medical and dental staff did not meet any of the three safeguarding training with a completion above the trust target of 95%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Average of Trust Target (%)</th>
<th>Average Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>44%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Nursing staff met two of the three safeguarding training target with a completion above the trust target of 95%.

Surgery at St Helier Hospital had a 75% safeguarding training completion rate and no modules met the 95% trust target.

However, as with mandatory training, senior staff informed us that the training cycle for safeguarding was not yet complete, with the period running from April to April, meaning that the department still had the opportunity to meet the target. Senior staff informed us that additional safeguarding training sessions were being planned for the near future. In addition, some staff, including managers and nursing staff, expressed concerns that the electronic system did not always update when they had completed their training and that, therefore, any safeguarding completion rate record may be inaccurate. The potential inaccuracy of the data recording system was of concern as it meant senior staff could not be fully assured of training completion rates.

However, all of the staff we spoke with had a clear understanding of the principles of safeguarding and when it was necessary to raise concerns. Staff had an awareness of female genital mutilation (FGM).

There was a named safeguarding lead for the hospital as well as a named nurse, doctor and midwife for child protection. However, a number of staff we spoke with were unable to name the safeguarding lead for the hospital and were not clear of the escalation process for safeguarding. Whilst all the staff we spoke with said they knew when to raise a safeguarding concern, not all were aware of the local process for doing so. Some said that they would raise the concern with their colleagues or line manager, whilst one said that they would “contact the hospital switchboard.” All staff said, however, that if they encountered a safeguarding concern they would make efforts to escalate it.

There was a trust wide policy for safeguarding which was available to all staff through the intranet. In addition, there was a separate children’s safeguarding policy. These had been independently ratified.

Safeguarding concerns were discussed at ward multidisciplinary team (MDT) meetings as well as at specific, hospital-wide safeguarding meetings, attended by social workers from the relevant local authority and other stakeholders.
Cleanliness, infection control and hygiene

The trust had an infection control policy and guidelines for staff. Staff were able to access this through the trust’s intranet.

The clinical areas we visited appeared clean and were tidy. “I am clean stickers” were in use on some equipment such as electrocardiogram (ECG) machines. However, their use was inconsistent across the hospital. We observed that there were dedicated staff for cleaning ward areas. The surgical wards we visited were clean and all patients we spoke with were satisfied with the cleanliness. There were cleaning logs in place.

Hand sanitising gel was available in all clinical areas and at the entrance and exit to all wards. There were signs asking staff and visitors to wash their hands, and clear guidance on best practice handwashing techniques displayed alongside the sinks and gel dispensers.

Clinical staff were ‘bare below the elbows’, in line with best practice to prevent the spread of cross infection. Throughout our inspection, we observed staff using hand sanitiser between patient interactions and when entering and leaving wards. In theatres, we observed staff following the World Health Organisation’s “Five Moments of Hand Hygiene” handwashing guidance.

Hand hygiene audits were held monthly to ensure staff were following The National Institute of Health and Care Excellence (NICE) QS61: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact and care.

On the wards, these audits were conducted inter-ward, 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.

We observed staff adhering to trust policies on the use of personal protective equipment (PPE). PPE gloves and aprons were available in each of the ward bays for use where appropriate and we observed their use by HCAs providing personal care. Throughout our inspection, we observed theatre staff wearing over-gowns when visiting wards or other hospital areas.

Staff had good infection control practices in theatre with regards to waste management, specimen handling, surgical techniques, and maintenance of sterile field. For example, all theatre staff stored personal belongings such as coats and bags in the changing rooms, and changed out of their outdoor shoes on arrival in theatres.

We observed staff cleaning theatre equipment appropriately between cases using neutral detergent or disinfectant wipes in adherence to the trust decontamination procedure.

There was a hospital-wide IPC nursing team. Nursing staff on the wards told us that the IPC team visited the wards regularly to carry out audits and training and to encourage IPC compliance.

Isolation rooms were available on all of the wards for patients suffering from or at increased risk of infection, this protected both the patient themselves as well as other patients on the ward. We observed staff using advanced PPE when entering the rooms of patients in isolation and the doors were clearly signposted to remind staff and visitors of this.

Throughout the hospital sharps bins with swing top, automatically closing lids were in use. All of the bins were signed and dated.

Patients were screened for meticillin-resistant Staphylococcus aureus (MRSA) on admission to the hospital. However, there was one case of MRSA within surgery in the period April 2016 to March 2017. This was a failure to meet the government’s target of no cases.
There had been two cases of Clostridium difficile (c. diff) between April 2016 and November 2017, meeting the government’s target of fewer than 37 cases.

The trust undertook surgical site infection (SSI) rate audits of orthopaedic, including spin and skull procedures and elective, day case and gastroenterology patients. In the period April to September 2017, there were six SSIs across 370 orthopaedic procedures, an SSI rate of 1.6%. There were no returns to theatre in this period as a result of SSIs within orthopaedic surgery. In elective, day case and gastroenterology surgery there were 68 SSIs across 2194 procedures, an SSI rate of 0.3%. There was one return to theatre as a result of an SSI within elective, day case and gastroenterology surgery.

Environment and equipment

Wards and theatres appeared clean and were clutter free. There was, however, an issue with the sterile surgical kits in theatres. Sterile surgical kits are labelled kits for a particular type of surgery, which should contain all of the equipment required for a particular operation. The majority of the kits in the store had components missing. Theatre nurses and operational department practitioners said that this was a longstanding issue and caused some frustration. They said that they frequently had to open a second kit to ensure that they had sufficient equipment, which was neither time nor cost effective. Theatre staff said that they had repeatedly raised the incomplete kits on the electronic reporting system, but many had given up doing so as the issue continued. We saw evidence of there having been 27 separately reported incidents relating to incomplete kits. They said that the missing components had not, to date, caused any patient safety issues, however, they acknowledged that this could potentially present a safety issue if an important component was missing and this was not realised prior to its being needed.

The sterile surgical kits were prepared by a private contractor, who was responsible for sterilising the equipment. The theatre management team said that they had been aware of the issue for over a year and that it was included in the risk register for surgery. They told us that the private contractor said that the missing components were the fault of the hospital, who returned the kits incomplete. Theatre staff maintained that this was not the case. One of the theatre managers had been meeting with a representative from the company on a weekly basis since September 2017 and, as of November 2017 there had been additional monthly meetings with senior hospital staff. Nonetheless, the issue remained the same at the time of our inspection in January 2018. When we raised the issue with senior staff, we were told that the meetings would continue to try to resolve the issue and that a theatre efficiency group would be commenced in February 2018, at which representatives of the contractor would be in attendance. We were told that, as an “interim measure” all theatre kits would be weighed upon their arrival at the sterilisation unit and again once they had been sterilised. Whilst this interim measure would ensure that no further components went missing from the kits, and would clarify where responsibility for the loss of components happened in the long term, it would not ensure that the kits as currently composed were returned to their full requirement of listed components.

The age of some of the theatre equipment was on the risk register. One of the clinical directors within the surgical division told us that they were currently going through the process of procuring new equipment for theatres. They said that the procurement process was comprehensive and effective and they were confident that the new equipment would be obtained in a timely manner. Bariatric surgical equipment was available.
The surgical wards were generally well laid out for the provision of care. Senior staff told us that there were plans in place to create a ‘surgical floor’ on which all of the surgical wards would be housed together on one floor as part of the ongoing refurbishment works at the hospital. However, a significant number of the staff we spoke to were not aware of this development. As part of the development a new surgical ward had opened, the Mary Moore Ward. This ward replaced Ward B5. The nurse in charge on Mary Moore told us that it was better laid out than B5 and more manageable, with only 24 as opposed to 31 beds. Despite the ward being new, there was a Controlled Drugs (CD) fridge on the ward that was not lockable. We spoke with a pharmacist and a matron about this. They said that a new fridge had been requested but that this would take some time to go through the procurement process. They were not clear how long the new fridge would take to be delivered.

There was a fully equipped resuscitation trolley on each of the surgical wards. This was checked daily and we saw evidence that these checks had been completed. On the Mary Moore ward the pads for the defibrillator machine had expired. We reported this to one of the nurses on duty. The following day the defibrillator pads had been replaced.

At the time of our inspection, there was an 8 bedded surgery escalation ward in within the day surgery unit in the Queen Mary’s Children’s Hospital, on site. This had been in use since November 2017. Although within a children’s ward, adult beds had been brought over to the unit. However, there was no adult resuscitation trolley on the unit. However, staff expressed concerns about the suitability of the environment. In particular, they were concerned that there had been patients in the unit under police custody, within the wider children’s hospital, which they felt was inappropriate. There were no adult toilets, commodes or washing facilities in the unit. Staff said that they had repeatedly raised concerns regarding the environment and equipment but no action had been taken.

Throughout the hospital, we observed oxygen cylinders stored in corridors, cubby holes and cupboards. The oxygen cylinders were not safely stored in frames or cages. This presented a risk of injury from cylinders falling on people or exploding. The oxygen cylinders were also vulnerable to theft.

**Assessing and responding to patient risk**

Pre-assessment for elective surgery took place at a designated pre-assessment unit at Epsom General Hospital. Patients were assessed for their suitability for surgery and anaesthetic staff told us all concerns were escalated to them via the pre-assessment notes. In our review of surgical notes, pre-assessment records were clear and detailed.

In theatres, staff used the World Health Organisation (WHO) five steps to safer surgery checklist. This is a checklist used before, during and after surgery to help minimise errors. At our last inspection in 2016, we raised concerns about the completion rate for the WHO checklist. The hospital carried out a detailed audit of the WHO checklist to enable trends to be identified, the 2017 audit indicated that there had been an improvement in compliance with the checklist since 2016.

We observed the WHO checklist being completed during a procedure. The list was fully completed, with all staff resent in the theatre fully involved. One of the Operational Department Practitioners (ODPs) told us that there had recently been a change to the WHO checklist, with
surgical divisional meetings. The WHO checklist was discussed in surgical divisional meetings. On surgical wards, nursing staff used a hand-held electronic device to input patient vital signs and observations into a centralised computer on the ward. Vital signs were measured and escalated using the National Early Warning Scores (NEWS). Patients with NEWS score at a certain level were referred to the critical care outreach team. The hospital audited the completion of NEWS scores on each of the surgical wards to identify the percentage of observations taken at night. Data was used to identify the percentage of breached observations by ward, to ensure the patients were having their observations done on time as per the NEWS policy. If there were high numbers of ‘breached’ observations this indicates staff are not taking observations appropriately and the matter was reviewed by the chief nurse. The results of the audits were then shared with ward manager and ward staff through the digital screens in the nurse’s stations. For the period June to December 2017, the SAU was the worst performing ward, with 23.8% of observations breached in December 2017. Staff on the ward told us that this was due to the number of patients on the ward, their acuity and a lack of adequate staffing. The best performing ward was A3, where the highest breach of the period was 11.6% in October 2017.

Patients had a documented risk assessment on admission to a ward. Risk assessments included a falls risk, manual handling assessment and a malnutrition universal screening tool (MUST) score. We saw that allergies were recorded for all patients admitted the wards and where a patient did not have an allergy, this was documented to confirm that the patient did not have allergies, as opposed to a failure to record. We also saw records of dementia assessments, frailty scores and falls risk. However, these were not always fully completed.

The trust audited the assessment of the venous thromboembolism (VTE) for patients admitted to the wards. There was a national target for 95% completion rate for VTE assessment. In December 2017, all of the surgical wards completed 100% of VTE assessments, with the exception of the SAU and B5 which scored 85.53% and 65% respectively.

We observed the use of anti-embolism stockings to mitigate the risk of VTE. In addition, pressure mattresses were used to reduce the risk of pressure sores. We saw occupational therapists (OTs) carrying out assessments of patients’ needs prior to their discharge from the wards. We spoke with two OTs, who told us that they worked closely with the hospital’s discharge team and the local authority to ensure that appropriate support mechanisms were in place for patients leaving hospital. OTs said that whilst they felt that their judgments were listened to, there were sometimes difficulties in ensuring arrangements were in place, particularly for patients living outside of the borough of Sutton.

Patients who required intensive or high dependency care after surgery were assessed to ensure a bed in the critical care unit (CCU) was available prior to surgery taking place.

There was a sepsis pathway in place, with clear guidance available to staff on the intranet to help them recognise and escalate patients suffering from sepsis. A number of the nursing staff that we spoke with were unaware of the sepsis pathway within the hospital.

Senior staff at the hospital told us that rapid tranquilisation had not been used at the trust for the last three years; however, Datix entries for the previous year showed that staff recorded the use of rapid tranquilisation five times in the surgery and ITU. The Datix entries did not state whether staff safely monitored the patients after the rapid tranquilisation medication. The trust did not formally
monitor the use of rapid tranquilisation. This meant that the trust was not monitoring whether patients were kept safe after the use of rapid tranquilisation medication.

**Nurse staffing**

The trust has reported their staffing numbers below for as of September 2017 for surgery. Please note that the trust did not provide a ward or department level breakdown for this information.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>311.11</td>
<td>285.07</td>
</tr>
</tbody>
</table>

There are 26 less WTE staff in place at the trust compared to what they had planned to provide safe care. All of the nursing staff that we spoke to, at all levels of seniority identified the staffing levels as the primary difficulty facing the service.

There was a shortage of nursing and medical staff across the surgical division. There were efforts in place to recruit additional staff. However, senior staff said that there was a shortage of qualified staff nationally.

Throughout our inspection, we saw the nurse in charge on wards being counted in the number of nursing staff, as opposed to their being supernumerary, in line with trust policy. Bank nursing staff were also used to fill shifts. Despite this, the established staffing numbers for safe care either failed to meet or were only being met through including the nurse in charge in the nursing number. We observed this on each of the wards we visited on at least one day of the inspection.

A number of nursing staff on the wards described the shortage of staff as ‘demoralising’. They said that they did not feel able to provide safe care as they were required to care for too many patients. Staff said that they were frequently moved between wards to ensure that shifts were filled, leaving their own wards short-staffed. In the SAU, staff expressed concern about the number of patients they were required to care for, one staff member told us that they had not been able to take their breaks on account of the workload. In addition, staff in the SAU were concerned that due to patients being admitted to the unit from throughout the surgical directorate, they were often required to provide care to patients of high acuity, meaning that they had less time to care for less acutely unwell patients. On the temporary surgical escalation ward in the Queen Mary’s Children’s Hospital, at the time of our inspection, there were only two nurses on duty to care for eight acutely unwell patients. In addition, the staff working in the escalation unit were isolated from the rest of the surgical nursing team. Since the inspection however, we were told that the temporary surgical escalation ward in the Queen Mary’s Children’s Hospital, had been closed.

The hospital employed an acuity tool to determine where there was most need for nursing staff within the hospital. This was reviewed daily at noon by the ward managers who then determined if staff should be moved. One of the nurses we spoke with said that they felt that this was “firefighting” and that they did not always feel listened to regarding the acuity of patients on their wards. One of the ward managers told us that she would personally visit wards where there were reports of high acuity, to assess the “reality” of the need. Some staff expressed frustration at this and said that it left them feeling undermined.

**Vacancy rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, the hospital reported a vacancy rate of 31.2% in surgery compared to a trust target of 10%.

**Turnover rates**

From October 2016 to September 2017, the hospital reported a turnover rate of 11% in surgery; compare to a trust target of 12%.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

From October 2016 to September 2017, the hospital reported a sickness rate of 1.6% in surgery; compared to a trust target of 3.8%.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and agency staff usage**

From October 2016 to September 2017, the hospital reported a bank and agency usage rate of 68% in surgery with 1,703 shifts unfilled.

*(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)*

**Medical staffing**

The trust has reported their staffing numbers below as of September 2017 for medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>221.3</td>
<td>205.76</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, the trust reported a vacancy rate of 17.4% in surgery compare to a trust target of 10%. At St Helier Hospital, the vacancy rate was 4.9%.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

From October 2016 to September 2017, the trust reported a turnover rate of 10% in surgery; compare to a trust target of 12%. However, St Helier Hospital met the 12% target.
Sickness rates

From October 2016 to September 2017, the hospital reported a sickness rate of 1.5% in surgery; compared to a trust target of 3.8%.

Bank and locum staff usage

From October 2016 to September 2017, the hospital reported a bank and locum usage rate of 84% in surgery with 43 shifts unfilled.

Staffing skill mix

From August 2017 to August 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at Epsom and St Helier University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>32%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</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

Records

Records were both electronic and paper across the surgical department. On the wards, observations and medication administration records were completed on hand held electronic devices, which fed into a centralised computer system. This allowed the nurse in charge to survey the care provision. We saw the centralised computer system in use when discussing patients during handover. Patient records were completed by all members of the MDT team, for example, a
number of the records we reviewed included speech and language therapist (SALT) assessments and physiotherapist’s care plans.

During our inspection, we reviewed 15 sets of patient records, including pre-assessments, theatre notes and ward notes. The ward notes were inconsistent in their completion. One of the patients whose notes we reviewed in the SAU was suffering from memory loss, however, no reference was made to this, or any capacity assessments in their notes. There was inconsistency in the recording of times for observations or medication administrations in all of the notes we reviewed. However, all of the notes evidence a VTE assessment having being completed and the patients having undergone MRSA screening on admission to the hospital, in line with best practice. Theatre notes were consistently completed and included evidence of consent, including consent with the assistance of a translator where appropriate, and evidence of a World Health Organisation (WHO) safety checklist having being completed before, during and after the operation, in line with best practice.

On Mary Moore Ward we found patient records stored in an unlocked cupboard. We raised this with the nurse in charge and the cupboard was locked immediately. In addition, on Mary Moore ward we found one patient’s notes within the records of another. We raised this with the nurse in charge.

On Ward B3, we found patient records stored on a shelf in a public area, among blank forms for staff to use. In addition there were a number of Route Cause Analysis (RCA) forms with patient identifiable information on them on the same shelves. These RCAs were dated from 2016 and therefore it was not clear if they had ever been sent to the centralised records department. Generally, we observed nursing and medical staff locking computers after using them. However, on the SAU a computer was left unlocked in a public area, with patient identifiable information on screen, and access to further records on the system. Poor information governance practices placed patients at risk from unauthorised access to their records and personal details.

Staff told us that orders for non-stock medicines could be placed via the electronic prescribing system and that as the pharmacist had access to the electronic prescription from the dispensary the clinical check of the prescription and the supply could take place more quickly.

**Medicines**

On the wards, medicines were stored in cupboards with coded entry locks. The codes were shared only with appropriately qualified staff. The store cupboards were well-stocked and all of the medication was within date. For drugs requiring refrigeration, there were fridges available on each of the wards and in the theatre anaesthetic rooms. However, the recording of fridge temperatures was inconsistent across the department, leading to the risk of drugs losing their efficacy. Medicines not requiring refrigeration in theatres were appropriately stored and were in date.

On B3, the Controlled Drugs (CD) cabinet was unlocked as the lock had been broken although the cupboard was still in use and contained CDs. We raised this with the nurse in charge, who said that they would escalate the concern. The following day, we returned to the ward and the lock had not been fixed. However, whilst we were there, a member of the hospital’s maintenance team fitted a padlock, for which the nurse in charge had the only keys, as a temporary measure until the lock could be repaired permanently. The CD book for ward B3 was not stored in the locked CD cupboard, meaning that it could be retrospectively amended or altered by unauthorised staff or staff acting independently rather than as part of a team of two qualified staff, as per the legal requirement.
On Mary Moore a former patient’s insulin pen which was one year out of date as stored in a medication fridge. We reported this to a pharmacist who disposed of the pen.

CDs were appropriately stored in a locked cabinet on all of the other surgical wards. The CD book for all wards was appropriately completed, with two qualified members of staff signing for the administration or refusal and disposal of all CDs.

All other medications on the wards were appropriately stored in rooms with coded locks, to which only authorised staff had access. All of the medications we looked at on the wards were in date, with the exception of those referred to above.

We observed pharmacists working on surgical wards, re-stocking and re-ordering medication. Ward staff said that the pharmacy team were always available and helpful.

**Incidents**

The hospital employed an electronic incident reporting system, which allowed all staff to report adverse incidents and near misses. These could then be reviewed by managers and acted on appropriately. There was a contrast between the incident reporting cultures in theatres and on the wards. All staff were aware of how and when to report an incident. Theatre staff we spoke with at all levels and across roles were able to describe incidents they had reported through the electronic system. However, ward staff on separate wards told us that they “did not have time to report incidents”. In addition, some staff said they did not always report low level incidents as they did not receive feedback in response to their having raised the concern and, therefore, were not confident that the issues they raised were addressed. In addition, the electronic reporting system suggested that of 838 incidents reported, only 661 were reported to the National Reporting and Learning System, of which 169 were recorded as not having been reported and eight had no information as to the reason they had not been reported.

**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 October 2016 to September 2017, the trust reported one incident classified as a never event for surgery.
The never event related to a child undergoing wrong site surgery, that is surgery on part of the body not intended to be operated on. Following the identification of the error, the child was returned to theatre and the correct procedure carried out.

The incident was reported on the electronic reporting system and investigated by the hospital.

A Root Cause Analysis (RCA) investigation was completed by an associate medical director, a clinical director, a theatre matron and the interim quality manager for surgery. A copy of the RCA was provided to the inspection team. The RCA was comprehensive and identified the contributing factors of the never event as: a failure to fully describe the intended procedure on the consent form, a failure to accurately mark the patient’s body prior to surgery, the lack of involvement of the registrar in the consent process, that the WHO checklist “timeout” stage was undertaken without the active participation of the surgeon.

The RCA made seven recommendations to mitigate the risk of a repetition of the Never Event, or similar in future. These included, that “the surgeon obtaining consent must state unambiguously the procedure to be undertaken with the laterality specified, and avoiding eponyms”; the development of a trust-wide operation marking policy for identifying the site to undergo surgery; the introduction of a pre-operative review by the operating surgeon to ensure consistency in the clinical record, diagnosis, treatment plan, investigation results, written consent and confirmation by the patient, parent or guardian.

The RCA also included arrangements for sharing learning and an action plan to ensure that the recommendations of the panel were met. Theatre managers told us that, as a direct result of the never event and the recommendations of the RCA, there had been a change in the way the WHO checklist was carried out; with surgeons now reading the WHO checklist out, to ensure their proactive engagement. We observed this during operations and one of the Operational Department Practitioners (ODP) confirmed that this had been the normal practice in theatres since the RCA.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The RCA detailed the application of the DoC following the never event.

Senior staff members were able to confidently explain the process they undertake when implementing the Duty of Candour (DoC) and gave examples of when they had to complete this. All staff demonstrated an understanding of the DoC.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported for serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2016 to September 2017. Of these, the most common types of incident reported were:

- HCAI/Infection control incident meeting SI criteria with one (25% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (25% of total incidents).
- Treatment delay meeting SI criteria with one (25% of total incidents).
- Slips/trips/falls meeting SI criteria with one (25% of total incidents).
Each of the serious incidents recorded had been reported through the electronic reporting system and we saw evidence that each had been investigated, with plans to mitigate future re-occurrence in place.

**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 13 new pressure ulcers, one falls with harm and 15 new catheter urinary tract infections from October 2016 to October 2017 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Epsom and St Helier University Hospitals NHS Trust**
Total
CUTIs
(15)
(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The trust had an appointed senior clinical audit and effectiveness co-ordinator in post that had responsibility for the daily management of NICE guidance. This included the dissemination of guidelines and monitoring the implementation across the trust. We saw minutes from the General Surgery Quality Meeting where both audit results and NICE guidance were discussed.

The trust used a handheld electronic system which captured patient observations which fed into a live patient tracking screen which displayed the latest results. This system flagged any patients whose scores were concerning and staff inputting the observations would be alerted via the hand held device of patients who required further monitoring.

Staff were aware of the sepsis 6 pathway and had laminated guidance in place. Staff on B3 ward described a recent incident where the pathway had been used and the situation had been resolved very quickly and efficiently.

Documentation of VTE risk assessments remained an issue in the notes we reviewed and the data provided by the trust, however, staff informed us that this was being monitored closely by a VTE nurse who oversaw VTE assessment compliance.

We observed good working practice in pre-assessment and theatres with staff following best practice guidance and managing patients well.

There was a clear pathway for patients with a fractured neck of femur (NOF), in line with nationally agreed standards. The trust contributed data to the National Hip Fracture Database and remained consistently above 85% during 2017 for patients having care which met best practice guidelines.

NICE guidelines on the prevention of surgical site infections in theatres were followed and instances of surgical site infections were minimal for the first admission and also any readmissions within 30 days.

Nutrition and hydration

The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. The tool (accredited screening tool) screens patients for risks of malnutrition but also obesity. MUST scores were recorded using the trust’s electronic recording system with scores visible on the patient tracking screens and historical observations were able to be viewed in more detail on the electronic hand held device. Fluid balance charts were also in place for patients, although these were inconsistently recorded in the patient records we reviewed.
Speech and Language Therapy (SALT) staff we spoke to were positive about the catering teams and described the team’s willingness to alter diets according to recommendations from the SALT team.

**Pain relief**

We observed effective pain management in place for patients on wards and several patients on the Surgical Assessment Unit commented on having timely pain relief. However, one patient we spoke to on Mary Moore Ward told us that there were often delays in getting pain relief.

Wards had access to a hospital-wide acute pain team that included a consultant anaesthetist. This service advised nursing staff on pain relief and visited and reviewed patients post-operatively. We observed use of the Bolton Pain Assessment Scale which included observing the patient and identifying any behaviours that indicated pain. Pain scores were recorded using the trust’s electronic system and in the patient notes, although the recording of this in the paper notes was inconsistent.

**Patient outcomes**

The trust contributed to relevant national audits. Audit results were discussed at the divisional quality meeting and the trust had action plans in place to address areas for improvement. A range of local audits were in place, 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.

The trust had enrolled in Anaesthesia Clinical Services Accreditation (ACSA) and an inspection of the services took place in October 2017. At the time of our inspection the trust were awaiting formal feedback from this visit.

The trust’s surgery performance scorecard for November 2017 indicated that there had been three pressure ulcers grade three and over for the year to date.

**Relative risk of readmission**

**Trust level**

From July 2016 to June 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

- Trauma & Orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

All patients at the trust had a lower expected risk of readmission for elective admissions when
compared to the England average.

- General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

### Elective Admissions – Trust Level

![Elective Admissions Graph]

*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 – Trust Level

![Non-Elective Admissions Graph]

*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 (01/07/2016 - 30/06/2017))

### Helier Hospital

From July 2016 to June 2017, all patients at St Helier Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at St Helier Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Ophthalmology patients at St Helier Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- ENT patients at St Helier Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

All patients at St Helier Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at St Helier Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at St Helier Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at St Helier Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.
**Elective Admissions - St Helier Hospital**

![Elective Admissions Chart]

*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 - St Helier Hospital**

![Non-Elective Admissions Chart]

*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: Hospital Episode Statistics)

**Hip Fracture Audit- St Helier**

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 3% which was a positive outlier. The 2015 figure was 6.5%.

The proportion of patients having surgery on the day of or day after admission was 92.1%, which was better than the national standard of 85%. The 2015 figure was 87.9%.

The perioperative medical assessment rate was 98.4%, which met / failed to meet the national standard of 100%. The 2015 figure was 96.6%.

The proportion of patients not developing pressure ulcers was 96.4%, which falls in the middle 50% of trusts. The 2015 figure was 98.7%.

The length of stay was 24.7, which falls in the in the middle 50% of trusts. The 2015 figure was 21.7 days.

Staff on A3 ward told us that work was being done to reduce patient length of stay and benchmarked data from the National Hip Fracture Database for 2017 showed the trust improving their overall length of stay to 21.4 days although this remains in the middle 50% of hospitals for the London region.

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 69.7% of patients undergoing a major resection had a post-
operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 68%.

The risk-adjusted 90-day post-operative mortality rate was 3% which was within expected range. The 2015 figure was 3.7%.

The risk-adjusted 2-year post-operative mortality rate was 17.6% which was within expected range. The 2015 figure was 19.6%.

The risk-adjusted 30-day unplanned readmission rate was 10.3% which was within expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 38.5% which within expected range. The 2015 figure was 31.4%

(Source: National Bowel Cancer Audit)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 30.1%. This placed the trust within bottom 25% of all trusts for this measure.

The trust was not eligible to provide data against the 90-day post-operative mortality rate.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 42.2%, significantly higher than national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker 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 St Helier

In the 2016 National Emergency Laparotomy Audit (NELA), the St Helier Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 148 cases.

We saw evidence of actions in place to address the poor performance through including risk of death and morbidity in the consent process. The trust improved this measure in the latest quarterly NELA data, collected between September and November 2017, achieving an amber rating with 60.9% of patients having a pre-operative documentation of risk of death compared to the national average of 77.4%.

The St Helier Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 106 cases.

The St Helier Hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 65 cases.

The St Helier Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 40 cases.
The risk-adjusted 30-day mortality for the St Helier Hospital was within expectations, based on 305 cases.

(Source: National Emergency Laparotomy 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

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was about the same as the England average.
For hip replacements, performance was better than the England average.
For Knee replacements was better than as the England average.
(Source: NHS Digital)

**Competent staff**

Ward staff cared for patients who had undergone different types of surgery, in addition to medical patients for whom no bed was available on a medical ward. Ward staff told us they felt confident caring for other patients but that access to medical staff for patients who were medical outliers could be difficult, particularly at night.

Staff on the Surgical Assessment Unit commented on the need for adequately skilled nursing staff to manage the range of patients on the ward. While arrangements were in place on the unit to supervise new and newly qualified staff, ongoing staff shortages impacted the ability of senior staff to deliver effective care and treatment.
Staff support and supervision was inconsistent across wards. This was in part due to a number of management vacancies and cover arrangements in place and had resulted in staff not having regular one-to-one meetings, or not feeling supported to be able to do their work to the best of their ability.

The 2017 national training survey by the General Medical Council (GMC) of doctors in training at St Helier Hospital scored largely similar to or slightly better than the national average for surgical specialties. Within urology, the hospital scored much better than expected for both induction and clinical supervision out of hours. Clinical supervision can help ensure that people who use services receive high quality care at all times from staff who are able to manage the personal and emotional impact of their practice.

Appraisal completion was variable across departments. Staff within theatres were positive about their appraisals and commented that the process was meaningful and identified areas for development. Staff we spoke to on the wards were less assured about the appraisal process, with some not having had an appraisal for over a year and others finding the process lacking relevance.

**Appraisal rates**

As at September 2017, 58.5% of staff within surgery at the trust had received an appraisal compared to a trust target of 80%.

A split by location can be seen in the graph below:

![Appraisal rates graph](Source: Routine Provider Information Request (RPIR) P43 Appraisals)

At the end of 2016/17, the majority of surgical wards at St Helier Hospital had met the trust appraisal target with the exception of Mary Moore Ward, where 59.1% of nursing staff had completed an appraisal.
Multidisciplinary working

We observed good multidisciplinary input in patient care from a range of therapies and disciplines, with staff interacting with patients and other staff on the wards. On A3 ward where most patients with a hip fracture were admitted, we observed input from physiotherapists and occupational therapists during handover and were told that multidisciplinary team (MDT) meetings were held twice weekly. We observed good physiotherapist presence on the ward during our visit and staff described close working relationships with therapy staff.

The patient records demonstrated input from therapists including dieticians, speech and language therapists, occupational therapists, pharmacists as well as the medical team.

We observed close working between the theatres, anaesthetic, surgical and medical staff in the main three theatres and in the eye day case theatre.

Nursing staff described good working relationships with the ward team. Nurses were not always able to attend ward rounds, and this was particularly a difficulty on the Surgical Assessment Unit due to the range of patients on the ward, the varying times of ward rounds and shortages in nursing staff. However, we observed liaison between doctors and the nurse in charge on plans for ongoing medical care.

Audits had also been conducted into ward rounds following challenges identified in having nurses present during rounds. Best practice guidance produced by the Royal College of Physicians and Royal College of Nursing recommend senior nursing presence during ward rounds in order to ensure key information is shared between the patient and medical team, particularly around patient observations and quality and safety checks, and also to support the patient. An initial audit in June 2017 identified 41% of patients having no nursing input during rounds and the subsequent re-audit presented to the Surgery Quality Meeting in September 2017 showed 43% of patients having no nursing input during rounds. Of the surgical wards included in the audit, patients on wards B3 and B5 (subsequently Mary Moore Ward) had less than a third of the rounds attended by a nurse. Best practice principles produced by the Royal College of Physicians and Royal College of Nursing state that absence of a nurse during ward rounds can impact effective communication, efficiency of ward rounds and also patient safety. The Surgical Assessment Unit performed much better with 71% of patients having a nurse physically present during their ward round. Actions were identified from the audit to increase communication between medical and nursing staff.

Seven-day services

Pharmacy services were available on weekdays from 9am until 5.30pm, 9am until 12pm on a Saturday and closed on Sunday. Pharmacists were on call out of hours. A review by the trust of seven day services in March 2017 provided details of diagnostic testing availability on both weekdays and weekends.
St Helier 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. Consultants were available on site for a minimum of nine to ten hours per day during weekdays and between four to ten hours per day during weekends, depending on specialty. Consultant input was available on call outside of these hours.

**Health promotion**

Speech and language therapists worked across the site responding to referrals from staff on the ward to support patients and their carer’s in establishing care plans for additional needs.

One set of patient notes that we reviewed showed good evidence of staff identifying palliative care needs and the subsequent discussion of this with the patient’s next of kin.

We observed a rehabilitation exercise class being conducted on A3 ward and were told this was an initiative to assess the impact of exercise on patient mood and wellbeing. Staff were engaged and encouraging and the patients were positive about the session.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Patients told us staff explained treatment and care and sought consent before proceeding. Staff we spoke to were clear about the processes for gaining and documenting patient consent and we found evidence of consent for treatment documented in patient notes.

We also observed information on wards about delirium and staff were aware of how to identify this in their patients.

Most staff we spoke to had an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS). However, some staff did not feel confident in assessing capacity.

There was mandatory training for all staff in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), which was also included in the trust’s staff induction.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that as of October 2017 their mental capacity act (MCA) and deprivation of liberty training (part of their Safeguarding Adults (Level 2) had been completed by 59.8% of staff within surgery.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

As of January 2017, none of the surgical wards at St Helier had met the trust target of 95% for completion of MCA and DoLS training (as part of the safeguarding adults level two training) with the lowest being Mary Moore Ward at 28.6% complete and the highest being B3 ward at 83.3%.
Compassionate care

Friends and Family Test performance

The Friends and Family Test response rate for surgery at Epsom and St Helier University Hospitals NHS Trust was 41% which was better than the England average from October 2016 to September 2017.

A breakdown of response rate by site can be viewed below.

Friends and Family Test response rate at Epsom and St Helier University Hospitals NHS Trust, by site.

There were posters throughout the wards inviting patients to complete the FFT. In each of the wards we saw thank you cards from patients to staff.

At the last inspection, we highlighted concerns relating to the care and compassion shown to patients in surgery, in particular in respect of privacy and dignity. Throughout our inspection, we observed nurses and other staff interacting in a caring manner with patients. Patients' dignity was maintained at all times. Whilst we had no concerns about patients' physical privacy, there were some concerns relating to the privacy of records and personal data.

We spoke with 12 patients and four family members. On the whole, patients were positive about the nursing staff. One patient told us that “they’ve been looking after me really well”, another said “we think the staff are fantastic”. The majority of the patients said that staff were caring and polite. However, there was

However, one of the patients told us “there’s not enough nurses for patients. They try their best
but there are delays.”

However, three ward nurses that we spoke with (on separate wards) told us that they did not feel they had sufficient time to provide the level of care they would like to provide to patients. For example, they said that they could not always spend sufficient time with a patient who needed additional support.

**Emotional support**

Staff provided emotional support to patients. There was a multi-faith chaplaincy service within the hospital and we saw leaflets about the chaplaincy throughout the surgical department.

On all of the wards we visited, there were thank you cards from patients for the support provided during their stay.

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

Patients we spoke to told us that they were involved in decisions about their care. They said that where there were options, staff discussed them with patients and their families. Patients in the SAU were provided with a notepad to write questions for the consultant ward rounds as they thought of them. Patients told us this was useful for ensuring they were kept informed.

**Is the service responsive?**

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

**Average length of stay**

**Trust Level – elective patients**

From August 2016 to July 2017, the average length of stay for all elective patients at the trust was 3.2 days, which is as expected compared to the England average of 3.3 days.

**Trust Level – non-elective patients**

The average length of stay for all non-elective patients at the trust was 7.0 days, which is higher
compared to the England average of 5.1 days.

**Non-Elective Average Length of Stay – Trust Level**

**St Helier Hospital - elective patients**

From August 2016 to July 2017 the average length of stay for All elective patients at St Helier Hospital was 1.9 days, which is lower compared to the England average of 3.3 days.

- The average length of stay for Trauma & Orthopaedics elective patients at St Helier Hospital was 1.5 days, which is lower compared to the England average of 3.3 days.
- The average length of stay for General Surgery elective patients at St Helier Hospital was 1.8 days, which is lower compared to the England average of 3.3 days.
- The average length of stay for Transplantation Surgery elective patients at St Helier Hospital was 2.3 days, which is lower compared to the England average of 5.7 days.

**Elective Average Length of Stay - St Helier Hospital**

**St Helier Hospital - non-elective patients**

The average length of stay for all non-elective patients at St Helier Hospital was 7.1 days, which is higher compared to the England average of 5.1 days.

- The average length of stay for General Surgery non-elective patients at St Helier Hospital was 5.1 days, which is higher compared to the England average of 3.9 days.
- The average length of stay for Trauma & Orthopaedics non-elective patients at St Helier Hospital was 13.1 days, which is higher compared to the England average of 8.9 days.
- The average length of stay for Urology non-elective patients at St Helier Hospital was 3.1 days, which is as expected compared to the England average of 3.0 days.

**Non-Elective Average Length of Stay - St Helier Hospital**
Meeting people’s individual needs

On each of the wards, there was a book in the nurses’ station which set out the cultural requirements of the majority of world religions and belief systems, to ensure that patients were provided care in accordance with their faith.

On the hip fracture ward, there was a pathway in place to meet the needs of patients with fractured hips. All patients on the unit were provided with air mattresses to prevent pressure sores. At the time of our inspection, the allied health professionals (AHPS) were carrying out a trial of the impact of regular exercise for elderly patients on recovery rates and wellbeing on the hip fracture ward. Patients who were able to do so were brought to the physiotherapy gym on the ward and engaged in light exercise under the supervision of a physiotherapist. The physiotherapist told us that this was useful for keeping patients active during their stay in hospital. Patients who attended the class told us that they enjoyed it. They said it was an opportunity to socialise with other patients on the ward.

There were link nurses for dementia and learning disabilities who could offer additional support, training and advice to nurses caring for patients with those conditions.

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2016 to August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average the most recent data for August 2017 found the trust with 72% of this group of patients were treated within 18 weeks versus the England average of 70%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, three of specialties were above the England average and two of specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>67%</td>
<td>62%</td>
</tr>
<tr>
<td>Urology</td>
<td>65%</td>
<td>77%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>86%</td>
<td>83%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>97%</td>
<td>74%</td>
</tr>
<tr>
<td>ENT</td>
<td>63%</td>
<td>65%</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.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Epsom and St Helier University Hospitals NHS Trust

Most recently in Q2 2017/18, this trust cancelled 174 surgeries, of the 174 cancellations 1% weren’t treated within 28 days.

Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, and was generally lower than the England average.

Cancelled Operations as a percentage of elective admissions - Epsom and St Helier University Hospitals NHS Trust
Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, and was generally higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

During our inspection, staff working on the SAU highlighted particular issues with patient access and flow. In particular, they were concerned that the unit was being utilised as a general surgical ward, as opposed to as a surgical assessment unit to which patients should be admitted prior to surgery. Whilst the hospital was, at the time of the inspection, facing an unprecedented demand for beds, the variety and acuity of patients in the SAU and their routes meant that staff were being required to care for a high number of unwell patients, whose care needs differed widely. Staff told us that they found this extremely difficult. The admissions book for the unit indicated that patients had been admitted to the unit as step-down from the intensive care and high dependency units, from theatre recovery and from other wards in the surgical department. In addition, there were outlying medical patients on the unit.

At the time of our inspection, the demand for beds also had an impact on the flow through theatres. During our inspection, the A2 theatres were not in use for a day, as there were no beds available for patients on their return from theatre recovery.

During our inspection, a patient from the critical care unit underwent surgery. Whilst they were in theatre, their bed on the critical care unit was taken by another patient who had been escalated from a ward. This meant that, on the completion of the procedure, the patient could not be returned to the critical care unit for recovery, as they required ventilation and input from the critical care outreach team, they could not be recovered in theatre recovery, as it did not have facilities for ventilation. As such, they had to be recovered in the theatre. The patient remained in theatre until 23:00 following their surgery, monitored by staff from the critical care unit outreach team. Whilst the involvement of critical care unit staff mitigated the risk, this nonetheless presented a risk to patient safety, as they did not have direct access to their critical care unit colleagues or equipment. Theatre staff told us that this did not happen frequently, but was a result of the high demand for critical care unit beds. In this instance, the patient remaining in theatre did not impact on the theatre list or theatre usage as they were in the theatre at night when it would not otherwise have been in use, however, had this happened in the day, it would have been likely to have impacted negatively on the flow through theatres.

There were daily bed meetings at lunchtime to ascertain the number of available beds and when a bed was likely to become available. Both theatre and ward staff, however, expressed concern that the bed meetings impacted negatively on flow as they led to patients being inappropriately placed on various wards, thereby leading to a blockage in the flow through the surgical pathway.
Meeting people’s individual needs

The hospital made use of a telephone translation service. In addition, a nurse told us that as she was bilingual, she and other bilingual colleagues were often called upon to translate on behalf of patients. She was clear, however, that this was only appropriate for translating for general conversation, whilst all consent for patients who did not speak English must be completed with the assistance of a professional translator. We observed posters throughout the wards in multiple languages advertising translation services. Leaflets could be printed in alternate languages if requested.

There was a link nurse for dementia within the hospital, who could provide additional support and training to staff caring for patients with dementia.

Learning from complaints and concerns

Summary of complaints

From November 2016 to October 2017 there were 32 complaints about surgical care out of 577 trustwide. The trust took an average of 90 days to investigate and close complaints, this is not with their complaints policy, which states complaints should be 35 days or 45 days for more complex complaints.

- St Helier: There were 17 complaints, the main themes relate to all aspects of clinical treatment with 10 complaints followed by four related to communication / information to patients (written and oral).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Outcomes of complaints were discussed at clinical governance meetings. Nursing staff were able to tell us about learning they had received arising from complaints across the trust, indicating that learning was shared both inter-departmentally and cross-site, where relevant.

Is the service well-led?

Leadership

Most of the ward staff described a disconnect between the operational staff and the executive leadership team. At the time of our inspection, in particular, they felt that there was an unrealistic expectation of what could be achieved with the staffing and resources available. Some staff felt that senior leadership team were reluctant to mitigate the issues faced by the department; in particular the shortage of qualified staff and the access and flow issues, which had been seriously exacerbated at the time of our inspection due to the unprecedented demand on services during the winter pressures. In the SAU in particular, a number of staff felt that the ward was able to function primarily as a result of the “good will” of medical, nursing, AHP and HCA staff working to capacity, without breaks rather than through appropriately planned care provision.

Consultants said that they had a positive relationship with their clinical directors and could raise any concerns directly with them and would be listened to. Theatre staff described the local
leadership as approachable and supportive. However, some expressed concern that the issue relating to sterile equipment packs had not been resolved.

On the whole, ward staff spoke highly of individuals within the local leadership, whom they described as committed, approachable and as responsible as they were able to be in the circumstances at the time of our inspection. However, they were concerned about the stability of the local leadership. In particular, a number of staff expressed concern about how many of the local leaders were covering more than one role, or were acting up. They were concerned that this meant that staff did not have the appropriate authority to make changes at a local level. During our inspection, a number of staff we met were acting up to the role above theirs, or who were covering more than one role for an absent staff member, on both short and long term basis. In some cases this led to the inappropriate delegation of responsibility, for example, on one ward the most junior member of staff on the ward was appointed as the nurse in charge, we were told that this was because they were the most senior member of permanent staff.

The NHS staff survey for December 2017 indicated a decline in the number of staff across the hospital responding positively in respect of the quality of communication between senior management and staff from 33.1% in December 2016 to 28.4%. On the surgical wards, staff felt that more personal interaction from senior leadership, in particular through their visiting the wards and speaking with patient-facing staff would improve their understanding of the day to day issues faced in the service.

**Vision and strategy**

As part of the improvement works being undertaken at the hospital, a “surgical floor” was being developed to bring all of the surgical wards into one physical space. The leadership team envisioned that this would improve access and flow for patients and co-operative and collaborative working for staff, as well as improving the sharing of learning, best practice and resources. At the time of our inspection, the first stage of this work had been completed, in the form of the Mary Moore Ward.

There was a trust-wide set of core values which were displayed in staff areas throughout the surgical department.

**Culture**

Many of the ward staff we spoke with described themselves as overstretched and a number described themselves as “exhausted”. They said that they did not have sufficient time to spend with patients to provide the level of care they would like to. They were, however, proud of their commitment to patients and their colleagues’ efforts to provide the best possible care for them.

Theatre staff described a positive working environment in which staff at all levels were treated with respect and their contribution valued. They said that this was particularly the case following the improvements made to the application of the WHO checklist.

AHPs described a positive MDT working environment. They said that they felt part of the team and that their expertise was listened to. We observed AHPs’ active involvement in patient care.
Although some staff said that they did not have time to report incidents and that they did not receive feedback on low level incidents, they said that incidents and their investigations were not treated as punitive against those who had made an error, but as learning opportunities.

**Governance**

There was a quality manager for surgery, critical care and anaesthetics who attended monthly clinical governance meetings. The clinical governance manager was responsible for cascading the information from meetings to operational staff. We were provided with a copy of the governance structure for surgery.

Audits at ward and theatre level were discussed at clinical governance meetings, and action taken at a local level to address concerns identified.

Policies were clearly written and up to date. They were available to all staff through the intranet. Policies were based on best practice and National Institute of Health and Care Excellence (NICE) guidelines.

**Management of risk, issues and performance**

There was a departmental risk register for surgery. However, there were no local risk registers for the wards or the theatre suites where local concerns that may not have met the criteria for inclusion on the departmental register, but nonetheless presented direct risks to a specific area could be recorded. Senior staff on the wards were unclear as to the process for a risk being included on the register.

We had sight of the departmental risk register, as last updated on 8 January 2018. There were 48 open risks recorded on the register. Each of the risks was graded with a risk score from “extreme risk” to “low risk”, there were 11 extreme risks recorded, these included risks related to staffing levels, the environment and equipment. All of the risks on the register had a list of “controls in place” to mitigate the risk as well as a review date, for when the risk was next to be reviewed and progress notes which provided updates as to actions taken and changes to the level of the risk.

The longest standing item on the register, relating to staffing levels of anaesthetists had remained on the register since 12 November 2007, the most recent notes, from 8 November 2017 indicated that there had been a risk meeting discussion and that “job planning [was] in progress”.

The issue relating to the missing components from sterile surgical kits had been recorded on the risk register since 14 September 2016. The latest update, from 8 November 2017 indicated Risk that the risk was still ongoing with theatre kit still going missing and that sterilisation remained substandard. The fact that this risk remained, despite weekly meetings between a representative of the theatre team and the contractor responsible for carrying out the sterilisation of the kits suggested a lack of proactive leadership in addressing the issue. The risk register indicated that there was, from November 2017 an intention to set up monthly meetings to include the head of nursing, matrons, representatives from the procurement and quality management teams, theatre managers and a clinical director with representatives of the contractor. However, at the time of our inspection, in January 2018, the issue remained unresolved.

Every ward had its safety performance prominently displayed on a notice board at the ward entrance, where staff, patients and visitors could see it. Data on the boards was clearly presented and up to date.

**Information management**
There was departmental monthly performance dashboard, which allowed the leadership team to identify and act on concerns in specific areas.

**Engagement**

Patients were encouraged to provide feedback on the care they received, through the Friends and Family Test. In addition, we saw comment boxes for patients and families on various wards. Patient feedback was included on the monthly performance dashboards on wards. In addition, there were “You said, we did” posters displayed on wards, indicating where the action had been taken in response to patients’ feedback.

Staff took part in the annual NHS Staff Survey. In the most recently published survey, from 2016, the hospital scored worse for engagement with the survey than in 2015, with a decrease in the number of responses. However, the trust met the national average response rate.

**Learning, continuous improvement and innovation**

The surgical department had capacity to support nine national surgical trainee placements. At the time of our inspection, there were eight trainees in placement. The department had been awarded “trainer of the year” for the South West Thames region. In addition, there were five ward based trainee doctors. There were two clinical fellows, one specialising in foot and ankle surgery and one in shoulder surgery undertaking leadership training modules at the time of our inspection.

The hospital was a regional centre for the care of patients with hip fracture and had established a specialist care pathway on the hip fracture ward.

There was a refurbishment programme for the surgical wards, with a “surgical floor” planned as part of the hospital building work. This was planned for delivery in early 2019.

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**Critical care- St Helier Hospital**

**Facts and data about this service**

St. Helier Hospital has one Intensive Care Unit (ICU) with 13 beds providing care for level 2 and level 3 patients. Epsom and St. Helier University Hospital's Critical Care department is part of the South London Adult Critical Care Network.

St. Helier generally admits accident and emergency referrals, medically ill patients, high risk elective patients requiring 1 or 2 days post-op care and takes all level 3 patients from Epsom General Hospital.

We inspected B2 ward which had beds one to seven which were generally used for level 3 patients and beds eight to thirteen were used for a mix of level 2 and level 3 patients.

The announced inspection took place from 9-11 January 2018 and we carried out an unannounced inspection on 22 January. We spoke with 27 staff members including consultants, junior doctors, ancillary staff, nurses, allied health professionals, and six relatives and one patient. We spoke with the divisional leadership team within critical care at the trust. We checked nine patient records and eleven pieces of equipment.

St Helier Hospital has 24 hour consultant intensivist cover provided by eight intensivists. Two consultants are on duty Monday to Friday, the second on-call consultant does a once-daily telephone ward round with the Epsom anaesthetic consultant. Intensivist advice is available 24 hours a day, seven days a week. Epsom Hospital cover is provided by consultant anaesthetists.
with advice from St Helier Hospital intensivists. The duty ICU consultant on either site is in overall charge of the clinical care of patients.

Nursing staff are accountable to the matron. Units are staffed in accordance with the Guidelines for the Provision of Intensive Care Services (GPICS) standards, including a Practise Development Team and audit nurses. The unit is supported by a team of allied health professionals.

The trust has adopted VitalPAC to facilitate the escalation of deteriorating patients. The management of acutely ill patients in the trust is addressed through the ongoing implementation of the Management of Acutely Ill Patients Programme/Policy.

Is the service safe?

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 November 2016 to October 2017, the trust reported no incidents classified as never events for critical care.

No never events were reported from St. Helier in the past three months.

Incidents were reported using an electronic system and all staff we spoke with during the inspection informed us that they knew how to report an incident, although feedback was not given to all staff. Near misses were also reported on the electronic system.

Senior management informed us that incident reports were discussed at safety huddles, weekly morbidity and mortality meetings, quality meetings and monthly clinical governance meetings, but not all nurses attended these meetings. They also told us that a ‘Critical Care Newsletter’ had been launched in December 2017 containing information about learning from incidents and achievements. Some nurses we spoke with said they received these emails but were too busy to read them. Nursing staff were unable to tell us about the last incident that occurred and learning from it, however, more senior nursing staff were able to give examples.

We looked at minutes from the clinical governance meetings which showed that serious incidents, root cause analysis and complaints were discussed.

The clinical lead told us that the majority of incident reports were delayed discharges. As a result of this, ICU bed reports continued to be e-mailed twice daily to bed managers and clinical site managers. This helped to identify and predict patients suitable for ward transfer in order to improve critical care capacity. Monthly delayed stepdown data was also sent to the head of capacity on each site.

Mixed sex breaches were recorded as an incident and on the risk register and staff were encouraged to escalate concerns regarding patient’s privacy and dignity to the matron. None were raised during November and December 2017.

The date of the last patient’s fall was in September 2017 and staff were aware of action taken as a result of this fall. Signs were created to identify patients at risk of falls and leaflets were displayed on the unit containing information about falls prevention.
All nursing staff were aware of the risk register and were able to give examples of the risks on the register and how to access it.

Staff were aware of their responsibilities relating to the duty of candour and were able to give examples of when this was displayed.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from November 2016 to October 2017.

**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.

The critical care unit displayed the Safety Thermometer data on the walls of the entrance along with the expected and actual staffing levels for that day. On the first day of our announced inspection, critical care had the required number of staff on duty. However, on the second and third day, the unit was short by one nurse and one healthcare assistant.

The date of the last fall was in September 2017, the date of the last pressure ulcer was noted down as more than 2 years ago. The last Clostridium difficile infection was displayed as July 2017 and the last MRSA infection was displayed as April 2013. There was no information displayed regarding catheter related urinary tract infections.

Records reviewed demonstrated that patients had undergone VTE assessments on admission and were receiving VTE prophylaxis where appropriate.

In November 2017 91.67% of patients were harm free with 8.33% of patients with new harms.

No catheter related urinary tract infections were reported by St. Helier from the past three months.

Data from the Patient Safety Thermometer showed that the trust reported two new pressure ulcers, one fall with harm and three new catheter urinary tract infections from October 2016 to October 2017.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Epsom and St Helier University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Total Pressure ulcers (2)</th>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Mandatory training

The trust set a target of 95% for completion of mandatory training which was not reached by the critical care core service teams.

A breakdown of compliance for mandatory courses as of October 2017 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Nursing staff</th>
<th>Trust Target (%)</th>
<th>Percentage number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>73%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Nursing staff had met and exceeded the trust target of 95% completion rate for mandatory training for three out of the ten modules. The lowest completion rate was 25% for Infection Prevention (Level 2).

St Helier Hospital had an 81% mandatory training completion rate, infection prevention (Level 2) was the lowest completion rate with 40%

Some staff we spoke with told us they were up to date with their training or were booked onto the training by the practice development nurse.

Medical staff did not meet the trust target of 95% for mandatory training. The lowest scores were information governance which was 33% and resus which was 44%

Safeguarding
Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as at October 2017 for medical/dental and nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Nursing staff</th>
<th>Trust Target (%)</th>
<th>Percentage number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>75%</td>
</tr>
</tbody>
</table>

The nursing staff had not met the trust target of 95% completion rate for safeguarding training of the two modules.

In the ICU at St. Helier Hospital, there were a total of 46 safeguarding referrals between 01/10/2016 to 30/09/2017.

Staff we spoke with were aware of their responsibilities regarding safeguarding vulnerable adults and could locate and describe the processes within the trust’s safeguarding policy. Staff were also able to give examples of previous safeguarding referrals and the processes involved.

Cleanliness, infection control and hygiene

The ICU, relative’s room and nursing stations were clean and tidy. Relatives we spoke with were satisfied with the cleanliness. Bed space curtains were labelled with the date that they were last changed.

ICU followed national guidance and staff mainly complied with Infection Prevention and Control (IPC) procedures. The latest hand hygiene audit result from December 2017 was 80% against a trust target of 80%. However, the hand hygiene target of 80% was a low target to aim for by the trust.

There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities when required.

Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns in relation to hospital acquired infections such as C. difficile and MRSA and performance in these areas were similar to comparable units. The rate of unit acquired infection in the blood was slightly higher than comparable units (1.2 compared to 0.6 for similar units and 0.9 in all units). The unit displayed their last C. difficile episode as July 2017 and MRSA was in April 2013. No information was displayed regarding catheter related urinary tract infections.

There was regular input from the microbiology consultant. The consultant provided specialist advice regarding blood cultures, review dates for antibiotics and antibiotic choices. A pharmacist was also present and gave advice on antibiotic dosing in a patient with renal impairment.

Side rooms were generally clean, however, only two side rooms had negative pressures and two side rooms did not have any pressures. When questioned what had been done about this, the matron told us that in the proposal for the new ICU, there would be four side rooms with reverse air flow. The ICU environment was also on the risk register.

In the previous report, staff were using heated wet wipes rather than soap and water to wash patients. This was on the advice of the IPC team as the tap water had tested positive for
pseudomonas bacteria. During the inspection, we were told by senior management that the pseudomonas test in January 2018 was negative and that this was not a current issue. However, due to the age of the building and the pipework, it could happen again hence staff were still using heated wet wipes.

Environment and equipment

The environment in ICU was small and space was limited. This meant that the service was not following Intensive Care Society standards regarding space between beds. Cleaning staff told us that it was difficult to clean when other members of staff or equipment were in the way. It was also sometimes difficult to have all the equipment required for procedures around the bed due to the cramped space.

The ICU had three side rooms, two of which were neither negative nor positive pressure rooms. Negative and positive air pressure rooms are used to either prevent patients from acquiring an infection, as they are immunosuppressed or to stop a patient’s own infection from spreading. There were plans about creating a new ICU by September 2018 with an improved environment and a meeting was taking place to discuss this new ICU on the unannounced visit.

The service had suitable equipment but did not look after it well. Several pieces of equipment such as the portable suction, ultrasound machine, enteral feeding pump, dialysis machines were not marked as clean and some were dusty. Refillable water bottles on the suction had no date to indicate how long they had been there. There was also an empty oxygen cylinder on the portable ventilator trolley.

The store room was chaotic with chairs and tables stored in the same room as Optiflow and dialysis machines. Haemodialysis fluid was stored in the equipment room.

There were gaps in daily and weekly cleaning schedules with no cleaning reported on 10/01/18 for either side of the unit. The Critical Care Unit had successfully recruited a Critical Care Technologist to support with the cleaning and maintenance of equipment. They started in the role during the week of the inspection.

The unit itself had secure access; however, one of the store rooms had the store room key code at the back of the sign. This meant that anyone could have access to the room.

Medicines

Prescription and administration charts were looked at for two people and these were in line with the medicines management policy. It was also possible to see that antibiotic prescribing was reviewed at appropriate intervals. Medicines were stored securely and were within their expiry dates. The resuscitation trolley was tamper evident and medicines were within their expiry date. Staff told us that the pharmacist visited daily. We saw that the pharmacist had clinically screened the prescription charts to ensure people’s medicines were optimised.

The controlled drug cupboard was checked and medicines were in date and stored in their original containers. CD record books were checked and we noticed errors crossed out but the book had been checked by the Pharmacy department.
Records

The ICU used paper-based records which included all the relevant assessment and risk documentation. Records we reviewed were legible, up to date and filled in appropriately; however, they were not always stored securely as some notes were left on top of trolleys or on the desk.

We also saw evidence in the patient records of patient and relative communication records which stated clearly all discussions that had happened with family members of patients on the unit.

We looked at discharge summaries which were filled in appropriately and saw evidence of completed nursing handovers when patient’s stepped down from ICU to the ward. The records showed that patient’s admission and discharge times and dates were recorded.

80% of nursing staff and 33% of medical staff completed information governance training.

Assessing and responding to patient risk

Senior management told us that currently, a second consultant on-call helped with referrals for deteriorating patients. The ICU team had now submitted a proposal for a nurse led critical care outreach service (CCOS), five days per week, which would be managed by the critical care senior management team. This was due to be implemented by April 2018.

The structure of the new service planned to include collaboration between CCOS and the hospital at night team. Ward cover from 08.00am to 20.15pm would be provided by CCOS with twice daily face to face handover with the hospital at night team. Medical cover was to be provided by the second on consultant for critical care at no additional cost. If the initial phase was successful, a full business case would then be completed including any impact on income before additional funding for a cross site seven day a week 08.00 am to 20.15pm service was sought.

A clinical software system was used when patients were ready to be discharged to the ward. This system allowed staff to use handheld devices to record inpatient observations e.g. heart rate, blood pressure and temperature at the bedside. The system used the data inputted to calculate the National Early Warning System (NEWS); however, staff told us there were no automatic calls if NEWS scores were amber or red. There was an expectation that the nurse would call a doctor to escalate the deteriorating patient.

Admission to the critical care unit was on a consultant to consultant referral basis and junior doctors felt they were able to easily access a consultant for advice when necessary.

The Management of Acutely Ill Patients in Hospital Policy (MAIP) had been updated whilst we were on inspection and contained information on managing acutely ill adults and children.

The trust had a ‘Crisis Course’ for detecting deteriorating patients which was an in-house version of the ‘Acute Life-threatening Events - Recognition and Treatment Course’ and they were working towards it being mandatory for staff in ICU.

Safety huddles were conducted daily and the purpose of these huddles were to highlight risks. For example, patients with allergies, any safeguarding issues, staff shortages, stock shortages and actions were discussed.

Treatment escalation plans were being used since April 2017 and we observed completed plans in patient’s notes.
A Darzi Fellow had joined the Trust in August 2016 for a one year post to develop a sepsis education programme and was involved in doing sepsis audits. The latest sepsis audit results were from June 2017 and no further data was available after this date. The clinical lead told us that they were in the process of compiling more recent results.

The trust had a sepsis policy which contained information about diagnosing and managing patients with sepsis and a sepsis screening and action tool. Staff had limited knowledge on the sepsis policy and we did not see these action tools being used. Some staff told us they used sepsis algorithms on the intranet instead.

**Nurse staffing**

The trust reported their staffing numbers below for September 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post at September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>97.7</td>
<td>87.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

As at October 2017, the trust reported a vacancy rate of 21.6% in critical care; which is higher than the trust target of 10%.

- St Helier Hospital: 25.5%

**Turnover rates**

As at October 2017, the trust reported a turnover rate of 7% in critical care; which is higher than the trust target of 12%.

- St Helier Hospital: 6%

**Sickness rates**

As at October 2017, the trust reported a sickness rate of 5.1% in critical care; which is higher than the trust target of 3.8%.

- St Helier Hospital: 3.5%

**Bank and agency staff usage**

From November 2016 to October 2017, the trust reported a bank usage of staff to cover 1,652 shifts and agency usage to cover 1,519 shifts (of which 44% were for Epsom Hospital), there was a total of 1,285 unfilled shifts (of which 66% were attributed to Epsom Hospital).

Staffing levels were displayed on the unit and the unit was fully staffed on the day of the inspection although on the second day and third day the unit were down by one nurse and one healthcare assistant.
The matron had told us that their vacancy rate had improved from 33% to 17%, however, at times it was a struggle to get agency staff and that band 5 nurses rotated between both sites. She mentioned that at times, supernumerary nurses were used to look after level 3 patients when there were staff shortages.

**Medical staffing**

The trust reported their staffing numbers below for September 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>26</td>
<td>17.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

As at October 2017, the trust reported a vacancy rate of 21.6% in critical care; which is higher than the trust target of 10%.

- St Helier Hospital: No data provided

**Turnover rates**

As at October 2017, the trust reported a turnover rate of 7% in critical care; which is higher than the trust target of 12%.

- St Helier Hospital: 0%

**Sickness rates**

As at October 2017, the trust reported a sickness rate of 5.1% in critical care; which is higher than the trust target of 3.8%. The trust did not provide us with data broken down by medical staff for sickness rates.

**Bank and locum staff usage**

From November 2016 to October 2017, the trust reported a bank and locum usage only at St Helier Hospital to cover 157 shifts with bank staff and an agency use to cover nine shifts, there were no unfilled shifts.

St Helier Hospital has 24 hour consultant intensivist cover provided by eight intensivists. Two consultants are on duty Monday to Friday, the second on-call consultant does a once-daily telephone ward round with the Epsom anaesthetic consultant. Intensivist advice is available 24 hours a day, seven days a week. Epsom Hospital cover is provided by consultant anaesthetists with advice from St Helier Hospital intensivists. The duty ICU consultant on either site is in overall charge of the clinical care of patients.

During an interview with the leadership team it was mentioned that the number of consultants had increased from a one in four rota to a one in eight rota and that this increase in staffing had resulted in more support for the ICU team.

**Major incident awareness and training**
We saw evidence of a major incident plan and action card in staff room folder and staff we spoke with were aware of what to do or where to look in the event of a major incident if they weren’t sure. We observed a fire escape plan displayed on the unit and band 6 nursing staff took in turns on a daily basis to be a fire warden. Each shift someone was allocated to undertake that role. Fire safety training from the trust showed 74% compliance for medical and nursing staff at St. Helier Hospital.

Is the service effective?

Evidence-based care and treatment

Senior management informed us that guidelines had now been agreed between the consultants. They felt this had improved vastly since the last CQC visit as the staffing numbers had increased which reduced pressure off the consultants and multidisciplinary (MDT) working had improved. Agreements were reached at monthly consultant meetings which were chaired by the clinical lead.

Examples of guidelines agreed between the consultants included the management of acutely ill patients in hospital policy, critical care pain, sedation and delirium guidelines and local safety standards for invasive procedures checklist. These were up to date and based on national guidelines.

Screening for delirium was carried out and patients’ sedation scores were filled in. Critical care pain observation tools were not always filled in and nurses were sometimes using a scale of 0-3 in practice.

A Quality Review Report published on 21st November 2017 identified areas that required improvement such as no clear escalation policy for junior trainees with regard to managing airways, if an airway-skilled person was not present on the unit. The quality review team heard that morning ward rounds were not being used as a learning opportunity. The trainees reported anxieties about very sick patients being managed outside of the unit, and the lack of ownership of acute medical patients after an Intensive Care Medicine (ICM) doctor had been called. The quality review team heard that there was a lack of clarity in regard to which team was responsible for making and initiating the initial treatment plan in the absence of immediate admission to ICM. The quality review team also heard that there was no clear escalation plan for the patients.

The Management of Acutely Ill Patients in Hospital Policy (MAIP) had been updated whilst on the inspection. The clinical lead informed us that MAIP had now been implemented and this contained information to ensure a robust escalation strategy, especially as the nurse led Critical care outreach service was due to be implemented in April 2018. The policy stated that the anaesthetic airway team would be involved in helping with establishing and maintaining airway, breathing and support with help from the emergency department and critical care as required. The policy also stated that referral to critical care would be on a consultant to consultant basis and the emergency department critical care interactions and referral pathway made clear who would do the rapid
assessment to establish provisional diagnosis, start urgent treatment and resuscitation and refer patients to speciality teams.

Critical care contributed to the ICNARC database for England, Wales and Northern Ireland. This meant that care delivered and patient outcomes were benchmarked against similar units nationally.

We observed that there was a guideline folder called ‘Guidelines at a Glance’ by every patient’s bed; however, not all the guidelines were up to date. The tracheostomy management guidelines were in place but were due for review on 1.4.16. The central venous catheter core bundle was in place, but was dated 2012 although they had placed a sticker on the document stating under review for 2017/2018. The mental capacity act guidelines were also due to be updated in January 2018. The infection control risk assessment had a review date from 2015.

Patients received daily physiotherapy as required by the National Institute of Health and Care Excellence (NICE) guidelines and intensive care society standards.

Physiotherapists used proformas which contained patient’s observations, objectives, SMART goals, evidence-based Chelsea Critical Care Physical Assessment Tool (CPAx), so patients’ progress could be monitored. A rehabilitation booklet was created as a result of the last CQC inspection which contained MDT plans, patient’s risk factors, nutrition plans, cognition, sections for SALT and dietician input. There was also a long term rehabilitation plan for patients on the unit for more than 7 days. This was developed to incorporate MDT input into the plans; however, this was not always filled in due to time constraints.

Nursing care plans were detailed and contained evidence based risk assessment tools such as the Richmond Agitation and Sedation Scale and the Glasgow Coma Scale.

Nutrition and hydration

Malnutrition Universal Screening Tools (MUST) are a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. Some patients had their MUST scores completed in the patients notes, one had not been completed for 5 days and one patient had been admitted over the weekend and not yet been seen.

From the records we reviewed, patients fluid balance charts had been completed and for patients who were able to drink water, there was water available by their bedside.

Pain relief

Pain relief was managed by consultants on critical care. Staff had access to a pain team if needed on referral and staff informed us they were responsive although they were not needed often.

Charts showed that the Critical Care Pain Observation Tool scoring system was used to determine patients’ pain, however, this was not always used and some nurses were using a scale of 0-3 instead.

Patient outcomes
The ICNARC standardised mortality ratio showed a trend of good outcomes on critical care. Mortality rates were within the expected range and risk-adjusted acute hospital mortality data was better than expected in comparison with data submitted by similar units.

The risk adjusted acute hospital mortality was 0.89 (Q1 2017-2018) which was better than expected compared to similar and all units. The risk adjusted acute hospital mortality, predicted risk <20% was 1 (Q1 2017-2018) which was about the same compared to similar and all units. The proportion of patients that survived following admission to the critical care unit was within the expected range compared to similar units.

Unplanned readmissions to critical care within 48 hours were better than expected compared to similar and all units.

The rate of non-clinical transfers to another unit was as similar (0.6% compared to 0.4% for similar and all units).

The mean length of stay on the unit for the period of 1st April 2017 to 30th June 2017 was 5.7 days which was higher compared to similar units (4.8 days for similar units and 4.3 days for all units).

Non-delayed patient discharges out of hours (between 22.00pm and 06.59am) to the ward was higher compared to similar and all units (2.8% compared to 1.2% and 1.6% in all units).

More patients had delayed discharges out of critical care when compared to similar units and all units in the case mix programme. The numbers of patients discharged direct to home accounted for 10.4% of all discharges compared to similar sized units which were 7.5%.

The time from admission to treatment withdrawal means the time from admission to ICU to a decision to withdraw treatment for end of life patients resulting in death of the patient. The clinical lead told us that the time from admission to treatment withdrawal in this unit was 130 hours compared to units of a similar size which was 58 hours. The clinical lead gave examples of reasons for this such as waiting for MRI results, consultants considering other options and newer consultants taking time to make the right decision. The clinical lead was going to meet with other consultants to try and find ways to improve these results.

The results for the National Emergency Laparotomy Audit (NELA) for Epsom and St. Helier Hospital (ESTH) from December 2015 to November 2016 showed that ESTH had a lower mortality rate within 30 days of surgery (National:10.6%, ESTH:10%). The mean length of hospital stay had continued to drop from 19.2 days in year 1 to 16.6 days in year 3. Improvements and recommendations from this audit were also mentioned, such as the surgical team improving the documentation of risk of death pre-operatively.

There was an organ donation committee to ensure no missed organ donations and potential organ donations. This was also discussed at safety huddles. There was also a Specialist Nurse for Organ Donation who was also the clinical lead for organ donation and covered both the Epsom and St. Helier sites. The clinical lead for organ donation informed us that the culture on ICU had now changed and that staff were now not afraid to talk about organ donation. He also mentioned that tissue donation had started to become a focus when ICU patients were not suitable for organ donation.

ICNARC Participation
The trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report.

Hospital mortality (all patients)
For intensive care/high dependency unit at St Helier Hospital, the risk adjusted hospital mortality
ratio was 1.14 in 2015/16. This was within expected limits. The figure in the 2014/15 annual report was 1.09.

**Hospital mortality (for low risk patients)**
For intensive care/high dependency unit at St Helier Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.13. This was about the same as the England average. The figure in the 2014/15 annual report was 1.50.

**Competent staff**

**Appraisal rates**

From January 2017 to March 2017, 80.7% of staff within critical care at the trust had received an appraisal compared to a trust target of 80%. The appraisal period for this trust is in quarter four of each year this data is based on quarter 4 16/17. 95.0% of staff in ITU at St Helier Hospital completed an end of year review from 2016 to 2017.

Nursing staff we spoke with said that they received plenty of support and training when they had started and that they had undertaken their appraisals twice a year. New starter nurses were supernumerary for six weeks and had in-house training and one week’s trust induction. The service specification for adult critical care Services required a minimum of 50% of nursing staff in critical care units to have a post-registration award in critical care nursing. In January 2018, the unit on the St Helier site were compliant with this requirement; 60% of staff working on the unit had completed a post-registration award in critical care nursing.

St. Helier Hospital had a full time audit nurse. Both Epsom and St. Helier had 3 practice development nurses, 2 of which were full time and covered both sites over the course of the week. Practice development nurse’s ensured staff was completing their mandatory training and supported the nurse induction programme.

Agency staff we spoke with had received an induction on ICU and felt supported on the unit. One of the agency staff members told us that she kept up to date for training via her agency.

Trainee medical staff we spoke with informed us that their induction on the unit was thorough and they also attended a training day at St. George’s NHS Healthcare Trust which incorporated shared learning between junior ICU doctors and an ICU consultant. One of the junior doctors told us that when she had started in ICU she was paired with a senior house officer for support and was allocated time for learning every week.

Junior medical staff received monthly consultant delivered teaching and weekly junior teaching. We also observed bedside teaching during daily ward rounds.

A Quality Review Report published on 21st November 2017 showed that ICU were working well in terms of trainees feeling that consultant engagement and support were good, and there was a high level of immediate contact between the consultants and the trainees. The full day intensive care teaching day at St. Georges was praised by all the trainees as being invaluable. There appeared to be very good teamwork between the team at the Intensive Care Medicine. The trainees spoke very highly of the nursing team, and the communication between nurses and doctors. The quality review team heard that incident reporting had been actively encouraged, and good feedback had been received by the trainees.
Multidisciplinary working

Daily multidisciplinary (MDT) ward rounds occurred at midday and consisted of two intensivists, a microbiology consultant, junior doctors, the nurse in charge, critical care pharmacist, dietician (who attended the round once or twice a week) and the SALT team. Due to the timing of the rounds, the physiotherapists were unable to attend this round but participated in the morning ward round instead. Everyone attending had the opportunity to contribute to and learn from the discussion.

From reviewing the ICU daily review charts we also observed input from the renal team and diabetes specialist nurse.

Seven-day services

St. Helier Hospital had 24 hour consultant intensivist cover provided by eight intensivists. Two consultants were on duty Monday to Friday, the second on-call consultant did a once-daily telephone ward round with the Epsom anaesthetic consultant. Intensivist advice was available 24 hours a day; seven days a week and trainees were available 24 hours a day with the support of ICU consultants.

ICU had access to an on-call physiotherapist, pharmacist, microbiology consultants and intensivists over the weekend. They had access to equipment such as x-rays and CT scans over the weekend but had limited access to MRI, ultrasound and echocardiograms over the weekend. The clinical lead told us that if patients urgently required an ultrasound or echocardiogram the intensivist would do this. If patients urgently required an MRI or other cardiology scans then they would send the patient to St. George’s NHS healthcare trust. The clinical lead told us that this was on the Trust’s own risk register.

Access to information

We observed completed nursing handovers for patients that were ready to be stepped down to the ward. These handovers contained all relevant information required when patients step down to the ward. On discharge from critical care, a comprehensive medical discharge summary was completed and a verbal handover to the receiving team was provided by doctors and nurses.

We observed patients’ medical discharge summaries which were completed by doctors and contained all relevant information.

Staff obtained most of their in-house information via the intranet. There were folders by the patients’ bedside which were called ‘Guidelines at a Glance’ which contained guidelines and policies for staff, although some of these were not always up-to-date.

Health promotion

We did not see any leaflets specifically relating to health promotion such as smoking cessation, weight loss, and support for patients with alcohol related problems. There was information available on falls prevention, patient information booklets on venous thromboembolism, helpful advice for patients about their hospital stay and discharge and chaplaincy support.

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

The trust reported that as of October 2017 Mental Capacity Act (MCA) and deprivation of liberty training has been completed by 63.7% of staff compared to a trust target of 95%. These two modules are completed within the training module Safeguarding Adults (Level 2).

Staff on the unit received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Patient’s mental capacity, DoLS and safeguarding concerns were discussed as part of the ‘Big 6’ at the post morning ward round doctors meeting. We observed DoLS forms that had been completed in patient’s notes where necessary and MCA forms had also been completed. The guidelines for the use of hand mittens in adult patients had a review date from July 2014 which had not been updated.

The unit had access to a learning disability nurse and we observed MCA forms that had been completed for a patient with a learning disability in ICU. We observed that consent had now been recorded on the modified World Health Organisation surgical safety checklist for tracheostomies.

Is the service caring?

We observed staff interacting with patients and their visitors in a respectful, considerate manner. For example, staff were asking patients if they were comfortable and explaining to patients what they were doing even if the patient was sedated.

Relatives commented on how ‘amazing’ the care was and one of the relatives told us they received a welcome pack with useful information such as contact numbers and parking support. They also told us that staff had been as accommodating as possible to be flexible with visiting hours.

Patient’s dignity and privacy were respected at all times and we observed staff pulling curtains around patient’s beds before completing care tasks.

Friends and Family Test (FFT) results were displayed on the walls however, there had only been one response from 1st November 2017 to 30th November 2017 and no other results displayed. When we spoke to the matron she said she had designed an online patient feedback system via ‘Survey Monkey’ where she had received more feedback response. This was introduced in November 2017. There were ten responses in November which were generally positive with some patients commenting on not being told the name of the nurse looking after the patient. There were two positive responses in December 2017.

Patients had their call bells within reach and those who were able to drink had water on their table. One of the patients said it could be noisy at night and that sometimes the light was left on.

Compliments were not displayed in the unit, however, these were requested via the matron and patients had thanked the staff for all their hard work and dedication and we really happy with the care they had received.
Understanding and involvement of patients and those close to them

During ward rounds staff engaged with patients even when they were sedated and one of the patients we spoke with felt involved in the decision making of their care and that the nurses and doctors made him aware of what was happening.

There were communication sheets in the patient’s notes which documented discussions with the families.

Patient diaries were filled in by the bedside and patients had the opportunity to discuss the diaries at follow-up clinics 3 months post discharge.

Relatives we spoke with were familiar with Intensive Care Unit (ICU) steps. ICU steps were founded in 2005 by ex-patients, their relatives and ICU staff to support patients and their families through the long road to recovery from critical illness.

One of the relatives we had spoken to said that staff had explained patient confidentiality to them and explained how they used patient’s information.

During a ward round we observed nurses informing patients what was going on and speaking gently to them to let them know what was happening.

Emotional support

We observed staff providing emotional support to relatives and saw one of the consultants speaking to the relatives in a separate room and answering their questions. On one of the ward rounds, the palliative care team had not been involved with the patient’s family or relatives, however, on questioning this, the consultant told us they would be getting the team involved and said that the palliative team were really supportive.

Feedback from one of the patients and relatives were all positive, however, the patient we spoke with said that he had never been outside the unit and that nobody put him in a wheelchair to take him off the unit. He also told us that he did not get to wear his own clothes even though he was capable of wearing them.

There was a chaplaincy and spiritual health service at the hospital and the unit displayed chaplaincy leaflets on the unit that contained information on how the service offered support and useful contact information.

The ward also provided leaflets for patient’s about their hospital stay and discharge which had information on additional support and contact numbers. A separate leaflet was available for patients wanting to raise any concerns and this was available in various languages.

Is the service responsive?

Service delivery to meet the needs of local people
Previously the critical care unit at St. Helier was divided into ICU and HDU, however, on inspection this was now combined so that the beds on the unit could be used flexibly to care for level 2 and level 3 patients.

ICNARC data showed that the unplanned readmission rate was 0% and the unit received patients from the emergency department, theatres and wards as well as all level 3 patients from Epsom General Hospital.

Patients discharged from ICU had access to a follow-up clinic. This clinic was run in outpatients where patients got seen 3 months post-discharge from ICU. The clinic was run by nurses, a physiotherapist, an occupational therapist and a consultant. Staff informed us attendance by patients was low but it gave them an opportunity to discuss any concerns, support required and their patient diaries. The clinic also gave patient’s opportunities to go back and visit the unit and could be attended by their relatives and friends if required.

There was a ventilator weaning group with a practice development nurse, a consultant and physiotherapist. For more complex patients, if long term ventilation weaning was required, St. Helier would liaise with St. Thomas’ Hospital and the patients would be transferred to that hospital's long term weaning unit if necessary.

We saw evidence that critical care consultants worked with the renal team to accommodate the needs of this group of patients on the unit.

The ICU lacked space and the unit environment was not responsive to the needs of patient. Senior managers told us there were plans for a new ICU to be built by September 2018.

**Meeting people’s individual needs**

A mixed sex breach occurs when level one or zero patients are placed in an open ward area with members of the opposite sex. Mixed sex breaches should not occur frequently on critical care units as patients are stepped down to a ward once they reach level one dependency. The unit was recording incidents of mixed sex breaches and on the risk register due to the high number of delayed discharges. St Helier ICU had 27 patients in November 2017, 14 patients in October 2017 and 11 patients in September 2017 who were in a mixed sex accommodation area at 22:00 after being declared ward ready. The matron said that staff were encouraged to escalate concerns regarding patient’s privacy and dignity. None were raised during December 2017.

ICU patients had access to bathroom facilities, but there was only one bathroom which was used for both male and female patients, although staff would always accompany patients to the bathroom.

There was an option to stay over as the relatives’ room had a sofa bed, but this was small and the matron said it was rarely used. Staff encouraged relatives to return home but they were able to ring the unit for updates at any time. The relatives’ room was clean and airy, and there was an additional room which was used by staff to have private conversations. There were drink making facilities and there was a folder for relatives with instructions on what to do if they were low on drink making supplies.

There was access to interpreting services and staff felt the service was useful and a poster was displayed on the unit offering language support for patients. Various information leaflets were available on the unit and some had information available in other languages if required.
Staff were able to describe various formats of communication with patients who could not speak for example, an alphabet for patients to point at letters, pictures with signs for sleep and using the bathroom.

A learning disability nurse was available on referral and patients with learning disabilities had appropriate care plans and review by a learning disability nurse when appropriate.

Staff knew how to refer a patient to the dementia nurse if necessary, although there were no dementia support leaflets displayed on the ward.

The unit was able to refer patients to a psychiatrist when necessary.

A number of posters and leaflets were displayed in the relatives’ room and corridor, which gave patients information about the unit such as visiting times, photos and names of staff within the department. There was also information on Patient Advice and Liaison Services (PALS) in the relative’s folder, displayed around the unit and a leaflet with options to receive translated copies of the leaflet.

The unit operated flexible visiting times for patients and these were displayed in the relative’s room and folder. The visiting times were 10-11.30am, 2.30-7.30pm, and 8.30-10pm.

The unit was also noisy at times due to the building work going on outside although we did observe a builder come into the relatives’ room and ask if they were okay with the noise.

Access and Flow

Bed Occupancy
From November 2016 to October 2017, Epsom and St Helier University Hospitals NHS Trust has seen adult bed occupancy as a steady monthly trend, this is about the same as the England average.

Adult critical care Bed Occupancy rates, Epsom and St Helier University Hospitals NHS Trust.

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.
(Source: NHS England)

Delayed discharges
For intensive care/high dependency unit at St Helier Hospital, there were 4,026 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 12.6%. This compares to the national aggregate of 5.3%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2014/15 annual report was 14%.

Non-clinical transfers
For intensive care/high dependency unit at St Helier Hospital, there were 647 admissions, of which 0.93% had a non-clinical transfer out of the unit. Compared with other units this unit was...
about the same as the England average. The figure in the 2014/15 annual report was 1.12%.

Non-delayed out of hours discharges to the ward
For intensive care/high dependency unit at St Helier Hospital, 446 of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was about the same as the England average. The figure in the 2014/15 annual report was 2.12%.

The table below shows the St. Helier Critical Care Occupancy from July to December 2017:

<table>
<thead>
<tr>
<th>Activity</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCCUPANCY %</td>
<td>82</td>
<td>91</td>
<td>86.4</td>
<td>87.2</td>
<td>90.1</td>
<td>94.7</td>
</tr>
<tr>
<td>L3 CCMDs*</td>
<td>157</td>
<td>164</td>
<td>180</td>
<td>158</td>
<td>161</td>
<td>274</td>
</tr>
<tr>
<td>L3 BED DAYS</td>
<td>143</td>
<td>144</td>
<td>164</td>
<td>139</td>
<td>145</td>
<td>258</td>
</tr>
<tr>
<td>L2 CCMDs</td>
<td>138</td>
<td>191</td>
<td>153</td>
<td>168</td>
<td>152</td>
<td>106</td>
</tr>
<tr>
<td>L2 BED DAYS</td>
<td>115</td>
<td>164</td>
<td>124</td>
<td>145</td>
<td>127</td>
<td>79</td>
</tr>
<tr>
<td>L1/O CCMDs</td>
<td>81</td>
<td>71</td>
<td>54</td>
<td>74</td>
<td>98</td>
<td>25</td>
</tr>
<tr>
<td>L1/O BED DAYS</td>
<td>72</td>
<td>58</td>
<td>48</td>
<td>66</td>
<td>77</td>
<td>19</td>
</tr>
</tbody>
</table>

ICNARC data from 1st April 2017 to June 2017, showed that patients were delayed more than 8 hours after the reported time that they were ready for discharge. The data showed 11.2% delays compared with 6.1% from other similar units. ICNARC data also showed patients were delayed for more than 24 hours after being ready for discharge with 7.6% compared with 3.8% of similar units. This could lead to access difficulties for patients requiring a critical care bed.

Discharge audits from the last three months were recorded the delayed discharges and action plans were developed as a result of this. Examples of action plans included reviews of delayed discharges at weekly morbidity and mortality meetings to ensure no patient harm, an escalation area plan which was due for the approval process in the beginning week of February 2018 and inclusion of transfer of care as part of the junior doctors’ induction.

ICNARC data showed non clinical transfers to another unit was about the same as similar units (0.6% compared with 0.4%) for Q1 2017-2018.

The critical care referral and response audit showed that the majority of admissions of patients to ICU were seen within thirty minutes by junior doctors and within one hour by consultants. The majority of the results were above 90% for the last three months.

The clinical lead told us a Commissioning for Quality and Innovation (CQUIN) target was in place to reduce the amount of delayed discharges. The trust had improved its delayed discharge bed days; it was still not reaching the CQUIN target.

During the inspection week, there had been a patient who had to stay in theatres post-op due to the lack of beds available in the ICU. The clinical lead said that this was a very rare occurrence and that this patient still received care from a ICU nurse and an incident report would be done and discussed at the next morbidity and mortality meeting. In this circumstance, one patient was stepped down from Epsom HDU and another patient from ICU went to Epsom HDU to facilitate a bed space for the patient who required a ventilator. When we went back on the unannounced visit, the clinical lead told us that an incident report had been completed and that the incident had been discussed at the governance meeting.

Access to the ICU was on a consultant to consultant referral basis and junior doctors we spoke with said that they received support from consultants when necessary.
Learning from complaints and concerns

Summary of complaints

From November 2016 to October 2017 there were no complaints about critical care. The trust had reported 557 complaints trust wide but none of them feature aspects of critical care services.

Information from the unit showed there had been one complaint in the last 6 months. The trust was in the process of responding to the complaint.

 Relatives told us they were aware of how to make a complaint and could reference the poster in the waiting room and signs in the corridor. Relatives also felt they could discuss any problems or concerns with staff on the unit.

Is the service well-led?

Vision and strategy

The leadership team told us that the external advisor from St. George’s NHS Healthcare Trust facilitated in creating the strategy for critical care and creating a gap analysis to identify where improvements could be made. The clinical lead said that the strategy was currently being reviewed to include changes implemented after the last CQC inspection and to ensure it is aligned to the trust’s five year plan.

The external reviewer praised the critical care and executive team and mentioned that a lot had changed since 2015. There had been an increase in number of consultants which meant there was more support and more agreement amongst consultants in developing guidelines. There was also a plan to create a new ICU unit. They mentioned they had a clinical fellow who worked for one year at Deloitte and then worked at St. Helier for 9 months looking at making improvements in relation to the financial deficit of critical care. The leadership team told us that the governance structure was better, morale was better and there was more collaborative working. We were also informed the vacancy rate of nursing staff had dropped from 33% to 17% and that they had secured funding for a nurse-led critical care outreach team. The ‘Managing Acutely Ill Patients in Hospital’ had been finalised and implemented on the CQC inspection.

The unit’s vision was displayed at the entrance of ICU. Staff we spoke to were aware of the vision and felt there had been a lot of changes for the better since the last inspection.

Governance, risk management and quality measurement

The critical care service was in the surgery, anaesthetic, and critical care directorate. Monthly clinical governance meetings were held with representation from staff at the Epsom site. These meetings were chaired by a consultant intensivist who was the lead for guideline development. We looked at minutes of the governance meetings which showed that serious incidents, root cause analysis, risk registers, patient feedback, staffing reports and performance were discussed.

Senior staff felt that directorate meetings were well represented by the management team, but felt that placing critical care under the surgical directorate needed to be reviewed as many acute trusts were now having a separate directorate for critical care.
The unit was engaged with governance activity within the hospital and had now updated and implemented the Management of Acutely Ill Patients in Hospital policy.

Senior management informed us that the governance structure had changed since the last CQC visit. The clinical lead mentioned that there had been more allied health professionals such as physiotherapists, pharmacists, dieticians and more consultants that attended the monthly clinical governance meeting. A risk manager also attended the governance meetings to look at incidents and disseminate learning from incidents.

The risk register was maintained and reflected the risks identified on the inspection. Risk registers were reviewed as part of the critical care governance meetings, although one of the risks from 2011 had recently been mitigated and was still on the risk register.

We looked at critical care and anaesthetics quality meeting minutes where audits were discussed and some of the points raised from the previous CQC visit were discussed with action points.

The senior management team felt that the executive team were very supportive, although frontline staff felt that the executive team were not visible. The senior management team felt that the governance structure was much stronger than before and that having input from the external advisor was a catalyst to many changes within the trust. There was a feeling that leadership in the past was more ‘vertical’ and there wasn’t a lot of MDT working, but now the team were moving away from ‘silent working’ and that the staffing improvements made it a less pressurised environment to work in.

Leadership of Service

The ICU was led by the clinical lead and the matron, who worked closely with the clinical director. The matron and clinical lead also covered the ICU at Epsom Hospital. Staff we spoke with felt they were very approachable and supportive and understood their roles within the hospital. Staff had felt that leadership had improved and felt there had been lots of changes since the last CQC inspection.

Consultants we spoke with said that they were happy with the changes. During an interview with the leadership team and external advisor they informed us that there would be monthly meetings with the external advisor to ensure quality was maintained.

The leadership team were happy to have had the external advisor and mentioned that he had been a catalyst to some of the changes made within the department. The leadership team were felt that the executive team were very supportive and were proud of the changes that had been made.

Staff we had spoken to on the unit were aware of the executive team but found that the team were not always visible.

Culture within the service

Staff were proud of their work and were driven to provide the best care for their patients. A senior member of staff approached the CQC to share how proud they were to work in the ICU and in particular the development of the follow-up clinics.
Staff felt able to raise concerns to the senior staff and felt supported by the team. One member of staff felt that some members of staff were unfriendly but said she felt supported by her manager and that she felt able to raise concerns if necessary.

Junior doctors felt well supported by the consultants although occasionally felt intimidated by being questioned in front of other staff during the ward rounds.

Staff felt they were encouraged to share ideas and felt like there was more of an MDT approach than before.

**Public and staff engagement**

Relatives and patients could complete feedback forms via the Friends and Family Tests but the response rate for these were consistently low with only one response from 1/11/17 to 30/11/17. The matron informed us that she had developed an online feedback survey for relatives. So far a total of 12 responses had been received.

There was also a sign displayed in ICU for patients to have their input in the development of the new critical care unit. At the main entrance of the hospital, there was a sign that displayed a website for patient’s to have their say in the future of Epsom and St. Helier 2020 to 2030.

Senior management told us that they looked at staff surveys about pressure and work life balance and were pleased to find that 9/10 staff would recommend their post to colleagues.

The matron held monthly meetings to discuss any concerns amongst the staff members, this included ancillary staff, nurses, physiotherapists, healthcare assistants, the ICU co-ordinator and any other members of staff in ICU that wanted to attend. There was also a comments box which was in the staff room and these comments were also discussed during the meeting.

Staff felt engaged in the decision making process in the unit

Staff felt that the work with the external advisor had introduced many changes and were happy that the unit had a better MDT approach to patient care than before.

**Innovation, improvement and sustainability**

Staff were focused on continually improving the quality of care. For example, after ward rounds doctors would discuss the ‘Big 6’ which looked at mental capacity assessments, consent, deprivation of liberty, infection prevention and control compliance, patient diaries, ensuring vitalpacs were updated, ensuring documentation was completed appropriately and to remind doctors to see critical care referrals within 30 minutes.

There was a structured ICU step-down for patients with medical and nursing handovers and they had introduced a follow-up clinic and daily morning safety huddles. The faculty of critical care was established between Epsom and St. Helier and St. George’s NHS Healthcare Trust which helped make changes within critical care. There were plans about creating a new ICU with an improved environment and a meeting was taking place to discuss this new ICU on the unannounced visit.

The clinical lead was very enthusiastic about teaching and told us she attended the yearly Post-graduate Medical Centre training where she shared learning from sepsis audits and she was the sepsis champion for critical care. She was also involved with ‘Crisis’ training which the trust was aiming to make mandatory and this covered sepsis, managing acutely ill patients and escalation processes.
There was teaching by consultants to the team on multidisciplinary ward rounds where junior doctors had the opportunity to present patient cases and receive feedback from the consultants.

**Maternity- St Helier Hospital**

**Facts and data about this service**

St Helier Hospital provides a community midwifery service for Sutton and Merton CCGs and community midwives undertake the majority of antenatal and postnatal care. The hospital offer specialist pre-conception and antenatal services, including teenage pregnancy, diabetes, mental health, obesity, perineal trauma, FGM clinics, antenatal workshops and classes, foetal medicine and substance misuse.

There is a named midwife for safeguarding and a specialist team.

*(Source: Trust Provider Information Return – Acute sites)*

From July 2016 to June 2017 there were 4,651 deliveries at the trust.

A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below.

Number of babies delivered at Epsom and St Helier University Hospitals NHS Trust – Comparison with other trusts in England.

Trends by quarter for the last two years can be seen in the graph below.

Number of deliveries at Epsom and St Helier University Hospitals NHS Trust by quarter
St Helier maternity unit serves the South West London Boroughs of Sutton and Merton. There were 2,714 births at St Helier Hospital between September 2016 and August 2017. These included 507 midwife led births, 2,202 obstetric-led births and five still births. Trust wide, there were 127 home births.

The maternity unit consisted of an antenatal outpatient area including a waiting area, six clinic rooms, an early pregnancy assessment unit (EPAU) and a maternity assessment unit (MAU). The inpatient antenatal ward had 16 beds while the postnatal ward had 22 beds. The delivery suite had two theatres, three recovery beds and seven delivery rooms. A room was used for women in cases of bereavement (it was known as the Poppy Room). The labour ward had eight delivery rooms while the birth centres had three birthing rooms and a post-natal room. The birth centre was well equipped with birthing pools, relaxing lighting, birthing balls and stools.

Community midwives provided antenatal care in community locations. Some specialist clinics were run in the hospital for diabetes, mental health, maternal medicine and foetal and maternal medicine.

During our inspection, we spoke to about 31 members of staff including midwives, maternity support workers, domestic staff, consultants and junior doctors. We spoke to 11 women who used maternity services and one of their partners. We observed care and treatment and reviewed seven sets of medical records.

**Is the service safe?**

**Mandatory training**

The trust set a target of 95% for completion of mandatory training. Senior staff informed us all midwives trained together across both sites, so managers did not usually split statistics by hospital site. There were three mandatory training days for midwives.
A breakdown of compliance for mandatory courses as at October 2017 for medical/dental and nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Mandatory training module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>84%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>72%</td>
</tr>
</tbody>
</table>

The trust met the manual handling object training course compliance with 100% whereas four of the seven training modules did not meet the 95% trust target, the lowest with 72% was Venous Thromboembolism.

St Helier Hospital had an 86% mandatory training completion rate, with four of the seven modules not meeting the 95% trust target the lowest was 67% was Venous Thromboembolism.

(Source: Trust Provider Information Return P14)

Mandatory training also included fire, health and safety, patient handling, information governance and equality and diversity. In addition to the standard statutory mandatory training, all clinical staff working in the delivery suite, were required to attend training in the use of cardiotocography (CTG) interpretation and foetal electrocardiogram (ECG) (known as STAN monitoring). STAN is a type of CTG that uses computer analysis of the baby’s heart rate and heart muscle function, to give clinicians an idea of how the baby is coping with labour, and assists in reducing the risk of unnecessary intervention. In June 2017, 90% of midwives and obstetricians had CTG/STAN training and 83% had achieved certification. The number of incidents where CTG interpretation was a factor had reduced since this training had started.

There was also mandatory multi-professional skills and drills training to rehearse response to obstetric emergencies including simulation. Training records showed that bank staff had also completed the required mandatory training.

Separate training records provided for 24 consultants showed many were not up to date with mandatory training. Areas of low compliance included resuscitation training (9), information governance (11) and duty of candour (9).

(Sources: DR56 Maternity database training, consultant statutory mandatory training)

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as at October 2017 for medical/dental and nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Safeguarding courses</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>69%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>37%</td>
</tr>
</tbody>
</table>
None of the safeguarding modules met the 95% trust target; the lowest was safeguarding adults (level 2) with 37%.

St Helier Hospital had a 72% safeguarding training completion rate.

(Source: Trust Provider Information Return P18)

The maternity service had dedicated midwives who specialised in women who had mental health needs, were at risk of domestic violence or who had other support needs such as substance misuse. Staff held weekly meetings to go through each patient’s case notes to review women who needed extra support. Where necessary, staff referred women to psychiatric mother and baby units so that expectant mothers received the care they needed during and after childbirth. Staff made use of protection plans and safeguarding processes to ensure mothers and babies were kept safe.

Staff were aware of their responsibilities in relation to safeguarding vulnerable women and to protect unborn and newborn babies. Staff could locate and describe the trust safeguarding policy. Staff said safeguarding team members were visible and approachable. Staff escalated safeguarding incidents to the safeguarding team. They could also report safeguarding incidents using an electronic system.

Staff spoke highly of the safeguarding team and said they were easily accessible and provided training to staff. Staff knew how to identify “high risk patients” and said they would refer such women to the mental health or safeguarding team. They also referred them to appropriate professionals for extra support if required.

Our review of women’s records showed social circumstances were assessed at the first antenatal appointment. Staff informed us women who accessed maternity services later on in their pregnancy or who transferred from other hospitals were automatically flagged.

Level 3 Child Protection Update Training was incorporated into the midwives’ mandatory training programme and compliance was 88% at the time of the inspection. There was a shortfall in the completion rate due to maternity leave, turnover and long term sickness. All staff had a two hour level 3 safeguarding refresher course each year.

The focus of the training during 2016-2017 was Child Sexual Exploitation, Female Genital Mutilation and PREVENT. Frontline staff had attended a training programme in domestic violence to raise awareness of the guidance and pathways for referring victims to local support services and the multi-agency risk assessment conference (MARAC).

The monthly maternity safeguarding forum provided multi-professional information sharing regarding vulnerable women and their families. Representatives from Sutton, Surrey and Merton Children’s Social Care services regularly attended this forum. Information about safeguarding was circulated through the Risk Management Newsletter. For example, the February 2017 newsletter highlighted forced marriage, honour based violence and how to escalate concerns and the role of the MARAC. Staff informed us of a case when they were able to protect a woman from honour-based violence in the course of the year.

Cleanliness, infection control and hygiene
Most areas of the maternity unit we inspected were visibly clean and tidy. These included sluices, storage areas, kitchen, wards and theatres.

The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene and use of personal protective equipment such as gloves and aprons.

There was easy access to personal protective equipment (PPE). Aprons and gloves were available in all areas we inspected and we observed staff using PPE as required. There was also sufficient access to handwashing facilities. The maternity unit displayed signage prompting people to wash their hands and have guidance on good hand washing practice.

Staff were ‘bare below the elbow’ and most staff 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 PPE when caring for patients. We observed one instance where staff did not use hand sanitisers when entering and exiting the unit.

Where women had a known or suspected infection, they were nursed in single side rooms. One side room in use had signs displaying presence of infection, which meant staff, and visitors were aware of the precautions to take prior to entering the patient area. We observed staff adhering to these protocols and doors remained closed to these rooms.

There were housekeeping staff for cleaning wards and cleaning staff understood cleaning frequency and standards. Domestic staff signed cleaning scheduled to confirm a particular area had been cleaned. Cleaning schedules and monthly cleaning scores were on display. We saw results for January 2018 with a score of 99% for the delivery suite.

Waste management, including those for contaminated and hazardous waste were in line with national standards. Needle sharp bins were available on the unit. Sharp bins were correctly labelled and none were filled above the maximum fill line.

However, we observed there were a number of non-laminated signs within the unit. It is important to laminate signs as laminated signs are easily wiped clean. We also observed blinds in some of the rooms on the delivery suite were either broken or absent.

**Environment and equipment**

Access to all parts of the maternity service was secure and restricted to staff with swipe cards. We observed staff waiting to ensure the door was closed following entry into the maternity unit.

The maternity unit consisted of an antenatal outpatient area including a waiting area, six clinic rooms, an early pregnancy assessment unit (EPAU) and a maternity assessment unit (MAU). The inpatient antenatal ward had 16 beds while the postnatal ward had 22 beds. The delivery suite had two theatres, three recovery beds and seven delivery rooms. A room was used for women in cases of bereavement (it was known as the Poppy Room). The birth centres had three birthing rooms and a post-natal room. The birth centre was well equipped with birthing pools, relaxing lighting, birthing balls and stools. The delivery rooms still looked clinical (as observed during our last inspection) and not conducive to normalising birth. Senior staff pointed out they would like to change the layout of the maternity ward if they could obtain funding for that.

There was appropriate emergency equipment on the delivery suite. We saw the resuscitation trolley was fully equipped, with drugs in date, and staff checks were signed and dated. ST analysis (STAN) equipment was available on the maternity unit.
During our last inspection staff indicated they had insufficient equipment to carry out their role. At this inspection, most staff indicated they had access to sufficient equipment to carry out their role. One community midwife mentioned there were occasional issues with lack/shortage of equipment particularly weighing scales for babies. However, they also mentioned that this was around community staff being organised and transferring equipment between themselves when changing duty. Another community midwife said they had enough equipment to work with and they did not really run out of anything.

Assessing and responding to patient risk

Maternity staff used the Modified Early Obstetric Warning Score (MEOWS) to recognise women who were becoming unwell. MEOWS charts are designed to give a clear visual record to help staff identify deterioration at a glance. There was an instruction to refer to a senior member of staff if a woman triggered a one red or two yellow scores at any time. We looked at women’s records on the wards and saw charts had been correctly completed.

Staff carried out risk assessments for women during antenatal care in line with national guidance. These included social assessment, VTE risk assessment and mental health assessment. Staff recorded relevant information during initial booking appointments including information about previous births and early pregnancy losses, tobacco use and drug use. Women were offered smoking cessation because of the impact of smoking on the baby’s growth. The trust’s maternity dashboard showed 92% of women were offered smoking cessation counselling at initial booking between April and November 2017. Midwives also documented on-going risk assessments at subsequent antenatal visits.

Staff assessed patients upon admission to the antenatal service to identify women who had extra needs. Staff triaged women into the mild to moderate pathway or moderate to severe pathway depending on the needs of the women. Those on the moderate to severe pathway had access to a specialist mental health consultant and mental health trained midwife. We looked at the care records of three women deemed at risk and found all of them had risk assessments, a birth plan co-produced with the patient, crisis plans and referrals to the local authority safeguarding team.

Staff held meetings weekly to go over patient case notes of women with mental health needs, to review incidents and to share learning.

There was a clear criterion for women wishing to give birth in the birth centre or have a home birth. This was in line with national guidance requiring such women to be fit and healthy and experiencing a normal pregnancy. Midwives undertook an environmental risk assessment of the home and birth space, lighting and equipment in the home. Midwives signposted women to Department of Health guidelines about equipment for home birth. A home birth pack was left at the home at 36 weeks. Women giving birth at home or in a birth centre were transferred to the delivery suite if midwives had concerns about foetal heart rate anomalies, failure for labour to progress and meconium in the waters. Meconium is baby’s first stool and its presence in the waters can sometimes be an indicator of foetal distress during labour.

Community midwives referred women who they identified as high risk for any medical reason to consultant-led clinics. A foetal medicine unit supported the identification of potential birth complications.

We attended a midwives ward handover on the labour ward. Midwives followed a standard format reviewing women on the ward and allocating staff as well as giving reminders on current safety issues. For example, senior staff reiterated the need to use the SBAR (Situation, Background,
Assessment and Recommendation) tool when conducting individual handovers. The SBAR tool provides a framework for communication between members of the healthcare team about a patient's condition. We observed midwives already had a printed copy of the tool with them in preparation for handover.

During our last inspection, we found the unit did not adhere to the induction of labour policy, which puts pressure on the unit if too many women were induced the same day. Senior staff said they had implemented a quality improvement programme to reduce the rate of induction. However, the rate had risen from 26% in 2016/17 to 31.6%. Senior staff said the introduction of growth assessment protocol (GAP) identified large babies. This helped to reduce the rate of stillbirths, however, it had the effect of increasing the induction rate.

There were two theatres on the maternity unit with the larger theatre used for emergency caesarean section. We saw evidence of safe practice including the use of the modified maternity World Health Organisation (WHO) surgical safety checklist. The maternity dashboard for St Helier Hospital showed the unit scored 97% for compliance with WHO checklist between April and December 2017.

**Midwifery staffing**

The trust has reported their staffing numbers below as at September 2017.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>201.2</td>
<td>191.1</td>
</tr>
<tr>
<td>Total</td>
<td>201.2</td>
<td>191.1</td>
</tr>
</tbody>
</table>

The trust had 10.1 less WTE staff than what they planned to provide safe care in September 2017.

(Source: Routine Provider Information Return (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From April 2016 to March 2017, the trust reported a vacancy rate of 5.8 in maternity;

- St Helier Hospital: 2.9%

(Source: Routine Provider Information Return (RPIR) P17 Vacancies)

**Turnover rates**

From April 2016 to March 2017, the trust reported a turnover rate of 16% in maternity;

- St Helier Hospital: 20%

(Source: Routine Provider Information Return (RPIR) P18 Turnover)

**Sickness rates**
From April 2016 to March 2017, the trust reported a sickness rate of 6.5% in maternity;

- St Helier Hospital: 7.5%

*(Source: Routine Provider Information Return (RPIR) P19 Sickness)*

**Bank and agency staff usage**

From April 2016 to March 2017, the trust reported a bank and agency usage to cover 2,805 bank shifts, as well as 597 agency shifts there was a total of 1,408 shifts unfilled.

*(Source: Routine Provider Information Return (RPIR) P20 Nursing – Bank and Agency)*

**Midwife to birth ratio**

As of July 2017 the trust had a ratio of one midwife to every 26.89 women.

*(Source: Electronic Staff Records – EST Data Warehouse)*

The trust had used a nationally recognised acuity tool in 2016 to calculate the required number of midwives needed in the service including that needed to maintain one to one care for women in labour. The tool indicated a birth to midwife ratio of 1:24 at a 90/10 skills mix. During our inspection, we were informed the trust had a ratio of one midwife to 27 women. This reduced to one midwife to 26 women if the number of specialist midwives were included.

As at January 2018, the maternity unit at St Helier Hospital was funded for 113.60 midwives, one theatre nurse, four Band 4 maternity support workers (MSWs), 5.6 Band 3 MSWs and 22.51 Band 2 MSWs. There was a deficit of 3.16 recommended midwives and 3.37 recommended Band 4 MSWs. It appeared the midwife to birth ratio was still being reported against funded establishment instead of the actual staff available on each site.

The maternity unit used bank and agency staff to provide safe staffing compliance. Bank and agency staff were inducted to the unit and were required to complete mandatory training. Staff discussed activity and acuity at daily safety huddles.

There appeared sufficient staffing levels during our inspection. The postnatal and antenatal inpatient unit were staffed by 13 midwives in line with the establishment. These included two midwives within the antenatal unit, two within the postnatal unit, two at the birth centre, six on the delivery ward and one for triage. Four MSWs were also rostered to cover the inpatient units. At night 12 midwives and four MSWs covered the inpatient unit. Senior staff explained they could reallocate staff within the unit depending on the needs of each area.

In addition, there were two midwives and two MSWs rostered to the antenatal clinic, one midwife and one MSW to the EPAU and one midwife and one MSW to the MAU.

A scrub nurse was rostered to assist with the elective caesarean list three days a week. As at the previous inspection midwives scrubbed for emergency caesarean sections. This further reduced the number of midwives available, particularly as the caesarean section rate was quite high.

Community midwives were fully established with 44.17 whole time equivalent (WTE) midwives

Delivery suite coordinators were supernumerary, an improvement from our last inspection. The
maternity service also consisted of the newly constituted home birth team consisting of four midwives. Senior staff informed us that community midwives where now fully established.

A policy on delivery suite staffing, combined with reporting "red flag events", such as delayed care, or inability to provide one to one care could act as a trigger for considering increasing staff numbers. There was a daily safety huddle where staff discussed capacity, activity and acuity. An escalation flow chart was on display within the unit.

Daily records of any differences between the number of midwives needed and those available for each day or shift were displayed within the antenatal outpatient unit.

Senior staff said they were good at retaining student midwives and attracted Band 7 midwives as well. However, they mentioned a national problem with recruiting Band 6 midwives.

Staff informed us community staff were sometimes used to cover staff shortages on the labour ward. We noted seven of the incidents reported between June and December 2017 were in relation to staffing issues. On one occasion an on call community midwife had worked for 20 hours in a 24-hour period. This occurred because the midwife was called to cover staff shortage on the ward following a prior shift in the community. On another occasion, a community midwife was on the labour ward for seven hours despite working 10.5 hours shift prior.

Medical staffing

Staffing skill mix

In August 2017, the proportion of consultant staff reported to be working at the trust (45%) was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 51.5 whole time equivalent staff working in maternity at Epsom and St Helier University Hospitals NHS Trust:

```
<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>47%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>4%</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)

There were 22 consultants working across the two sites and another consultant was due to start in February 2018. Of these, 12 consultants worked a rota at St Helier Hospital and provided 98 hours consultant cover.
Most consultants within the maternity and gynaecology service worked in both obstetrics and gynaecology (O&G).

Medical staffing also consisted of four clinical fellows, eight deanery trainees and seven senior house officers (SHOs).

A duty anaesthetist was available to the delivery unit 24 hours. This was a dedicated consultant for elective caesareans, and out of hours, a consultant was on-call.

Records

The unit used the national colour coded national maternity notes: green for antenatal care, yellow for labour and delivery and purple notes for postnatal care. The service also held its own set of ‘pink’ antenatal notes. Notes were stored securely and readily accessible to staff.

All women attending antenatal clinics carried their own pregnancy-related care notes and brought them when they came to the hospital.

We looked at seven sets of women’s records and three records for babies. The records were mostly comprehensive with all appropriate risk assessments completed. All the records reviewed were legible, signed and dated. Staff completed checklists including VTE risk assessments, partogram (a composite graphical record of key maternal and foetal data during labour), WHO checklist, charts for growth and early warning scores. Staff also recorded details of previous births and early pregnancy losses, social assessments, mental health assessments tobacco and drug use and pain score.

We noted however, that staff did not always write their designation or name in two maternal and three baby records reviewed.

Medicines

Medicines were generally stored safely and securely. All drug storage cupboards were securely locked and regular audits were completed regarding the accuracy of controlled drug documentation. Medicines requiring cold storage were stored in dedicated fridges in treatment rooms.

However, we observed the treatment room where drugs were stored on the birth centre was left unlocked. The fridge in the treatment room was also unlocked. We raised this with staff and they stated they would review the situation. Three other treatment rooms on the maternity unit were locked.

We found the treatment room on the birth centre locked during an unannounced inspection, however, the fridge remained unlocked. Senior staff explained they had left it unlocked for ease of access during an emergency.

Midwives were aware of the importance of documenting allergies and we saw evidence of this in women’s notes.

At the last inspection, midwives had started training in prescribing. During this inspection, we saw that midwives had had the appropriate training to prescribe certain medicines covered by midwives’ exemptions in the course of their professional practice without the need for prescription from a doctor. This allowed them to give timely medication, such as pain relief to women. After training, midwives gave the flu and pertussis (whooping cough) vaccine. They also had training in
anaphylaxis (a sudden and serious allergic reaction) and Bacillus Calmette – Guerin (BCG) vaccination.

Obstetric anaesthesia charts were completed including details of drugs and infusions in relevant notes reviewed.

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 November 2016 to October 2017, the trust reported no incidents, which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in maternity, which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with six (67% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only with one (11% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (11% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with one (11% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Staff reported 264 incidents at the St Helier Hospital site between June and December 2017. Of these, 160 incidents were classified as “no harm”, 88 as “low harm”, 11 as “moderate harm”, three as “severe harm” and two as “death caused by incident”. The two deaths were in relation to
neonatal still births. In addition, community midwives reported 20 incidents across both sites. One was classified as “low harm” whilst 19 were classified as “no harm”.

There had been three serious incidents at St Helier between June and December 2017. Compared with findings from our last inspection, action plans following serious incidents were time bound and actions were monitored effectively. We reviewed the root cause analyses of two of the incidents and were satisfied they were appropriately carried out. The results were presented to the local and directorate risk teams, the Labour Ward Forum, the bi-monthly quality meeting and the trust SI panel.

Staff at all levels were able to tell us how to report an incident and told us they received feedback both on individual incidents they reported and on incidents that affected their unit. Senior staff debriefed or supported staff involved in SIs. Trainee doctors were supported by their clinical supervisors and midwives by their supervisor of midwives. At the last inspection, we found trainee doctors were not involved in SI investigation. At this inspection, we saw evidence from RCA reports, which showed trainee doctors’ involvement in SI investigation panels.

Learnings from incidents were shared during handovers, team meetings, on staff notice boards and newsletters. Staff understood their responsibility under the duty of candour regulations and we saw examples of the correct process being followed from our review of RCA reports.

A trigger list for maternity incident reporting and a copy of the maternity service SI quality meeting was displayed within notice boards in staff areas.

Mortality and morbidity meetings were discussed at monthly perinatal meetings. We reviewed meeting notes from May 2017 to December 2017 and saw staff held detailed discussions about different maternity cases and learnings from these.

Safety thermometer

The maternity safety thermometer is a measurement tool for improvement that focuses on: blood loss over 500ml, perineal tears (tears to the area between the vagina and rectum during birth), maternal infection, the psychological well-being of the mother and the baby’s health scores in the first 10 minutes after birth.

The trust did not complete the national maternity safety thermometer at the time of this inspection, but most of the data was reported on the maternity dashboard.

The ward displayed ‘harm free care’ information from the standard safety thermometer. The number of staff planned and actual was also displayed.

Is the service effective?

Evidence-based care and treatment

There were clear policies and procedures in line with best practice guidelines. These included National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). Staff had access to guidelines on the trust’s intranet system. We reviewed some of the guidelines and found they were up to date.

A maternity guideline committee developed guidelines in the light of new evidence. At the last inspection, information about changes were inconsistently shared with staff. At this inspection,
there were systems in place to communicate changes in national guidance through monthly risk management newsletters, flash alerts and presentations to staff.

Several areas of concerns raised in our last report had been addressed. Data on numbers of women booking their first antenatal appointment by 10 weeks was now reported on the maternity dashboard. The unit now offered one to one care for women in labour in line with RCOG guidelines, Safer childbirth: minimum standards for the organisation and delivery of care in labour.

Midwives in the maternity assessment unit had access to fact sheets on key conditions such as hypertension in pregnancy and management of reduced foetal movements. These had flow charts to assist quick decision making. There were also brief guidelines to prompt evidence-based practice including post-partum haemorrhage (PPH) risk factors, third and fourth degree tear management and hypoglycaemia. A flow chart for midwifery red flag triggers was visible within the unit.

Sepsis screening and management was in line with national guidance. The use of the sepsis screening tool was embedded on the unit. Staff attended simulation training with a lot of concentration on sepsis management. A Sepsis 6 box was visible in all areas visited. Boxes were labelled with contents, which included high flow oxygen mask, catheter or urometer, intravenous fluids, antibiotics, blood culture bottles and blood gas signing for lactate. There were prompts visible on computers and around the unit stating “think sepsis, spot it, treat it. Beat it”.

The unit took part in national maternity audits such as the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK). They also took part in initiatives such as Sign Up to safety from which they had obtained funding for CTG interpretation and the introduction of the STAN foetal monitoring system.

The unit contributed data from the GROW (Gestation Related Optimal Weight) charts, customised antenatal charts for plotting fundal height and estimated foetal weight as part of the co-ordinated growth assessment programme (GAP).

There were 28 maternity-related audits on the Women’s division health tracker on a range of topics. These included PPH, intrapartum care, emergency caesarean audit, maternal sepsis, perineal trauma, obstetric anal sphincter injuries (OASIS) re-audit amongst others.

Data from the trust showed antenatal newborn screening compliance was 97.4% against a target of 95%.

(Sources DR8, DR59)

**Nutrition and hydration**

The maternity unit had the United Nations International Children’s Fund (UNICEF) baby friendly initiative Level 3 accreditation for supporting new mothers with the feeding of newborns (an international initiative to encourage breast feeding). The unit was now aiming for Achieving Sustainability Gold award in 2018. Between April 2017 and December 2017, the unit’s breastfeeding initiation was 83.5%.

Breastfeeding specialist midwives and maternity support workers helped support new mothers with breastfeeding. Ward staff carried out a structured assessment of breast feeding before mothers and babies went home to ensure that feeding was well-established. Women received a guide to feeding and caring for their baby as part of their antenatal information and midwives gave new mothers further guidance before discharge from the postnatal ward.
Senior staff informed us they did not have dietitians in the trust anymore. However, they had specialist midwives including diabetes midwife specialists who provided advice in line with women’s conditions. Diets were provided in line with patient’s dietary needs.

**Pain relief**

Women told us they received pain relief when required and this was reviewed regularly. Women’s options for pain relief included epidural analgesia and other options such as nitrous oxide (gas and air) and pethidine. Pain relief at the birth centre included the use of a birthing pool, massage, breathing and relaxation techniques.

At the last inspection, epidural rates were not reflected on the maternity dashboard. This data was now collected and the rate between April 2017 and December 2017 was 24.9%.

**Patient outcomes**

At the last inspection, the unit did not collect data on some of the standard maternity outcomes as recommended in line with the RCOG good practice guideline No 7 (Maternity Dashboard: Clinical Performance and Governance Score Card). It was not used to monitor staff sickness, use of agency staff or vacancies. Staffing details such as midwife to birth ratio, midwifery vacancy levels as well as compliance with some mandatory training modules were now recorded on a trust wide level.

At the previous inspection the hospital was only achieving one to one care for 90% of women in labour. The rate of one to one care in labour had now improved to 99.7%. Managers now prioritised one-to-one care of women in labour, which appeared not to have been a priority at the previous inspection.

At the time of the last inspection, the rate for episiotomy was 40%. However, there are no regional national or international expected rates. An episiotomy is a procedure performed during labour, in which a clinician cuts the area between a woman's vaginal wall and perineum (the area between the vagina and anus) in order to allow the baby to pass through the vagina more easily. Episiotomy is not recommended without clinical need as it is generally more painful for the woman, leads to greater blood loss and takes longer to heal. The current rate had fallen to 22.25%.

The previous inspection had shown higher than expected rates of severe post-partum haemorrhage (PPH) of 4%, or excessive blood loss during childbirth, which is a significant cause of morbidity and mortality. At this inspection, this had reduced slightly to 3.63% and we found the hospital was responding to these rates on several fronts. There was an audit into the accuracy of blood loss measurement associated with deliveries with greater than 1500 mls. The results of the audit would be reported to the Board Patient Safety and Quality Committee. The drug, carbetocin was being trialled to see whether its use was more effective at preventing PPH. In addition, the service had started to use a foetal pillow, a balloon device designed to elevate the foetal head when it is deep in the pelvic cavity during a caesarean section, making the delivery safer, easier and less traumatic for the mother and baby. Senior staff informed us it was too early to assess the impact of these changes.

The percentage of third and fourth degree tears during birth (also known as obstetric anal sphincter injury – OASI) had increased in the last year from 3.29% to 3.81%. The hospital had appointed a new specialist lead for perineal tear. The lead midwife covered both antenatal and postnatal services including education of staff on several areas including intrapartum care. The trust had adopted the use of episcissors, which have been found in research studies to reduce the incidence of anal sphincter injury by 43%. The trust aimed to keep the tear rate between 1.5 and
3.5%. We saw that the practice development newsletter for April focussed on promoting techniques to avoid injury to the anal sphincter as recommended by RCOG and there was a care bundle to support this.

The induction of labour rate was 31.67%, an increase from 27% at our last inspection. Senior staff explained that the introduction of GAP helped to reduce the rate of stillbirths. However, this also had the effect of increasing the induction rate.

Planned caesarean section (C-section) rate was about 9.3%, which was better than the England average. However, the overall caesarean rate was 28.97%, which was high. There had been a review of all category two and three caesarean sections. In addition, there were daily consultant reviews and quarterly C. section quality review meetings.

The rate of instrumental deliveries had slightly decreased from 12.83% last year to 12.48%. This was in line with the England average of 12.5%.

The unit had a 76% uptake of vaginal birth after caesarean section (VBAC). Clinics were held for women as part of birth choices.

An enhanced recovery programme for women having a planned caesarean section was in place. This encouraged early mobilisation to enable women to recover quickly after surgery and 93% of women had benefitted from this.

Very few women were smoking at the time of birth – the rate of 6.6% was below the national figure of around 10%. VTE assessment rate was 94.5%

There had been two stillbirths since April 2017. This was within the normal range of about five per 1000 births in England and Wales.

**National Neonatal Audit Programme**

In the 2016 National Neonatal Audit, Epsom and St Helier Hospitals performance was as follows:

Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?

**St Helier Hospital**
There were 41 babies born at <32 weeks included in this audit measure for the unit. 100% of these babies had their temperature measured within an hour of birth; this was above the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

**St Helier Hospital**
There were 104 eligible mothers identified for inclusion in this audit measure for the unit. 90% of these mothers were given a complete or incomplete course of antenatal steroids; this was above the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

What proportion of babies < 33 weeks gestation at birth were receiving any of their own mother’s milk at discharge to home from a neonatal unit?

**St Helier Hospital**
In order to more confidently attribute feeding outcomes to the unit, only babies who had a final neonatal discharge to ‘home’ at the end of their first episode of neonatal care are included in this analysis. Babies who were transferred between neonatal units at any point are excluded.

There were 41 babies born at <33 weeks who met the criteria for inclusion in the unit. 76% of these babies were receiving mother’s milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit; this was above the national average, where 59% of eligible babies were receiving any mother’s milk at the time of their discharge from neonatal care.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Standardised Caesarean section rates and modes of delivery**

From July 2016 to June 2017 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections as expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
<td>Caesarean rate</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.1%</td>
<td>496</td>
<td>10.7%</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.4%</td>
<td>832</td>
<td>17.9%</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.5%</td>
<td>1,328</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

In relation to other modes of delivery from July 2016 to June 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>EPSOM AND ST HELIER UNIVERSITY HOSPITALS 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>1,328</td>
<td>28.6%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>705</td>
<td>15.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>2,610</td>
<td>56.1%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>8</td>
<td>0.2%</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,651</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(n=608,950)</td>
<td></td>
</tr>
</tbody>
</table>

Normal (non-assisted) delivery rates were lower than the England average and instrumental (vacuum) delivery rates were higher than the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of November 2017 the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE 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 5.1. The comparator group was 5.19. The previous year’s score was 4.49.

(Source: MBRRACE UK)

Competent staff

There was a Practice Development Midwife (PDM) based on each site of the trust. The PDMs were led by a lead PDM. The practice development team monitored midwife competencies to make sure they were up to date with current practice based on national benchmark standards.

There were systems to ensure staff were competent to carry out their role. Newly qualified band 5 midwives had a one-year preceptorship programme. New staff were required to complete competency-based assessments before they could work independently. They went through an orientation program designed to make them familiar with all aspects of maternity care.

There was a buddy system where band 6 staff acted as buddies for band 5 staff. The mentor sign off list was displayed in inpatient areas. Senior staff explained they were getting new band 6 staff through mentorship training quickly so that they could mentor band 5 midwives.

There were specialist midwives for antenatal screening, diabetes, infant feeding, risk management, governance and bereavement as well as midwife sonographers. Some of the specialist midwives worked clinically one day a week.

Midwives we spoke with were complementary about the practice development midwives. They felt they could discuss training needs with senior staff who were flexible in accommodating their needs. There were leadership development courses for band 6 midwives who hoped to progress to band 7.

Some midwives were trained in the New-born and Infant Physical Examination (NIPE). Hospital paediatricians were also carrying out NIPE checks. A new NIPE clinic had been started for which appointments were available to ensure babies had the check within 72 hours of birth and then again (by the health visitor) at 6-8 weeks of age.

Some midwives had training in mental health and in safeguarding.
Band 7 midwives had neonatal advanced life support (NALS) training. The home birth team also had NALS training. We were told most midwives had intermediate life support training.

Only one midwife on each site was trained in HDU level 2 care. This was not enough to ensure there was always someone with this training on every shift. Senior staff said they would like to support band 7 roles to become HDU leads.

Midwives attended annual study days. These involved scenario-based training covering emergency obstetric situations such as post-partum haemorrhage (excessive bleeding after childbirth) and shoulder dystocia (where baby’s shoulder becomes stuck in the birth canal after delivery of the head). PDMs told us they reviewed training needs every year and incorporated learnings from incidents. Midwives told us they found these sessions useful and attending allowed them to keep their skills up-to-date should an emergency happen. There were also regular unannounced ‘skills and drills sessions’.

The trust had also adopted human factors training and was training the trainer. Human factors training supports safety by helping staff gain better understanding of the behaviour of individuals, their interactions with each other and with their environment to help prevent accidents.

Midwives felt rotation into the risk role was helping to embed safety, and midwife rotation across sites had been valuable for their development and enabled the units to work better together as well as influencing the culture.

Trainee doctors were satisfied with the level of support they received from obstetricians. This included regular and adhoc teaching as well as opportunities for involvement in audit.

(sources: DR20, DR78)

**Appraisal rates**

The trust have an annual appraisal cycle. End of year reviews are completed in quarter four each year. The most recent data therefore is for quarter four 2016-17 and there is no year to date information to provide.

From December 2016 to March 2017, 59.2% of staff within maternity at the trust had received an appraisal compared to a trust target of 80%.

A split by unit group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Maternity unit</th>
<th>Percentage of last year</th>
<th>Number completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal (St Helier) - Nursing</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>Antenatal Pod (STH)</td>
<td>90.9%</td>
<td></td>
</tr>
<tr>
<td>Community Midwifery (St Helier) - Nursing</td>
<td>31.7%</td>
<td></td>
</tr>
<tr>
<td>Midwifery Management - Trust Wide</td>
<td>83.3%</td>
<td></td>
</tr>
<tr>
<td>Neonatal Unit (STH)</td>
<td>70.6%</td>
<td></td>
</tr>
<tr>
<td>Ward Maternity (STH)</td>
<td>76.8%</td>
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</table>

St Helier Hospital had a 67.2% appraisal completion rate.

(Source: Routine Provider Information Return (RPIR) P43 Appraisals)

Staff confirmed they had annual appraisals. Some of the staff we spoke with had not yet had an appraisal in 2017 but expected to have it before the end of the financial year in March 2018.
The pattern was for Band 6 staff to appraise band 5 staff and Band 7 staff to appraise Band 6. An experienced midwife had recently been appointed to support supervision of midwives.

**Multidisciplinary working**

Staff reported good working relations between the medical team, midwives and other staff. We observed good communication between midwives and obstetricians in delivery of care.

The maternity unit held a huddle at 9AM every morning to assess workload and ensure effective communication and distribution of staff. We observed a morning huddle and it was attended by multidisciplinary team of midwives, students, doctors, ward managers, the consultant midwife and lead community midwife.

There were weekly multidisciplinary team meetings to discuss women with screening results, which may impact their pregnancy, and plans are made for delivery.

Many women had their antenatal care from midwives in GP surgeries. Midwives reported they had good working relationships with GPs and other community specialists. We saw that midwives completed the child health record (Red book) to handover care to health visitors. There was a process for midwives to inform health visitors of all pregnancies and to alert them to post-natal issues at discharge.

Staff held a monthly antenatal safeguarding forum, which included social workers from the local authority, health visitors and the clinical lead. Staff created action plans for patients at risk during those meetings. Staff held bi-weekly meetings with a liaison psychiatrist and an officer from Public Health England to discuss patients with extra needs. This ensured that women with extra needs benefit from a coordinated approach from different agencies.

**Seven-day services**

Consultants covered the delivery suite every day including weekends between 8am and 9pm (98 hours a week). Each consultant covered a full day 8am to 5pm and all consultants took part in the rota. This is an improvement from the last inspection when consultant cover Saturdays and Sundays was for six hours each day. A consultant was always on call and could attend within 30 minutes.

The early pregnancy assessment unit operated an appointment based system. Senior staff said they did get the occasional walk in patient. It was opened from 8.30am to 12 noon, Monday to Friday. At weekends, on call medical team see all emergencies at the accident and emergency unit. Community midwives ran clinics for antenatal and postnatal women on Saturdays.

The maternity assessment unit opened from 8.30am to 5pm, Monday to Friday. Senior staff explained they have moved to an appointment based system to manage flow.

Home birth services were available 24 hours a day, every day of the week.

**Health promotion**

The trust participated in a number of initiatives to promote the health and wellbeing of women and babies. Babies were offered BCG vaccination and there was access to mental health provision for pregnant woman and mothers, with referral to psychiatric input if needed. Women also had access to specialist clinics including diabetes and weight management.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
The trust reported that as of October 2017, Mental Capacity Act (MCA) and Deprivation of Liberty training part of the module called safeguarding adults (level 2) had been completed by 38% of staff in within maternity.

(Source: Trust Provider Information Return P14/P49)

Staff had access to mental health/deprivation of liberty safeguards guidelines on the trust intranet. Staff were able to talk about the deprivation of liberty safeguards (DoLS) and how this would impact a woman on the unit. Staff were aware of their responsibilities under the Mental Capacity Act.

Our review of patient notes showed that staff completed mental health assessments with prompts to identify anxiety and depression. We saw staff obtained and recorded verbal consent where appropriate, such as before a vaginal examination and written consent was recorded for procedures such as caesarean section.

Is the service caring?

Compassionate care

Feedback from women and their partners were mostly positive. Most women were complementary about the antenatal and postnatal care received on the unit. Women said they were pleased with their care and described as “good” and “excellent”. Women described staff as polite, professional, well informed and organised. They said midwives and consultants were friendly and caring.

However, one mother we spoke with on the postnatal ward said midwives did not always attend to her when she rang the bell. She also said her requests were sometimes forgotten. Another mother on the postnatal ward said staff were responsive and supportive. She said staff had been “really fantastic and I feel really looked after”.

All observations of care we made were positive, showing kind and compassionate care. We observed staff interactions with patients. Staff were courteous, professional and engaging. We saw staff maintaining patient privacy and dignity by drawing the curtains around patient areas before completing care tasks.

We saw many “thank you cards” from mothers displayed within the unit. Staff confirmed they were satisfied with the level of care they provided to patients. One staff mentioned that they would sometimes go over allocated hours to ensure they provided safe care.

Friends and Family Test performance

Friends and family Test performance (antenatal), Epsom and St Helier University Hospitals NHS Trust
From October 2016 to September 2017 the trust maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average with a seasonal drop during winter months.

Recent data showed between April and December 2017 St Helier’s maternity Friends and Family Test result for the antenatal unit was 90%. On average eight women a month commented which was low.

Friends and Family Test performance (birth), Epsom and St Helier University Hospitals NHS Trust

![Graph showing Friends and Family Test performance (birth) for Epsom and St Helier University Hospitals NHS Trust from October 2016 to September 2017. The graph shows that the performance was generally similar to the England average with a peak in December 2017.]  

From October 2016 to September 2017 the trust maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

Most recently in September 2017 the trust performance was 98% recommended compared to 96% of the England average.

Recent data showed between April and December 2017 St Helier’s maternity Friends and Family Test result for the delivery suites was 94%. The delivery suites had a higher response rate (compared with the antenatal unit) with an average of 27 women a month responding.

During the same period, St Helier’s maternity Friends and Family Test result for the birth centre was 98% with an average of 26 women a month responding.

Friends and Family Test performance (postnatal ward), Epsom and St Helier University Hospitals NHS Trust

![Graph showing Friends and Family Test performance (postnatal ward) for Epsom and St Helier University Hospitals NHS Trust from September 2016 to September 2017. The graph shows that the performance was generally better than the England average with a peak in September 2017.]  

From October 2016 to September 2017 the trust maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally better than the England average.

Performance of the postnatal ward was 99% for the trust compared to 94% of the England average.

Recent data showed between April and December 2017 St Helier’s maternity Friends and Family Test result for the postnatal wards was 98% with a response rate of 17 women a month.
Friends and family test performance (postnatal community), Epsom and St Helier University Hospitals NHS Trust

From October 2016 to September 2017 the trust maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

Performance of the postnatal community was 89% for the trust compared to England average score of 98% in September 2017.

(Source: NHS England Friends and Family Test, DR8 – maternity dashboard)

We were informed the Maternity Friends and Family response were lower than the London average and at a relatively low level compared to 2017. The trust aimed for a response rate of 30% and scores of 95% for 2018. Staff were seeking to identify options for improvement, including working with the Patient Experience Team.

CQC Survey of women’s experiences of maternity services 2015

The trust performed similar to other trusts for all 16 questions in the CQC maternity survey 2015.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
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</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>About the same</td>
<td>8.62</td>
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<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>7.89</td>
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<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>About the same</td>
<td>9.23</td>
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<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>About the same</td>
<td>9.45</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.06</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>About the same</td>
<td>7.75</td>
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<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>7.91</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>About the same</td>
<td>9.34</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth,</td>
<td></td>
<td>8.35</td>
</tr>
</tbody>
</table>
were you involved enough in decisions about your care?  the same
Thinking about your care during labour and birth, were you treated with respect and dignity?  About the same 9.04
Did you have confidence and trust in the staff caring for you during your labour and birth?  About the same 8.77

Care in hospital after the birth
Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?  About the same 7.25
Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?  About the same 6.90
Thinking about your stay in hospital, how clean was the hospital room or ward you were in?  About the same 7.83
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?  About the same 6.99
Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?  About the same 5.86

The trust performed similar to other trusts for all most questions in the CQC maternity survey 2017. The trust performed better than other trusts in three questions:

‘Did the staff treating and examining you introduce themselves?’ (9.6/10)
(9.6/10)
‘Did you have confidence and trust in the staff caring for you during your labour and birth?’ (9.4/10)
‘Were your decisions about how you wanted to feed your baby respected by midwives?’ (9.6/10)
The trust also used the feedback gathered by the maternity voices partnership to monitor feedback from women.

(Sources: CQC Survey of Women’s Experiences of Maternity Services 2015, AC30, AC31)

Emotional support

Most women we spoke with confirmed staff explained processes in detail and were reassuring. Women using maternity services could access support for specific health related issues including diabetes or mental health needs. Midwives assessed women for anxiety and depression during their initial antenatal appointment.

Women had access to counselling services, which included one to one counselling with a midwife counsellor. A bereavement midwife was responsible for speaking with women who had been bereaved during or after childbirth or had a late miscarriage or termination for medical reasons. Such women receive postnatal support and were cared for in a dedicated room for bereaved women called the “Poppy Room”.
Counselling staff expressed their desire to set up a local bereavement group in Sutton for mothers/couples affected by pregnancy loss or neonatal death.

Trained screening midwives counselled pregnant women undergoing screening tests to check for genetic anomalies. This process ensured women were fully informed about the test and the possible implications before going ahead. Midwives or consultants provided de-brief appointments for women whose antenatal screening results identified anomalies. As well as providing the opportunity for emotional support, these meetings allowed women to discuss their results, the implications, and to plan the next steps.

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

Women we spoke with said they had been involved in decisions about their choice of birth location and benefits and risks of each. They felt staff supported their decisions. One partner who was present at the time of our inspection informed us they felt included in the process.

Women said they had been given a range of information and were clear about their birth plans and explanations of treatment. Most women said doctors and midwives had answered their questions and were reassuring.

Our review of care records showed women were advised of their options at every stage of their pregnancy including when complications occurred. Staff recorded consent was obtained before caring out procedures in line with women’s care.

The consultant midwife led one to one debrief/birth reflections for women who wanted to obtain a greater understanding of events surrounding the birth, why possible intervention was necessary, and the possible implications for future births.

**Is the service responsive?**

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

Women were either referred to maternity services by their GP or could refer themselves to the hospital. Women were advised to self-refer before the end of their ninth week of pregnancy to ensure they went through the necessary screening processes. Women were provided with relevant information about their pregnancy and care at the maternity unit. These included a booklet titled “Your parent journey starts here: What you can do to meet your baby’s needs”. Mothers were provided with a newborn pack, which included relevant information about services they could access.

Community midwives offered antenatal booking appointments in community premises, mainly GP surgeries and community centres. Community teams had recently been reconstituted from two teams to four teams with each team covering a specific geographical area. This helped to ensure women had access to midwives in their local area. The service was moving towards establishing continuity of care for women before and after birth. In line with this, community midwives had started booking women for antenatal appointments, a role previously solely carried out by midwives within the antenatal unit. Four of the women we spoke with said they had not seen the same midwife during their antenatal care while two confirmed they had seen the same midwife.

An early pregnancy assessment unit (EPAU) ran weekday mornings for women in the very early stages of pregnancy who had concerns about their baby. It was staffed by one midwife and one maternity assistant. Staff used an EPAU assessment sheet designed to save mothers repeating the same distressing information at each appointment in the unit. At the last inspection, there was no access to drinking water on the EPAU and women had to go to the antenatal clinic to get a glass of water. During this inspection, we found there was still no access to drinking water for
women in this area. Staff informed us they supplied drinks to women on request.

Women over 20 weeks attended the maternity assessment unit (MAU) for assessment of pregnancy specific concerns including reduced fetal movement, presentation scans, CTG monitoring or for concerns about pre-eclampsia.

A midwife led birth centre in the main maternity unit had facilities for women with low-risk pregnancies to give birth to their babies. The birth centre was well equipped with birthing pools, relaxing lighting, birthing balls and stools. Eighteen per cent of deliveries took place at the birth centre between April and December 2017.

There was also an option of home birth, which accounted for 1.36% of deliveries between April and December 2017. Senior staff said they aimed to increase this to 8%.

The obstetric led delivery suite provided for women over 34 weeks gestation.

Women had access to antenatal classes ran by midwives. These included an antenatal infant feeding workshop.

The room designated for women who were bereaved (Poppy room) was on the labour ward. At the last inspection, we found this was clinical in appearance with a hospital bed and no sympathetic design features. The room still looked clinical in appearance, however, was an ongoing initiative by a woman who had previously used the service to raise £20,000 to redecorate the Poppy room.

**Bed Occupancy**

From April 2016 to September 2017 the bed occupancy levels for maternity were generally lower than the England average, with the trust having ~40% occupancy in Q2 2017/18 compared to the England average of ~60%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)
Meeting people’s individual needs

There was a range of leaflets in display on the antenatal waiting areas providing information about antenatal classes and maternity care. Women could also access a range of information on the trust’s website.

The maternity dashboard showed about 5.36% of women booked between April and November 2017 required an interpreter. All of these women had access to interpreting services. Access to language support was written in 11 different languages and displayed within the antenatal clinic area.

Women on the postnatal ward said they had access to good shower facilities. They also said they were provided with a new born pack as well as food and water. Women in the inpatient units had access to hot food at any hour of the day.

Single rooms were prioritised for women’s use on a case by case basis. Staff confirmed they usually prioritise women with complex needs. However, it was also offered for private payment services when available.

All women were offered up to three parent education sessions delivered by community midwives in children centres.

Women had access to a variety of clinics including diabetes clinics and weight management clinics. Newborn and infant physical examination (NIPE) clinics were scheduled to commence in February 2018.

Staff had access to mental health services and referred women were necessary.

Women could access the learning disabilities nurse advisor and midwives referred them as appropriate.

Breastfeeding support was provided and the unit advertised the values of breastfeeding to mother’s and staff.

Face to face breastfeeding support was available daily within the area covered by the trust. These were in antenatal clinics and GP surgeries, and infant feeding support workers gave advice to women after birth.

Access and flow

Women informed us they found it easy to make appointments with the antenatal team. We received mixed feedback about waiting times. One woman said appointments were on time with no delays, another said they waited for approximately 20 minutes whilst another said they waited for 40 minutes. The trust did not routinely audit waiting times for patients seen in the antenatal clinic.

St Helier maternity dashboard showed 82% of women booked their maternity appointment by nine weeks and six days of pregnancy with 94% of women booking by 12 weeks and six days. This was an improvement from data presented during our last inspection, which showed 75% of women booked their first appointment by the 13th week of pregnancy.

Did not attend (DNA) rates were high at 9%, an increase from 7.84% in the previous year. Senior staff told us DNA rates was on their radar especially in relation to perinatal mental health. There was a new policy in place to contact patients after a missed appointment. Vulnerable patients were to be contacted earlier by phone.
A high proportion of women still cancelled appointments, on average 15.75% up from 13.24% the previous year. This showed no improvement from our last inspection.

Admission processes when women thought they were in labour had improved. At the last inspection, we found women were not offered a dedicated telephone line for triage. At this inspection, a triage service had been established with the benefit of managing capacity on the delivery suite and quicker assessment for women. There was a dedicated triage midwife on duty in line with NICE guideline CG190.

Between April and December 2017, the postnatal length of stay after vaginal birth (equal or less than two days) was 78%. During the same period, the postnatal length of stay after caesarean section (equal or less than three days) was 74%.

There had been no closure in the last year due to overcapacity.

(Source: DR8, DR18, DR60 - DR62)

**Learning from complaints and concerns**

**Summary of complaints**

From October 2016 to September 2017 there were 34 complaints about maternity. Eighteen of the complaints relate to all aspects of clinical treatment, followed by five around staff attitude and four relating to communication/information to patients (written and oral).

(Source: Provider Information Return P55)

The most recent data from the trust indicates there were 14 complaints about the maternity unit at St Helier between April 2017 and December 2017.

Information on how to make a complaint was available to women in the antenatal clinic as well as on the wards. Women also confirmed they understood the procedures for raising complaints.

We visited the Patient Advice and Liaison Service (PALS) office and were informed the maternity service did not get as many complaints as they used to. Staff in PALS explained they had good working relationship with the maternity team. They said complaints were now handled well by management, treated as important and dealt with quickly.

The trust had implemented an early morning urgent slot (for scanning) at the maternity assessment unit in response to complaints from women about the length of time they waited.

**Is the service well-led?**

**Leadership**

There had been leadership changes with the appointment of a new head of midwifery and a new clinical director for obstetrics. The head of midwifery and clinical director for obstetrics reported to the divisional director for women and children.

Medical leadership also included a clinical lead for obstetrics, consultant lead for risk and quality in obstetrics and a delivery suite lead at each site.

Three consultant midwives, one for public health and two who promoted normal births, supported the head of midwifery. There were lead midwives for inpatients, as well as antenatal and
community midwives on each site. There was also a lead midwife for governance. A Band 7 midwife led each team. Band 7 midwives were often rotated across both sites. Band 7 staff were allocated seven and a half hours per month for administrative duties.

We received mixed feedback about the leadership of the unit. Doctors felt supported by the wider team as well as medical colleagues and told us they received good support from consultants. Some staff (including doctors and midwives) informed us the management within the maternity unit was visible and approachable. They felt the leadership was calm and relaxed with a clear tone of responsibility and direction and collaborative working was much more evidence. However, some midwives felt they did not receive support from their line manager. Some felt the leadership was a bit disjointed and felt there was a lack of communication from their direct line manager.

Vision and strategy

At the last inspection, we found there was no shared strategy or vision. St Helier maternity services were part of a Better Births project in conjunction with other local hospitals, and building on improved provision of safe local maternity care for local women and increasing the proportion of women having normal births. From our discussions with senior staff we felt individual leaders had specific aspects of the service that they wanted to improve rather than a shared vision.

The Women and Children’s Division Operational Plan for 2018-19 set out the strategic objectives. The major project for the year ahead was implementation of Maternity Information System.

The trust had committed to the Caring for You Campaign (The Royal College of Midwives) and constructed an action plan for maternity services to deliver the charter which is about caring for staff well so they can provide good care to women and families.

The trust had set out a long-term plan, now at consultation stage, to gain support for investing in a new specialist acute unit for the trust on a new site. For maternity, this would mean a larger delivery suite and birth centre on one site, enabling 168 hours consultant cover as opposed to the 98 hrs a week cover that was in place. Antenatal and postnatal clinics would continue at all sites and in the community. However, no staff mentioned this long-term plan to us on inspection.

Staff were aware of the trust’s values of putting the woman first; working as a team and showing mutual respect, and demonstrated these in their care.

(Source: DR64, P121, DR123, AC32)

Culture

We received mixed feedback about the culture of the unit. Some staff mentioned that they loved their jobs and had opportunities for training and development. They felt they worked in a positive environment with friendly staff.

Other staff mentioned they were just told what they had to do. They felt senior staff could do more to listen to staff and also to involve staff in any changes they wish to implement, for example, rotating staff within the maternity unit. Some staff felt there was limited flexibility for work life balance and community staff said they had very busy days and sometimes worked late.

There were some equality and diversity issues and a section of staff did not feel listened to, or valued. Some of these staff members described the work environment as “toxic”. At the time of our inspection, Black and minority ethnic (BME) midwives had raised a collective grievance about unfair treatment within the maternity unit. BME midwives felt they were more likely to enter formal disciplinary process following an incident compared with non-BME colleagues. They also felt
discriminated against in terms of promotion and opportunities for development. Some felt targeted and victimised for being too vocal. BME midwives we spoke with gave examples of unfair treatment including lack of support to develop into management roles, being given more workload and more complex cases, and lack of confidentiality when going through a disciplinary procedure.

The chief executive met with BME midwives following the grievance raised and listened to their concerns. Senior staff informed us they had looked at addressing issues raised in the grievance and have trained staff to address any skills shortages. We were informed some BME staff were successful in a recent recruitment to Band 7 posts.

The trust conducted an investigation into the grievance raised. BME staff confirmed the trust had met with them collectively and individually. However, they expressed disappointment that minutes of meetings held did not reflect the discussion they had with the trust.

Following our inspection, the trust provided us with a copy of the investigation report, which provided details of the trust’s findings, recommendations, and action plan. The investigation found there was more positive leadership of the service following the appointment of a new Director for Midwifery and specialist midwives. However, it highlighted lack of management skill at Band 7 level and indicated this rather than race discrimination would account for many unfavourable work experiences detailed by BME midwives. The report also indicated there had been a serious breakdown in trust and confidence between black and white midwives. Several recommendations were made and these included a program of diversity training for Band 7 managers, review of the criteria for caseload allocation and career progression, and a corporate structure for investigations.

The trust had recently created a new role for an Equality, Diversity and Inclusion Manager. This manager was appointed to the role in September 2017 and they aim to develop an equality, diversity and human rights strategy by April 2018.

**Governance**

Maternity was within the Women’s and Children’s Services Division and the management structure included gynaecology. The lead midwife for clinical governance held responsibility for managing risk within the maternity services, including monitoring Datix and compliance with learning outcomes, and action resulting from serious incident review. Two part time risk midwives (one for each site) supported the lead.

Senior staff held bi-monthly divisional review meetings covering the Women and Children’s Division. There were monthly maternity risk meetings and quarterly directorate meetings chaired by the divisional director. There were monthly /bi-monthly guideline meetings to review and update guidelines. Following any updates, newsletters were sent to staff to ensure they were aware of the updates. There was also a labour ward forum led by the lead midwife for inpatient services. This was open to all staff to attend.

We noted the maternity dashboards now contained some staffing information. However, this was trust wide and did not reflect staffing needs on each site. Although information on the dashboards were colour coded to reflect areas of concern, it did not reflect trust targets or national comparisons.

**Management of risk, issues and performance**

At the last inspection the management of risks was reactive not proactive. This has now improved and most high level risks we identified were on the maternity risk register and mitigating controls were in place. There were risk midwives based on each site. They reviewed all maternity incidents
and ran weekly meetings to review the more significant incidents. They produced a risk newsletter each month to share learning from incidents and complaints. We saw copies on display on noticeboards. Senior staff highlighted improvements made on serious incident reports which now featured a glossary of terms.

The information technology system was identified as an extreme risk on the risk register. The system was not robust and entries on the system were subject to errors. The maternity unit had secured funding to replace the system by April 2018. Obstetric sonographer vacancies were identified as a high risk due to a national shortage of trained sonographers. A business case was put in place to train up to six midwives to carry out ultrasound scans. Three midwives were already trained by the time of our inspection.

Senior staff identified retention of Band 6 midwives and the grievances of BME staff about opportunities and support as a concern. However, these were not highlighted on the risk register.

The hospital had better data than at the previous inspection but outcomes for women were in some cases below the trust’s expectations. Quality improvement projects aimed at addressing these areas had yet to show impact on performance in a number of areas including caesarean sections and induction in labour.

There was an audit schedule in place, which covered a number of areas of risk. Findings were fed back to staff through clinical quality half days on which all elective clinical activity was cancelled to enable staff to attend.

Regular risk meetings were open for all staff to attend if they wanted to. Learning from these meetings were disseminated in the newsletter.

The trust had reviewed its response to the Kirkup inquiry recommendations following the Morecambe Bay investigation (2015), to provide assurance that key issues identified there could not occur at the trust. They had reviewed and updated this in December 2017 after Supervision of Midwives arrangements, on whose shoulders many of the actions fell, had ended. They had appointed an experienced midwife to manage supervision in January 2018.

(Source: DR63)

**Information management**

Relevant information were displayed on notice boards within the maternity unit including assessment tools, flow charts, information around risk management, the risk register, maternity newsletter and the trust’s maternity dashboard.

The trust had implemented plans to replace the IT system by April 2018. The new system would allow easier analysis of data and would allow real-time recording of all events in the community. Staff hoped the infrastructure would support faster intranet access through the new system. Community midwives would have remote access to the new system through a tablet.

Guidelines were stored in an electronic resource on the trust’s intranet. Those we reviewed were up to date.

**Engagement**

The hospital used the Friends and Family Test to engage with women and seek feedback. However, the response rates were relatively low.

The trust had an active maternity voices partnership (MVP) an advisory group made up of professionals and parents working in partnership, including staff, representatives of clinical
commissioning groups (CCGs), parents who have used the services in the last five years and other community groups such as National Childbirth Trust (NCT). We also saw evidence of engagement between maternity services and a local Healthwatch group. This was a significant improvement in engagement with local stakeholder groups since our previous inspection in 2015.

The trust had been creative in improving the spread of information among staff at handovers, risk meetings, skills and drills, ward meetings and through newsletters and risk alert.

The unit celebrated success both in highlighting staff good practice and performance results such as high levels of completion of the WHO surgical safety checklist or high levels of assessment for the risk of blood clots. The unit recognised outstanding members of staff through the employee of the month award.

Staff had access to a staff room equipped with a fridge, kitchenette. Information displayed noticeboards included staff shout outs. This allowed staff to post notes on what they were doing well and say something great about colleagues.

The Maternity BME network group was set up last year. The network group aimed to hold listening workshops on quarterly basis to encourage meaningful and productive engagement with staff from minority ethnic backgrounds. The network invited speakers to speak on a variety of topics during the listening workshops. The Director of Midwifery was scheduled to attend the workshop as a guest speaker in April 2018.

The trust staff survey response rate was 56% - well above the national average. The engagement score in the staff survey was 3.8. This was about national average, and lower than in 2015. We did not have a breakdown for the maternity service.

We received mixed feedback about staff engagement. Most midwives were positive about recent changes and staff involvement in planning. However, some midwives felt they were just told what to do and their views were not reflected in the delivery of services.

**Learning, continuous improvement and innovation**

The maternity unit had recently received the health star award for patient care.

A midwife counsellor at St Helier was awarded the midwife of the year award by the foundation for infant loss training. This was in recognition of feedback received from patients and professionals for the support provided to bereaved families.

The trust had secured successful bids in the last one year for several initiatives including maternity safety training funding, safeguarding education, better births ‘early adopter’ site at Epsom and better births ‘pioneer’ site at St Helier.

The sepsis toolbox developed in maternity unit contained items required by the ‘sepsis 6’ protocol and was now widely used throughout the hospital.

Community and home birth midwives were working with the ambulance service to support paramedics with training in delivering babies.

The Home Birth Lead had won the Birthplace Matters ‘Home Birth Midwife of the Year’ award for 2017. The trust had set up a dedicated team of experienced and enthusiastic midwives, to offer home birth with individualised continuity of care for women and their families.
Facts and data about this service

The children’s service at Epsom and St Helier University Hospitals NHS Trust is provided on two sites: St Helier Hospital in Carshalton, in the London Borough of Sutton and Epsom General Hospital in Surrey. This report is about services at Queen Mary Hospital for Children at the St Helier Hospital site.

The trust’s hospitals provide services for neonates, children and young people. These include two dedicated emergency departments, two children’s inpatient wards, dedicated day surgery units, outpatient facilities and medical investigation/assessment units.

Neonatal care is provided on both sites. St Helier Hospital has a Local Neonatal Unit (level two). (Source: Routine Trust Provider Information Return (RPIR) – Sites Acute tab).

The neonatal unit (NNU) at Queen Mary’s Hospital for Children on the St Helier Hospital site, provides high dependency, level 2 care which includes two intensive therapy, four high dependency and 12 special care cots.

The Queen Mary’s Children’s Hospital has an 18 bed children’s inpatient ward. In addition, there is a six bed assessment unit, which opens from 8am to 8pm seven days a week. The children’s outpatient department has 10 clinics seeing approximately 170 patients a day. Surgery for children is carried out in the day surgical unit on the third floor of the children’s hospital. A children’s community nursing team are based in the hospital, providing care for children within the local community following discharge from their original point of care.

Epsom and St Helier University Hospitals NHS Trust percentage of spells in children’s services by type of appointment and site from August 2016 to July 2017.

![Graph showing percentage of spells by type and site]

**Total number of children’s spells by Site, Epsom and St Helier University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helier Hospital</td>
<td>3,765</td>
</tr>
<tr>
<td>Epsom Hospital</td>
<td>2,164</td>
</tr>
<tr>
<td>This trust</td>
<td>5,929</td>
</tr>
<tr>
<td>England total</td>
<td>1,098,341</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)
Is the service safe?

Mandatory training

We reviewed the children and young people service compliance rates of mandatory training completion. This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 95% for the completion of all mandatory training. The trust provided training completion data as at August 2017.

The mandatory training programme included basic life support, infection prevention and control, medicines management, information governance, safeguarding, manual handling, conflict resolution, equality and diversity, health and safety and patient handling.

Mandatory training was undertaken as e-learning modules, classroom-based learning and simulation sessions.

Mandatory training completion rates

A breakdown of compliance for mandatory courses as at October 2017 for medical/dental and nursing/midwifery staff in children’s services care is shown below:

<table>
<thead>
<tr>
<th>Medical Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>83%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>75%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>75%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>74%</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>95%</td>
<td>74%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>66%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>61%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>49%</td>
</tr>
</tbody>
</table>

The medical and dental staff did not meet any of the training rates with a completion above the trust target of 95%; the lowest completion rate was for information governance with 49%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling – People</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>82%</td>
</tr>
</tbody>
</table>
The nursing staff met six of the 10 training with a completion above the trust target of 95%; the lowest completion was for information governance with 39%.

St Helier Hospital had an 84% mandatory training completion rate; three modules met the trust target of 95%. *(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

Training completion rates were higher at St Helier Hospital for nursing and midwifery staff when compared to the medical and dental staff group across the trust, with an overall completion rate of 84%. The completion rates for information governance (82%), blood transfusion (85%) and venous thromboembolism (67%) were below the trust target of 95%. *(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

Medical and nursing staff told us they were given sufficient time to complete their training. However, when we reviewed the data provided by the trust, compliance levels were below the required target in some modules such as resuscitation training for medical staff at 75% completion.

**Safeguarding**

We reviewed the trust’s organisational policy and procedures on safeguarding children and young people, which were available on the trust intranet. The policy was current and detailed individual responsibilities and the process to follow for reporting and escalation of concerns about child welfare or maltreatment. There was a named safeguarding lead nurse contactable by dedicated telephone number. There was also a named safeguarding lead doctor and designated doctor contactable via the main hospital switchboard. Named professionals received regular safeguarding supervision. The service also had nine safeguarding supervisors in post and had identified five more staff to undertake training.

All of the staff we spoke with had a good understanding of safeguarding for both adults and children and were aware of their responsibilities. They were able to define triggers that would prompt them to obtain a safeguarding assessment and were clear about who they would contact if they needed to escalate safeguarding concerns.

Safeguarding information, including contact numbers and details of the trust lead were easily available on wards and staff were aware of how to access this support. Staff were able to give examples of concerns they had identified and when referrals were made.

A protocol was in place for sharing information between agencies when there were child protection concerns. Nurses could describe how they would contact the safeguarding midwife, health visitors and local authority social workers regarding a baby or child both during the day and out of hours if required. Community nursing staff received regular safeguarding supervision for their case load.

Child protection information including social information was recorded on patient records. Medical and nursing staff routinely discussed safeguarding concerns at daily handover meetings, for example children who were subject to child protection plans.

The staff we spoke with were aware of female genital mutilation (FGM), (the practice of partially or totally removing the external genitalia of girls and young women for non-medical reasons), and there was a protocol in place for escalation. Staff told us they felt comfortable to report and escalate concerns.

The trust participated in local safeguarding children’s boards with other partners in the local health and social care economy. The trust had developed an adults’ and children’s
safeguarding hub and safeguarding team. The team enabled the monitoring of children and young people’s safeguarding in divisions where children and young people attend within all areas of trust. The safeguarding hub provided daily tracking of inpatients between 16 and 18 years of age who were receiving care from other trust services and not only the children’s division.

Safeguarding children training formed part of the trust’s mandatory training programme. Clinical staff working with children and young people completed level three safeguarding training which consisted of face to face training. Doctors in training also completed level three safeguarding training and attended safeguarding meetings each week.

The trust provided training completion data relating to children’s safeguarding levels 1, 2 and 3 modules as at October 2017. The trust set a target of 95% for completion of safeguarding training. St Helier Hospital had an overall safeguarding training completion rate for all medical/dental and nursing/midwifery staff in children’s services of 75%.

Data submitted by the trust in January 2018 reported that safeguarding training figures had improved and 88% of medical staff had level 3 safeguarding training, 100% of nursing staff in the outpatients department had level 3 training, and 90% of NNU staff had level 3 training.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as at October 2017 for medical/dental and nursing staff in children’s services is shown below

<table>
<thead>
<tr>
<th>Medical Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>79%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>79%</td>
</tr>
</tbody>
</table>

The medical and dental staff did not meet any of the three safeguarding training with a completion above the trust target of 95%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>97%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>70%</td>
</tr>
</tbody>
</table>

The nursing staff did not meet one of the three safeguarding training modules with a completion above the trust target of 95%. However, staff explained that staff that received level 3 training superseded the requirement for eligible staff to complete level 2.

**Cleanliness, infection control and hygiene**
All of the children and young people clinical areas were visibly clean and clutter free. Hand sanitisers were available throughout the wards and at the point of entry. There were clear, child friendly handwashing instructions at handwashing basins as well as signage to inform visitors to use hand sanitisers. There was easy access to personal protective equipment (PPE) such as aprons and gloves throughout the wards and at the entrance to side rooms. We witnessed staff using PPE effectively.

Throughout our inspection most staff were observed to be ‘bare below the elbow’ and adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces. Staff told us they felt confident to challenge staff to ensure they were ‘bare below the elbows’ and used PPE such as gloves and aprons. We observed reception staff on the neonatal unit (NNU) asking visitors to wash their hands upon entering the unit.

Infection, prevention and control (IPC) was part of mandatory training and trust records showed it was completed by 100% of nursing staff as at October 2017. This was above the trust’s target of 95%. For medical staff, infection control training completion was 83% which was below the trust’s target.

Each paediatric clinical area had a dedicated IPC link nurse. Clinical staff knew who their link nurse was and reported good access. IPC compliance was audited monthly. We viewed the NNU monthly IPC audit control programme. This provided a comprehensive programme of audit across the NNU, including the environment and hand hygiene. We also viewed the results of the audits from October to December 2017. There was 90% compliance for the environment and hand hygiene for these months. However, this was below the trust target of 100%. The matrons’ audit for paediatric wards found 92% compliance with hand hygiene technique in the same period.

Noticeboards on the paediatric ward and children’s outpatients department communicated to staff and visitors the results of monthly audits such as hand hygiene. Noticeboards on wards consistently showed 100% hand hygiene compliance for the month immediately prior to our inspection.

The IPC standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

Cleaners worked to standardised cleaning schedules which detailed the types of cleaning tasks that needed to be completed. There was a dedicated cleaner for the children’s inpatient ward. We observed cleaners working throughout the day maintaining the cleanliness of the ward. However, we found cleaning staff were using a printed cleaning schedule dated 2012, which was displayed on the wall in the sluice. However, cleaning tasks were recorded in a diary which was checked and signed by the cleaning services manager daily.

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

Play services staff were responsible for cleaning toys. Play services staff told us that playrooms were cleaned every morning and toys that had been used by infectious patients would receive deep cleaning before they were used by other children.

We inspected various items of equipment, such as commodes, bed tables, wheelchairs, weighing scales and blood pressure cuffs and found a good level of cleanliness. We checked a sample of toilets and shower rooms on the wards and found them to be visibly clean.
Isolation procedures were in place for patients with infections and cubicles were marked clearly with a notice to alert staff and visitors of an infectious patient with instructions of the precautions to take prior to entering the cubicle. We observed staff adhering to these protocols and doors remained closed. We saw leaflets were available for patients and visitors about infection control. These provided details about the purpose of infection prevention and control and what actions were required to adhere to these processes. A specialist deep cleaning team would clean isolation rooms following the discharge of an infectious patient.

Waste management and removal, including those for contaminated and hazardous waste was completed in accordance with national standards.

There had been no cases of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C diff) in the previous 12 months.

**CQC Children’s Survey 2016 – Q26**

In the CQC children’s survey 2016 the trust scored 8.8 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts. *(Source: CQC Children’s Survey, RCPCH)*

**Environment and equipment**

We found the children’s ward did not have secure entry and exit procedures. The ward had a buzzer to enable staff to monitor who entered the ward. However, there was a push button exit that allowed people to leave the ward without supervision. In addition we saw that the door was not monitored at all times, as the ward clerk’s desk was in the middle of the children’s ward. We drew this to the attention of the lead nurse, who took action immediately and had a swipe card exit system installed at the time of the inspection. This meant only authorised staff could allow visitors or patients to exit from the ward.

There was one lift in Queen Mary Hospital for Children which serviced four floors including the first floor, offices, physiotherapy, electroencephalogram (EEG, this is a test used to find problems related to electrical activity of the brain); second floor, children’s ward and paediatric admissions unit (PAU); third floor day surgery unit; and fourth floor, computerised tomography (CT) scan. The risk of this single lift breaking down was on the services risk register as it would affect children requiring the departments arriving in pushchairs and wheelchairs and being unable to negotiate the stairs easily. There was also a risk that patients may not able to be transported safely to and from the paediatric departments as a consequence of the lift breaking down; delays in transferring children back from theatre; delays in transferring child from the ED, that could lead to breaches in ED waiting times; and delays and difficulties in transferring children who required transfer to or from other hospitals. To mitigate the risk there was an annual lift service plan; this included planned lift maintenance with ambulances booked to transfer children during the lift maintenance downtime. Children in the ED would also be risk assessed and transferred to Epsom Hospital if required when the lift was not in operation. The service also had a business case to build a new lift on the exterior of the building to give the hospital a further lift option.

The environment on the children’s wards was clean and child friendly. The children’s outpatients was bright and welcoming with pictures and stickers on the walls. Most waiting areas, wards and clinical treatment areas were free of clutter.

Emergency trollies were available on every ward and were secured with plastic snap locks, so it was clear if someone had accessed the resuscitation equipment. Trolleys were checked daily and weekly with staff signing a log to confirm the checks had been made. Consumables and equipment were appropriately stored and labelled and the paediatric cardiac arrest box was secure and dated. We checked various consumables, such as fluids and found that they were sealed and in date.
We saw evidence that equipment was regularly serviced and calibrated. We checked various items of equipment such as defibrillators and blood pressure monitors and found they had been safety tested.

Fire extinguishers and oxygen tanks were stored securely and were in date. However there were two of four oxygen cylinders on the children’s ward which were indicating that they were empty.

Needle sharps bins were available throughout wards and within the medication preparation area. The bins we inspected were correctly labelled and none were filled above the maximum fill line.

The environment in the playrooms on wards was child friendly and contained toys for all ages. Playrooms were spacious enough to accommodate patients in wheelchairs.

There were tailgating notices attached to the doors on children’s ward areas. This is signage that alerts visitors not to allow other people they do not know to enter the ward. However, the notices were included with other notices and there was a risk that visitors might miss the message the notice conveyed.

A list of all scores from the CQC children’s survey 2014 which fall under the safe domain are listed below.

CQC Children’s Survey questions, safe domain, Epsom and St Helier University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.86</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.86</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.71</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

Assessing and responding to patient risk

Children and young people were monitored for signs of deterioration using a paediatric early warning score system children’s observation and severity tool (COAST). A sepsis tool had also been incorporated into the COAST chart to help staff escalate appropriately when signs of sepsis had been detected. COAST and sepsis observations protocols were available on the trust’s intranet.

Nursing staff we spoke to were aware of escalation protocols if a patient scored higher than expected. Senior nurses received in depth one to one training on the use of the COAST chart. We reviewed a number of patients’ nursing charts and found that the COAST score was recorded in all cases. The COAST charts and guidance contained a clear escalation plan and actions and contact details in the event of a deteriorating patient. However, the trust were
rolling out a new electronic mobile observations system in the children and young people’s service in February 2018. This would reduce the time clinicians spent on routine observational tasks. For example, early warning scores would be calculated automatically on the new system eliminating the risk of error. This meant deterioration would be detected and escalated earlier.

The NNU had introduced the newborn early warning trigger and track (NEWTT) tool to identify babies at risk of deterioration.

The trust’s nursing and midwifery establishment review dated June 2017 stated the service were not always able to meet basic level 1 critical care standard and were not always able to provide the required 1:2 nurse to patient ratio. In mitigation, acuity and dependency was monitored three times daily through ‘safecare’ and staffing moved or increased where possible. However, the services risk register identified that this was not sustainable. Children and young people requiring this level of care were nursed on the ward and supported by the available senior team. During the winter months when acuity was higher the service would reduce beds to ensure safe nurse to patient ratios.

A child or young person needing a critical transfer to a paediatric intensive care unit (PICU) was managed according to the trust’s ‘Managing The Acutely Ill Child Policy’ 2016. A child needing this level of care would require 1:1 care. However, this meant a nurse was taken away from the paediatric inpatient ward. On average the trust had one retrieval, (child transferred to a PICU), per week across both Epsom Hospital and St Helier Hospital sites. The dependency and acuity of children was monitored and recorded three times daily. One to one care was provided for children with a tracheostomy, (this is an opening created at the front of the neck so a tube can be inserted into the windpipe), and staffing was increased to reflect the child or young person’s higher acuity. Children with long term ventilation requirements were not admitted to the inpatient wards. However, the service did not have the established number of nurses to provide 1:2 care for all children requiring level 1 high dependency care. Although the service was working towards achieving the Healthy London Partnership standards. For example, increasing the number of nurses trained in advanced paediatric life support (APLS), (see the responsive section of this report).

Children requiring child and adolescent mental health support services (CAMHS) were admitted to wards from the emergency department (ED) and were seen by a member of the CAMHS team. Staff developed mental health management plans for these children and young people and the trust policy was for them to remain as inpatients until a specialist bed became available. A registered mental health nurse remained with the patient throughout their time on the inpatient ward. Staff told us that they were fully supported by the CAMHS team including out of hours.

We attended a morning medical handover in the paediatric inpatient ward and found this to be well structured and detailed. There was detailed discussion regarding the patient’s care and medicines management. There were also twice daily nursing handovers where a detailed handover sheet was completed.

Nurse staffing
There was a safer staffing noticeboard on the children’s ward. This displayed expected and actual staffing levels. They were updated daily and we found them to be accurate. The neonatal unit (NNU) used guidance from the British Association of Perinatal Medicine (BAPM) regarding staffing levels. The NNU annual report, September 2017, reported that all vacant shifts were submitted to bank and agency. Staffing from paediatric areas was also utilised for special care, these included the practice development nurse, shift coordinator and matrons. The NNU had an ongoing recruitment plan.

Children and young people’s services used the ‘safecare’ tool to determine ward staffing levels and skill mix. This is an evidence-based tool that enables nurses to assess patient acuity and
dependency, incorporating a staffing multiplier to ensure that nursing establishments reflected patient needs in acuity/dependency terms. The ‘safecare’ tool was attached to the e-rostering system, and measured patient acuity three times a day by ward to provide a picture of patient acuity. A report on staffing was circulated twice daily to the senior nursing team using ‘safecare’ criteria.

The trust’s nursing and midwifery establishment review dated June 2017 reported that the service was not meeting the 1:4 staff to patient ratio at night. In response the service had introduced staff working cross-site as seasonal flexing over the winter months when acuity was greater, and the provision of an extra healthcare assistant (HCA) to support night shifts.

The vacancy rate from October 2016 to September 2017 was 13%. The nursing and midwifery establishment review dated June 2017 reported that the high vacancy rate meant the service were not able to staff all shifts up to requirement and would often have to work with one less nurse per shift. In mitigation the service had safety huddles in the mornings to plan for the day’s activity, with activity monitored by the matron team, the service also reviewed patient acuity three times a day, as well as staff working flexibly across areas and sites, ward managers reducing supervisory days to support clinical areas, and matrons and practice development nurses supporting areas when staffing was short.

Staff were encouraged to complete an incident report when staffing was considered to be an issue. This was monitored through the children and young people’s governance committee. There was also an escalation policy in place. Staff escalated to the site team and would reduce the bed base if it was considered that staffing posed a risk to patient safety.

The service had a rolling recruitment programme for nursing staff. This included a European nurse recruitment drive. However, the trust had only recruited one nurse from Europe due to a lack of paediatric trained European nurses. The trust had embarked on a transformation programme aimed at lean working. The service were also developing new links with student clinical placements to encourage recruitment of newly qualified nurses.

The community nursing team were fully established with a skill mix of predominantly band 7 nurses who had completed the specialist practitioner course or who had extensive experience.

We viewed the winter plan for 2017/2018. This assessed the potential increased demand on the service during winter months and costed the increased staffing required to meet the demands on the service. For example, the plan included an extra band 6 nurse working 10am to 10 pm on Saturday and Sunday to support the extended opening of the paediatric admissions unit (PAU) beds for emergency department (ED) patients.

In most instances, nurses in charge were ‘supernumerary’ during the day which meant they could focus on managing and leading the ward instead of doing clinical tasks. At night and on weekends the nurse in charge was not supernumerary. However, there was access to a senior children’s nurse for advice at all times. We saw that nursing associates also supported nurses on the wards.

The trust has reported their staffing numbers below for as of September 2017 for children and young people’s services

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>121.63</td>
<td>107.54</td>
</tr>
</tbody>
</table>

There were 14.9 less WTE staff in place at the trust in September 2017 compared to what the service had planned to provide safe care. *(Source: Routine Provider Information Request)*
(RPIR) – P16 Total numbers – Planned vs actual tab

From October 2016 to September 2017, the trust reported a vacancy rate of 10.4% in children’s services across sites compared to a trust target of 10%. The vacancy rate at St Helier Hospital was worse than the trust target at 13%. (Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Senior staff told us the trust had been unable to successfully recruit band 6 nurses. In response they had over recruited band 5 nurses in lieu of this, and were supporting staff through the practice development team to band 6 competence.

From October 2016 to September 2017, the trust reported a turnover rate of 13% in children’s services compared to a trust target of 12%. The turnover rate at St Helier Hospital was worse than the trust target at 23%. (Source: Routine Provider Information Request (RPIR) P18 Turnover)

From October 2016 to September 2017, the trust reported a sickness rate of 3.8% in children’s services compared to a trust target of 3.8%. The sickness rate of 7.5% at St Helier Hospital was worse than the trust’s target rate. (Source: Routine Provider Information Request (RPIR) P19 Sickness)

From October 2016 to September 2017, the trust reported a bank and agency usage rate of 17% in children’s services. St Helier Hospital: 1,216 bank shifts covered and agency usage amounted to 218 with 422 shifts unfilled amounting to a total of 2094 shifts. (Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing
Medical staffing levels met the Royal College of Paediatrics and Child Health (RCPCH) standards for general paediatrics and the British Association of Perinatal Medicine (BAPM) standards for neonates.

Doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and at night. There was 24 hour consultant cover for the children’s ward and neonatal unit (NNU) seven days a week. The Royal College of Paediatric and Child Health standards were being met for consultant cover regarding medical staffing for acute paediatric services. A consultant anaesthetist was also available 24 hours a day, seven days a week. The paediatrician or neonatologist on call would also provide specialist paediatric medical advice to consultants and doctors in training.

Consultant medical staff reviewed children’s care twice daily during the weekdays and once daily ward round over weekends. We saw consultants undertaking daily ward rounds and medical handovers happened twice daily. We observed a handover and saw good evidence of multidisciplinary working.

Emergency admissions were seen and assessed by a consultant in the paediatric emergency department (ED) until 10pm. Children admitted after 10pm were seen on the consultant ward round the next day. The paediatric ED had consultant and trainee doctor cover. There was paediatric consultant presence in the ED between 9am and 10pm daily. Adult ED consultants also offered advice and support as needed, for example, with trauma patients.

We viewed the winter plan for 2017/2018. This assessed the potential increased demand on the service during winter months and costed the increased staffing required to meet the demands on the service. For example, the plan included an extra specialist registrar for eight hours a day seven days a week, between 4pm and midnight.
Senior managers identified that recruiting ‘Tier 1’ medical staff in the ED was an on-going challenge for children’s services. Staff told us the ED was managing staffing. However, recognised that this could increase risks in the form of longer waits for assessment and in the management of the ED, although staff said this had not had a negative impact on patient care.

89% of doctors had job plans agreed at Queen Mary Hospital for Children as at January 2018.

The trust has reported their staffing numbers below as of September 2017 for medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>88.6</td>
<td>93.41</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From October 2016 to September 2017, the trust reported a vacancy rate of 10.4% in children’s services compared to a trust target of 10%. St Helier Hospital’s vacancy rate was worse than the trust target at 12.8%. (Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From October 2016 to September 2017, the trust reported a turnover rate of 13% in children’s services compared to a trust target of 12%. St Helier Hospital was meeting the trust’s turnover rate with a rate of 12%. (Source: Routine Provider Information Request (RPIR) P18 Turnover)

From October 2016 to September 2017, the trust reported a sickness rate of 3.8% in children’s services compared to a trust target of 3.8%. St Helier Hospital had a turnover rate that was better than the trust target at 1.6%. (Source: Routine Provider Information Request (RPIR) P19 Sickness)

From October 2016 to September 2017, the trust reported a bank and locum usage rate of 4% in in children’s services. At St Helier Hospital: 431 bank shifts were covered in the period. Locum usage amounted to 85 shifts with 97 shifts unfilled amounting to a total of 695 shifts. (Source: Routine Provider Information Return (RPIR) P21 Medical Locums)

In August 2017, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

The chart below shows the staffing skill mix for the 75 whole time equivalent staff working in children’s services at Epsom and St Helier University Hospitals NHS Trust.
Records
We found the completion of records was good throughout children and young people services. We reviewed a number of care records. Overall, we found that notes were legible and all staff involved in the care of children and young people completed them accurately and recorded relevant information. All of the records we reviewed were well organised and person centred. The notes we reviewed in the neonatal unit (NNU) were well organised and baby centred.

Some parts of the service used paper records, while others were on the trust’s electronic patient record system (EPR). On most wards nurses used paper documentation to record patient care and nursing interventions. Doctor notes were also paper based. Paper documentation included a range of risk assessments, pain scores, paediatric early warning scores (COAST), allergies and care plans for patients. Nursing notes were kept securely on trolleys in view of the nurses’ station.

The NNU used a maternity EPR system that was widely used in the NHS. This was linked to electronic laboratory results and prescribing systems.

The records system had a ‘flag’ system to alert staff to children with specific concerns, for example child protection plans and other confidential social information. Children with learning disabilities were also flagged via the ‘flag’ system.

Information governance and data protection training formed part of the mandatory training which all staff were required to complete. Data provided by the trust showed that by October 2017, 82% of nursing and midwifery staff had completed information governance training which was below the trust target of 95%. Medical staff had completed 49% which was below the trust target.

We saw examples of completed World Health Organisation (WHO) surgical checklists which recorded safety checks prior to surgery, during surgery and following surgery. We found these to be completed in accordance with the WHO guidelines.

Children and young people’s services had audited the use of the COAST early warning tool between February and April 2017. The service had produced an action plan in response to the audit. This included COAST champions, these were members of staff with extra knowledge and training in the use of the tool, and engagement with staff on how the tool could be adapted for use on the electronic observation record the trust was introducing to children and young people’s services in 2018.

Medicines
Staff reported good access to the paediatric pharmacist who visited the wards on a daily basis and was part of daily ward rounds. Paediatric pharmacists regularly checked prescription charts and controlled drugs (CD) books.

Nursing staff were aware of the policies on the administration of controlled drugs (CD); these are medicines requiring additional security. CD were stored in lockable, wall-mounted cupboards. On each ward, the keys for these cupboards were held by the nurse in charge. Registers containing details of the contents of the CD cupboards were stored within the cupboard and identified the expected stock of each medicine. Two members of staff checked...
the CD stock levels together on a daily basis. We checked the CD stock levels documented in the stock books and found them to be accurate. We checked a sample of medicines and found them all to be in date.

Medicines to take out (TTO) were stored securely until the patient was discharged.

Medicines were stored in dedicated medicine fridges which were locked and fridge temperatures were recorded daily. The fridge temperature logs that we checked were all within acceptable tolerance and there were no recording gaps. The ambient room temperature where medicines were stored was also recorded in treatment rooms and checked daily and did not exceed recommended levels.

We viewed a medicines audit dated October 2017. The service had achieved 75% compliance with the trust’s standards. However, an action plan was in place and a re-audit in January 2018 showed the service had improved and achieved 100% compliance.

**CQC Children’s Survey Data – Q53**

In the CQC children’s survey 2014 the trust scored 9.75 out of ten for the question ‘For most of their stay in hospital what type of ward did your child stay on?’ The measure is if children spent most of their time of a children’s ward rather than an adult ward. This was similar to other trusts. *(Source: CQC Children’s Survey, RCPCH)*

**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 November 2016 to October 2017, the trust reported no incidents classified as never events for children’s services. *(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from February 2017 to January 2018.

Between the months of February and December 2017, the number of reported incidents reported on the trust’s electronic incident reporting system was 257. Of these, 222 incidents were recorded as no harm, 31 were low harm and four were recorded as moderate harm. One incident required the application of Duty of Candour.

The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had knowledge of duty of candour, but had not had specific training in this.

The trust used an electronic incident reporting system to report incidents. Staff were aware of how to report incidents and could show us how to access the online system. Staff told us they were encouraged to report incidents and were able to identify types of situations that should trigger incident reporting completion, including ‘near miss’ situations.

Staff told us they received feedback when they reported incidents. There were weekly and monthly ward meetings where nurses discussed incident reports and complaints. Doctors in training told us they took part in weekly ‘grand rounds’ where incidents were also discussed.
A monthly staff newsletter provided safety information and messages to staff, including feedback from incident investigations. Newsletters were accessible on the trust intranet and were emailed to staff.

Staff who investigated incidents received root cause analysis (RCA) training. Senior ward nurses told us they received a lot of support from the trust in learning how to investigate incidents.

Paediatric surgeons at the hospital attended regular cross-site ‘Mortality and Morbidity’ (M&M) meetings every eight weeks. Minutes of the meetings were recorded and circulated to staff via email. M&M meeting were incorporated into the teaching programme for medical staff.

The annual neonatal services report carried reviews and learning from incidents from across both hospital sites that were level 3 ‘moderate harm’ to patients or above. For example, the NNU had introduced the newborn early warning trigger and track (NEWTT) chart for neonates in response to an incident where there had been missed observations of a neonate. The NEWTT chart enables staff to identify a baby at risk of deterioration and promotes early intervention.

**Safety thermometer**

The NHS 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.

The service completed the adult safety thermometer and the National Children and Young Person’s Safety thermometer to monitor parameters more appropriate for the paediatric population including: use of an early warning tool, extravasation, pain and pressure sores. At the time of inspection the service were 100% harm free.

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 no new pressure ulcers, no falls with harm, and no new catheter urinary tract infections from November 2016 to October 2017 for children’s services.

*(Source: NHS Digital)*

### Is the service effective?

**Evidence-based care and treatment**

The trust’s care pathways for children and young people services were delivered in line with national clinical guidance. We reviewed a sample of trust policies including those for management of a deteriorating child and safeguarding processes and found they were within date and appropriately referenced current good practice and national guidelines from organisations such as the National Institute of Health and Care Excellence (NICE) and Royal Colleges. They contained appropriate guidance for screening, referrals, escalation, specific interventions and further sources of advice and information.

Staff accessed policies and corporate information on the trust’s intranet. There were protocols, policies and guidance for clinical and other patient interventions and care on the intranet. Staff could also access paper copies of policies in wards and theatres. For example, neonatal nursing was supported by the British Association of Perinatal Medicine Standards (2011) and the Toolkit for High Quality Neonatal Services, (DoH, 2009).
Understanding of and adherence to NICE guidelines was embedded in multidisciplinary working and evidenced through the use of audit programmes to benchmark practice. There were regular quantitative and qualitative audits including weekly audits of hygiene and infection control, pain management, environment and equipment, patient feedback, cancellations and attendances amongst many others. The results of these regular monthly audits were shared at monthly governance meetings.

There were effective processes for the identification and implementation of new clinical guidelines. This included regular emails from clinical leaders and the college tutor about new guidelines and protocols. Matrons also shared information and this was printed and displayed on wards.

The hospital participated in a number of national clinical audits, including the national paediatric diabetes audit.

The neonatal unit had achieved level 3 UNICEF ‘Baby Friendly’ accreditation. This is based on a set of interlinking standards designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development.

**Nutrition and hydration**

There were appropriate processes in place to ensure that patients’ nutritional needs were met. There were systems for measuring children’s calorie intake calculation for overweight children and children living with Diabetes. Patients with eating disorders had specific food charts and their food management plan was developed and closely managed by a consultant paediatrician.

The hospital dieticians attended children and young people wards to support nutrition planning, management of peripherally inserted central catheter feeding, and advice and guidance to nurses on patient suitability for food.

There were protected meal times on children and young people inpatient wards and we saw these were respected by staff and visitors, but the meal service was flexible around the needs of the patient. This meant all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal and staff would assist patients with their meals as necessary. Nursery nurses and HCAs were available to support eating. Snacks were available between meal times.

Dietary plans were included in patient care plans. Dietitians made arrangements for special menus. There were specific food menus for different patient groups including those with specific needs, such as patients with allergies or food intolerances, and those requiring low fat or high calorie diets. There was provision of easy to eat food such as yoghurts and fruit juice for those patients who felt nauseous post-surgery.

Pre-surgery fasting guidelines were in place to ensure patients were ready for their procedure. After recovery, children and young people were given sips of water immediately as they came to the ward, and as they improved they were given fruit juice and food. There was a variety of sandwiches, fruit, yoghurts and snacks available for day case patients post-surgery, and hot food was available for inpatients.

We checked a sample of milk formula on the NNU. All were sealed and within date. Bottles and teats were available to assist with feeding.

Nursery nurses and healthcare assistants were available to support patients during mealtimes if required, for example with bottle feeding.
Pain relief
There were effective processes in place to ensure patients’ pain relief needs were met and pain was well managed in the children and young people service.

Patients told us nurses were responsive to their pain relief needs. All of the patients we spoke with were aware they could use the call bell to request additional pain relief. There was a multidisciplinary pain team at the hospital. The team provided a consulting service for chronic and acute pain across the hospital. Nurses told us the pain team was accessible and helped to review patients on a daily basis. We were told they provided good guidance and teaching, including updates on pain management good practice.

The pain team prepared detailed care plans for each patient, for example what would happen if their cannula failed. The care plans were personalised to the patients’ needs, including recognition of their cultural understanding and manifestations of pain.

Pain management protocols were available on the trust intranet for staff to access. The service used evidence-based visual analogue scales such as the Wong-Baker faces tool to help children communicate about their pain. They also used the face, legs, activity, cry, consolability (FLACC) scale as a measurement to assess pain for children between the ages of two months and seven years or those who are unable to communicate their pain, (the FLACC scale is scored in a range of 0–10 with 0 representing no pain).

Patient outcomes
The trust contributed to relevant local and national patient outcome and performance audits, including benchmarking activities and peer review with other NHS hospital trusts. The children and young people’s service participated in external reviews and assessments such as the Healthy London Partnership (HLP) service reviews of children and young people’s specialities in 2017. The HLP peer review identified areas for improvement as well as areas the service was providing well. There was an action plan in place to address areas for improvement and this was monitored quarterly by the trust’s clinical quality and assurance committee.

The children and young people’s service had a network wide audit plan in place. Work in progress or approaching completion included the national neonatal audit programme (NNAP), the paediatric diabetes audit, cystic fibrosis registry audit, paediatric pneumonia audit, and paediatric bronchiectasis audit.

We viewed the child health audit report summary dated December 2017. There were nine audits in progress, including a paediatric sepsis audit and feverish illness in children under 5 years of age. The service also had five newly registered audits, including compliance with newborn blood spot screening and an audit of compliance with NICE guidance for head injuries. Audits were monitored at the quality meeting and a quarterly audit report was also produced and shared across the women and children’s division.

The service had introduced a divisional scorecard. Staff told us this was a recent introduction and the paediatric scorecard was still in development. We viewed the scorecard for November 2017. The scorecard gave a snapshot of children and young people’s services key performance indicators (KPI) on a month by month basis. For example, from November 2016 to November 2017 94% of children and young people had a venous thromboembolism (VTE), (this is a condition where a blood clot forms in a vein), assessment completed. This was close to the trust target of 95%.

Work was in progress on a neonatal sepsis re–audit, ‘antibiotics for early-onset neonatal infection: empirical treatment of suspected infection’. This audit was looking at combined working with microbiology to achieve 36 hour results, including the weekends, in order to reduce mothers and babies lengths of stay, whilst continuing to provide a safe and effective service.
Paediatric diabetes audit 2015/16
HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows that in the 2015/16 paediatric diabetes audit, Queen Mary’s Hospital for Children performed better the England average.

The proportion of patients receiving all key care processes annually was 63% which was significantly better than expected, compared to a national aggregate of 36%; the previous year’s score was 73%.

The average HbA1c value (adjusted by case-mix) at the trust was 76% which was significantly worse than expected, compared to a national aggregate of 68%. The previous year’s score was shown as a negative outlier.

The median HbA1c value recorded amongst the 2015/16 sample was 70%, which was shown as a clinically significant improvement compared to the previous year’s median which was 73%.

(Source: National Paediatric Diabetes Audit 2015/16)

Emergency readmission rates within two days of discharge
The data shows that from June 2016 to May 2017 there was a lower percentage of under ones readmitted following an elective admission compared to the England average and a lower percentage of patients aged 1-17 years old readmitted following an elective admission compared to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST</th>
<th>ENGLAND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>No speciality at the trust had six or more readmissions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST</th>
<th>ENGLAND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>0.7%</td>
<td>903</td>
</tr>
<tr>
<td>No other specialty at the trust had six or more readmissions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest...
volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from June 2016 to May 2017 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average and a lower percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty

(June 2016 to May 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST</th>
<th>ENGLAND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.5%</td>
<td>1,154</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty

(June 2016 to May 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST</th>
<th>ENGLAND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.7%</td>
<td>2,882</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

From July 2016 to June 2017 the trust performed worse than England average for the percentage of patients under the age of one who had multiple readmissions for epilepsy.

The trust performed better the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for epilepsy.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

(July 2016 to June 2017)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST</th>
<th>ENGLAND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>1-17</td>
<td>16.2%</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1-17</td>
<td>-</td>
<td>46</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td>1-17</td>
<td>38.5%</td>
<td>39</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

**National Neonatal Audit Programme**

In the 2016 National Neonatal Audit Epsom & St Helier Hospital performance was as follows:

Do all babies <1501g or a gestational age of <32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

At St Helier Hospital here were 50 babies born with a birth weight <1501g or with a gestational age at birth <32 weeks who were assigned to the unit for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

In the national neonatal audit programme to the question to the question ‘Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?’ There were 251 first episodes of care that were eligible for inclusion in this audit measure for the unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 100% of the eligible episodes; this was above the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

In the national neonatal audit programme to the question to the question ‘Are rates of normal survival at two years comparable in similar babies from similar neonatal units?’ There were 19 babies born at <30 weeks born between July 2013 and June 2014 who have been assigned to the hospital for two year health assessment based on their final neonatal discharge. Data was entered for 79% of the babies assigned to the unit, whilst nationally data was available for 61% of babies born at <30 weeks born between July 2013 and June 2014.

In the national neonatal audit programme to the question ‘What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?’ There were 115 babies born <32 weeks in the hospital who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies 16 were identified as having Significant BPD.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Competent staff**

We spoke with senior leaders about appraisal completion rates during the inspection and were provided with evidence that demonstrated 90% of staff had received their annual appraisal. Staff told us they found their appraisals useful to review their performance and plan their development. Managers and their staff had regular planned catch up meetings at six monthly intervals, as well as more informal meeting to review their performance.
There were group supervision processes in place for all teams with a clinical caseload, including management supervision. However, the service informed us there was no formal clinical supervision for nursing staff.

There was an induction process for all new starters and temporary (agency) staff, including a one day corporate induction and local orientation. Nurses in the service described the induction as helpful and that it covered use of equipment, a tour of their ward, fire evacuation procedures, safeguarding and emergency contact telephone numbers. The induction period was also used for new staff to complete specific training relevant to their ward such as using ventilation equipment.

There was an agency staff folder on the wards which included induction to the ward forms for the required training in paediatric early warning scores (COAST), sepsis identification and escalation protocols, handover, drug charts, and bleep numbers. The agency provided a checklist of competences which were signed off for each agency staff member.

The trust supported continued professional development of its staff, including formal qualifications and, practical training. There were opportunities for leadership and management training for senior nurses and clinicians.

Students and newly qualified nursing staff reported a supportive and encouraging learning environment in children and young people services with good supervision. Student nurses told us they enjoyed their placements at the hospital and many told us they would like to work there after graduating. Students and newly qualified nurses told us there were lots of study days and good exposure to different patients and conditions which made it a good learning environment.

Newly qualified nurses were allocated a mentor, preceptor and buddy to help with orientation and competency development. The hospital education team managed the programme, which incorporated the preceptorship programme objectives.

Specialty doctors in training told us the hospital was a good place to work with approachable and supportive consultants, good supervision and good access to practical teaching and learning opportunities. For example, 97% of consultants in children’s services had an up to date annual appraisal. There was an annual local teaching programme for doctors in training. During term time, ‘grand round’ lectures were held on a weekly basis. The lectures consisted of interesting case presentations and were aimed at an audience across all specialties and grades. For example, we viewed the grand round programme for January to March 2018, these included presentations from cardiology, renal medicine, and paediatric medicine.

Consultant paediatricians and nurses told us the trust was supportive of revalidation.

There was a dedicated paediatric theatre at St Helier Hospital called QMH. QMH had 10 members of staff, of which, six were qualified in paediatric intermediate life support (PILS) training. Occasionally children would be operated in the hospital’s main theatres on the trauma or the emergency (CEPOD) lists. 10 of the 11 recovery staff in main theatres were trained in PILS and four of the operating department practitioners (ODP) were also PILS trained. There was a lead anaesthetist for children and young people’s services who supported the training and development of the team.

The head of nursing, matrons and ward sisters had completed accredited training on the care of acutely ill children, high dependency unit (HDU) and/or paediatric intensive care unit (PICU) modules. One matron was an advanced paediatric life support (APLS) instructor. There was a senior practice development nurse studying for the advanced paediatric nurse practitioner qualification.
The practice development team organised update days and coordinated learning activities in the trust for children and neonatal nurses. Topics covered included bereavement, venepuncture and cannulation.

There was a clinical nurse educator for paediatrics and neonatal services in the hospital. Many nurses told us that there was limited access to funding for post-qualifying courses and qualifications, but cases were considered and funding allocated on the merit of the application.

There was a focus on providing ‘in-house’ training to reduce expenditure. There was a selection of in-house training available to nurses and HCAs. Top-up degrees were encouraged but through staff self-funding.

An advanced neonatal nurse practitioner (ANNP) provided education and training on subjects such as advanced paediatric life support (APLS), paediatric immediate life support (PILS), ventilation training, parenteral nutrition and paediatric early warning scores. The role encompassed clinical teaching to all neonatal nurses including cot side teaching and full study days. Nurses told us practise educators were accessible and supportive. 88% of paediatric staff were qualified in PILS and 97% of NNU staff. 100% of paediatric managers had PILS training.

The department of anaesthesia also carried a register of anaesthetists’ paediatric competencies, this included staff that were competent in APLS and PILS.

The NNU were meeting British Association of Perinatal Medicine Standards (2011) with a minimum of 70% of the registered nursing and midwifery workforce establishment holding an accredited post-registration qualification in specialised neonatal care (qualified in specialty).

The NNU had 69% of qualified nursing staff who had completed all post registration qualifications in neonatal care and 80% of nurses had completed post registration courses in special care or high dependency care.

Nursery nurses were being offered the opportunity to develop the nursery nurse role into the nursing associate role.

The service had a business plan in place to increase the provision of speech and language therapy (SLT) services.

As at September 2017, 81.8% of staff within medicine at the trust had received an appraisal compared to a trust target of 80%. However, the trust target was low when compared to other similar services where the target was 90%.

A split by location can be seen in the graph below:
Multidisciplinary working
There was an effective multidisciplinary team (MDT) working environment within children and young people services at St Helier Hospital. We found evidence of good multidisciplinary relationships supporting patients’ health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards and other clinical areas such as the paediatric emergency department and paediatrics outpatients.

Patient records demonstrated input from the full clinical team of doctors and nurses, as well as allied health professionals (AHPs) including physiotherapy, dieticians, occupational therapists, pharmacists.

The paediatric inpatient ward was nurse-led and we saw nurses were proactive at seeking support from other healthcare professionals. Nurses reported timely access to and effective support from paediatric therapists including occupational therapy, physiotherapy, dieticians and play therapy. We also saw staff liaising with child and adolescent mental health services (CAMHS) staff.

Each morning nurses on wards worked with paediatric physiotherapists to review all patients and identify those requiring therapy support. Therapists attended the nursing handover on some occasions. Nurses told us therapists were easily accessible by telephone when required.

The NNU had daily safety huddles twice a day to plan activity in partnership with maternity staff. Nurses reported good working relationships with the medical team and they felt that consultant paediatricians were very approachable and accessible.

There was specialist paediatric pharmacy support in the hospital. The paediatric pharmacist attended paediatric inpatient wards every day and there was 24 hour on call paediatric pharmacy support.

The service’s clinical governance and morbidity and mortality (M&M) meetings were MDT in their approach.
Discharge planning meetings included involvement from clinicians, therapists, psychologists, community practitioners and parents.

There were appropriate processes in place to support patients’ transition between services, for example, from the NNU to paediatric inpatient ward, and from paediatric to adult services. This was facilitated by established MDT links between internal teams and external professionals. For example, the service began preparing young people with diabetes at the age of 14 years, by working with the hospital diabetes team.

There was evidence of effective MDT partnership working with external agencies and professionals. For example, nurses on paediatric inpatient wards had regular contact with community school nursing and health visiting teams, social services and safeguarding teams, as well as support from specialist community teams.

The children and young people’s service met regularly with the South Thames Retrieval Service (STRS), an intensive care service, transporting critically ill children from local hospitals to intensive care units (PICUs), twice a year.

Clinicians reported good communications with local GPs. Discharge summary letters were sent to the patient’s GP and where relevant to community school nurses and parents and carers were encouraged patients to attend their GP shortly after discharge.

**Seven-day services**

The hospital delivered a full inpatient service for children and young people over seven days with on-site consultant paediatrician availability seven day per week. There was one reserved emergency paediatric operating theatre, as recommended by the NCEPOD report (1990). This theatre was available 24 hours per day seven days a week for emergency cases.

The hospital neonatal unit (NNU) was a level two centre which provided care for sick newborn babies requiring special, high dependency and intensive care.

Paediatric therapies such as physiotherapy and play therapy provided a week day 9-5pm service. Therapies covered all paediatric wards including the NNU. There was no overnight cover and no weekend on call cover for paediatric therapies.

**Health promotion**

There was a range of health promotion initiatives across children and young people’s services. The neonatal unit (NNU) were working towards the BLISS charter 2018; this is a practical framework to standardize family-centered care across the UK. It is a practical framework for neonatal units to self-assess the quality of family-centered care they deliver against a set of seven core principles.

There was a range of information and support available for patients and their families and carers. Across all paediatric clinical areas there was a range of good quality patient literature with informative content. There were boards on all the children and young people’s departments with public health information on smoking cessation and applying for carer support. There were also leaflets on managing different health conditions for example for children living with asthma. All of the information we saw was easy to read and written in plain English.

There were a number of examples across the children and young people service of staff helping patients manage their own health. This included the provision of teaching and learning opportunities for patients and their families, as well as support and guidance. For example, the NNU had four nursery nurses who provided hands on care and other activities such as breast feeding advice, parent craft and resus training for parents.
On paediatric inpatient wards care plan templates were pre-printed but could be tailored to record specific individual needs

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Mandatory training in Mental Capacity Act (MCA) awareness was provided to all staff working in the trust.

Patients and their parents and carers told us staff explained treatment and care and sought their consent before proceeding. The clinicians we spoke with were all aware of the concept of shared decision-making with patients.

The sample of patient records we reviewed demonstrated consent for treatment and surgery was in most cases completed in full and signed and dated appropriately.

Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA), although this only applied to children and young people aged 16 and above. Staff told us they would refer patients to the trust safeguarding team if they required a MCA referral. Staff told us they knew who to contact for advice in cases where a patient may require support.

The clinical staff we spoke with were knowledgeable about Fraser guidelines and Gillick competencies to help assess whether a child had the maturity to make their own decisions without consent of a parent or guardian and understand the implications of those decisions. They were aware of the situations where these principles would be applied.

Patient records detailed individual patients’ specific mental health support needs, including whether the patient was allowed to leave the ward or clinical area. There were mental health management plans in paper form which were kept in medical notes.

The trust policy was for patients with mental health support needs to be accompanied by registered mental health nurse at all times to ensure there were staff with appropriate risk management and de-escalation skills in challenging situations. We saw a young person being supported by a registered mental health nurse on the children’s ward.

There were no designated cubicles on paediatric inpatient wards designed for patients with mental health support needs. However, the paediatric ward had a ligature risk assessment in place.

There was a current trust-wide absconding policy which included ‘lockdown’ procedures in the case of children and young people going missing in the hospital estate.

The trust reported that as of October 2017, Mental Capacity Act (MCA) and Deprivation of Liberty (part of safeguarding adults level 2) training had been completed by 65% of staff in within children’s service. *(Source: Trust Provider Information Return P14/P49)*

**CQC Children’s Survey Data 2016**

The trust performed about the same as other trusts in the majority of questions relating to effective in the CQC children’s survey 2016 (five out of six).

CQC Children’s Survey questions, effective domain, Epsom and St Helier University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
</table>
Did you feel that staff looking after your child knew how to care for their individual or special needs? 0-15 adults 8.43 About the same as other trusts E3

Did staff play with your child at all while they were in hospital? 0-7 adults 7.36 About the same as other trusts E4

Did different staff give you conflicting information? 0-7 adults 8.61 Better than other trusts E4

Did the members of staff caring for your child work well together? 0-15 adults 8.96 About the same as other trusts E4

During any operations or procedures, did staff play with your child or do anything to distract them? 0-15 adults 7.62 About the same as other trusts E4

Did hospital staff play with you or do any activities with you while you were in hospital? 8-11 children and young people 4.44 About the same as other trusts E4

(Source: CQC Children’s Survey, RCPCH)

Is the service caring?

Compassionate care
Throughout our inspection we saw all clinical staff interacting with patients and their family members and carers in a caring, polite and friendly manner. All of the people we spoke with during the inspection were very happy with the care and treatment provided by the trust. Direct comments from patients including children and their parents and carers, which were representative of this feedback, included: “nurses can’t do enough for you” and “staff are very caring.”

There was very good rapport between nurses and patients. Staff spent time with children to help make their experience more comfortable and relaxed. We witnessed nursery nurses using soothing language and stroking babies to calm them.

The service participated in the NHS Friends and Family Test (FFT), the results of which were consistently very good across children and young people service areas, with an annual average satisfaction score of 95% for the period November 2016 to November 2017. Across wards the average annual FFT response rate was 21%, which was lower than the England average of 30%.

There were paper FFT feedback forms and comments boxes on wards. Senior nurses told us their aim to embed patient feedback in the culture of ward so all patients are given a form and encouraged to complete it as soon as they have been identified as suitable for discharge. We sampled FFT feedback on wards and found that it was complimentary and positive about the care received and the staff who delivered it.

Overall, patients’ privacy and dignity was respected. However, a few members of staff shared concerns that day surgery was being used as an escalation area for adults. One member of staff told us that as a result the paediatric assessment unit (PAU) was very busy and there
were mothers breast feeding at the same time as and a child with a percutaneous endoscopic gastrostomy (PEG) was being fed in the play area, (a PEG is a medical procedure in which a tube is passed into a patient’s stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate) The member of staff said other people could see this and it “did not seem dignified”.

**CQC Children’s survey 2016**
The trust performed about the same as the England average for 10 out of 10 questions relating to compassionate care in the CQC children’s survey 2016.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>9.19</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.99</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.52</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.44</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.34</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.34</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 children and young people</td>
<td>6.39</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 children and young people</td>
<td>8.74</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 children and young people</td>
<td>9.40</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>
Overall, how well do you think you were looked after in hospital?

<table>
<thead>
<tr>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-15 children and young people</td>
<td>9.00</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

**Emotional support**

There was a dedicated play service which worked very closely with doctors, nurses and therapists to incorporate play into clinical interventions and therapies. The play therapy team focused on children aged 0-16. Play therapy staff used distraction methods to help prepare children and young people before their phlebotomy or surgical procedures. This included talking to them and using play techniques to help them feel at ease and reduce anxiety and stress. The play service was available on weekdays from 9-5pm but there was no weekend provision. The play service team had a dedicated budget for toys, and there were many high quality, age appropriate toys across all wards and in children’s outpatients. Parents told us they found the play therapists kind and supportive.

There was a hospital chapel which provided a peaceful space for contemplation and reflection. The hospital chaplains were available to offer emotional support to parents and carers. The hospital chaplains also worked across the children and young people wards to provide spiritual support and pastoral care. Tailored training was provided to staff to help them support the emotional needs of end of life care patients and their families, which included reflective practice and communications skills.

A counselling service was available to parents and families of sick babies on the NNU, in addition to a parents’ support group.

**CQC Children’s survey 2016**

The trust performed about the same as other trusts for five out of five questions relating to emotional support in the CQC children’s survey 2016.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.16</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.44</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.44</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children and young</td>
<td>9.21</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>
If you felt pain while you were at the hospital, do you think staff did everything they could to help you?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Trust Score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-15 children and young people</td>
<td>8.49</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

Source: CQC Children’s Survey, RCPCH

Understanding and involvement of patients and those close to them

We observed doctors, nurses and therapists working in partnership with parents and families. Staff in children and young people’s services demonstrated a patient-centred approach which encouraged family members to take an active role in their child’s healthcare. The parents we spoke with told us nurses were very supportive, explained treatments and what was going to happen. Doctors kept them informed of progress, clinical interventions and referrals to other services.

Throughout our inspection we saw that staff worked hard to make sure children and young people were comfortable and spoken with in an age appropriate way so they understood their treatment and had opportunities to ask questions.

There were patient information boards throughout the children and young people areas of the hospital, which provided clear and accessible information on a variety of different subjects. Clinical nurse specialists provided tailored teaching and support to a wide spectrum of families with home management across a range of subjects, for example, pain management and parenteral feeding. Patients could also access support and guidance by telephone.

CQC Children’s survey 2016

The trust performed about the same as other trusts for 19 out of 21 questions relating to understanding and involvement of patients and those close to them in the CQC children’s survey 2016. The trust performed better for the following questions, did members of staff treating your child communicate with them in a way that your child could understand? As well as did you feel that the people looking after your child listened to you?

CQC Children’s Survey questions, understanding and involvement of patients, Epsom and St Helier University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age Group</th>
<th>Trust Score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>9.37</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>8.41</td>
<td>Better than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.16</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
</tbody>
</table>
Did staff involve you in decisions about your child’s care and treatment?
0-15 adults 8.41

Were you given enough information to be involved in decisions about your child's care and treatment?
0-15 adults 8.71

Did hospital staff keep you informed about what was happening whilst your child was in hospital?
0-15 adults 8.67

Were you able to ask staff any questions you had about your child’s care?
0-15 adults 9.02

Before your child had any operations or procedures did a member of staff explain to you what would be done?
0-15 adults 9.56

Before the operations or procedures, did a member of staff answer your questions in a way you could understand?
0-15 adults 9.65

Afterwards, did staff explain to you how the operations or procedures had gone?
0-15 adults 8.61

When you left hospital, did you know what was going to happen next with your child’s care?
0-15 adults 8.08

Do you feel that the people looking after your child listened to you?
0-7 adults 9.16

Did hospital staff talk with you about how they were going to care for you?
8-15 children and young people 8.73

When the hospital staff spoke with you, did you understand what they said?
8-15 children and young people 8.61

Did you feel able to ask staff questions?
8-15 children and young people 9.37

Did the hospital staff answer your questions?
8-15 children and young people 9.69
Were you involved in decisions about your care and treatment?  
8-15 children and young people  
12-15 children and young people  
5.98  
About the same as other trusts  
C2

If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?  
8-15 children and young people  
No Score  
No Score  
C2

Before the operations or procedures, did hospital staff explain to you what would be done?  
8-15 children and young people  
9.34  
About the same as other trusts  
C2

Afterwards, did staff explain to you how the operations or procedures had gone?  
8-15 children and young people  
8.12  
About the same as other trusts  
C2

When you left hospital, did you know what was going to happen next with your care?  
8-15 children and young people  
7.93  
About the same as other trusts  
C2

(Source: CQC Children's Survey, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people  
Epsom & St Helier University Hospitals NHS Trust is a large acute Trust serving an approximate population of 490,000 people across Southwest London and Northeast Surrey.

Queen Mary’s Hospital for Children is the trust’s dedicated hospital for children, based on the St Helier Hospital site. It provides a wide range of general and specialist services to children and young people predominately from Sutton and Merton. The hospital runs a dedicated children's ward which cares for young people with a variety of surgical, orthopaedic and medical conditions. The children's ward also provided specialist care for cystic fibrosis, sickle cell disease and Ilizarov fixation, (a leg lengthening procedure for children who have shortened limbs).

The main ward area was divided into the main inpatient area and a paediatric day care assessment unit. The paediatric assessment unit (PAU) provided care for children requiring periods of assessment and observation prior to potential admission to the ward or discharge, as well as for medical investigations and day care facilities.

The neonatal unit (NNU) provided emergency care for newborn and premature babies. The unit is part of the south west London Neonatal Network sharing expertise and resources with other hospitals across south London. The NNU provides high dependency, level 2 care which includes two intensive therapy, four high dependency and 12 special care cots.

Women who were identified as having babies likely to require level two neonatal care were transferred for delivery at St Helier Hospital. In addition, protocols were in place to stabilise and transfer other less stable neonates who unexpectedly required level 2 support.
Staff told us there was a business case for a high dependency unit (HDU) at Queen Mary Hospital for Children. This was in response to an increase in the number of children with complex needs and to reduce the number of children transferred to other hospitals for high dependency care. Care for high dependency children was identified on the services risk register. The risk register identified actions the service had taken to minimise risks to children requiring high dependency care. This included the use of early warning scoring tools, review of children’s acuity and dependency three times daily, staffing ratios of one to two nurses to patients with complex needs, with the trust’s agreement that the service could recruit agency staff beyond the established number of staff, as well as annual training for staff in observation and assessment.

There was no designated paediatric HDU in the hospital, but patients requiring level three paediatric intensive care (PICU) were transferred to other centres with the required level facilities. Senior leaders of the service explained their long term aspirations to develop a paediatric HDU at the hospital. However, during our inspection some nurses voiced frustration that the unit was taking children who met HDU admission criteria or those with unclear dependencies. Some nurses felt that the unit was being used as a ‘catch all’ when capacity was limited elsewhere in south London. Nurses were proud of the care they provided but felt that the unit was not sufficient geared towards caring for acute high dependency medical needs or long term patients. Staff told us a business case had been submitted for a HDU at the hospital as they thought this would provide greater clarity, purpose and direction for high dependency care at the hospital.

We asked the trust about high dependency care at the hospital. The trust informed us A business case had been considered but not implemented due to the service not being commissioned. The risk of not being able to provide HDU level care was on the divisional risk register for the Women and Children Division (Datix Risk ID: 1568).

In March 2016 standards were published by the Healthy London Partnership (HLP) which support the delivery of paediatric critical care Level 1 in all district general hospitals as well as supporting paediatric critical care Level 2 for short periods whilst the patient was stabilised and their transfer to another hospital’s HDU coordinated.

As part of the ‘commissioning for quality and innovation national goals’ (CQUIN), (this is a system to make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of patient care), implementation the paediatric intensive care units in South London, coordinated by the South Thames Retrieval Service (STRS), are collecting data on HDU activity from nine hospitals in the region. They also agreed to establish the baseline of current paediatric high dependency provision against paediatric critical care levels 1 and 2 and against the published London HDU standards for all hospitals in the region. Epsom and St Helier were asked to submit HDU activity data and this process is ongoing. As part of this ongoing development the divisional team were supporting education and training for all nursing staff to be able to deliver paediatric critical care level 1. This included: tracheostomy care; high flow oxygen therapy; paediatric intermediate life support courses for all nurses as part of mandatory training; Crisis simulation training for all band 6 nurses as part of mandatory training; and the development of a children and young people’s crisis multidisciplinary team (MDT) faculty.

The day surgery unit was being used at the time of inspection as an adult winter pressures escalation ward. This was on the services risk register. The risk register identified that there was a risk to admissions to the PAU, as children requiring observation from the emergency department (ED) would not be able to be accommodated on the PAU during this time, and this could lead to breaches in ED waiting times; the risk register also identified that the waiting area on the PAU was the play room, and this could become over crowded as it was used by both the children’s ward patients and PAU patients. In mitigation the trust had produced a standard operating procedure (SOP). The risk of cancellation of day surgery and medical investigations was monitored by the service manager and matron each day. Senior leaders told us the day surgery unit was the hospital’s last area of escalation and would only be used in the case of...
severe winter pressures. The service would utilise all available resources on the children’s inpatient ward and PAU to avoid cancelling day surgery lists. If lists were cancelled senior staff told us they would prioritise children and look at the procedures prior to cancelling any lists. For example, staff told us they would prioritise tonsillectomy due to the amount of time parents had to take off work whilst their child recovered.

The children’s outpatients in the hospital provided clinics for: diabetes, endocrinology, neurology, autism, attention deficit hyperactivity disorder (ADHD), gastroenterology, respiratory, cystic fibrosis, cardiology, epilepsy, allergies, ear nose and throat (ENT), clinical psychology, renal, orthopaedic and paediatric surgery, haematology, neonatology, paediatric surgery, and epilepsy. The unit was open from 9am to 5pm.

The community nursing team provided generic community nursing care and also specialist nurses for: diabetes, epilepsy, oncology, respiratory, cystic fibrosis, allergy and endocrine, as well as continuing care for children and young people in Sutton and Merton.

The trust had a business continuity plan in place. This provided guidance for staff in the event of a disruption to services caused by staffing, IT failure, or premises. The policy detailed the escalation process and actions the trust would take to mitigate risks to the continuity of services.

**CQC Children’s survey 2016**
The trust performed about the same as other trusts for all 17 out of 17 questions relating to responsiveness in the CQC children’s survey 2016.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.94</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child’s physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.92</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.92</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>6.27</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.00</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 children and young people</td>
<td>8.37</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Question</td>
<td>0-7 adults</td>
<td>8-15 children and young people</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>8.28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did your child like the hospital food provided?</td>
<td>5.67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>8.84</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>8.97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>7.46</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>7.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>7.74</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>7.35</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8.28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>5.16</td>
<td></td>
<td></td>
<td>R3</td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>8.28</td>
<td></td>
<td></td>
<td>R3</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

**Meeting people’s individual needs**

There was provision to meet the individual needs of children and young people using services at the hospital, including vulnerable patients and those with specific needs.
There were efforts across the hospital estate to make the environment more child-friendly and welcoming and engaging for young people. There was a spacious waiting area in the outpatients department which was equipped with a wide variety of toys and games. Staff told us this was to provide children and young people with activities whilst waiting for their clinic and reduce anxieties about care and treatment.

Staff had access to 24 hour CAMHS cover as well as telephone support.

Staff had sufficient access to appropriate translation and advocacy services to support patients with English as an additional language. Nurses told us translation services could be booked for telephone interactions. They told us the service was accessible and timely.

Staff told us the trust’s accessible communications team could provide information for parents in most languages on the same day it was requested.

The hospital catering service provided a wide variety of child friendly food and snacks and there were specific menus for children and young people. The menus included options for specific cultures, tastes and specific needs. For example, there were halal or kosher food options.

The hospital cared for children and young people with learning disabilities. Staff were aware of the learning disability ‘hospital passport’ scheme, which was incorporated in paper notes and on the electronic patient record. It identified the individual patient’s specific needs so that all clinical staff had immediate access to this information to help inform decision making to meet the needs of the individual. There was specific equipment for staff to use to help engage and care for children and young people with learning disabilities, for example multisensory toys.

The trust policy was for all children and young people with learning disabilities to be pre-assessed before surgery to identify their specific support needs and for example play provision was pre-booked at that time.

In response to a Healthy London partnership peer review in March 2017, the trust had recruited a learning disability nurse. The action plan in response to a Healthy London partnership peer review also recorded that the service were working with adult services to support the training needs of staff working with young people with complex needs that were transitioning from children and young people’s services to adult services.

The hospital play service provided a programme of play support to children aged 0-11 across all paediatric inpatient wards and paediatric surgery. There were dedicated playrooms on the outpatients and inpatient wards which contained toys for all ages. Each room was spacious enough for patients to go in with their wheelchairs or support equipment. The play team worked closely with the multidisciplinary team to incorporate play into daily routines and development plans for long term patients.

The play team utilised distraction techniques to help support children in the children’s outpatients and before surgery procedures. This helped calm children and help them express how they were feeling. Play staff also provided support to parents and carers to help reduce their anxieties about their child’s treatment.

The outpatients waiting area was large and spacious. Staff told us the waiting area had been developed in response to children, young people and families’ feedback. The waiting area was equipped with a wide range of toys and indoor sports equipment to suit both younger and older children. Staff said the activities available in the play area helped to alleviate children and young people’s anxieties whilst they were waiting for their appointment.
The NNU offered overnight accommodation for parents of particularly sick children, while a playroom, kitchen facilities and a television made the ward a comfortable place for families.

**Access and flow**
Children were admitted to the unit by the emergency department for periods of assessment and observation, prior to either discharge or in-patient admission. Children requiring regular tests and investigations could also receive these in this unit.

There were a total of 67 retrievals or transfers of children to a paediatric intensive care unit (PICU) across the trust’s children and young people’s services between January and December 2017. Children were transferred to PICU via the South Thames Retrieval Service (STRS, this is an intensive care service, transporting critically ill children from local hospitals to PICUs).

There was timely access to children and young people services and most specialities were meeting referral to treatment targets (RTT). There was a good overall compliance of 98% to 100% for RTT for all specialities at the hospital. The average length of stay was two days. Outpatient clinics ‘did not attend’ (DNA) rates were high at 11% in December 2017. However, following our inspection the trust highlighted that a peer review in March 2017 had reported the DNA as 4%.

The flow within children and young people services from admission, through theatres, wards and discharge was mostly managed effectively at St Helier Hospital. We observed the patient journey through paediatric theatres and found that children and young people were transferred from the recovery area to the ward appropriately and without unnecessary delays.

There were daily paediatric huddles which reviewed bed management twice a day to ascertain capacity issues and assign responsibility for the senior paediatric bleep. The meeting included discussion of all deteriorating patients and any children with concerns (those requiring mental health or safeguarding support). There was daily tracking of young people aged 16 to 18 years old who were outliers; these are children that are inpatients in adult wards, by the trust safeguarding team and matron.

Trust referral protocols were recorded and available on the trust intranet and included internal and external referral processes for different services including therapies, social services, mental health, GP and community services. They included contact details and referral process details.

ED was supported by paediatricians and provided seamless access to the paediatric inpatient ward. Daily huddles between ED and the inpatient team supported access and flow. The paediatric assessment unit (PAU) was used to facilitate admission and discharges. Where admission to the ward was not possible, transfer of patients was facilitated by the paediatric ED team to both Epsom Hospital and other hospitals.

In the paediatric ED all children under the age of 16 were seen by paediatricians in the paediatric ED. Some patients over 16 were also seen by paediatricians. These included: self-harm patients up to 18 years of age; children over the age of 16 but under 17 years old who were under paediatric specialties, for example, paediatric respiratory who were still under a paediatrician and had not yet transitioned to adults services.

The NNU had not had any occasions in the previous 12 months when it had closed its doors due to being full.

We viewed the women and children’s division scorecard. This recorded between November 2016 and November 2017, 88% of discharge summaries were completed; this was less than the trust target of 95%.
The scorecard recorded that the women and children’s division were close to the trust target of 92% for 18 week referral to treatment time (RTT) for incomplete pathways. Between November 2016 and November 2017 the trust met 90% of 18 week RTT.

From September 2016 to August 2017, the trust has seen neonatal bed occupancy at 100% until October 2017 and then dropped to 50% for the remaining period; this is better than the England average.

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.

(Source: NHS England)

Parents and carers of children using the children’s outpatients told us the hospital was very flexible with appointment times and they felt this better suited the needs of their children. Appointments were confirmed in letters and there were also text message reminders to ensure appointments were not missed. Parents and carers told us that if they missed an appointment or could not attend at late notice, the service was responsive in quickly booking another date.

Learning from complaints and concerns
From November 2016 to November 2017 there were 54 complaints about the women and children’s division: 67% of complaints were responded to within the trust’s timescales as set out in the complaints policy. This was much lower than the trust’s 75% target.

Senior leaders of the service told us they received few complaints comparative to the size of the service. Senior staff said there were some general themes around staff attitude and communication.

There were weekly meetings for the general managers, ward managers, lead nurses and matron for all children and young people’s areas to review complaints. Investigations were conducted to identify learning from complaints and to address concerns. The service had responded to concerns around communications by setting up training for staff on appropriate communication skills and how to communicate with different people.

Senior ward nurses told us they tried to address concerns ‘on the spot’ by speaking with patients and families directly and addressing their concerns immediately.

From November 2016 to October 2017 there were 16 complaints about children’s services out of 577 trustwide. The trust took an average of 80 days to investigate and close complaints; this was not in accordance with the trust’s complaints policy, which stated that complaints should be resolved within 35 days or 45 days for more complex complaints. St Helier had 13 complaints in the period, the main themes related to all aspects of clinical treatment with four complaints, followed by two complaints related to communication / information to patients (written and oral).
Is the service well-led?

Leadership
Staff told us senior leaders of the service were visible, approachable and supportive and they felt that children and young people’s services were generally well-led. All of the staff we met told us that service leadership had a good understanding of frontline challenges on wards and in clinical areas. Staff also told us the trust’s senior leadership team including the chief executive would sometimes attend wards and speak with them. Staff told us they felt secure to raise concerns.

There was clear representation of children and young people services at trust board level. This included an executive director ‘children’s champion’.

We found positive and co-operative working relationships between the triumvirate of medical, nursing and operational leadership. Managers told us they worked well together as a team and there was regular communication and meetings, which fostered an open, trusting and transparent culture.

We saw an action plan the trust had produced in response to a Healthy London partnership peer review in March 2017. The action plan had been updated in February 2018. The review update addressed areas the service had taken action to address including listening events, management walkabouts, and breakfast with the boss.

Consultant doctors told us they had good access to senior clinicians and the divisional medical director, who were seen as accessible and available.

The senior nursing team provided senior clinical nursing leadership across sites; these included the lead nurse for paediatric and neonatal nursing, matron for acute paediatrics, matron for neonatal services, advanced neonatal nurse practitioner, senior nurse practice development nurse, and practice development neonatal nurse.

The community nursing team told us the team lead was very experienced and supportive. However, staff acknowledged that further managerial input was needed to ensure performance measures such as audits and staff supervision would be completed in a timely way.

Vision and strategy
The women and children’s division had an operational plan for 2018/19. This included a strengths, weaknesses, opportunities, threats (SWOT) analysis of services across the division. The plan looked at risks across the division and what the service had in place to mitigate the risks. For example, there was only one lift in Queen Mary Children’s Hospital. The plan also reviewed what the division had in place to strengthen leadership across the division. For example, the head of paediatric nursing had returned to their post following a period of secondment.

The trust had published was a trustwide clinical strategy in November 2017, which detailed the vision for the trust from 2020 up to 2030. Senior leaders of the division told us they were reviewing the sustainability of services and new models of care to meet future demands. Divisional leaders were clear that they wanted to ensure excellent acute services and care at both of the trust’s hospital sites in the short-term. However, a new children’s hospital was under discussion in the longer term, as well as further integration with local community and education services, and the introduction of new service pathways to improve patients’ experience.

Culture
We found an inclusive and constructive working culture within children and young people’s services. We found highly dedicated staff that were very positive, knowledgeable and passionate about their work and passionate about caring for children and young people.

All of the clinical staff we spoke with, including doctors, nurses, HCAs and therapists consistently reported approachable and supportive colleagues and an inclusive and welcoming working environment. The staff we met told us they felt respected and listened to by their peers and managers.

The staff we met understood their local challenges and demonstrated a desire to improve children and young people’s services for the benefit of patients. However, a few members of staff raised issues with the day surgery being used as an escalation ward for adults. We raised this with managers who told us the day surgery was a last resort in the hospital’s winter pressures plan and whilst they understood staff feeling perturbed, the hospital had to utilise all available space at times of high demand.

Senior leaders of the children and young people’s service were proud of their teams and told us staff were committed, respectful to patients and made a positive difference to their local communities.

**Governance**

Governance structures were in place across the children and young people’s services and staff felt they were effective. For example, we viewed a flowchart which clearly identified the children and young people’s governance structure. The service held regular planned governance meetings. There were forums and meetings for staff to monitor quality, review performance information and to hold service managers and leaders to account. For example, there were six weekly children and young people’s quality and child health audit meetings. In addition there was a children and young people’s committee that reviewed performance data across children and young people’s services. The purpose of these meetings was to monitor both divisional clinical and non-clinical risks and performance. Members of the meetings included the clinical director, general manager, head of nursing, matrons, ward managers, and representatives from the clinical audit and safeguarding team.

The service had established some cross-site clinical governance forums. For example, morbidity and mortality meetings were held quarterly, the meeting minutes were recorded and circulated to all clinical staff via email. There were weekly divisional management meetings, weekly head of nursing and matrons meetings, and monthly senior nurses and matrons meetings. This meant there were pathways for information to flow across sites as well as from ward to board.

Governance and performance information was shared with all staff in the children and young people’s service via a monthly newsletter which contained relevant data and was available on the trust intranet and in printed form.

**Management of risk, issues and performance**

Senior leaders and managers of the children and young people’s service had a good understanding of risks to the service and these were appropriately documented in risk a risk register and actions the service had taken to mitigate risks recorded.

The risk register contained 45 risks. Identified risks included: the lack of a high dependency unit, unfilled medical staffing rotas and lack of speech and language therapy support. Risks were reviewed on a monthly basis and documentation submitted by the trust demonstrated clear action plans to address these risks.

Service leaders recognised clinical staffing as a strategic challenge for all children and young people’s services, including neonates, and the service was investigating new models of
working to best utilise limited staff resources, for example by supporting the nurse associate programme.

There were processes in place to mitigate risks for nurses working in the local community. There was a trust lone working policy and staff carried a mobile telephone with them while on community visits to ensure they could contact the team.

**Information management**

There were computer stations with intranet and internet access available on the children and young people’s wards and clinical areas such as children’s outpatients for staff to use. There were sufficient numbers of computers for staff to access information.

The children and young people’s service used a combination of paper and electronic records. Nursing notes and doctor notes were written in paper records. Staff in the neonatal unit (NNU) used a paper-based records system. Throughout the service we saw that notes were stored in dedicated notes trolleys in a visible, secure area.

The trust had invested in electronic handheld devices for clinical staff to record patient vital signs to support monitoring and escalation of early warning scores. However, at the time of our inspection this system was not available in children and young people’s services and staff used a paper-based system to record this information. However, children and young people’s services were rolling out a mobile clinical system that monitored and analysed patient’ vital signs providing clinicians with accurate, real-time information commencing in February 2018.

On wards there were clearly labelled units which contained patient forms in separate files for easy access.

There were standardised quality information boards across all children and young people’s wards which provided current quality data such as staffing levels and safety performance. Notice boards along the ward corridors were neatly organised with information for staff and patients, including visiting hours, protected meal times and senior nurse contact details.

**Engagement**

Staff told us there was good communication from the trust and senior team. The trust provided a number of communications in the form of regular newsletters and all staff emails which highlighted local news, achievements, changes and policy updates. There were weekly communications from the trust CEO which staff found useful and informative. The CEO also had a monthly breakfast meeting which any staff member could attend. Most of the staff we spoke with felt well informed and supported.

In response to a Healthy London partnership peer review in March 2017, which identified communication across teams as an area for improvements. The trust had introduced a weekly message from the CEO; this was a weekly email update from the CEO to staff, a quarterly nursing newsletter, and a weekly ‘listening event’ for staff to attend and feedback to the trust’s leadership team.

Staff told us they recognised that engagement with young people and parents was an area that could be improved. However, there were ‘you said we did’ notice boards in wards and clinical areas which provided information about patient feedback and what actions had been taken as a result. For example, the service received a comment from a parent about the lack of flavoured ice cream. As a result the service had liaised with caterers to offer flavoured ice creams.

The trust had an annual staff survey. We viewed the action plan in response to the 2017 staff survey. The staff survey identified four areas of concern: job satisfaction; health and wellbeing of staff; managers; and equality and diversity. The action plan was comprehensive and detailed.
how the trust intended to address the areas of concern. For example, in response to equality and diversity issues the trust were in the process of establishing a black and minority ethnic (BME) network for children’s services staff, which would be operational from April 2018. This included training for staff and the launch of an annual BME network report commencing in April 2018.

**Learning, continuous improvement and innovation**

Work was in progress on the development of a parent communication tool ‘Train to Home’; this was a pathway for discharge planning which supported the NHS discharge initiative and family-centred care principles.

The head of nursing was working with Health Education England reviewing workforce and staffing models for the future.

The trust had developed an adults’ and children’s safeguarding hub and safeguarding team. The team enabled the monitoring of children and young people’s safeguarding in divisions where children and young people attended within all areas of trust. The safeguarding hub provided daily tracking of inpatients between 16 and 18 years of age who were receiving care from other trust services and not only the children’s division.

Staff told us the outpatients waiting area had been developed in response to children, young people and families’ feedback. The waiting area was equipped with a wide range of toys and indoor sports equipment to suit both younger and older children. Staff said the activities available in the play area helped to alleviate children and young people’s anxieties whilst they were waiting for their appointment.
Epsom Hospital provides urgent and emergency care services through the Accident and Emergency department, which is open 24 hours, seven day a week. Services are provided to the local populations within areas of north east Surrey and the London Boroughs of Sutton and Merton. The hospital covers a large catchment area of residential, rural and industrial communities in north east Surrey.

The emergency department (ED) at Epsom is not a trauma receiving unit, and it does not treat patients who may need emergency surgery. The ambulance services will not bring these patients to Epsom ED; however, these patients may present themselves at triage. Patients who present into the ED at Epsom and need emergency surgery are transferred to St Helier Hospital for further assessment and treatment.

The hospital receives emergency adult, paediatric and maternity patients.

In 2016/17 152,843 patients were treated through the urgent and emergency care services. Of these, 15,898 (26.9%) were ages 17 years or under.

During 2016/2017 they were in the top ten performing trusts nationally for the Accident and Emergency standard of 95% of patients being treated and admitted or discharged in under four hours.

There is a dedicated Ambulatory Care Unit within the emergency departments for patients who require on-going treatment or assessment. Epsom hospital site have an Acute Medical Unit, which provides the rapid assessment hubs for medical admissions. This enables patients to be reviewed by a senior clinician prior to being admitted to the main bed-base.

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department are seen initially by the triage nurse. (Triage is the process of determining the priority of patients’ treatments based on the severity of their condition).

The department has different areas where patients are treated depending on their acuity including an area for minors, a resuscitation area, and an area receiving patients with major concerns. There was a separate paediatric ED with its own waiting area and cubicles. In addition there is a separate Ambulatory Care Unit (ACU).

**Activity and patient throughput**

**Total number of urgent and emergency care attendances at Epsom and St Helier University Hospitals NHS Trust compared to all acute trusts in England.**
There were 151,887 attendances from April 2016 to March 2017 at Epsom and St Helier University Hospitals NHS Trust as indicated in the chart above. (Source: NHS England)

The trust reported in pre-inspection information that in 2016/17 152,843 patients were treated through the urgent and emergency care services. Of these, 15,898 (26.9%) were ages 17 years or under.

Updated figures provided after the inspection indicated that between April 2016 and March 2017 59,431 patients attended the ED at Epsom.

Urgent and Emergency Care attendances resulting in an admission

The percentage of ED attendances at this trust that resulted in an admission slightly increased from 2015/16 to 2016/17. In 2016/17, rates were higher than the England average.

(Source: NHS England)
Updated data provided by the trust post inspection indicated that during the period April 2016 and March 2017 15,495 patients seen in the ED were then admitted to a hospital bed.

**Urgent and Emergency Care attendances by disposal method**

*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

(Source: Hospital Episode Statistics)

**Is the service safe?**

**Mandatory training**

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of October 2017 for medical/dental and nursing/midwifery staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Medical and Dental staff</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>69%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>64%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>56%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>55%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>49%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>44%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>44%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>40%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>36%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>29%</td>
</tr>
</tbody>
</table>

The 95% target was met for none of the 10 selected mandatory training modules shown above for medical staff.
The 95% target was met for two of the ten selected mandatory training modules shown above for registered nursing staff.

A breakdown of compliance for mandatory courses as of October 2017 for medical and nursing staff in Epsom Hospital is shown below:

<table>
<thead>
<tr>
<th>Epsom Hospital</th>
<th>Trust Target (%)</th>
<th>Percentage number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>87%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>83%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>81%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>81%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>74%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>64%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>60%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>60%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>58%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>39%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>23%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust indicated to us that Information Governance training has to be completed each financial year. Therefore the next deadline for completing the training was 31st March 2018.

The trust’s Statutory and Mandatory Training Policy identifies the legislative, as identified by the NHS Litigation Authority (NHSLA), and specific training staff were required to attend to fulfil the requirements of their role. Subjects had been identified along with the frequency of completion. For some this was once only at induction, whilst other subjects were to be completed yearly or every three years.

Staff told us that much of the mandatory training was on-line and was done in their own time, as it was difficult to have time allocated for completion in work hours. There were additional difficulties in completing training on-line when IT systems crashed.
We asked to see training rates for mandatory subjects for ED staff and were shown the 'WIRE' database. Excluding new staff who were going through induction and those on maternity leave, it was still evident that there were gaps in staff completing the required training. For example, patient manual handling was to be completed every two years and there were seven staff who had not done this since 2014, and one staff member who last completed this training in 2013.

Similarly there were gaps in annual resuscitation training, with last recordings for staff as far back as 2013 and 2015. The records did not give any indication as to what level the resuscitation had been completed, be it immediate, advanced or paediatric in content. Therefore we were not assured staff had been suitably trained.

Senior staff told us that WIRED did not reflect the true level of compliance within the ED. They were not aware of any plans to resolve this. This meant that senior staff could not be assured that staff working within the ED had the appropriate skills and knowledge.

The trust provided a summary of mandatory training figures to us after our inspection. This indicated that paediatric ED staff had completed 100% of their training. However, none of the nursing or medical staff training targets had been achieved in main ED.

The mandatory training completion rates had deteriorated since our previous inspection. Although there were still three months left of the financial year in which to undertake training, the likelihood of this being achieved was low, given the additional pressures on staff related to high patient activity.

**Safeguarding**

Staff had access to information related to safeguarding vulnerable adults and children. Contact details and guidance was readily available and visible within the department.

Staff we spoke with were aware of their responsibilities to prevent avoidable harm and to alert relevant people where a possible safeguarding matter needed to be considered.

The trust had a safeguarding hub covering both hospital sites. The safeguarding hub had monthly meetings which included community leads inform various agencies. The agenda of the meeting included consideration of staff reporting around safeguarding, child protection, domestic violence and learning disabilities.

There was a Safeguarding Children’s Meeting held weekly at Epsom Hospital. There were five missed safeguarding referrals for November and December 2017, reported formally to the weekly safeguarding meeting.

We noted the patient records contained a section where staff were prompted to ask about any current involvement with social services.

The Safeguarding children’s team was led by the named nurse for safeguarding children. They reported directly to the safeguarding lead with professional support from the head of nursing – paediatrics and neonatology and through to the chief nurse, who was the executive lead for both adult and children safeguarding.

The Safeguarding Children Committee met monthly and were responsible for ensuring staff were made aware of new guidance, legislation and recommendations from national and local Serious Case Reviews. Minutes reviewed by us demonstrated the meetings were multi-agency and had appropriate representation from respective leads.

Safeguarding supervision was provided by the safeguarding team. We noted from the annual report that there had been 2224 consultations in 2016/17. This was a 56% increase from 2015/16 data and averaged 185 formal referrals to the team a month.
The safeguarding hub supported staff to complete Level one and Level two safeguarding training which covered the Mental Capacity Act and DoLS. Mental Health training was delivered as a separate module and included suicide awareness. Staff had access to safeguarding training as part of the mandatory programme. Female Genital Mutilation (FGM) and Child Sexual Exploitation (CSE) was covered within the lesson plan. Safeguarding Adults, the Mental Capacity Act, Deprivation of Liberty Safeguards, and Caring for People with Complex Needs, such as learning disabilities formed part of this. There were various levels of training available, from level 1 to 5. Safeguarding Adults and Learning Disabilities continue to be part of the induction for all nurses and midwives.

Safeguarding with Prevent awareness was to be completed every three years. Similarly Safeguarding Adults, the Mental Capacity Act 2005 and Deprivation of Liberty (DoLS) training was to be completed three yearly.

Training records were entered on the corporate training register (WIRED), which we were able to view. Performance since 10th March 2017 was at 96.11% trust wide. There were systems to remind staff of the need to undertake training and alert processes for booking such sessions.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.
The trust provided their training for all staff within the urgent and emergency core service.

The trust was not meeting any of the three safeguarding modules, the lowest with 37% Safeguarding Adults (Level 2).

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>70%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>67%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>37%</td>
</tr>
</tbody>
</table>

The 95% target was met for none of the two safeguarding training modules for which medical staffs in urgent and emergency care were eligible.

The 95% target was met for one of the three safeguarding training modules for which qualified nursing staff in urgent and emergency care were eligible.

A breakdown of compliance for safeguarding training courses as of October 2017 for medical and nursing staff in Epsom Hospital was 53.7%
The trust provided updated data for Safeguarding training with respect to ED staff. For medical staff completion of level two children’s was at 55.5%, level three was at 56.2%, both with a target of 95%. Nursing staff training figures were at 72.7% and 63.6% respectively. Training figures for adult safeguarding awareness was reported to be 72.2% for medical staff and 92.7% for nursing. There was no training data for the number of medical staff who had completed Safeguarding Adults level 2 Mental Capacity Act (MCA0, Deprivation of Liberty Safeguards (DoLS), and only 44.19% of nurses had completed this as of the 12 January 2018.

The trust produced separate Safeguarding Children and Adults Annual Reports for 2016 – 2017. Information therein detailed the data related to attendance at the ED for mental health and suicidal reasons, or assault, along with data on referrals to children’s social care.

Between 1 October 2016 and 30 September 2017 there were 91 safeguarding referrals made from the ED at Epsom.

The trust had an ‘Infant and Child Abduction Policy’ which provided information and guidance on the required actions for staff in ED as well as ward areas.

**Cleanliness, infection control and hygiene**

The infection prevention and control team had been restructured and they now had a head of nursing and a new data co-ordinator. An Infection Control Improvement Plan, dated for the period 2017/18 included information for the reporting period September to October 2017, along with areas to be addressed in the A&E. This included the need to commence the ‘Saving Lives’ audits related to Peripheral Cannula, and training for staff in the use of PICC lines. Posters were to be made available around the ED for staff to cross reference practice. We noted there were no dates set for commencement of the latter or targets to check progress.

There was access to policies and procedures to support the practices related to infection prevention and control (IPC). We observed clinical and domestic staff carrying out their activities taking into account; The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. For example, with regard to appropriate dress code, hand washing, management of different waste products, and the cleaning of the environment. The
majority of staff used personal protective equipment, (PPE), which included gloves and aprons. It was noted that a consultant did not wear an apron when they carried out an aseptic procedure.

We checked all areas within the ED and noted they were generally visibly clean. It was however, difficult to keep all areas clean in between use due to the pressures of patient turnover. For example, we noted floors in the cubicle areas and treatment rooms in the Ambulatory Care Unit (ACU) would have benefited from additional cleaning. A patient who returned for daily treatment in this department commented to us that they thought the cleanliness could be improved. They told us they brought disinfectant wipes with them for the chair and table.

We noted chairs in the ACU had damaged to their fabric coverings and therefore could not be adequately cleaned, making them a potential risk of harbouring contaminants.

Staff were responsible for cleaning equipment used by patients and we saw that this happened. Staff or volunteers cleaned and prepared trolley beds in between patients. A volunteer we spoke with confirmed they had received IPC training.

Domestic staff were employed through a designated provider and were aware of their responsibilities and the requirements to maintain a suitably clean environment. They had guidance on their duties, were provided with nationally recognised colour coded equipment, and had their work checked by a supervisor.

We observed cleanliness scores were displayed for December 2017, showing a score of 97%, which was above the expected target of 95%.

A full programme of infection control training was offered in 2016-17, including induction and mandatory update training for all clinical staff who had direct contact with patients and for non-clinical staff who worked regularly in the clinical environment, including domestic staff and porters. In addition bespoke training was also delivered for specific groups. The vascular clinical nurse specialist commenced Aseptic Non-Touch Techniques (ANTT) training delivery on induction.

The IPC Committee received information via an Exception Report for the Medicine Division in which ED sits. Minutes from the November 2017 meeting indicated the hand hygiene audits results across the department. These ranged from 80% to 100% for the preceding year. The exceptions to this were the months of July (50%), and September for adult areas, (10%). No data was provided for paediatric ED in October 2017.

There was an action plan related to IPC in the ED, which detailed areas of focus and the required action, along with individuals responsible and target dates.

The director of IPC, head of nursing for IPC and lead microbiologist also presented an executive report. This summarised all relevant information, all be not specifically about the ED.

**Environment and equipment**

The environment was laid out in separate well defined areas. This included a main reception, which afforded mostly direct viewing of patients from the reception desk. A triage room was off the reception. We noted this was very small and would present problems if a patient within it suddenly deteriorated and required additional support.

The area used for minor treatment led off from reception via a connecting corridor. This could only be accessed by the release of a button by reception staff, or a swipe card. The minor’s area was made up of five cubicles, one of which was used for plastering. One cubicle was used for ENT and one for eye problems. There was a separate sluice and clean room.
Resuscitation was accessed directly by ambulance and consisted of five bays, one of which was used for paediatrics, but was also used by adults if the need arose. Space around the trolleys in each bay was limited and further reduced by the presence of equipment.

The area used for ‘major’ patients was overseen directly by the nurse/doctor station. There were ten trolley cubicles, one woman’s health room, one psychiatric interview room, a rapid assessment cubicle, a decontamination cubicle, and a relative’s room.

At the last inspection, we noted that there was a separate room designated for interviewing patients with mental health needs. We observed that this room had only one exit and did not have an emergency call button. A ligature point was also noted. At this inspection, we found a number of improvements had been made. The assessment room now had emergency panic alarm strips in place, there were no ligature points, and there were two exits to the room.

However, the mental health assessment room presented a risk of mental health patients absconding, or presenting a risk to themselves or others. The mental health assessment room had two doors that swung outwards, but the second door was kept off the latch, so that it swung to the touch. The second door opened into the next cubicle. At the time of the inspection, the next cubicle had a patient and their family in the room, but no staff. We witnessed a patient in the assessment room inadvertently push the door into the next cubicle. There were no staff present in the assessment room at this time. Staff told us that staff were always present in the assessment room, but in the space of an hour, we saw three instances where patients were left alone in the assessment room. This was escalated at the time of the inspection.

Furniture in the psychiatric assessment room was extremely heavy and did not pose any risk of being used as a weapon. There were no ligature points.

The department had its own x-ray facility in the major’s area. We saw appropriate safety signage was in use when the x-ray room was in use.

There was a small kitchen where drinks and sandwiches could be prepared for patients.

Separate areas with secure access were provided for nursing staff for medicines and waste disposal. There was secure access to the managerial rooms and staff areas leading off from the major’s area.

Since the last inspection the paediatric ED had been moved and now occupied a larger area. This had the facility to take six children, either in a cubicle or one of the two single rooms. The paediatric area had its own reception. Access was secure via two routes, either from the majors or main reception. Children were not brought through the adult area, which was an improvement on the previous findings.

The paediatric ED had its own waiting room with some books and toys provided.

There was a designated triage room in paediatrics. Children and young people up to the age of 16 or 18, if they met the criteria were seen by the nursing and medical staff.

The separate Ambulatory Care Unit (ACU) had three treatment rooms and two cubicles, plus a seated area used for some re-attending patients. There was a small reception/nurse station and clean utility area.

Equipment was provided in each separate area relevant to the type of patient needs. Items of equipment checked by us indicated they had been subject to safety checks and were suitably clean.
Staff told us there were shortages of equipment, such as lack of monitors in some cubicles in majors, and other portable equipment. Whilst they felt this did not compromise patient safety staff said it made things difficult having to hunt for items. Further, some of the patient technical equipment purchased in the past had been selected without any checks on compatibility with other current equipment.

Resuscitation trolleys were accessed in majors and the resuscitation area. These were subject to regular checks and top up. Check lists in the resuscitation area did not always indicate if required actions had been taken to replace missing items.

In the paediatric ED there was no resuscitation trolley. There was however, an airway trolley, which enabled staff to carry out the first stages of resuscitation before transferring the child to the resuscitation room.

There were emergency transfer bags, portable suction and a crash team grab bag. These were subject to routine checks.

**Assessing and responding to patient risk**

Walk in patients were booked in by reception staff and asked to sit in the waiting area before triage by a designated nurse.

The triage process which we witnessed for both a child and an adult included a detailed assessment of the presenting problem, along with other initial information necessary for deciding the most appropriate pathway through the department. Information, including the record of the patient’s physiological observations on a National Early Warning Score (NEWS) or for children, the Children's Observation and Severity Tool (COAST) was gathered by the trained triage nurse.

The triage nurse could make direct requests for x-rays of limbs only. Patients were then streamed to adult minors or majors for further review, possible investigation and treatment or to the paediatric area.

The ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment so a team was waiting for them on arrival. Ambulance staff pre-alerted the department of patients who required access to the specialist stroke team, so that immediate assessment and necessary treatment could start straight away.

Patients brought in by ambulance came into the majors or directly into resuscitation via the direct ambulance route. Patients being received in the major’s area were booked in and handed over at the ambulance handover reception. A data base was accessed here which recorded ambulance timings including time of arrival and handover to staff.

Staff used a risk based process of known as SBAR, which included considering the patients situation, background, assessment and recommendations. They also continued to monitor the condition of their patients using the early warning score system.

The department met Royal College of Emergency Care (2017) quality standard with regard to timely access to a senior doctor where a patient’s condition warranted this.

There were processes to ensure patients were safe where their condition indicated specific treatment and care. A sepsis policy was available to support staff in identifying and responding to patients with clinical indications of this. We were able to see evidence that staff followed a sepsis pathway.

We were told the sepsis lead recently changed and staff were not sure who had taken over the role or how well the trust or ED was performing in this area. Although we saw information from the
trust indicating there were sepsis champions in each clinical directorate, staff were unsure who these were.

Staff completed patient risk assessments, including frailty, pressure areas and nutrition. Specific observational tools were used to assess the patient’s condition, for example the Glasgow Coma Scale. Staff were fully aware of escalation procedures where a patient's condition deteriorated.

A psychiatric liaison service was provided by the local mental health NHS trust and was available on site, adjacent to the ED. The service was available 8am to 3am daily then the ‘home treatment team’ responded to referrals.

Epsom Hospital ED was not a legally “designated place of safety”. However, if staff agreed, then the A&E could temporarily become a “place of safety” for a specific patient detained under Section 136 who was in need of immediate treatment for physical illness or injury such as self-harm. Patients who present to ED under Section 136 were escorted to an available 136 suite, or if one was not available at the time of the request, once the patient was medically cleared.

Patients who were at risk as a result of their mental health received a mental health assessment within ED or the assessment unit by a qualified mental health professional and their suicidal risk was managed by the provision of one to one nursing where indicated following risk assessment.

We were told child adolescent mental health service (CAMHS) patients were admitted to a bed.

**Restraint and restrictive practices**

Security staff and clinical staff restrained patients if they posed a risk to themselves or others. The security staff covered Epsom and St Helier Hospitals. Security staff attended awareness training for Mental Health, Mental Capacity, Safeguarding and other courses provided by the trust. Security staff were trained in how to safely restrain patients who were vulnerable. The head of security attended regular meetings with other departments in the trust and cascaded learning through security team meetings.

Before restraint was used on any patient, the responsible clinician filled out documentation to state under which legal framework the restraint was being used. The responsible clinician stated whether restraint was carried out under the Mental Capacity Act, the Mental Health Act, or under common law.

Security staff did not monitor or audit the use of restraint. Staff told us that restraints were logged as incidents on the incident reporting framework, Datix. However, when we looked at the Datix entries for the last year in the emergency department, it mentioned use of restraint only four times. The forms from the security office showed that security were called to restrain patients 75 times during the past year. The trust did not formally monitor the use of restraint in the hospital.

Staff said that the trust did not use the security staff for monitoring or observing vulnerable patients, except for short periods of time (under two hours), while the trust located a mental health nurse to support patients, or while the patient awaited transport to another facility. However, the use of security staff for monitoring patients was not monitored by the trust.

There was acute paediatric support for the investigation of sudden unexpected death in childhood. The on-call paediatric consultant attended such situations and there was a pack to support the process.

There was a formal process with action plans, together with appropriate equipment to manage HAZMAT patients. These are patients who may have been at risk as a result of chemical, biological, radiological and nuclear material of a hazardous nature.
Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard at all for the 12 month period from November 2016 to October 2017.

Performance against this standard showed a trend of decline. In October 2017 the median time to treatment was 88 minutes compared to the England average of 59 minutes.

Ambulance – Time to treatment from November 2016 to October 2017 at Epsom and St Helier University Hospitals NHS Trust

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

The trust provided updated information on request in relation to average time taken from ambulance handover before treatment was given. This was reported to be one hour, eight minutes and 13 seconds for the period November 2016 to October 2017.

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was better than the overall England median in the 12 month period from November 2016 to October 2017.

In each month from November 2016 to October 2017 the median time to initial assessment was one minute compared to the England average of eight minutes.

Ambulance – Time to initial assessment from November 2016 and October 2017 at Epsom and St Helier University Hospitals NHS Trust

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

The trust provided its figures on the average time of ambulance arrival to triage as being two minutes and 52 seconds for the period November 2016 to October 2017.

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Epsom General Hospital
From December 2016 to November 2017 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Epsom General Hospital.

In November 2017, 74% of ambulance journeys had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Epsom General Hospital**

<table>
<thead>
<tr>
<th></th>
<th>Between 30 and 60 minutes</th>
<th>Over 60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-16</td>
<td>900</td>
<td>300</td>
</tr>
<tr>
<td>Jan-17</td>
<td>900</td>
<td>300</td>
</tr>
<tr>
<td>Feb-17</td>
<td>900</td>
<td>300</td>
</tr>
<tr>
<td>Mar-17</td>
<td>900</td>
<td>300</td>
</tr>
<tr>
<td>Apr-17</td>
<td>900</td>
<td>300</td>
</tr>
<tr>
<td>May-17</td>
<td>900</td>
<td>300</td>
</tr>
<tr>
<td>Jun-17</td>
<td>900</td>
<td>300</td>
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<tr>
<td>Jul-17</td>
<td>900</td>
<td>300</td>
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<tr>
<td>Aug-17</td>
<td>900</td>
<td>300</td>
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<tr>
<td>Sep-17</td>
<td>900</td>
<td>300</td>
</tr>
<tr>
<td>Oct-17</td>
<td>900</td>
<td>300</td>
</tr>
<tr>
<td>Nov-17</td>
<td>900</td>
<td>300</td>
</tr>
</tbody>
</table>

(Source: National Ambulance Information Group)

**Emergency Department Survey 2016**

The trust scored “about the same as” other trusts for all five of the Emergency Department Survey questions relevant to safety.

<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>8.8</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>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a 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?</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.8</td>
<td>About the same as 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>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

**Number of black breaches for this trust**

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 October 2016 to September 2017 the trust reported 169 (Epsom – 50; St Helier – 119) “black breaches”.

**Nurse staffing**

The trust reported their registered nursing staff numbers as below as of October 2017.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post - October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>141.3</td>
<td>122.8</td>
</tr>
</tbody>
</table>

There were 18.4 less WTE nursing staff than the trust had planned to provide safe care within the urgent and emergency care core service.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

We asked for nursing staffing levels by site and were provided with the following: The compliment in ED was 54 whole-time equivalent (WTE) and consisted of the following; eight healthcare assistants Band 2, two associate practitioner at Band 4, 17 nurses at Band 5, and nine nurses at Band 6. There were 17 Band 7 nurses (including emergency nurse practitioners), and a nurse manager at Band 8a. This was higher than the previous establishment of 49.

The number of nursing staff working cross both ED sites was said to be; One nurse at Band 8a, a deputy head of nursing Band 8b, and the head of nursing, Band 8c.

The trust did not hire agency mental health nurses and relied on NHS bank or agency RMNs. The trust gave inductions to RMNs coming to the hospital, and each ward supported the RMNs on the necessary procedures and policies. The psychiatric liaison team also provided a RMN to support patients in Epsom hospital.

**Vacancy rates**

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)
As at October 2017, the trust reported a vacancy rate of 26.5% in urgent and emergency care;

- Epsom Hospital: 39.3%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

As at October 2017, the trust reported turnover rate of 29% in urgent and emergency care;

- Epsom Hospital: 56%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The trust monitored reasons for staff leaving. Exit interviews were offered to staff once it was known they were leaving. Exit questionnaires were also sent to the leaver electronically or by post. Any comments that could be considered negative or required further action were provided to the people business manager for discussion with the line manager of the member of staff who was leaving. We noted from information provided that feedback had been received for four staff who left the ED at Epsom Hospital. Reasons given ranged from lack of manager flexibility, to staff pressures.

Sickness rates

As at October 2017, the trust reported a sickness rate of 5.1% in urgent and emergency care;

- Epsom Hospital: 8.3%, which was higher than the previous inspection rate of 7.1%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

As at October 2017, the trust reported bank and agency usage in urgent and emergency care. The trust used 4,880 bank staff to cover shifts, a further 1,650 shifts were covered by agency staff (of which 57% were at the Epsom Hospital site) and a total of 2,453 (62% were at the Epsom Hospital site) were unfilled for this core service.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

An electronic rostering system called ‘SafeCare’, provided acuity and dependency of patients and then calculated the utilisation of the nursing hours rostered on wards. Real-time data was available to inform decision making on the allocation of the nursing resources to ensure that all areas were safely staffed, based on the level of care that patients required.

The clinical manager told us the acuity tool was not used in ED. There were always band 7 and 6 nurses on duty, with seven staff on a morning shift going up to nine on the late shift, where activity tended to be higher, and then a staged reduction back to seven for the night shift.

The additional winter allowance funded an extra healthcare assistant on a long day shift and an extra night nurse.

The deputy head of nursing had reviewed working patterns, recognising there were some entrenched habits. Staff had met the manager’s requests for changes half way, such as longer days for some and twilight shifts. They had also put in place rotation and offset shortfall by having cross-site working from St Helier.
Epsom ED was using staff from St Helier ED on a two week rotation. This had been possible as it was easier to recruit at the sister hospital and they had been able to over recruit, allowing greater flexibility. We spoke with a nurse who had started in the department having come from St. Helier. They were happy they had been made to feel welcome and had been shown around. Daily reports to ensure robustness of acuity and dependency data were circulated. There was senior nurse cover from 4-8pm and handover of staffing plans for the nights and weekends were reviewed and actioned by the senior nurse. Information from ‘SafeCare’ formed part of the yearly establishment reviews for wards, to ensure that the right levels of staffing and skill mix were agreed for the levels of acuity and dependency of patients.

Nursing staff cover was displayed for each part of the day during the period we were on site and indicated there was sufficient cover. However, we were told by nurses that staffing was still a concern, although it was improving. Sickness, they said, had the greatest impact on staffing.

Nurse handovers took place between shift changes and staff were assigned to work in an area.

We were told a mental health liaison nurse worked one day per week in ED seeing children and young people with associated needs up to the age of 18 years.

A patient re-attending the department as part of on-going treatment commented to us on the better staffing levels noted during our inspection. They also told us there were times the consultant was undertaking nurse related tasks such as dressings as there was not sufficient nursing staff.

**Medical staffing**

Medical staff reported that there difficulties with gaps in the rota at middle grade and senior house officer (SHO) level. These were filled with long and short term locums. However, they had recently recruited three new consultants and there was additional recruitment taking place.

We were told the recruitment process was very slow, which had meant doctors had taken jobs elsewhere.

One long term middle grade acted up as a consultant on a Friday evening to fill a gap on the consultant rota but, that invariably left a gap at registrar level that was not always filled.

A new role of physician associate had commenced and there were two such staff members in the department. We were told they worked at SHO level but did not prescribe. We asked to review the job description and noted the physicians associate were required to work different areas of the department to assess and examine patients, present them, initiate and interpret investigations and recommend treatment. Supervision was undertaken by a designated consultant with individual mentorship to overview career development.

Improvements since the last inspection included locum induction, which consisted of local and corporate induction.

The trust reported their staffing numbers below as of October 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post- October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>73.0</td>
<td>79.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

We asked for information of medical staff grades and were provided with the following information as of October 2017; there were 13 consultants working across both ED sites, which was one
less than they had at the previous inspection. In addition there were six FY2s, one specialty registrar, eight specialty doctors, and a trust doctor.

**Vacancy rates**

As at October 2017, the trust reported a vacancy rate of 37.7% in urgent and emergency care;

- Epsom Hospital: 19.7%

(*Source: Routine Provider Information Request (RPIR) P17 Vacancies*)

**Turnover rates**

As at October 2017, the trust reported turnover rate of 29% in urgent and emergency care;

- Epsom Hospital: 12%

(*Source: Routine Provider Information Request (RPIR) P18 Turnover*)

**Sickness rates**

As at October 2017, the trust reported a sickness rate of 5.1% in urgent and emergency care;

- Epsom Hospital: 2.3%, slightly lower than the previous inspection findings.

(*Source: Routine Provider Information Request (RPIR) P19 Sickness*)

**Bank and locum staff usage**

As at October 2017, the trust reported bank and locum usage in urgent and emergency care; The trust used 2,900 bank staff to cover shifts, a further 136 shifts were covered by agency staff (of which 61% were at Epsom Hospital) and a total of 327 (46% were at Epsom Hospital) were unfilled for this core service.

(*Source: Routine Provider Information Request (RPIR) P21 Medical Locums*)

**Staffing skill mix**

During August 2017, the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 54 whole time equivalent staff working in Urgent and Emergency Care at Epsom and St Helier University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>19%</td>
<td>28%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>30%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Junior*</td>
<td>26%</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)

On both ED sites there was a minimum of 14.75 hours of consultant presence on weekdays, and a minimum of 12 hours at the weekend. This was complemented by a further eight acute paediatric consultants who provided a paediatric on-site presence in the ED until 10pm every day. The trust was aiming to increase the adult consultants to 16 WTE, to strengthen the staffing.

During weekdays, there was a consultant on each site for a minimum of 8am-10:45pm, then on-call overnight providing cross-site cover. At weekends there was consultant on-site for a minimum of 8am-4pm at Epsom Hospital, then on-call providing cross-site cover afterwards.

At present there was an additional consultant on both sites from 2pm -10pm Friday to Tuesday.

Medical staffing levels and grade of medical staff was displayed for each of the days we were on site. We noted where there was lack of cover this was reported as a vacant position for the respective time of day. For example, there were two junior doctor level gaps of cover on the 10 January for the period 8am until 4:30pm.

There were regular handovers between outgoing and incoming medical and nursing staff. Board huddles also took place at 10am, 4pm and 8pm. These provided an opportunity to discuss the status of patients in each part of the department.

Nursing staff in paediatrics told us they had a junior doctor in the unit all the time but they could get support from the main ED consultant, as well as support from the ward paediatric team. They told us there was a paediatric consultant between 4pm and 10pm weekdays and at the weekend between 1pm and 10pm. These were the busiest times for children coming through the department.

Records

Records related to patients were kept at the nurse stations in the majors, minor and paediatric areas. In resuscitation where there was no nurse station, they were managed by the staff at each bay.

Patient records were completed on paper and were scanned following their discharge from the department onto a patient data base. Adult records were then destroyed but children’s were stored securely for the required length of time.

A discharge summary was sent directly to the patient’s GP for those that were discharged directly from the department.

The trust ensured that when staff detained patients under the Mental Health Act (MHA), they filled out the correct paperwork and ensured that patients had their rights explained to them.

All healthcare professionals recorded care and treatment using the same document. If the patient was admitted, a copy of these were sent with the patient to the ward and the record was then scanned and added to the computer system so it could be viewed if the patient was re-admitted.

We reviewed seven records for adult patients attending various areas within the department and four records for children attending the paediatric area. The majority were completed in full, with time of arrival noted, the initial triage or assessment, the time activities were carried out such as
recording of an ECG or blood tests. The discharge time was noted along with the discharge destination, be that home or to another area within the hospital.

Nursing and medical entries were clear, as were entries made where the staff recorded the condition and physical results of blood pressure and heart rate for example.

On occasion the time of discharge preceded the timings on the ECG test carried out. We fed this back to staff who advised the ECG would need to be recalibrated to correct this.

We also reviewed three ED patient records of patients who had arrived within the previous 48 hours after suicide attempts. They were completed in full and showed attention to risk and information sharing with the community agencies.

There had been a re-audit of the completion of the paediatric early warning score records, which included children seen in ED and those admitted to the paediatric wards between February 1st and April 30th 2017. This showed an improved picture in many areas but there were a number of actions identified, with time frames for implementation.

**Medicines**

The trust had a medicines optimisation strategy, which set out its aims to improve the safety and outcomes achieved from the investment in and use of medicines by ensuring their utilisation in the most effective way.

Medicines were not prescribed electronically in ED but on paper prescription charts. If a patient was admitted to a ward, the prescription was transferred onto an electronic patient record.

Medicines were stored securely. Controlled drugs (CD) were stored and managed appropriately, and improvements were seen in the recording of CD checks.

However, as we found at our previous inspection, temperature records for medicines requiring refrigeration were incomplete, with only 10 readings having been taken between October and December 2017. This meant that the provider could not be sure those medicines were fit for use.

We found one resuscitation trolley contained medicines which were out of date. Checks on trolleys were not always completed daily.

A trolley containing medicines commonly prescribed for discharge was stored securely in the department. These medicines were given to people at the point of discharge to avoid delays in waiting for prescriptions to be dispensed. Staff told us this had reduced the time people had to wait for discharge.

There were regular checks and top up of medicines used in the department; this included the medicine cupboards where items used for patients to take home were given during out of hours.

The medicines room in the adult area was secured with a keypad lock so was only accessible to authorised staff.

Medicines in paediatric ED were stored in locked cupboards but not within a secured room. The fridge used to store temperature dependent medicines was unlocked and we were told it had been reported for repair.

Dosing guidelines for children were available for some medicines. Staff also had access to medicines formulary guidance.

**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 November 2016 to October 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with five (83% of total incidents)
- Pending review (a category must be selected before incident is closed) with one (17% of total incidents)

(Source: NHS Improvement - STEIS (01/11/2016 - 31/10/2017)

An electronic system was used to report incidents, including near misses. Staff were aware of the process to report such matters, and of the type and range of incidents they would be expected to report.

We were provided with a list of reported incidents, of which there had been 198 in the Epsom ED. These were graded by type, specialty and severity of harm. We noted the incident information contained details of the action taken at the time.

Nursing staff told us they received feedback on serious incidents and that they would be sent a report for signing if they were directly involved. Staff meetings only happened once or twice a year at staff nurse level and so this did not provide a useful opportunity to share learning. There was however, ‘top ten tips’ coverage in the morning handover.

We were told that learning from investigation, including root-cause analysis was shared with staff. A file was available at the nurse station of the adult area. When we looked at this we saw limited information to evidence that regular information was communicated in respect to incidents. The few items within the folder were not recent, and although there was a signatory page to indicate staff had read the learning and action points, we found this system could be improved.
We were provided with a typed list titled ‘Incident Summary and Learning/Changes. This listed 13 incidents with a very brief summary and the action taken as a result of reviewing the incident. The document was not dated and there was no indication as to when the incidents had occurred or what process had been followed to review the incident. There were three issues noted to require resolution still. Whilst this was a useful snapshot, the content did not demonstrate a robust systematic process for reviewing and learning from incidents. However, following the inspection, we were told that the trust did have systems in place for staff to learn from incidents including, clinical governance meetings, divisional quality meetings, MDT safety meetings, a newsletter and emergency department study days.

A member of nursing staff told us about learning from an incident, which was reflected on the aforementioned document. This related to patients who absconded or self-discharged. The resulting action had led to the development of a protocol, a copy of which we saw.

We requested and received information related to SI and the investigative process, including learning outcomes. We saw from the information provided there was a thorough process from start to end. Relatives were informed of the process and outcome where relevant, in accordance with duty of candour.

The trust’s policy for mortality reporting and mortality peer review process worked in conjunction with the policy for Reporting and Managing Incidents, and reflected the ‘National Guidance on Learning from deaths: Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care’.

We asked what the process was for mortality and morbidity reviews was in the department and were told there wasn’t a regular meeting to hold such reviews. Where discussion took place minutes were not taken. As a result it was not clear how any learning from the review process could be identified, communicated and evaluated.

The trust had a Reducing Avoidable Death and Harm (RADAH) Committee to oversee and coordinate work in this area. Meetings were held monthly with the purpose of receiving and reviewing reports to seek assurance from a number of sub groups with the purpose of identifying and providing recommendations on specific initiatives to improve service transformation, improving recognition and treatment of the deteriorating patient working towards the elimination of all avoidable in hospital mortality and ensuring transformational change meets clinical best practice.

We reviewed minutes of Reducing Avoidable Death and Harm Steering Group meetings and noted action logs were reviewed, in addition to risks and mitigations, such as those related to sepsis. There had also been presentations of information related to cardiac arrest and the mortality group dashboard.

Staff told us about changes arising from an incident related to a patient death. The learning from this had resulted in a change to the head injury proformas.

The trust had applied the principles of duty of candour 19 times in relation to ED services since October 2016 and September 2017.

**Safety thermometer**

The Safety Thermometer was 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.

The department did not display any safety related information apart from cleanliness scores. However, data from the Patient Safety Thermometer showed the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from October 2016 to October 2017 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

**Is the service effective?**

**Evidence-based care and treatment**

Staff working in the ED had access to professional policies and procedures. Where relevant, these made reference to the Royal College of Emergency Medicine (RCEM), and other guidelines. We saw professional guidance was available for a range of situations, including; paediatric anaesthesia and emergencies, resuscitation, anaphylaxis, malignant hyperthermia, major haemorrhage and numerous treatment pathways.

The trust had policies and procedures in place to meet the needs of people with mental health needs. The trust had a Service Level Agreement with the local mental health trust to help administer the documentation of patients detained under the MHA, to support staff in treating patients with a mental health illness, and to train staff.

There were a number of patient pathways for acceptance into the Ambulatory Care Unit, including anaemia, headaches, gastrointestinal bleed.

The trust participated in the national sepsis commissioning for quality and innovation (CQUIN) for 2017/18. Data for quarters one and two 2017/18 indicated 150 ED patient records reviewed confirmed the individuals had sepsis. Of these, 124 were recognised and recorded as sepsis by the clinicians giving a percentage compliance of 83%.

There were 103 cases of severe (red flag) sepsis or septic shock diagnosed in ED. Of these, 57 received IV antibiotics within 60 minutes of presentation giving a percentage compliance of 55%.

We observed patient care which reflected best practice, as outlined in the trust’s adult sepsis policy. Assessment and interventions of staff reflected the appropriate pathway, and the patient’s treatment and care record had been completed with the details.

**Nutrition and hydration**

Staff considered the nutritional and hydration status of patients who were brought into the resuscitation or major’s area. Intravenous fluids were prescribed and given where indicated and we saw this was noted in patient records.

**Pain relief**

As part of their patient assessment, we heard staff asked them if they had any pain. The response from adults was recorded in the patient record on a national early warning score (NEWS) area of the record, and for children on the children’s early warning severity tool (COAST). Pain relief was prescribed and given as needed in the records we reviewed.
Patients who spoke with were not always asked if they had pain or given pain relief. A patient in minors told us they had pain and we reported this to the nurse.

We asked if nursing staff had received training to enable them to give intravenous paracetamol whilst awaiting a doctor seeing the patient. We were told only some of the emergency nurse practitioners could do so.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.7 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.5 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question</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>5.7</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>7.5</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>6.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey – September 2016)

**Patient outcomes**

**RCEM Audit: Moderate and Acute Severe Asthma 2016/17**

In the 2016/17 Moderate and Acute Severe Asthma report, the trust failed to meet any of the standards for Epsom Hospital.

The trust was in the lower UK quartile for one standard:

- Standard 1a (fundamental): O2 should be given on arrival to maintain saturation 94-98%. Trust: 6.9%; UK: 19.3%.

The trust’s results for the remaining six metrics were all between the upper and lower UK quartiles.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the Emergency Department (ED). Trust: 16.7%; UK: 26%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust: 35.3%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Trust: 80%; UK: 77%.
- Standard 5: If not already given before arrival to the ED, 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
    - 5a: Within one hour of arrival (acute severe) Trust: 15.4%; UK: 19%.
- 5b: Within four hours (moderate) Trust: 31%; 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
    Trust: 51%; UK: 52%.

We asked for explanatory information about the results and were given a document summarising the CQUIN for asthma. This indicated that out of 21 admissions to the ED between 1 January and 31 March 2016, 16 patients received the asthma care bundle. This represented a performance of 76% against a target of 80%.

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, the trust failed to meet two of the standards for Epsom Hospital.

The trust was in the upper UK quartile for two standards:

Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Trust: 19%; England: 11%.

Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age. Trust: 33.3%; UK: 8%.

The trust was in the lower UK quartile for one standard:

Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Trust: 0%; UK: 12%.

The trust’s results for the remaining one standard were all between the upper and lower UK quartiles.

Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Trust: 5%; UK: 10%.

(Source: Royal College of Emergency Medicine)

We followed this up with the trust and were provided with the following explanation: The lack of compliance with standards 3 and 4 of the consultant sign off audit run by the Royal College of Emergency Medicine was due to a lack of detail within Emergency Department documentation and issues identified around the entry of data to the online webtool. A number of actions had been devised to improve compliance with the standard, and these were outlined to us.

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe Sepsis and Septic Shock audit, the trust was in the upper UK quartile for none of the standards for Epsom Hospital.

The trust was in the lower UK quartile for six standards:

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Trust: 0%; UK: 30.4%.
• Standard 4: Serum lactate measured within one hour of arrival. Trust: 0%; UK: 60.0%.
• Standard 5: Blood cultures obtained within one hour of arrival. Trust: 0%; UK: 44.9%.
• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Trust: 0%; UK: 43.2%.
• Standard 7: Antibiotics administered: Within one hour of arrival. Trust: 0%; UK: 44.4%.
• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Trust: 0%; UK: 18.4%.

The trust’s results for the remaining two metrics were all between the upper and lower UK quartiles.

• 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. Trust: 88%; UK: 69.1%.
• Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Trust: 68.7%; UK: 64.6%.

We asked for an explanation of the results and any factors which may have contributed to the number of scores achieving a nil percentage. There was no real awareness of this data at senior nurse level and when we discussed with senior managers they too were not certain of the reasons. They suggested this was possibly as a result of a data input problem.

**Unplanned re-attendance rate within 7 days**

From November 2016 and October 2017, the trust’s unplanned re-attendance rate to ED within seven days was generally worse than the national standard of 5% and generally worse than the England average in latest period, October 2017, trust performance was 7.6% compared to an England average of 9.1%.

**Unplanned re-attendance rate within 7 days - Epsom and St Helier University Hospitals NHS Trust**

![Graph showing unplanned re-attendance rate within 7 days]

(Source: NHS Digital - A&E quality)
The unplanned re-attendance rate for Epsom ED within 7 days was 2,510 (4.23%) for the period November 2016 and October 2017.

Competent staff

Two practice development nurses (PDN) had been appointed in the trust and were approximately three months into their roles. One PDN was allocated to each hospital but they worked closely together.

The PDN recognised there was a lot of work to be done with regard to training, including a review of core competencies and extended roles of nurses, such as suturing. They had created an online record related to staff training in the anticipation of capturing data with respect to what staff had already completed.

An education strategy had also been developed by the PDN, which included the plan to bring study days in-house. The strategy recognised there needed to be focus on competencies. Competencies had started to be put together for cannulation and phlebotomy. Currently there was not a fully developed venous access team. The infection control team dealt with intravenous lines (IV) and such like. The hope was to have teaching support for IV lines and sepsis.

The Epsom Hospital was in the south west STP and had a share of the London wide capital funding for some courses. The PDN were planning courses at level one and two competency levels and they would be running nine study days for band 5 nurses to start with. The PDN had a ‘train the trainer’ role too and worked alongside new staff during a supernumerary period, during which they supported them to achieve the required competencies with glucose monitoring and other specifics.

We were told by a senior staff member there were competencies in plastering fractured limbs, with training provided by a technician. A learning package accompanied the training with sign off as skills were achieved.

We asked about competencies related to patient group directions, particularly around the provision of pain relief. (Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription). With the exception of emergency nurse practitioners there were no other nurses who had such competencies. There had been a process to train staff in the past but recently as so many staff were new, it was not a priority.

The trust trained staff in the MHA and supporting patients with mental health needs. This training was delivered by the psychiatric liaison service which targeted staff in the emergency department as a priority. The trust did not provide data on how many staff members attended this training.

A newly qualified nurse told us how they had a full induction and they spent one day per month at St Helier Hospital, undertaking training specific to their role. They did not have a named preceptor but were part of a ‘WhatsApp’ group, sharing links, discussion and support with others.

Appraisal rates

The appraisal rate for staff working in ED had not improved since our previous inspection.

As of October 2017 28% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 80%.

The trust runs their appraisal period in quarter four of every year this data is for quarter four, 2016/17.
A split by staff group can be seen in the graph below:

**Appraisal rates**

<table>
<thead>
<tr>
<th>Department</th>
<th>Percentage completed last year</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; E (Epsom) - Nursing</td>
<td>10.0%</td>
<td></td>
</tr>
<tr>
<td>A &amp; E (St Helier) - Med Staff</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>A &amp; E (St Helier) - Nursing</td>
<td>36.7%</td>
<td></td>
</tr>
<tr>
<td>A &amp; E Paeds (QMCH) - Nursing</td>
<td>92.3%</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Centre (St Helier)</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

Epsom Hospital had a 10% appraisal completion rate.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

We asked for an update of the appraisal rate for medical staff and received the following information: ED medical staff appraisals: January – December 2017. Out of 38 doctors, including two on sabbaticals, 31 doctors had their appraisal completed. Two doctors had permission to defer due to illness. Five doctors were late in completing their appraisals; two of the 5 should have had their appraisal in December 2016. However, it did not take place so carried over in to 2017.

We discussed the process and were told objectives were set at the start of the year and these were followed up at a mid-year review. When we reviewed the system we saw it enabled the inclusion of objectives, milestones and actions. We noted very few staff had actually set objectives or had a mid-year review. A new staff nurse told us they had not set any goals or objectives or had any review of progress, even though they started work in September 2017. They did tell us they worked with a team with leaders who were interested in their development.

Senior nursing staff recognised there was much work to be done to ensure appraisals were carried out. The process was made harder by having to complete these in a relatively short period of time towards the end of the financial year, rather than on the anniversary of staff joining the trust. The completion of staff reviews was unlikely to be achieved at a time when winter pressures impacted on the service.

**Multidisciplinary working**

We observed a multidisciplinary approach to the review of activities and patient case mix, with staff sharing up to date information in a clear manner. Staff, including radiographers reported working well as a team and that communication was generally good.

A registrar who spoke with us told us there was good multidisciplinary team working. This included assessing, planning and delivering care to patients, as well as effective handovers.
We noted the bed meeting, which considered the activity within the ED was not attended by a representative from the department, although they obtained information from the department in advance of meeting.

At the last inspection, staff from the psychiatric liaison service informed us that A&E staff did not always involve them in the care of patients who may require their service. During this inspection, staff from the psychiatric liaison service told us the working relationship between them and the staff was good. There was good external MDT working for patients who had mental health needs. We attended a mental health assessment. The summary of psychiatric assessment was kept on patients’ files in the emergency department so that trust staff were able to support patients with mental health needs.

We spoke to the psychiatric liaison team and the trust staff. They said that the target response time for psychiatric support was one hour for the emergency department; however, staff told us that the psychiatric liaison team usually responded quicker than this.

We reviewed three patient records for patients who had arrived at the emergency department after attempting suicide. Staff completed information sharing consent forms for each of the patients so that the trust was able to share information with community services and the patients’ GPs. Staff referred each patient to the psychiatric liaison team, who responded within an hour. Staff took physical health observations, completed a risk assessment, and completed an action plan for the safe discharge for each patient.

**Seven-day services**

The service was open 24/7. There was access to x-ray facilities during this time, including portable x-ray. The trust used the Picture Archiving and Communications Systems (PACS) and images could be shared across sites.

CT scans were available during day time hours and on-call at night. MRI was said to be rarely used but urgent requests could be made if needed.

Chest physiotherapy was available via the on-call team and they also attended patients who required Bilevel Positive Airway Pressure (BiPAP). This is a non-invasive form of therapy for patients needing pressurised air through a mask to keep the patient's airways open.

Pharmacy services were available: 9am - 5.30pm Monday to Friday; 9am - 12pm on a Saturday; 10am - 12pm on bank holidays, and were closed on a Sunday.

Outside of the pharmacy opening hours there was one pharmacist on-call covering the Epsom site. The on-call pharmacist was available out of hours for all requests for advice and supply of medicines that were not available in the Emergency Cupboard and for discharge medication.

To facilitate discharge out of hour’s pre-packs of commonly prescribed medicines were available in the ED.

**Health promotion**

There was a range of health information promotion literature on display in waiting areas, such as that related to smoking. In addition there were a number of advisory leaflets related to particular health related subjects.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported as of October 2017, that both Mental Capacity Act (MCA) and deprivation of
liberty training (part of the Safeguarding Adults (Level 2) training module) has been completed by 37.3% of staff in within urgent and emergency care.

(Source: Trust Provider Information Return P14/P49)

The staff had access to a detailed policy related to consent, which included information related to adults, children and young people, along with mental capacity.

We observed consent was obtained for treatments and procedures undertaken by staff. We saw and verbal consent had been documented in patient records.

At the last inspection, the trust was recommended to make sure that all relevant staff were clear on how a Deprivation of Liberty Safeguard authorisation (DoLS) should be used. During this inspection, we found that staff were unclear on when a DoLS authorisation should be used. Senior staff told us that there were four patients currently under a DoLS authorisation at the hospital; however, we did not find DoLS applications for these patients in their care records and staff told us that these patients were not under a DoLS. This demonstrated a lack of clarity around the use of DoLS among staff.

The trust applied for 238 Deprivation of Liberties Safeguard authorisations from the local authorities for the financial year 2016 to 2017. The trust did not provide information regarding the number of DoLS applications for Epson hospital.

At the last inspection, we observed that staff upheld the principles of the Mental Capacity Act 2005; however, the mental capacity of patients was not recorded in any of the records we reviewed in detail. During this inspection, we reviewed four records of patients that staff had identified as lacking in capacity to make decisions about their care and treatment. There were no mental capacity assessments in the patient care records and staff could not locate them in any other records.

The trust stated in its policy, ‘Mental Capacity Policy’ that staff assessing patients’ mental capacity must clearly document the assessment in the patient notes, and the trust provides a capacity assessment tool; however, we did not see this template used in the patient records of patients staff said lacked capacity.

The trust trained staff in the Mental Capacity Act, Deprivation of Liberty Safeguards and caring for people with complex needs including learning disabilities. Trustwide compliance with this training was 96% as of 10 March 2017.

Mental Health

From 1 December 2016 to 30 November 2017, the trust saw 6803 patients with a diagnosis relating to mental or behavioural disorders to Epsom General Hospital. Staff supported patients with mental health needs through the psychiatric liaison service and by hiring bank and agency mental health nurses. A mental health nurse was available at Epsom General hospital through the psychiatric liaison service 24 hours a day, seven days a week.
The trust trained staff in the Mental Health Act (MHA) and supporting patients with mental health needs. This training was delivered by the psychiatric liaison service which targeted staff in the emergency department as a priority. The trust did not provide data on how many staff members attended this training.

The trust ensured that when staff detained patients under the MHA, they filled out the correct paperwork and ensured that patients had their rights explained to them. We looked at nine records of patients who had been detained under the MHA. These were appropriately filled out and indicated that staff had to seek consent from patients before giving medication or treatment for physical health illnesses. Staff said that the trust faxed over mental health documentation to the Mental Health Act office at the mental health trust and kept the originals.

The trust had policies and procedures in place to meet the needs of people with mental health needs. The trust had a Service Level Agreement with the local mental health trust to help administer the documentation of patients detained under the MHA, to support staff in treating patients with a mental health illness, and to train staff.

**Restraint and restrictive practices**

Security and staff restrained patients if they posed a risk to themselves or others. The security staff covered Epson and St Helier Hospitals. Security staff attended awareness training for Mental Health, Mental Capacity, Safeguarding and other courses provided by the trust. Security staff were trained in how to safely restrain patients who are vulnerable. The head of security attends regular meetings with other departments in the trust and cascaded learning through security team meetings.

Before restraint was used on any patient, the responsible clinician filled out documentation to state under which legal framework the restraint is being used. The responsible clinician stated whether restraint was carried out under the Mental Capacity Act, the Mental Health Act, or under common law.

Security staff did not monitor or audit the use of restraint. Staff told us that restraints were logged as incidents on the incident reporting framework, Datix. However, when we looked at the Datix entries for the last year in the emergency, maternity, surgery, and ITU, it mentioned use of restraint four times. The forms from the security office showed that security were called to restrain patients 75 times during the past year. The trust did not formally monitor the use of restraint in the hospitals.

Senior staff at the hospital told us that rapid tranquilisation had not been used at the trust for the last three years; however, Datix entries for the previous year showed that staff recorded the use of rapid tranquilisation five times in the surgery and ITU. The trust did not formally monitor the use of rapid tranquilisation. This meant that the trust was not monitoring whether patients were kept safe after the use of rapid tranquilisation medication.
Staff said that the trust did not use the security staff for monitoring or observing vulnerable patients, except for short periods of time (under two hours), while the trust located a mental health nurse to support patients, or while the patient awaited transport to another facility. However, the use of security staff for monitoring patients was not monitored by the trust.

**Is the service caring?**

**Compassionate care**

Despite the additional pressures staff were facing related to activity and patient acuity, we saw that staff were mindful of the need to demonstrate compassion and empathy, and to treat people with dignity and respect. This was observed to start at reception, where staff acknowledged the patients and took the necessary details in a respectful and non-judgmental manner.

The triage nurse undertook their assessment in a kind and considerate way, taking her time to ask relevant questions and obtain a response. They recognised when a patient or relative was anxious and tried to reassure as much as they were able.

Whilst we did not observe direct patient care activities we saw staff and heard them being kind and attentive towards patients and their relatives. Privacy and dignity was respected by having curtains closed around cubicles.

We heard a nurse speaking with a patient and explaining what was happening and then checking their understanding. They provided comfort and a caring approach.

Patient who had received treatment and care in the minor area commented favourably on the nurses. We were told they were seen relatively quickly by the triage nurse, one then waited for about an hour and the other was seen quickly. Nurses were said to be “kind”, and “lovely”. One patient who was accompanied by a relative said the staff had been “brilliant, efficient and good”. Everything was explained to both patients. The x-ray service was described as good by one.

Patient who spoke with us in majors told us nursing staff were “spot on”, “caring and helpful”. Other patients told us staff were kind and caring in their approach, they were “very effective” and they had no complaints.

Another patient told us communication could be poor and nursing staff didn’t always appear to be able to do anything, which meant the consultant had to do nursing related tasks. They described the consultant as “fabulous” and said some of the nurses were good too.

A patient who spoke with our expert by experience team member told us “The care I received today and on Monday has been brilliant. I couldn’t wish for better, I really couldn’t”.

We spoke to two patients with mental health needs. They said that staff treated them with dignity and respect, and that they felt safe while they were in the emergency service.

We observed four instances of respectful and kind care between staff and patients who had mental health needs.

We spoke to one young person in the paediatric area and they told us whilst they had been in for several hours, they had found the staff to be very nice, caring and “funny”. They had been offered a choice with regard to the area in which they received care. They also were asked if they wished their family to be informed.

**Friends and Family Test performance**
The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was generally worse than the England average from November 2016 to October 2017.

A&E Friends and Family Test Performance - Epsom and St Helier University Hospitals NHS Trust

![Graph showing A&E Friends and Family Test Performance](chart)

(Source: NHS England Friends and Family Test)

We asked for the friends and family data to be split by each ED and were provided with the following information for the period November 2016 to October 2017; Out of 7,937 (17.4%) responses, 85.9% would recommend the service and 7.7% would not recommend it.

**Emotional support**

We observed staff providing emotional support to patients and their relatives. This was done in a kind and considerate manner. They gave open and honest answers to questions and explained the next steps in order to provide reassurance.

Patients and their relatives who spoke with us told us they were kept informed in the majority of cases. A young patient told us they had seen a doctor early after their admission as well as by the specialist team. They felt supported and that nothing could have been done better for them.

There was provision of support to relatives of patients who died in the department. A chaplain was available to the department for emotional support if required.

Staff had access to support and a debrief was held after a traumatic situation. Counselling services were available for staff to access as well as support from peers and senior staff.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 23 of the 24 questions relevant to caring. The remaining question scored worse than other trusts, which was “Q39. Did a member of staff tell you about medication side effects to watch out for?"
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.5</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>8.1</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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examine 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>9.0</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>7.7</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>8.8</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>7.7</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>9.0</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>7.8</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>6.0</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>8.3</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>8.5</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>8.9</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>9.2</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>4.1</td>
<td>Worse than 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>5.8</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>5.1</td>
<td>About the same as 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>6.0</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>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey September 2016)

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

We heard doctors and nurses providing information to patients. Test results and an explanation of continuing medication as well as what to do if things didn’t improve was heard to be given to a patient via telephone. The doctor checked the recipients understanding prior to ending the call.

A relative told us they had been kept informed of investigations and the treatment plan. A parent of a young child told us they had not been updated as to what was happening.

Patients who spoke with us mostly knew what was happening and the reasons why they were waiting, and said they had been kept informed.

We observed a nurse communicating in a calm and reassuring manner with a patient who had mental health related needs.
Is the service responsive?

Service delivery to meet the needs of local people

Meeting people’s individual needs

Emergency Department Survey 2016

The trust scored “about the same as” other trusts for all 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>7.4</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>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey September 2016)

The ED was accessed directly through automatic opening doors, leading into the waiting area and reception desk. The reception desk did not have any privacy/safety screen but we witnessed staff taking information from patients in a way which minimised confidential information being heard. There was a good number of seats available and we did not witness anyone having to sit on the floor. Reception staff told us at times of high activity the latter did happen.

There was no electronic system to notify patients of the length of wait to be seen. There was a small manually updated sign visible, which reception changed to indicate time delays.

A vending machine containing drinks and snacks was available in the reception area. Patient catering was available in the department and staff told us this was good. Sandwiches were delivered daily and there was access to hot meals if needed with a good choice. Allergies or food sensitivities were taken account of, and there were frequent drinks and snacks available.

We saw staff offering food and drinks to patients. However, a mother of a 10 month old child in paediatric ED said no food had been provided to feed the child and they hadn’t brought any with them.

The intercollegiate standards for Children and Young People in Emergency Care Settings recommend departments seeing more than 16,000 children per year employ a play specialist or have access to a play specialist. As the trust was not yet treating this number of children and young people there was no such arrangement in place.

From 1 December 2016 to 30 November 2017, the trust saw 6803 patients with a diagnosis relating to mental or behavioural disorders to Epsom hospital.

The child and adolescent mental health service team (CAMHS) was available Monday-Friday only. There was no out of hour’ service. As a result children waiting for CAMHS had to go to an inpatient bed or wait. During our visit we spoke with a young patient who was awaiting the CAMHS team. They told us they had stayed overnight in the department.

Emergency Department Survey 2016
In the CQC Emergency Department Survey, the trust scored 6.4 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey – September 2016)

A small triage room enabled the triage nurse to gather sensitive and confidential information about the patient’s presenting problem before deciding the most appropriate area to be seen in.

The triage nurse was able to make a direct referral for psychiatric assessment without the patient having been seen by a doctor. There was a number of criteria to guide this judgement.

Staff supported patients with mental health needs through the psychiatric liaison service and by hiring bank and agency mental health nurses. A mental health nurse was available at Epsom hospital through the psychiatric liaison service 24 hours a day, seven days a week.

There was a psychiatry interview room. This was in the corner of majors.

There was access to learning disability staff Monday to Friday between the hours of 9am and 5pm.

The trust had a dementia strategy 2015-2020. This indicated there would be dementia champions in departments. However, there were no such staff representatives in the department.

Staff undertook the ‘Dementia Friends’ course as part of their induction. Staff recognised there were limited distraction tools for patients who were living with dementia. Whilst dementia tool boxes were available on wards they were not as yet in ED.

Language Line provided a telephone interpreting services up until the end of November 2017. They were used a total of six times at Epsom Hospital ED for the period of 1st June 2017 to 30th November 2017. Telephone interpreting services were now provided by Language is Everything. Since December 2017 the Trust has not had to use them for telephone interpreting.

The ED had its own x-ray facility, which helped staff to obtain a diagnosis fairly quickly.

We reviewed information presented within the Analysis of Corporate Compliments December 2017 Report, which indicated complimentary information for Epsom ED.

### Access and flow

The department was open 24/7 and was accessed by direct referral, via ambulance or from a referral by the patient GP or 111. Information on patient access and flow was recorded manually on a whiteboard as there was no electronic system at Epsom ED.

We spoke to paramedics and were told there had been an increase in waiting to handover during the recent holiday period. They added that the handover in the resuscitation area could be very poor at times. This happened at times when no staff were present in the area on their arrival.

As we found at our previous inspection there was no live updated electronic tracking system of patients to indicate clinical priority. A whiteboard was used to record patients who were currently within the department and updated regularly, although there was no clinical priority recorded on this board. The nurse in charge was responsible for checking different areas of the department to update the whiteboard continuously.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

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 ED.
The trust met the standard eight times from December 2016 to November 2017.

The trust breached the standard four times from December 2016 to November 2017.

From December 2016 to November 2017 performance against this metric showed a trend of stability compared to the national standard and better than the England average for the full period.

We asked for information on the number of breaches and were told that out of 59,273 attendances for the period November 2016 and October 2017 there were 2,933 breaches. This represented a performance of 95.1% overall. The updated figures provided to us for 1 October – 31 December 2017 indicated 1,236 type one and two breaches.

Whilst we were inspecting we checked the number of breeches for this standard and were told for the 24 hour period on the 9 January there had been 22 breeches. Four people waited 11 hours and the longest wait was 13 hours. On the 10 January the number of breeches was three in total, two adults and one child out of 132 patients, almost achieving a 100% performance.

We were informed after our site visit that the trust achieved just over 90% for ED for the whole of the week during which we undertook our inspection. This was one of the best in London and 5% better than the England average.

Whilst we were in the department we witnessed no more than two patients waiting with ambulance staff to handover and this was done within 15 minutes of arrival. There were delayed handover forms available for completion if needed.

The trust’s operational plan for 2017-18 indicated that during the first six months of 2016/17 there had been a 4% increase in non-elective demand through the emergency departments on both hospital sites. To deal with this they implemented a patient flow transformation programme aimed at streamlining existing systems and processes to mitigate an increase in activity and effectively manage non-elective demand.

The trust had a bed management policy which aimed to support the delivery of expected targets. This included a target of 95% of ED patients spending less than four hours in the department from arrival to admission. A separate target for stroke patients being admitted to a stroke unit with four hours of their admission was set at 90%.

One consultant told us targets were linked to finances and to avoid breaches a patient in majors may get an inpatient bed before a patient who is in the Ambulatory Care Unit. Bed managers could override consultants to achieve the four hour target.

There were nine formal pathways into the ACU, plus pathway number 44. This was used for patients who didn’t fit into one of the other pathways.

We attended a site meeting where activity across wards and the ED was discussed. Estimates of predicted emergency admission demand were made each day by the site teams, allowing for known day to day fluctuations. Electronic screens were wall mounted and displayed various items of key data, including information for ED. The person leading the site meeting updated a large whiteboard with information such as ward discharges, admissions, moves to the discharge lounge, and ED or ACU patients waiting for beds.

The site manager was responsible for assisting ED and assessment unit staff to access support services for patients who did not require hospital admission for clinical reasons but did require support to ensure immediate and safe discharge. They also updated the web-based Capacity Management Systems (CMS) used by the Emergency Bed Service (EBS), London Ambulance Service (LAS) and South East Coast Ambulance Service (SECAMB). In addition they monitored...
ED activity and supported the staff in anticipating admission activity throughout the day and night. They attended the departmental huddles with the purpose of sharing information, although we did not see this during the inspection.

The trust had a ‘Paediatric A&E Service Model’, which supported the expectations around staffing and the access route through the department and onwards for admission, if required.

Staff told us how the provision of a ‘home team’ had improved the re-admission rates for some patients. This was a project funded for two years and involved 20 local GP practices. The help of this service was requested where a patient could go home but they needed some additional support. The service was described as “invaluable”.

A GP service was also available to support the winter pressures, with a GP on-site between the hours of 6:30pm and 10pm

A staff nurse working in resuscitation explained the additional pressures they had experienced with very ill patients. They told us it had been difficult to get patients to the wards but that the site manager came regularly and helped by assisting to transfer patients.

Matron told us the Ambulatory Care Unit could be used for ‘boarding’ at times when capacity and flow was a concern. In such cases patients who were waiting take home medications or to be collected could move into the seating area, which could accommodate three borders. There were other areas in the hospital including the winter pressure ward which helped to reduce pressure in A&E, and thus assist in access and flow.

**Four hour target performance - Epsom and St Helier University Hospitals NHS Trust**

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

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

From December 2016 to November 2017, Epsom and St Helier University Hospitals NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average. Performance against this metric showed a trend of stability over the period.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Epsom and St Helier University Hospitals NHS Trust**
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from December 2016 and November 2017, one patient waited more than 12 hours from the decision to admit until being admitted in March 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-16</td>
<td>101</td>
<td>0</td>
</tr>
<tr>
<td>Jan-17</td>
<td>80</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>43</td>
<td>1</td>
</tr>
<tr>
<td>Apr-17</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>63</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>78</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>38</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From November 2016 to October 2017, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse to the England average.

From July 2017 to September 2017 performance against this metric showed a trend of improvement and then declined in performance. In October 2017 the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 4.8%, compared to the England average which was 2.9%.
We asked for the numbers related to the above to be split by site and were told that 2,343 patients left without being seen at Epsom ED, which represents 3.95% out of the total number of attendances.

**Median total time in A&E per patient (all patients)**

From November 2016 to October 2017, the trust's monthly median total time in ED for all patients was consistently higher than the England average. Performance against this metric showed a trend of decline. In October 2017 the trust's monthly median total time in ED for all patients was 174, which is worse than that of the England average which was 148.

**Median total time in A&E per patient - Epsom and St Helier University Hospitals NHS Trust**

(Source: NHS Digital - A&E quality indicators)
At Epsom Hospital, a capital project was underway to establish an Urgent Care Centre in a newly created ambulatory care facility. This would allow for the creation of an observation ward, a dedicated ambulance offload area, and a paediatric assessment unit. We viewed the department which was nearing completion and saw that the facility would improve access and flow to the benefit of patients.

**Learning from complaints and concerns**

The trust had a complaints policy which was available to members of the public, including versions in Braille and alternative languages. The latter was on request through the Patient Advice and Liaison Service (PALS). The policy set out staff responsibilities and the commitment to deal with Complaints in line with the trust’s ‘Duty of Candour and Being Open Policy’, and where the duty of candour did not apply, to ensure communication with complainants was open and honest. Time scales for closure of complaints was stated.

We observed information displayed advising patients how they could raise a complaint.

**Summary of complaints**

The trust received 606 formal complaints in 2016/17, which was a 3% decrease on the previous year. In 2016/17 610 complaints were closed. Of these cases 313 (51.3%) were upheld, 161 (26.3%) were partially upheld and 136 (22.3%) were not upheld.

From November 2016 to October 2017 there were 120 complaints about urgent and emergency care services. There were two complaints in progress, with target set for resolution and two which had been completed from October and December 2017 but were still being monitored.

The trust advised us three people had been invited to attend training days in the ED. They consist of a mixture of complainants and relatives. Two of them had not taken up the offer. The relative of a patient would be attending a joint Acute Medical Unit and Emergency Department training day for nursing staff on 20th February 2018.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

**Is the service well-led?**

**Leadership**

The urgent and emergency care services had a leadership structure led by the clinical director and director of unplanned care. Reporting upwards to these roles were a number of key staff roles, including for example; clinical leads, divisional general manager, and the head and deputy head of nursing.

A number of roles had been developed since the previous inspection including; director of unplanned care, clinical director for the ED, head of nursing and deputy head of nursing. The trust had also appointed a clinical quality lead for medicine who was allocated protected time to prioritise quality and safety improvement initiatives.

Staff who spoke with us described the leadership and working in the department positively, with comments that included, the department was “Fantastic”, and managerial staff were supportive, even when an individual did not have previous experience of working in an ED.
We observed the senior doctors were visible and approachable to all grades of staff. They responded to questions and provided advice and instruction in a manner which was respectful of their colleagues.

Senior nursing staff were visible and easily accessed for help and support. They provided good managerial oversight of activity in the department and co-ordinated things to ensure an effective and response service.

A number of nursing staff in senior positions had been in place for a relatively short time. They had recognised and taken the steps to consider the department functionality, the areas of concern and immediate actions required. In particular this had been a focus in the recruitment, which they realised impacted in a number of ways. They were now in the process of making additional changes and doing this in a measured way, rather than risking in making changes without any real reason.

Staff worked in separate teams with their own leadership support. Departmental pressures were said by nursing staff to have prevented regular team meetings, although there were regular day to day interactions and opportunities to discuss and share information.

The trust provided information which indicated a range of team meeting and the frequency of these. For example; for Band 5 nursing staff every three months; for Band 6 nursing staff every three months; Band 7 nursing staff, emergency nurse practitioners and paediatric nurses held separate bi-monthly meetings.

We had the opportunity to review minutes from staff meetings at grades 5, 6 and 7. These indicated a broad range of discussion. We also reviewed minutes from the Medicine Senior DMT Meetings, which covered areas such as risk management, governance and complaints.

Just over 48 staff from various roles vacated their positions across the ED services on both sites.

**Vision and strategy**

There was a five-year strategy in place for the development of the ED. These included plans to maintain the environment, increase consultant cover to 16 hours seven days per week as recommended for ED departments by the Royal College of Emergency Medicine (RCEM) and increase the number of middle grade doctors.

We asked staff what they understood the vision and hospital strategy to be, as there was limited awareness of this at the previous inspection. There was no clear response from junior staff. They mentioned the development of the unit with the new areas, as well as having an understanding the hospital was making at least five year plans, with the assumption it would be open beyond 2010. There was more optimism about the short term future but still no longer term vision or expression of the values of the trust.

Since the last inspection the aim to move paediatric ED had been achieved, although there was still some work to do around air conditioning and provision of a sluice.

We saw too that the development of a new Acute Assessment Unit was nearing the first stage of completion. Staff were looking forward to having this area and anticipated it improving access and flow.

**Culture**

There was a strong emphasis on team work, shared commitment and enthusiasm for delivering a service which met the patient needs. Despite the increase in work load and recent activity it was
clear the team pulled together and worked in a manner which was collaborative, respectful and harmonious.

One consultant described his colleagues as “dedicated” but added their good will was “being eroded”. This same consultant spoke about the lack of willingness by some staff to address concerns and suggestions with regard to patient flow and the use of the discharge lounge.

We observed staff interactions with one another and saw they were supportive, friendly and helpful. A nurse who had come for a cross site placement told us they had been made to feel welcome and shown around as it was their first day.

A staff nurse explained how they had teams but in general everyone worked well as part of a team. They told us the healthcare assistants were “excellent”. We observed the HCA working in a way which demonstrated proficiency and commitment to get things done efficiently.

Staff were aware of their responsibilities to challenge one another if needed and to work in a way which was open and receptive to feedback and improvement. There was recognition of the importance of being open and honest with patients and their relatives, to report matters which did not go as expected and to follow these up. However, there was acknowledgement that things could be improved in terms of shared learning, and a need to improve dialogue with junior staff regarding SI, and general department awareness.

Staff knew who they reported to and what they were accountable for and to whom. The culture clearly focused on the needs of patients and ensuring their experiences were delivered to the best of their abilities.

Administrative staff told us there was a “real can-do attitude” in the department. There was recognition of the challenges around staffing but staff were able to see arising problems and did their best to resolve it.

Reception and administrative staff reported having a good working relationship with clinical staff, and of having open and effective communication.

Recognising the type of difficult situations staff were exposed to at times, there was access to counselling and debriefing, which helped to promote a caring culture. We were given an example where a de-brief happened after a child death, to which ambulance crew were invited.

Where security issues impacted on staff these could be escalated. Staff knew where panic alarms were and stated that the response time from their experience was effective.

Staff told us there was access to training and professional development was valued. They did recognise that regular reviews and appraisals did not always get carried out on time or effectively.

There were opportunities for team engagement and discussion of issues impacting on the service. We saw minutes of band 6 nurses meetings and band 7 meetings which confirmed this.

**Governance**

Governance meeting was currently managed as part of the medicine division governance meeting. Urgent issues were said by the trust to be raised at the Medicine Division Cross Site Clinical Governance Meeting, in order to strengthen the overall divisional management of quality and governance issues.

Minutes from the Medicine Division Cross Site Clinical Governance meeting we reviewed indicated discussion and consideration of a range of matters. This included by way of example, incidents, root-cause analysis, shared learning, and complaints. Incidents were closely monitored and
information reviewed indicated each incident was categorised and graded, along with actions taken.

We found at the last inspection that there were no formal mortality and morbidity (M & M) meetings taking place. Although the department had since tried to establish these, it had been recognised by senior medical staff there was poor attendance at M & M meetings. As a result clinical governance activity was communicated by teaching and through emails.

A consultant told us the monthly governance meeting was attended by a consultant from the department. There were however, teaching sessions, which took place on Wednesday mornings for middle grade doctors and in the afternoon for SHO. Information related to audit and serious incidents formed part of the teaching. An example of the latter was given to us related to a missed diagnosis of pericarditis. This is inflammation of the lining around the heart (the pericardium) that causes chest pain and accumulation of fluid around the heart (pericardial effusion).

We were told by the consultant there was on average one email with interesting cases, serious incident or audit sent to medical staff each week. They were not aware of the ‘Incident Summary Newsletter’ which another member of staff told us had recently been introduced.

The Sepsis group reported into the Reducing Avoidable Death and Harm (RADAH) group. Practice development educators had a remit within the educational strategy to lead on sepsis for all relevant clinical areas.

Management of risk, issues and performance

There was a quality team led by the quality manager for the site and a shared quality lead. The Patient Safety and Quality Committee met monthly with a remit to seek assurances that the quality of patient services was of the highest standard with a particular focus on patient safety, clinical effectiveness and patient experience.

There was a variety of weekly performance data collected for the ED. For example, facts and figures related to ambulance handover delays, activity by site including the number and type of patient, child or adult, and triage breaches amongst other statistics. This information enabled the trust to have oversight of performance and to identify where improvements were needed.

We explored the issues of governance related to some of the audit data, in particular where scores of zero percent had been reported. There was no clear oversight as to the reason for this and as result we were not assured there were adequate processes in place to review such information. Further, as there was a lack of awareness of the results, we were not assured there was any associated action plan to address areas falling below expected standards.

Risks related to the ED services were incorporated into the medicines risk register. It was not clear from the document that risks related to one or both ED sites without having to read the detailed information. Each risk was rated, had a review date and a named manager responsible for overseeing the risk. For each item on the risk register there were details of the actions taken to mitigate the risks. However, we saw that not all the risks had been reviewed within the last three months. Further, we noted there were no stated risks related to nursing staffing levels at Epsom ED and no mention of the issues related to recording of mandatory safety training on WIRE. Because of these points we were not assured the risk register was being used to its full potential.

We were told by staff that staffing levels was a risk in the ED. They also commented on the slow and lengthy process for recruitment, which impacted on stabilising team structures and was seen as a risk.
Information management

Patient records were not electronic. They were stored and managed in accordance with data protection. Records related to adults were scanned onto the data base before destruction. Children’s records were retained in paper form until they reached 18 years of age.

Staff had secure access to electronic information, including policies and procedures, training and personal development.

We were told there were some issues with information governance related to training data. For example, the ‘Wired’ training system fails to show up accurate details when staff complete. This had been reported to IT but there was no time stated for resolution.

Engagement

The trust had a ‘Children’s and Young People’s Survey’, which had been designed with typed statement and questions, with a range of expressive faces from to which to pick according to their responses. We noted the survey had not been written in child friendly language and used words which they may not have understood, for example, service in place of hospital. Younger children may have needed an adult to read this to them in many cases.

The trust valued the information provided by patients through the Emergency Department (ED) Survey. This enabled patients to give feedback on their thoughts and experience of the accident and emergency services provided by the trust. The ED survey is required by the CQC, and is conducted every two years (last carried out in 2014). The ED survey and its results were discussed by staff within the chief executives team meeting in November 2017. We noted one of the outcomes of the discussion was to develop and action plan.

Patients were encouraged to feedback on the service via the Patient Advice and Liaison Service (PALS), NHS Choices, and the trust’s social media channels. These were actively promoted on the trust website and in some patient information.

The trust ran a Patient First Programme which had a mixture of 420 patients and local people signed up to offer their views and share their thoughts from a patient’s perspective.

In July 2017 the trust launched an involvement conversation: Epsom and St Helier 2020-2030. Based on previous estates engagement activities, it focused on gaining support for investment within the trust, including building a membership database to assist with further engagement activities.

Learning, continuous improvement and innovation

We were told a research team was being developed and they would be looking at patients who attended ED having used recreational drugs.

The trust had considered and taken on a programme of improvement of the ED through the provision of a new Urgent Care Centre, which would be run by the trust.
Medical care (including older people’s care)- Epsom General Hospital

Requires improvement ● Down one rating

Key facts and figures

Epsom and St Helier University Hospitals NHS Trust provides a comprehensive medical service incorporating all the key medical specialties including renal, diabetes and endocrinology, rheumatology, elderly care, cardiology, stroke, gastroenterology, dermatology, haematology, oncology and respiratory medicine.

Medical care at Epsom General Hospital is part of the medicine division. During our inspection at Epsom General Hospital we visited Buckley, Swift, Ebbisham, Alexandra, Gloucester, Northea, Croft wards as well as the acute medical unit (AMU) and coronary care unit (CCU). We visited the Epsom Health and Care @Home service team.

We spoke with 18 patients and seven visitors or carers. We spoke with seven doctors including consultants, and 27 nursing staff including ward managers, matrons, specialist nurses and healthcare assistants, occupational therapists and physiotherapists, and interviewed divisional management teams for medicine and reviewed patient care records.

Summary of this service

Facts and data about this service

Acute medicine – There are 43 AMU beds at Epsom. The AMU has rapid assessment hubs where admissions are managed. Through capital investment the trust is expanding its medical ambulatory care services at both sites.

General inpatient medicine - Three wards per site. The on-call rota is covered by 13 consultants per site.

Elderly care - At Epsom the service was integrated with General Medicine, with a GP-led sub-acute ward.

Gastrointestinal - Specialist gastroenterology and endoscopy services at both sites.

Other key medical services:
Cardiology/Respiratory - Epsom has one cardiac and one respiratory ward. The Respiratory Team provided in-reach to the acute medical wards. There was a cardiac catheter laboratory at Epsom.

Haematology/Oncology – Day care is centred at Epsom. Both sites provide daily acute oncology services jointly with the Royal Marsden.

Epsom Health and Care @ Home service - a formal alliance between the acute trust, community provider, local GPs and Local Authority. It aims to deliver a new integrated model of care for the people of the Epsom locality, breaking down organisational barriers developing new pathways.
and ways of working in order to deliver coordinated person-centred care

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 34,215 medical admissions from August 2016 to July 2017. Emergency admissions accounted for 17,573 (51%), 1,021 (3%) were elective, and the remaining 15,621 (46%) were day case.

Admissions for the top three medical specialties were:

- General Medicine 22,571
- Gastroenterology 3,213
- Pain Management 2,270

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Completion of mandatory training such as resuscitation, infection control, information governance and manual handling training was variable across medical wards.

Nurses and healthcare assistants across medical services told us that ward managers tried to ensure they completed their mandatory training, although they were not always successful in being able to release staff for training due to work loads and staffing issues.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of October 2017 for medical/dental and nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Medical staff Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>79%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>76%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>75%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>66%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>66%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>64%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>57%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>56%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>47%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>24%</td>
</tr>
</tbody>
</table>

The medical and dental staff only met one of the 11 training with a completion above the trust target of 95%; the lowest completion was for information governance with 24%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Module</td>
<td>Average of Trust Target (%)</td>
<td>Average of Number of staff trained (YTD)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>70.1%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>58.3%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

The medical and dental staff did not meet any of the three safeguarding training with a completion above the trust target of 95%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>52.3%</td>
</tr>
</tbody>
</table>

The nursing staff did not meet any of the two safeguarding training with a completion above the trust target of 95%.

(Sourced: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
trust target of 95%.

Epsom Hospital had a 70% safeguarding training completion rate, no modules met the 95% trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff knew how to access the trust’s safeguarding policy and demonstrated a good understanding of safeguarding processes and how to escalate and report concerns. We saw proactive communication with the trust and local authority safeguarding teams during safeguarding investigations.

Staff were also aware of how to recognise female genital mutilation (FGM). On one of the wards we visited a staff member told us how they would identify if a patient was a victim of FGM and would report this to the safeguarding team and ward manager.

The trust had a safeguarding hub covering both hospital sites, which coordinates the efforts of staff in safeguarding, child protection, maternity, independent domestic violence and learning disabilities. The safeguarding hub had monthly meetings which included community leads in agencies supporting people in these different areas.

Cleanliness, infection control and hygiene

All the staff we spoke with were aware of current infection prevention and control guidelines.

On four wards we visited, we noted data from hand hygiene audits was displayed. For December 2017 two of the wards scored 100%, and the other two wards scored 90%. (AHM19, 02, 03 and 06). 100% of the staff we saw were bare below the elbow. There were sufficient supplies of hand sanitising gels at the entrance to all wards and hand washing facilities on the wards we visited. All the equipment we inspected was visibly clean. All other clinical and communal areas were visibly clean and in a good state of repair.

We spoke with cleaning staff on several of the wards we visited. They showed us how they had cleaning rotas and systems in place to ensure all areas and equipment was cleaned on a regular basis. The domestic staff appeared to have pride in the wards they worked on.

We observed staff consistently following hand hygiene practice and ‘bare below the elbow’ guidance. Personal protective equipment (PPE) was readily available in all areas and staff told us there was sufficient PPE.

Side rooms were used as isolation rooms for patients identified as an increased infection control risk (for example, patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.

Environment and equipment

At our previous inspection in 2015, we had found Control of Substances Hazardous to Health (COSHH) products inappropriately stored and we found this again during this inspection. We saw products falling under COSHH regulations stored in an unlocked open cupboard on the AMU, Alexandra and Gloucester Wards.

Throughout the wards we visited staff reported shortages in pressure-relieving mattresses. All the equipment we observed had been serviced within the agreed time on the service label.

On Gloucester Ward we found that the room containing medicines was very warm (29°C) and so staff had left the door open to cool it down. This meant that people not authorised to access areas containing medicines may have been able to do so. Staff told us that both the ward and the
medicines room became very hot in the summer months. Storing medicines significantly above the temperature recommended by the manufacturer (usually 25°C) for long periods of time may reduce their shelf life. Refrigerator current temperatures were measured daily. However, the minimum and maximum temperatures were not measured.

There were gaps on records of daily checks of resuscitation trolleys in three different wards where staff had omitted to completed checks on the trolley for a number of days.

**Assessing and responding to patient risk**

Risks to safety due to changes to services were assessed, planned for and managed effectively and the movement of patients was managed in a safe way during transitions to other wards or at discharge. Swift and Ebbisham Wards had undergone some reconfiguration and changes to patient type (surgical ward taking medical patients) and managers and staff had managed the disruption well. Ebbisham Ward was usually a paediatric assessment unit but had been reconfigured into an eight bedded step down ward for patients preparing to return home.

Staff recognised and responded appropriately to changes in risks to patients. Records of care including individual risk assessments were updated regularly and/or when a patient’s needs changed.

Patients who were at risk of falls were identified and measures were taken to help reduce the risk. Risks to patients were assessed, monitored and managed on a regular basis. These included signs of deteriorating health or medical emergencies. Staff used a National Early Warning Score (NEWS) observation charts to identify deterioration in patients, including early recognition of sepsis. Staff were very clear about the sepsis pathway and explained the steps they took to identify if patients were at risk. The sepsis pathway was the steps taken to identify, investigate treat and monitor a patient who was suspected or had been diagnosed with sepsis.

**Patient moves per admission**

From October 2016 to October 2017, 27% of individuals did not move wards during their admission, and 43% moved once or more.

(Source: Trust Routine Provider Information Return (RPIR) P51 Bed Moves)

The hospital managed the transfer of patients internally, through the ‘Internal transfer policy’. This clarified the needs of patients transferred between wards or departments and the role and responsibilities of trust staff. The transfer of deteriorating patients or those requiring specialist care from a different directorate was managed within the policy. The transfer of patients between hospitals was defined within the ‘Intra-transfer between hospitals policy’. Nursing staff reported good responses from medical staff when a patient's condition deteriorated.

**Nurse staffing**

At our previous inspection in 2015, there were concerns about staff recruitment and retention and we found that although there had been some improvements there were still some concerns about this. Staffing levels and skill mix for both nursing and medical staff were planned, implemented and continually reviewed.

Most of the wards had nursing staff vacancies and data provided showed that there were occasions when the nurse staffing fill rates were less than 90% .There was a high reliance on
staff working extra shifts to fill gaps. Where ward vacancies for qualified nurses and healthcare assistants were identified, senior staff told us that shortfalls were covered by the ward’s own staff working overtime.

At our previous inspection in 2015, a recruitment drive was on going but the hospital was finding nurse vacancies were difficult to fill. This was the same at this inspection. Recruitment of staff, especially nurses, was not just a local issue but a national one.

On Buckley Ward, which was a 33 bedded ward, we saw that on the Monday prior to our inspection that there were only two out of four registered nurses and 2 healthcare assistants covering the ward during the day shift. Every effort had been made to bring in other staff, but these had been unsuccessful. This resulted in nurse to patient ratios of 1:17/1:16 which was considered unsatisfactory.

During our inspection we reviewed staff rotas on the wards and saw that the majority of shifts had at least one nurse less than the planned number for the shift. Managers were working on the wards when they should have been attending to managerial duties.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust has reported their staffing numbers below for as of September 2017 for medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>423.9</td>
<td>346.1</td>
</tr>
</tbody>
</table>

There are 77.8 less WTE staff in place at the trust compared to what they had planned to provide safe care.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, the trust reported a vacancy rate of 26.7% in medicine compare to a trust target of 10%.

- Epsom Hospital: 42%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From October 2016 to September 2017, the trust reported a turnover rate of 16% in medicine; compare to a trust target of 12%.

- Epsom Hospital: 18%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Sickness rates

From October 2016 to September 2017, the trust reported a sickness rate of 4.5% in medicine; compare to a trust target of 3.8%.

- Epsom Hospital: 1.1%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From October 2016 to September 2017, the trust reported a bank and agency usage rate of 21% in medicine.

- Epsom Hospital: 15% bank and agency usage with 5,257 shifts unfilled

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

The trust provided us with information that stated there were medical staff shortages. When we spoke with medical staff they told us that they had felt under pressure from the shortages of staffing. However, staff told us they felt supported by colleagues and senior staff.

Nursing staff reported excellent medical cover across all wards, with minimal delays when requested to assess patients whose condition had deteriorated.

We observed a board round and ward round and saw they were still carried out efficiently and effectively, with appropriate staff present.

The trust has reported their staffing numbers below as of September 2017 for medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>176.9</td>
<td>182.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From October 2016 to September 2017, the trust reported a vacancy rate of 26.7% in medicine compare to a trust target of 10%.

- Epsom Hospital: 13%
Turnover rates
From October 2016 to September 2017, the trust reported a turnover rate of 16% in medicine; compare to a trust target of 12%.

- Epsom Hospital: 10%

(Sources: Routine Provider Information Request (RPIR) P17 Vacancies)

Sickness rates
From October 2016 to September 2017, the trust reported a sickness rate of 4.5% in medicine; compare to a trust target of 3.8%.

- Epsom Hospital: 1.2%

(Sources: Routine Provider Information Request (RPIR) P18 Turnover, P19 Sickness)

Bank and locum staff usage
From October 2016 to September 2017, the trust reported a bank and locum usage rate of 33% in medicine;

- Epsom Hospital: 34% bank and locum usage with 286 shifts unfilled

(Sources: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix
In August 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 193 whole time equivalent staff working in medicine at Epsom and St Helier University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</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: Routine Provider Information Request (RPIR) P20 Medical Staffing mix)
Records

Patient records were stored in trolley near to the nurse’s station or in a corridor near by the nurse’s station. None of the patient records storage trolleys we viewed were locked. Some did not have a locking system and others which had a lock were not locked. Patients’ nursing records were stacked up on the windowsill in some ward areas or stored at the end of patient beds in other wards. Staff could access information they needed to assess, plan and deliver care, treatment and support to patients in a timely way. Up to date information about patient test results was available in electronic form on each ward, and patient medical and care notes were in paper format available on the wards. Staff reported that they could get patients’ notes from the records stores within one hour of requesting.

Nursing records were updated regularly and included care plans. We saw comprehensive timely assessments of pressure ulcer risks using the Waterlow score, skin and nutritional assessments. When patients were assessed as being at risk of or had a pressure ulcer, appropriate repositioning took place and care plans documented the care to be administered, including wound care, and equipment to be used to prevent skin damage and promote skin healing. Patient wounds were documented on body maps, and regularly evaluated wound care plans were in place. Falls, use of bed rails and manual handing assessments were completed appropriately as were plans of care. We saw malnutrition universal screening tool (MUST) assessments were completed for the majority of patients however, they were not always repeated on a regular basis. In one set of patient notes we observed that a patient had been weighed when they arrived on the ward. The patient was then weighed seven days later and they had lost nine kilograms, but there was nothing written in their medical notes noting this concern, and no referral was made to dieticians.

We particularly looked at do not attempt cardiac pulmonary resuscitation (DNACPR) forms. We reviewed six DNACPR forms. We found that there was a variable level of completion. Capacity decisions were not supported by a capacity assessment. Necessary conversations with relatives were not always documented. In the patient notes we reviewed where a DNACPR form was present we saw that it was the first document under the front cover to make sure staff were aware of the decision even in an emergency when non ward staff might attend.

For the patient who was on a DNACPR and who staff said lacked capacity to make decisions about their treatment, there was no DoLS authorisation in place, so it was not clear how the hospital was legally keeping them on the ward.

Medicines

Staff knew how to report medicines errors and some gave examples of learning. Staff generally felt that the pharmacy team was responsive to their needs in terms of advice provision and chart screening. Staff generally felt that medicines supply from pharmacy to wards happened in a timely manner. We saw and were told by staff on one ward that waste medicines were not always collected for return to pharmacy in a timely manner.

On Gloucester Ward we found that the room containing medicines was very warm (29°C) and so staff had left the door open to cool it down. This meant that people not authorised to access areas
containing medicines may have been able to do so. Staff told us that both the ward and the medicines room became very hot in the summer months. Storing medicines significantly above the temperature recommended by the manufacturer (usually 25°C) for long periods of time may reduce their shelf life.

Medicines were generally stored in an orderly manner. Controlled drugs were stored and managed appropriately. However, we found some nebules (for inhalation) stored in the name container as ampoules for intravenous administration. The National Patient Safety Agency (NPSA) has previously issued an alert on this.

Refrigerator current temperatures were measured daily. However, the minimum and maximum temperatures were not measured. We also found that dates of opening were not always on medicines, as appropriate. The resuscitation trolley was tamper evident. All medicines were within their expiry dates. We found some defibrillator pads had recently expired. However, the nurse immediately arranged for some more to be brought to the ward.

We looked at prescription and administration charts for three people. People’s allergies were documented appropriately and there were no missed doses. The pharmacist had also clinically screened the charts to ensure people’s medicines were optimised.

On Swift Ward, medicines were stored securely and within the recommended temperature range. Controlled drugs were stored and managed appropriately. We looked at prescription and administration charts for three people. People’s allergies were documented appropriately and there were no missed doses. The pharmacist had also clinically screened the charts to ensure people’s medicines were optimised.

We visited Ebbisham Ward at Epsom Hospital. We looked at prescription and administration charts for two people. People’s allergies were documented appropriately and there were no missed doses. The pharmacist had also clinically screened the charts to ensure people’s medicines were optimised. We were told the pharmacy team were responsive to requests for advice.

Medicines were stored securely. Medicines requiring refrigeration were stored at an appropriate temperature. Controlled drugs were stored and managed appropriately. The ward medicines trolley contained a box with many strips of different medicines mixed together. This practice may increase the risk of incorrect selection. Liquid medicines were opened but not dated. Opening liquid medicines sometimes reduces their shelf life so it is important to note the date of opening so they are not used past their expiry date.

Incidents

Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses and told us they were fully supported when they did so. When something went wrong, investigations were conducted and lessons were learned. Staff told us they received feedback through various methods including face to face from a manager, in a safety huddle, in team meetings or at handover. When things went wrong, staff apologised and gave patients honest information and suitable support.

We reviewed the root cause analysis for two of the medical services serious incidents and found appropriate investigations had taken place. We found the trust had analysed the contributing factors to the incident and identified actions to reduce the risk of similar incidents occurring in the future.
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 November 2016 to October 2017, the trust reported one incident classified as a never event for medicine at Epsom Hospital.

Source: NHS Improvement - STEIS (01/11/2016 - 31/10/2017)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:
- Treatment delay meeting SI criteria with two (33% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (17% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (17% of total incidents).
- VTE meeting SI criteria with one (17% of total incidents).
- Slips/trips/falls meeting SI criteria with one (17% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer
We saw that each ward we visited had a noticeboard displayed in a public area showing performance against the trust’s own safety and patient satisfaction targets, which included some safety thermometer data. The information was updated monthly, and clearly displayed for patients, visitors and staff to see.

The information on the safety thermometer included prevalence of pressure ulcers, falls, venous thromboembolism (VTE or blood clots) and catheter-acquired urinary tract infections. The safety and patient satisfaction information on the noticeboards we saw included pressure ulcers, falls, meticillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C diff), (types of infection) and ‘Friends and Family Test’ returns.

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 39 new pressure ulcers, 19 falls with harm and 74 new catheter urinary tract infections from October 2016 to October 2017 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Epsom and St Helier University Hospitals NHS Trust**

![Graph showing prevalence rate of pressure ulcers, falls, and catheter urinary tract infections (CUTIs) from October 2016 to October 2017.]

Source: Safety thermometer - Safety Thermometer

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**Is the service effective?**
Evidence-based care and treatment

All health care professionals worked together to plan and implement care and treatment for individual patients as per evidence based guidance. Patients' needs were assessed and plans for care and treatment were in place. We saw that patients' care plans and pathways were structured with clear goals in place for individual patients.

We talked to staff of various clinical and non-clinical grades and found that they understood their roles, and clinicians worked within their scope of practice in accordance with their professional governing bodies.

Policies and procedures were available on the trust’s intranet page and staff were able to show us how to access them.

Joint Advisory Group (JAG) accreditation is a formal recognition that an endoscopy service is fully competent to deliver against specific measures, as identified by the ‘Global Rating Scale (GRS)’ standards. The endoscopy unit had JAG accreditation.

Clinical guidelines were in place to guide patient care and treatment for specific procedures and interventions. We saw evidence that clinical guidelines were written in line with current best practice and referenced national standards.

Nutrition and hydration

A Malnutrition Universal Screening Tool (MUST) was completed on admission, but we did not consistently see regular reviews in the notes we reviewed.

Dietitians and nutritional specialists were available for advice and support where required.

Patients’ nutritional needs were assessed and care plans developed. Special diets were catered for and staff assisted patients who needed help to eat and drink. We saw patients being assisted to eat their meals and to drink. One patient had difficulty swallowing and had been assessed by the Speech and Language Therapy (SALT) team and we saw they were served a soft fork mash diet; other patients used beakers for hot drinks.

Fluid balance charts were used to monitor the fluid intake and output for some patients. We saw evidence that these were put in place and reviewed by staff at regular intervals. We saw patients were provided with jugs of water at their bedside. We also observed ward assistants doing drinks rounds and asking patients what they would like to drink, giving them a choice.

Pain relief

We observed staff assessing patient’s pain levels and taking appropriate actions to ensure pain relief was administered in a timely way.

Patient’s pain was usually managed via oral or intravenous (IV) medicines. When patients were in a lot of pain they could be referred to the hospital pain team

Patients we spoke with told us, and we saw that staff asked them regularly if they needed any more pain relieving medicine.

Assessments of patient’s pain were included in a routine set of observations. Patients were asked to rate the severity of their pain between one and 10. These pain scores were recorded in patient’s records. We checked bedside records across all wards we visited and found pain scores completed for all patients.
Patient outcomes

Relative risk of readmission

Trust level

From July 2016 to June 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in General Medicine had a similar expected risk of readmission for elective admissions
- Patients in Clinical Haematology had a higher than expected risk of readmission for elective admissions
- Patients in Nephrology had a lower than expected risk of readmission for elective admissions
- Patients in General Medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in Geriatric Medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in Nephrology had a lower than expected risk of readmission for non-elective admissions

Elective Admissions – Trust Level

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 – Trust Level

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 (01/07/2016 - 30/06/2017))

Epsom Hospital

From July 2016 to June 2017, patients at Epsom Hospital had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average. Although it was noted that the population of the surrounding area were from an older demographic.
• Patients in General Medicine had a lower than expected risk of readmission for elective admissions
• Patients in Clinical Haematology had a higher than expected risk of readmission for elective admissions
• Patients in Gastroenterology had a higher than expected risk of readmission for elective admissions
• Patients in General Medicine had a similar expected risk of readmission for non-elective admissions
• Patients in Geriatric Medicine had a higher than expected risk of readmission for non-elective admissions
• Patients in Cardiology had a higher than expected risk of readmission for non-elective admissions

The trust was in line with other trusts nationally for:
• Acute and unspecified renal failure
• Acute bronchitis
• Acute cerebrovascular disease
• Acute myocardial infarction
• Chronic obstructive pulmonary disease and bronchiectasis
• Fracture of neck of femur (hip)
• Pneumonia
• Septicaemia (except in labour)
• Urinary tract infection

The trust was better than other trusts nationally for readmissions relating to:
• Fluid and electrolyte disorders

**Elective Admissions - Epsom Hospital**

![Elective Admissions Chart](chart.png)

*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 - Epsom Hospital**

![Non-Elective Admissions Chart](chart.png)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive*
Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade D grade in latest audit, April 2017 to July 2017 for Epsom Hospital.

Epsom Hospital

There is a trend of decline over the six quarter period between October to December 2015 April to July 2017 with a number of domains rated at levels E for both patient and team centred performance. Such as the stroke unit and speech and language therapy.

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<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
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<td>A↑</td>
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<td>C↓</td>
<td>D↓</td>
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</table>

Source: Royal College of Physicians London, SSNAP audit)

**National Diabetes Inpatient Audit - Epsom**

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 47 inpatients with diabetes at Epsom Hospital, 88.4% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile two.

In Epsom Hospital, on average 0.01 diabetes specialist nursing hours per week were spent with each patient in 2016, which places this site in Quartile 1.

2.1 per cent of patients with diabetes in Epsom Hospital were admitted with active foot disease in 2016, which places this site in Quartile 1.

In Epsom Hospital in 2016, 8.5 per cent of patients with diabetes received a diabetic foot risk assessment within 24 hours of admission, which places this site in Quartile 1. 8.5 per cent of patients received a diabetic foot risk assessment at some point during their hospital stay, which places Epsom Hospital in Quartile 1.

In Epsom Hospital in 2016, 4.3 per cent of patients had been on an insulin infusion in the last 7 days, which places this site in Quartile 1. The healthcare professionals collecting the data suggested that the use of insulin infusions was not appropriate for 50.0 per cent of these patients (unable to assign to quartiles due to the high proportion of organisations with 0.0 per cent returned).

In Epsom Hospital in 2016, 0.0 per cent of patients with diabetes admitted with active foot disease were seen by the multidisciplinary diabetic foot team (MDFT) within 24 hours, which places this site in Quartile 1.

In Epsom Hospital in 2016, 20.7 per cent of patients with diabetes experienced one or more medication error, which places this site in Quartile 1. 6.9 per cent of patients with diabetes experienced at least one medication management error, which places this site in Quartile 1. Of the patients on insulin, 10.3 per cent experienced one or more insulin (prescription or medication management) error, which places this site in Quartile 1.

(Source: NHS Digital)
Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2014 to March 2015, 90% of nSTEMI patients were admitted to a cardiac unit or ward at Epsom Hospital and 70% were seen by a cardiologist or member of the team compared to an England average of 95.1% and 55%.

The proportion of nSTEMI patients who were referred for or had angiography at Epsom Hospital was 81% compared to an England average of 79%.

<table>
<thead>
<tr>
<th>2014/15</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epsom Hospital</td>
<td>126</td>
<td>126</td>
<td>83 (83)</td>
</tr>
<tr>
<td></td>
<td>89.7%</td>
<td>69.8%</td>
<td>80.7% (No data)</td>
</tr>
<tr>
<td></td>
<td>90.8%</td>
<td>36.7%</td>
<td>68.5% (No data)</td>
</tr>
<tr>
<td>England: overall</td>
<td>45500</td>
<td>45500</td>
<td>38099 (38099)</td>
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<tr>
<td></td>
<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 0%, which was worse than the audit minimum standard of 90%. The 2015 figure was not available.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 30%; this is not significantly different from the national level of 24%. The 2015 figure was not available.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 20%; this is significantly worse than the national level of 64%. The 2015 figure was not available.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 11%; this is significantly worse than the national level of 69%. The 2015 figure was not available. The one year relative survival rate for the trust in 2016 is 34%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017 - Epsom
The trust had a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 14% this below the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 17% this below the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 30% this below the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 62% this similar the national aspirational standard of 100%.

(Source: Royal College of Physicians)

**Competent staff**

**Appraisal rates**

As at September 2017, 34.2% of staff within medicine at the trust had received an appraisal against a trust target of 80%. However, it should be noted that the trust told us they had an annual appraisal cycle with end of year reviews being completed in the period from 1 January to 3 March. Although the figures for appraisal rates show that the hospital was below target, at the time of our inspection in January 2018, the time period during which the trust conducted appraisals had not yet elapsed.

A split by location can be seen in the graph below:

![Appraisal rates graph](image)

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
All new staff were inducted into the trust. The induction programme included the mandatory training staff needed to complete. It also included essential information such as the values, trust aims and objectives, policies and procedures and information about health and safety.

All staff in medicine including bank and agency were provided with a local induction in the workplace which helped introduce them to their area of work.

Junior doctors we spoke with said they felt supported by consultants and they could access consultants for help and advice where necessary. There was access to training on a regular basis for development.

There were practice development nurses (PDNs) who provided educational learning and teaching to staff.

Staff attended handovers, safety huddles, multidisciplinary team (MDT) meetings and bed management meetings on a regular basis. We attended MDT meetings, a handover and a bed management meeting and found that all staff were knowledgeable about their ward and patients.

Most staff we spoke with told us they received regular appraisals which involved the setting and measuring of objectives, and this was useful. Although the figures for appraisal rates for Epsom above show that the hospital was below target, at the time of our inspection, the reviews for 2017-18 had only just begun. Some staff told us that they were not up to date on their appraisals because the ward was busy, and due to short staffing they did not have time to undertake their yearly appraisals.

There was an onsite simulation suite which was used to train staff in CRISIS (Care, Recognition, Initial, Stabilisation In Simulation). It was part of mandatory training for all nursing staff and key junior medical staff and allowed multi-professional staff to simulate their management of medical emergencies in a safe environment.

**Multidisciplinary working**

Multi-Disciplinary Team (MDT) working was working well throughout the medical division. Regular MDT meetings with the involvement of specialists and health care professionals ensured patients received the right care at the right time by the right professionals. Medical teams made timely internal and external referrals to other healthcare professionals, and this process worked efficiently to ensure patients received the right care at the right time by the right professionals.

There was a good relationship with the Epsom Health and Care @home service team which was a multidisciplinary team of doctors, nurses, social workers and allied health professionals who worked with the ward staff to help get patients home with the right care in place as quickly as possible.

Health care professionals worked together as a multidisciplinary team to plan and implement care and treatment for individual patients as per evidence based guidance.

Therapists worked closely with ward staff to implement rehabilitation plans for each patient and we saw nursing staff and therapists working together to complete patient tasks and rehabilitation during the inspection.

Board rounds were held on a daily basis on the medical wards and were attended by the multidisciplinary team (MDT). There were also daily ward rounds with the wider team including medical, nursing, therapy and social care staff.
There was an obvious professional respect between doctors, nurses and therapists which made communication of patient information at handovers, board meeting, ward rounds and multidisciplinary team meetings effective and efficient.

**Seven-day services**

We saw that consultant cover was a seven-day service. This service provided continuous patient review and staff told us they felt supported to manage patients’ care effectively. Patients were adequately supported by a team of consultants and registrars to ensure a seven day service. This included a ‘consultant of the day’ and an on call rota.

Physiotherapy services were available seven days a week by a dedicated physiotherapist’s team; an on-call physiotherapist was available out of hours. There was also access to pharmacy seven days a week.

Endoscopy clinics were available five days a week (Monday to Friday).

**Health promotion**

We saw a range of health promotion leaflets across medical wards included smoking cessation and information regarding drinking too much alcohol.

The services were supporting national priorities, such as smoking cessation and dementia by offering information and advice. For example, information leaflets were available on most wards regarding smoking cessation.

Patients identified as needing extra support, such as for drinking too much alcohol, were referred to the relevant team as and when required. This was judged on an individual basis depending on the patient’s needs.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that as of October 2017 their mental capacity act (MCA) and deprivation of liberty training (part of their Safeguarding Adults (Level 2) had been completed by 47% of staff within medicine.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Mental Capacity Act and Deprivation of Liberty Safeguards**

At the last inspection, the trust was recommended to make sure that all relevant staff were clear on how a Deprivation of Liberty Safeguard authorisation (DoLS) should be used. During this inspection, we found that staff were unclear on when a DoLS authorisation should be used. Senior staff told us that there were four patients currently under a DoLS authorisation at the hospital; however, we did not find DoLS applications for these patients in their care records and staff told us that these patients were not under a DoLS. This demonstrated a lack of clarity around the use of DoLS among staff.

The trust applied for 238 Deprivation of Liberties Safeguard authorisations from the local authorities for the financial year 2016 to 2017. The trust did not provide information regarding the number of DoLS applications for Epsom hospital.
At the last inspection, we observed that staff upheld the principles of the Mental Capacity Act 2005; however, the mental capacity of patients was not recorded in any of the records we reviewed in detail. During this inspection, we reviewed four records of patients that staff had identified as lacking in capacity to make decisions about their care and treatment. There were no mental capacity assessments in the patient care records and staff could not locate them in any other records.

The trust stated in its policy, ‘Mental Capacity Policy’ that staff assessing patients’ mental capacity must clearly document the assessment in the patient notes, and the trust provides a capacity assessment tool; however, we did not see this template used in the patient records of patients, staff said lacked capacity.

The trust trained staff in the Mental Capacity Act, Deprivation of Liberty Safeguards and caring for people with complex needs including learning disabilities. Trust wide compliance with this training was 96% as of 10 March 2017.

We reviewed four patients’ care records who staff said lacked capacity. There were no mental capacity assessments on file for these four patients. Senior staff identified three of these patients as being on a DoLS, but there were no forms for DoLS on the patient files. We spoke to two staff members caring for these patients, who did not understand the difference between a patient being on a DoLS and a patient for whom a safeguarding alert had been raised with the local authority.

**Mental Health Act**

From 1 December 2016 to 30 November 2017, the trust saw 6803 patients with a diagnosis relating to mental or behavioural disorders at Epsom hospital. Staff supported patients with mental health needs through the psychiatric liaison service and by hiring bank and agency mental health nurses. A mental health nurse was available at Epsom hospital through the psychiatric liaison service 24 hours a day, seven days a week.

The trust trained staff in the MHA and supporting patients with mental health needs. This training was delivered by the psychiatric liaison service which targeted staff in the emergency department as a priority. The trust did not provide data on how many staff members attended this training.

The trust ensured that when staff detained patients under the Mental Health Act (MHA), they filled out the correct paperwork and ensured that patients had their rights explained to them. We looked at nine records of patients who had been detained under the MHA. These were appropriately filled out and indicated that staff had to seek consent from patients before giving medication or treatment for physical health illnesses. Staff said that the trust faxed over mental health documentation to the Mental Health Act office at the local mental health trust and kept the originals.

The trust had policies and procedures in place to meet the needs of people with mental health needs. The trust had a Service Level Agreement with the local mental health trust to help
administer the documentation of patients detained under the MHA, to support staff in treating patients with a mental health illness, and to train staff.

Staff supported women with mental health needs through triaging them in the ante natal department and using a multi-agency approach to meet their needs. The total number of referrals to mental health services of women at any stage in their pathway was 517 for both hospitals.

**Restraint and restrictive practices**

Security and staff restrained patients if they posed a risk to themselves or others. The security staff covered Epsom and St Helier Hospitals. Security staff attended awareness training for Mental Health, Mental Capacity, Safeguarding and other courses provided by the trust. Security staff were trained in how to safely restrain patients who are vulnerable. The head of security attends regular meetings with other departments in the trust and shared learning through security team meetings.

Before restraint was used on any patient detailed under the MHA, the responsible clinician filled out documentation to state under which legal framework the restraint is being used. The responsible clinician stated whether restraint was carried out under the Mental Capacity Act, the Mental Health Act, or under common law.

Staff said that the trust did not use the security staff for monitoring or observing vulnerable patients, except for short periods of time (under two hours), while the trust located a mental health nurse to support patients, or while the patient awaited transport to another facility. However, the use of security staff for monitoring patients was not monitored by the trust.

Mental health nurses (RMN) on the wards supported patients with mental health needs where necessary. The trust did not hire mental health nurses and relied on NHS bank or agency RMNs. The trust gave inductions to RMNs coming to the hospital, and each ward supported the RMNs on the necessary procedures and policies. The psychiatric liaison team also provided a RMN to support patients in Epsom Hospital. (MH inspector’s notes)

The hub supported staff to complete Level 1 and Level 2 safeguarding training which covered the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Mental Health training was delivered as a separate module and included suicide awareness.

We reviewed three patients’ Do Not Attempt Cardiopulmonary Respiration (DNACPR) records on Swift Ward. Staff said that one of these patients lacked capacity to consent to DNACPR, but there was no mental capacity assessment form in the patient’s files, and staff could not locate an assessment on any other system. Two patients had capacity and the DNACPR forms recorded that a clinician had a discussion with the patient regarding the decision to not attempt resuscitation, but there were no details of the discussion in line with good practice as stated by the Resuscitation Council and in line with the trust’s own policy on mental capacity.

One of the patients who was identified as being on a DoLS because they were at risk to themselves from interfering with medical intervention. Staff made this patient wear gloves so that
they could not harm themselves. Staff did not record a best interest meeting or decision in this patient’s notes. This was not in line with the Mental Capacity Act guidance or the trust’s own policy on mental capacity.

**Is the service caring?**

**Compassionate care**

**Friends and Family Test performance**

The Friends and Family Test response rate for medicine at the trust was 26% which was similar to the England average of 25% from October 2016 to September 2017.

**Friends and Family Test – Response rate from October 2016 to September 2017 by site.**

![Graph showing the Friends and Family Test response rate](Source: NHS England Friends and Family Test)

All of the patients we spoke with said staff had treated them with compassion and kindness. For example one patient on Buckley Ward said, “The nursing staff are very kind. You can’t fault the staff here”. On AMU patients said “they’ve been caring for me very well indeed, they are all so kind and pleasant”.

The hospital supported carers who were able to visit the patient(s) they cared for outside of usual visiting hours.

We observed positive examples of staff encouraging patients to take their medicine in several clinical areas. For example staff used positive reinforcement and warmly congratulated patients who managed to take medicines they found difficult to swallow. Staff achieved this without patronising patients and there was evidence of the genuine rapport we saw between staff and patients.

We saw numerous thank you cards across the wards we visited with comments such as: “thanks for all the care and everything you did”, “we are so incredibly grateful for all the attention and care” and “we’d like to say a huge thank you for the way you cared for our family member”.

**Emotional support**
There was a chaplaincy service which offered support to patients and their relatives and carers. They provided spiritual and religious care regardless of belief. We saw information leaflets about the chaplaincy service throughout the medical wards in the hospital. We saw the chaplain on a ward who had responded to a request by staff to attend a patient.

Staff were able to refer to the psychiatric liaison service within the trust if support was needed to assess mental health needs of patients.

We observed a nurse sitting and holding the hand of a patient who was upset. They were very caring and stayed with the patient until they were calmer.

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

On the ward rounds we observed, doctors and nurses involving patients in their care. They explained tests that were to be carried out or results from test to patients and answered any questions that patients had. They talked to patients about when they were going to be discharged and about the support they had at home.

Patients we spoke with said they felt involved in their care and treatment.

Speech and language therapists worked with relatives to develop communication strategies and assist patients with swallowing problems. This helped families understand how they could communicate with patients receiving treatment and helped them to plan for their discharge.

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### Is the service responsive?

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

**Average length of stay**

**Trust Level**

From August 2016 to July 2017 the average length of stay for medical elective patients at the trust was 5.9 days, which is higher than the England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.6 days, which is higher than the England average of 6.6 days.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in Nephrology is lower than the England average
- Average length of stay for elective patients in General Medicine is higher than the England average
- Average length of stay for elective patients in Gastroenterology is lower than the England average

**Average length of stay for non-elective specialties:**

- Average length of stay for non-elective patients in General Medicine is higher than the England average
- Average length of stay for non-elective patients in Nephrology is higher than the England average
- Average length of stay for non-elective patients in Geriatric Medicine is higher than the England average
Epsom Hospital

From August 2016 to July 2017 the average length of stay for medical elective patients at Epsom Hospital was 3.6 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 8.5 days, which is higher than England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in General Medicine is higher than the England average
- Average length of stay for elective patients in Cardiology is higher than the England average
- Average length of stay for elective patients in Gastroenterology is lower than the England average

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in General Medicine is higher than the England average
- Average length of stay for non-elective patients in Geriatric Medicine is higher than the England average
- Average length of stay for non-elective patients in Cardiology is higher than the England average

Elective Average Length of Stay - Epsom Hospital
Due to the area surrounding the hospital having a large elderly population, there were a higher percentage of admissions from this population group. Additional elderly care consultants had been recruited.

Between October 2016 and September 2017 the trust reported no mixed sex accommodation breaches. A mixed sex breach occurs when a male and female patient were cared for in the same clinical area. During the inspection we saw no mixed sex breaches.

There were relatives’ rooms and quiet rooms available on medical wards for relatives and patients to use. Visiting times on medical wards were generally between 2pm and 8pm, with protected times scheduled for meals.

The Epsom Health and Care @home service supported the ward staff to facilitate discharge from hospital with the right care and support at home for elderly residents of the borough.

Meeting people’s individual needs

Staff carried out an initial assessment of patient’s needs and care plans were formulated to ensure individual needs and preferences were considered and acted on. On Alexandra Ward we saw the use of the ‘forget me not’ scheme to assist people living with dementia. There were two old style suitcases which contained pictures and photographs of movie stars, singers and groceries, which could be used as conversation starters or for distraction purposes with patients who were living with dementia.

Patients we spoke with were complimentary about the food they received. They told us that there was good choice and food was “quite tasty”. Care and treatment was coordinated with other services and providers. This included liaising with social and therapy services, families and carers and ensuring that all services were informed of any patient requirements that needed to be taken into consideration, including those with urgent needs.
There were quiet rooms for relatives and patients to sit and have a few minutes together away from the bedside on each ward. Translation and interpreting services were provided by a telephone services for those for whom English is not their first language. Patients who were living with learning disabilities used a passport system to guide staff in their desires and needs.

Patients were provided with choices of meals and completed their menus beforehand with the help of staff where needed. Special diets were catered for such as diabetic, gluten free, egg free, healthier choice and vegetarian. Cultural meals were also available for example halal, kosher, African-Caribbean and Asian vegetarian.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From October 2016 to September 2017 the trust’s referral to treatment time (RTT) for admitted pathways for medicine patients treated within 18 weeks showed a similar trend versus the England average.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

One specialty was 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>Rheumatology</td>
<td>96.1%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

Three specialties were 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>Geriatric Medicine</td>
<td>95.6%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.9%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>93.8%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Swift Ward was a surgical ward but had been designated as a medical outlier ward. On the days of inspection 19 of the 22 beds were occupied by medical patients. We observed the staff handover and care on this ward during our inspection and found staff respected patient’s dignity and privacy. They were caring and had worked to build relationships with patients despite the patients being on an outlier ward.

There were still issues with patient flow through the wards which had existed when we inspected in 2016. When patients needed further care or residential accommodation there were delays in arranging the services to support them in the community. This meant that patients who were
medically fit for discharge were not leaving wards to make space for patients coming through from the emergency department. However, the Epsom Health and Care @home service were supporting patients to get home as quickly as possible with the correct care packages in place to support their needs.

Eight patients who were medically fit for discharge were placed in Ebbisham Ward, which was usually a paediatric assessment unit but had been turned into an escalation ward area, whilst residential/nursing home places were found or care packages were put in place for them.

Staff in each specialty and service area used three daily bed meetings to coordinate flow across the trust’s services. We attended a bed meeting and saw it was attended by the wider multidisciplinary and divisional teams with a focus on timely and safe discharge. This meeting process enabled teams to speed up communication with community services, including social care, to facilitate more complex discharge cases.

**Learning from complaints and concerns**

**Summary of complaints**

From November 2016 to October 2017 there were 166 complaints about medical care out of 577 trustwide. The trust took an average of 115 days to investigate and close complaints, this is not within their complaints policy, which states complaints should be 35 days or 45 days for more complex complaints.

- Epsom Hospital: There were 62 complaints, the main themes relate to all aspects of clinical treatment with 29 complaints followed by nine related to admissions, discharge and transfer arrangements.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected.

Patients we spoke with told us they knew how to give feedback about their experiences and could do so in a range of accessible ways, including how to raise any concerns or issues.

The senior nursing staff and managers told us that complaints were discussed at clinical governance meetings, and we saw evidence of this in the minutes of meetings.

We saw that learning and improvement from complaints took place. Learning from complaints was discussed in team meetings and handovers.

When patients and/or family members made suggestions or complaints, trends were displayed on an information board on wards referred to as a “You said, we did”.

**Is the service well-led?**

**Leadership**

Staff told us the leadership team were present on the wards. The heads of nursing, matrons and ward managers were visible throughout services and staff said they felt comfortable approaching them if they had any issues they wished to raise.
Managers were proud of and committed to their staff teams on all of the medical wards we visited. The manager on one of the medical wards described their staff team as “a dedicated and committed staff team” and the staff said this was a “tight team, who felt empowered to raise concerns and have their say” and the manager had an open office policy.

Vision and strategy

The trust had a clear statement of vision and values, driven by quality and sustainability. The clinical quality and education nurses based their teaching on the wards around the trust’s vision and values, and staff said this helped them to understand how their roles fitted in to achieving the trust’s goals.

The trust’s vision included continuous quality improvement, delivering excellent experience and outcomes for patients, reducing staff vacancy rate and staff turnover, increasing staff retention, and sustainability. All staff we asked were aware of the vision and mission and we saw these were displayed on the notice boards on the wards we visited.

The trust’s mission statement was “to put the patient first by delivering great care to every patient, every day.” This fed in to the trust’s five year strategy (2015 – 2020). Staff had been consulted with during the development of the strategy.

The senior divisional team had identified recruitment and retention of nurses as a key priority. To address this they had introduced a recruitment strategy, completed a period of overseas recruitment and developed career pathways for nurses.

Culture

Staff we spoke with were universally proud of the contribution they made to the hospital individually and as part of the team. Staff were hard-working and committed to providing the best care possible to their patients on a daily basis. Staff from all disciplines spoke with passion about their work and conveyed how happy they were to be working for the trust. We spoke with ward managers and matrons who regularly ‘rolled up their sleeves’ and worked a shift as a member of the nursing staff to cover staffing shortfalls.

We found the culture of care delivered by staff across all medical services was dedicated, compassionate and strongly supported at divisional and ward level. Managers encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported.

Governance

There were established governance mechanisms within the trust to monitor and improve standards of patient care. We reviewed post-acute medicine division cross site clinical governance meeting minutes and saw a wide range of topics were discussed including incidents and root cause analysis, complaints, risk register, clinical audits and effectiveness. We noted that various items were actioned after discussion and named individuals were tasked with the action and to report back at the next meeting. Clinical governance meetings took place every three months and all staff were encouraged to attend.

The quality committee was part of the governance structure, which reported to the board (chaired by non-executive directors, with the chief nurse as the executive lead, supported by a medical director). Within the division, there were divisional clinical governance boards. These were chaired by divisional medical directors supported by the clinical governance team, clinical directors, head
of nursing and service managers. The framework monitored quality performance and risk; including serious incidents, complaints and investigations.

Mortality and Morbidity meetings were held monthly.

**Management of risk, issues and performance**

During the inspection we met with the senior leaders of the medical division and asked them what they thought were the biggest risks to the medical services. We found the senior leaders had good oversight of the risks we found in the service. For example staffing, recruitment and retention of staff.

Fortnightly meetings were held to review risks and the risk register. Performance score cards were used to measure assurance, performance and meeting governance structures and how risks were escalated through channels from receptionist to head of nursing.

The ward managers we spoke with told us the trust was actively recruiting both within the UK and overseas. However, on many of the wards and units senior grade staff were filling in to mitigate staffing shortages on shifts which took them away from their designated roles.

**Information management**

Service performance measures were reported and monitored. The ward managers had access to an electronic dashboard at all times that displayed performance measures. On the entrance to the wards there were also results of the safety thermometer displayed so that visitors are able to see how the wards were performing on a number of measures.

Patient records on wards were kept in trolleys, which were easily accessible and were not lockable. We found patient paper records kept on portable hangers with a lid. We noted the lids were kept opened while doctors and nurses accessed records. Staff had personal logins for the computer systems and were able to access electronic records.

There were not robust arrangements to maintain the safety and confidentiality of identifiable information. We found patient identifiable information in ward areas, in unlocked trolleys and in ward areas which was easily accessible by members of the public.

**Engagement**

Patients told us they felt engaged in their care and treatment. They were given information in ways they could understand and were given time to ask questions. Staff also sought consent before completing all tasks. On the entrance to the wards we saw a board containing evidence of patient satisfaction results.

The trust had a range of methods around patient engagement including patient surveys and patient stories. Staff told us they had regular ward meetings where a range of items were discussed including staffing and learning from incidents. In addition, this gave staff the opportunity to raise any concerns or issues identified in their service.

The hospital provided the opportunity for the general public and patients to provide feedback online via the trust website. The trust engaged well with external stakeholders to have a shared understanding of the challenges within the local healthcare system.
Board meeting minutes were also available on the trust’s website, along with dates of future public trust board meetings. The trust produced a newsletter and chief executive blog to update staff on current and future plans.

### Learning, continuous improvement and innovation

Since the last inspection, the hospital had introduced an electronic whiteboard system enabling clinicians to capture patient’s vital signs electronically in association with the NEWS score, improving accuracy and aiding better patient care.

The division has rolled out the implementation of ‘safety huddles’. These real-time MDT meetings prioritised patient safety issues. The huddles promoted awareness of key themes such as falls and highlighted particular individual patient needs or concerns surrounding safety risks. The forum shared lessons learnt from incident feedback.

Hospital patient deaths were reviewed at speciality level meetings. These meetings were overseen by a mortality lead for each specialty. Action relating to any issues in care, trends or notable learning was driven through divisional mortality review groups and the trust wide mortality surveillance group. The trust actively identified learning from both expected and unexpected deaths and used the process to improve outcomes where death was unexpected, and to improve care and services to patients where death was expected.

Electronic patient monitoring was being introduced to assist staff to recognise and promptly respond to deteriorating patients. Since the last inspection the hospital had launched a new sepsis box and sepsis screening tool to help staff diagnose and monitor suspected and actual cases of sepsis.

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**Surgery - Epsom General Hospital**

### Facts and data about this service

The hospital has eight main operating theatres used for main and day case surgery, covering general and colorectal surgery; urology; ophthalmology; ENT; oral and maxillo-facial services; and trauma and elective orthopaedic surgery across the two sites. The hospital has two surgical wards with 22 inpatient beds.

The trust had 31,173 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 3,860 (12 %), 19,742 (63 %) were day case, and the remaining 7,482 (25%) were elective.

### Is the service safe?

#### Mandatory training
The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of October 2017 for medical/dental and nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Medical staff Module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>84%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>82%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>68%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>55%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>54%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>53%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>53%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>42%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>31%</td>
</tr>
</tbody>
</table>

The medical and dental staff only met one of the 11 training with a completion above the trust target of 95%; the lowest completion was for information governance with 31%.

<table>
<thead>
<tr>
<th>Nursing Module</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>91%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>87%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>84%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>83%</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>95%</td>
<td>82%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>60%</td>
</tr>
</tbody>
</table>

The nursing staff met three of the 11 training with a completion above the trust target of 95%; the lowest completion was for information governance with 60%.
Epsom Hospital had a 72% mandatory training completion rate; no modules met the 95% trust target for completion.

Further data provided by the trust post inspection, showed that for certain core topics, both nursing and medical staff had achieved a 100% compliance rate. For example, equality, diversity, and infection control. Some core topics had an amber rating, which meant compliance had not yet been met, but staff were still within the period to complete this.

Information governance (IG) scored the lowest compliance rate for most staff. The trust told us IG had to be completed each financial year, and therefore, the next deadline for the completion of training was the end of March 2018.

Managers and nursing staff told us the data provided by the trust’s electronic training records system was not always accurate or reliable. Staff gave examples of training they had completed, but the electronic system had yet to update their individual training record and this impacted on the overall compliance score.

Staff were given the time to attend training. Training was provided both face to face and electronically and staff we spoke with reported they felt the training was informative and enjoyable. Although every effort was made to ensure staff could attend, it was sometimes more difficult to undertake electronic learning due to clinical and ward needs taking priority.

Responsibility for attending training was held by individuals and their managers. Monthly updates were sent to managers and e-mails were sent to show individual staff members who were due training.

Staff completed the Care, Recognition and Initial Stabilisation in Simulation, (CRISIS) course, which was a mandated simulation course for managing the deteriorating patient. This course focused on human factors, which is the study of how humans behave physically and psychologically in relation to a particular environment. Part of the course involved the management of patient sepsis. We visited the training centre and spoke with the training leaders who were able to show us the different training facilities available for staff.

Safeguarding

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as at October 2017 for medical/dental and nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Medical Module</th>
<th>Average of Trust Target (%)</th>
<th>Average of Number of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>83%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

The medical and dental staff did not meet any of the three safeguarding training with a completion above the trust target of 95%.
<table>
<thead>
<tr>
<th>Safeguarding Adults (Level 1)</th>
<th>trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
</tr>
</tbody>
</table>

The nursing staff met two of the three safeguarding training with a completion above the trust target of 95%.

Epsom Hospital had a 73% safeguarding training completion rate, no modules met the 95% trust target.

Information we received post inspection, showed all areas within surgical services had achieved compliance for the adults safeguarding awareness course. The safeguarding training programme ran from April to April, so staff still had time to complete the different safeguarding modules.

Staff we spoke with had a clear understanding of what a safeguarding concern was and how to report abuse. They were clear about the hospital’s safeguarding escalation process. Safeguarding information was available on the surgery wards. Staff were able to tell us about the independent domestic violence abuse advisor who worked for the hospital and of the social workers who attended multidisciplinary meetings.

Safeguarding concerns were discussed in ward multidisciplinary (MDT) meetings. We observed a meeting where safeguarding concerns were discussed and actions taken to ensure the patient was kept safe. For example, discussions took place on a patient’s discharge and whether they had the appropriate equipment and support when they left the hospital.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The trust had an infection control policy and guidelines for staff to follow. Staff completed annual infection control training as part of their mandatory training. All staff we spoke with had a good understanding of infection control procedures and most staff told us the trust placed a great deal of emphasis on infection control practices.

Staff said they received up to date key IPC information though the intranet and discussed IPC in regular team meetings. The wards had infection prevention and control link nurses that were responsible for attending infection prevention and control meetings and communicating learning and changes to the rest of the ward staff.

All clinical areas we visited within the surgery division appeared to be visibly clean and tidy. We observed staff following good infection control practices, by washing their hands and using hand sanitiser gel at appropriate times when attending to patients. Staff wore personal protective equipment (PPE), of clean nursing uniform or scrubs (when working in the theatre environment) and wore clean gloves and aprons when attending to patients or handling equipment. All staff we observed were bare below the elbows. At our last inspection in 2015, we observed theatre staff wearing protective clothing such as blue gowns and theatre caps outside of the theatre environment. During this inspection and from our observations we did not see this happening.

We observed staff adhering to good IPC practices in theatre with regards to specimen handling, waste management, surgical techniques and maintenance of the sterile field. Staff cleaned equipment in-between cases using neutral detergent or disinfectant wipes.
The hospital conducted monthly hand hygiene audits. This enabled the trust to have oversight and ensure staff were following correct procedures to minimise cross infection. From the months of May to November 2017, the surgery division consistently scored above 90%. Senior nurses conducted the audits by observing up to 130 members of staff of all levels in their working environment.

Ward based cleaning was carried out by an external company. There was a cleaning work schedule for the housekeeping staff 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.

Results from Patient-Led Assessments of the Care Environment (PLACE) showed good results. The most recent data at the time of our inspection, showed a cleanliness score of 99% against a national average for acute services of 98.4%.

Patients were screened for meticillin-resistant staphylococcus aureus (MRSA) as part of their pre-assessment. During our inspection, we found MRSA pre-screening checks had been completed for all records we viewed. Data from November 2016 to December 2017 showed there was one MRSA case and two Clostridium difficile (CDIFF) cases.

Surgical site infection (SSI) rate audits covering April to September 2017 showed there were six SSIs across 370 orthopaedic procedures, which was a rate of 1.6%. For elective, day case and gastroenterology surgery, the rate was 0.3%.

At the time of our inspection, the hospital was experiencing unprecedented levels of patient activity due to ‘winter’ pressures. To accommodate patients, elective surgical patients were moved to the inpatient ward of the South West London Elective Orthopaedic Centre (SWLEOC) which is located on the Epsom General Hospital campus. SWLEOC is a hip and knee replacement centre and run in partnership with a number of local trusts. We found the ward practiced good infection control standards by ensuring all MRSA tests were completed before patients were admitted to the ward.

The surgical ward had a cleanliness matters board which displayed IPC related information. The national cleanliness score for the month of December 2017 was 98.1%. This was a nationally approved auditing process, which included joint monitoring with nursing staff and cleaning staff representatives. The audit covered the cleanliness of areas such as, toilets, mirrors, bidets, cupboards and other areas.

Within the surgical ward on certain side, rooms where patients had more infectious conditions posters of enhanced cleaning checklists were displayed to show the times and dates the rooms had been cleaned. A special hygiene poster was also displayed to alert staff and patients that extra IPC precautions were required when entering the room.

**Environment and equipment**

At our previous inspection in 2015, we found some equipment items were old and staff told us this was affecting their ability to treat patients effectively. Since then, the trust had invested in the purchase of new equipment. However, there was still an issue with certain pieces of equipment. Four incidents had been reported between July and November 2017, whereby instruments used in theatres, including resectoscopes were not fit for use. Two incidents resulted in the cancellation of patient’s surgery.

There were still problems with the patient’s trolleys in the day case unit. Four new trolleys had been replaced with a remaining eight needing replacement. The capital bid submission in 2015 was not successful and a further submission was due in the new financial year. There were mitigating actions for staff to take to ensure the trolleys were safely functioning. However, staff told us the trolleys were not ideal, as they were old and in a bad state of repair.
There were problems with the reprocessing service provided by an external organisation with the sterilisation of surgical instruments. Most instruments were either missing or replaced with substandard instruments. We were shown around the storage room, which contained all surgical sterilised instruments and saw approximately 70% of all instruments packages were either missing equipment or had replacement items. This was a high risk on the surgical services risk register. The problem stemmed from the lack of ownership and effective communication from the external organisation. Weekly meetings were held with the company but there was also a lack of senior management meeting to hold the company into account. Staff told us of instances when they had to taxi equipment that had been incorrectly sent to other trusts. During the inspection, we were told that meetings would continue in an attempt to resolve poor relations and a theatre efficiency group meeting would start in February 2018, whereby members of the external organisation would be in attendance.

The trust told us they were working with procurement to purchase three to four new anaesthetic machines for this financial year, that were much needed.

A review was currently being undertaken for theatres to ascertain all replacement kit required for the year ahead. The trust were considering a managed contract service with an outside provider that worked well with the hospitals elective orthopaedic centre. However, we were not provided with any firm dates for a definite confirmation this would happen.

Staff told us the female changing area in the theatres lacked sufficient ventilation and was stuffy and uncomfortable.

A new surgical care suite had been opened in May 2017 and this proved to be a light and spacious area for patients to attend pre-operatively. The suite was a vast improvement from the previous arrangements and gave a more dignified experience for the patient. The suite was adjacent to the theatres and provided reclining chairs and private consultation rooms where patients could be prepared for surgery. However, to accommodate for this suite the anaesthetist on call ‘mess’ room had been changed and so far no alternative area with decent rest facilities such as reclining chairs had been made. Staff told us this had an impact on their welfare when they needed sufficient rest.

The surgical ward was spacious, tidy and uncluttered. There was sufficient space between patient’s beds to warrant privacy and dignity and the old pre-operative areas on the ward was now a spacious area for patients and relatives to use.

We looked at the resuscitation trolleys and found equipment was available, fit, and ready for use and had been checked regularly. Medical equipment in theatres and the surgical wards we inspected had stickers to indicate they had been serviced and maintained and were in date.

There was a sepsis box in the surgical ward, which held all the relevant equipment and medication to manage sepsis. This had been regularly checked and was readily available for use.

Staff managed clinical waste in line with trust policy. Sharps were disposed of safely in correctly assembled and dated sharps disposal boxes.

Assessing and responding to patient risk

Overall, throughout the patient’s surgical journey, risk assessments were completed to help keep patients safe. Patients attended a pre-operative assessment clinic in the weeks prior to surgery and were assessed for their suitability for surgery. Assessments of the patients past medical history and social circumstances were completed and any required investigations were performed at this time. Patients identified with concerns or potential anaesthetic risk were escalated to the anaesthetist for further review.

Venous thromboembolism (VTE) rates were monitored and VTE was part of mandatory training for all staff. At the time of the inspection, the surgery division achieved 93.5% compliance for VTE risk assessments. This was just below the trust target of 95%. Urology was the worst with compliance
averaging 85%. However, with the introduction of two new urology consultants the trust was positive of increased rates. The hospital recognised there was still some work to be done on increasing the VTE compliance score.

Prior to surgery staff used the World Health Organisation (WHO) five steps to safer surgery checklist, used to check all safety elements of a patient’s operation before proceeding. At our last inspection in 2015 we identified that not all stages of the checking procedure were being followed. During this inspection, we observed four patient cases and saw all five steps had been completed correctly. The WHO audits were in depth and scrutinised all steps of the checklist. The audits for 2017 showed an improvement on 2016 figures, however, there were still areas of improvement and we saw actions taken against these, where the compliance fell below the trust target. The audits covered both locations of the trust, so we were unable to identify if certain non-compliance was related to Epsom or St Helier sites. Overall the trust had seen an improvement since 2016. We saw WHO compliance and areas for improvement were discussed in theatre and surgical governance meetings.

On admission to the surgical ward, staff undertook patient risk assessments and used certain tools for determining pressure ulcer risk, moving and handling, malnutrition universal screening tool (MUST), waterlow, and a safeguarding assessment. From the records we viewed risk assessment had been completed for all patients and sufficient care packages put in place for those patients that required additional support.

The trust used the National Early Warning Scores (NEWS) system for monitoring patient’s vital signs of deterioration. The system provided an escalation trigger protocol. Patients who had a high NEWS score were escalated for urgent review by the consultant. Staff used an electronic system to record patient’s observations and we saw this being used by staff during the inspection. Details were uploaded to the patient’s electronic record, and information could be accessed by the relevant staff. Audits were completed and data was pulled to identify the percentage of observations at night. Where the percentage breached was over 18% enabled the hospital to monitor individual observation charts. Data was also pulled to identify percentage of breached observations by ward. This enabled the trust to monitor whether staff were not taking observations appropriately. The audit from June to December 2017 showed Swift Ward had not breached any observations; however, they were on amber rating which meant they were close to the breach targets. The data was circulated weekly as a table by ward for all ward areas to view. The implementation of electronic whiteboards meant the information was also visible to ward staff.

Nursing staff carried out intentional rounds (a structured process where nurses carry out regular checks with individual patients). Patients we spoke with confirmed nurses regularly visited and carried out checks on them.

Emergency call arrangements were in place and staff had good knowledge of what to do in the event of a patient deteriorating. Staff told us they had attended mandatory CRISIS human factor simulation training for the deteriorating patient.

Patients, who deteriorated and required additional care from the other site St Helier’s facilities, were transferred accordingly. Staff told us they felt the system worked well; however, there were occasions when transport delayed the process. They advised there had been no occasions when the patient’s safety had been compromised.

Handover meetings at shift changes meant patients safety needs were assessed and discussed. We observed a handover meeting where each patient’s individual care was discussed and any areas of concern were highlighted, such as risk of falls, safeguarding and extra support for those patients with dementia.

Sepsis six protocols were in use on the surgical ward and gave staff clear direction on escalating patients where there was a suspected infection. The Sepsis Six care bundle outlines six actions, to be undertaken within one hour, for early management of sepsis. Swift Ward had a sepsis box,
which provided all the necessary equipment and guidelines so staff could treat patients as quickly as possible.

Senior staff at the hospital told us that rapid tranquilisation had not been used at the trust for the last three years. Reported incident entries for the previous year showed that staff recorded the use of rapid tranquilisation five times in the surgery and ITU. The reported incident entries did not state whether staff safely monitored the patients after the rapid tranquilisation medication. The trust did not formally monitor the use of rapid tranquilisation. This meant that the trust was not monitoring whether patients were kept safe after the use of rapid tranquilisation medication.

**Nurse staffing**

The trust has reported their staffing numbers below for as of September 2017 for surgery.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health</td>
<td>311.11</td>
<td>285.07</td>
</tr>
<tr>
<td>Visiting Staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There are 26 less WTE staff in place at the trust compared to what they had planned to provide safe care.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The hospital monitored staffing levels using the SafeCare application. Data from the software was used to inform decision making and the allocation of nursing resources to ensure all areas were safely staffed based on the level of care patients required. However, there were shortages of staff across the whole of surgical services. The hospital was making best efforts to recruit nursing staff against a national shortage. Swift Ward had a full complement of nursing staff that were experienced and had been working at the hospital for a number of years. However, nursing staff were used to cover shortages within other wards, which often meant there was a shortage of at least one registered nurse on a daily basis. At the time of our inspection, Swift Ward were short of one registered nurse for all shifts. Staff told us this had affected them as they were faced with an increased workload and felt under constant pressure. The sister of the ward often managed a ‘bay’ of patients, which meant they were unable to fulfil the other parts included in their role.

At the time of our inspection, the hospital was facing unprecedented and increased levels of patient demand due to ‘winter’ pressures, and the surgical ward had mostly medical patients. Nursing staff told us the demands from acute medical patients often meant they required more one to one care. Staff told staff shortages on the ward placed them under immense stress. Staff told us they did not feel the increased pressure was the fault of the hospital but was a national problem. However, staff were demoralised and tired.

The hospital had a continual recruitment campaign in place in an attempt to recruit nursing and medical staff. Northey Ward had a recent high turnover of staff; however, this was due to international nurses returning to their home countries and the added pressure of nurses being able to move to other London hospitals where an inner London additional payment was offered. The hospital were able to use regular bank staff that were familiar with the hospital and the working environment. Agency staff were only used if bank staff were unable to fill any shifts and authorisation for use in theatres or wards had to be agreed up to one week in advance..
Nursing staff shortages was a high risk on the surgical division risk register and the corporate risk register. Updates in November 2017 showed the vacancy factor had increased, but efforts to recruit new staff continued.

**Vacancy rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, the trust reported a vacancy rate of 17.4% in surgery compare to a trust target of 10%.

- Epsom Hospital: 18%

*Source: Routine Provider Information Request (RPIR) P17 Vacancies*

**Turnover rates**
From October 2016 to September 2017, the trust reported a turnover rate of 10% in surgery; compare to a trust target of 12%.

- Epsom Hospital: 12%

*Source: Routine Provider Information Request (RPIR) P18 Turnover*

**Sickness rates**
From October 2016 to September 2017, the trust reported a sickness rate of 4% in surgery; compared to a trust target of 3.8%.

- Epsom Hospital: no data provided for this site

*Source: Routine Provider Information Request (RPIR) P19 Sickness*

**Bank and agency staff usage**
From October 2016 to September 2017, the trust reported a bank and agency usage rate of 64% in surgery.

- Epsom Hospital: 56% bank and agency usage with 1,043 shifts unfilled

*Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency*

**Medical staffing**
The trust has reported their staffing numbers below as of September 2017 for medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>221.3</td>
<td>205.76</td>
</tr>
</tbody>
</table>

*Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual*
Vacancy rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, the trust reported a vacancy rate of 17.4% in surgery compare to a trust target of 10%.

- Epsom Hospital: 10.3%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The hospital had recently recruited two urologist consultants and had agreed to recruit up to three new anaesthetists. The trust were still actively recruiting for senior house officers (SHO’s) and were in the process of looking at incentives, such as fellowships.

Turnover rates
From October 2016 to September 2017, the trust reported a turnover rate of 10% in surgery; compare to a trust target of 12%.

- Epsom Hospital: 6%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From October 2016 to September 2017, the trust reported a sickness rate of 4% in surgery; compared to a trust target of 3.8%.

- Epsom Hospital: 0.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
From October 2016 to September 2017, the trust reported a bank and locum usage rate of 78% in surgery;

- Epsom Hospital: 72% bank and locum usage with 71 shifts unfilled

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

There was a system used to assess staffing and acuity on the wards called SafeCare. This system was completed three times a day every 24 hours.

Staffing skill mix
As from August 2017, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was slightly lower.

Staffing skill mix for the whole time equivalent staff working at Epsom and St Helier University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>48%</td>
</tr>
</tbody>
</table>
Records

Records were both electronic and paper based. At our previous inspection, we raised concerns with the level of nursing input into patient care records and the recording of patient VTE assessments. During this inspection we reviewed nine sets of patient’s notes and found patient records were fully completed. Patient risk assessments had been completed and included VTE, nutritional assessments, falls, and pressure ulcer and infection control assessments. Patient care records included input from all members of the multidisciplinary team, such as, anaesthetists, pharmacy, nutritionists, and physiotherapists. The name and grade of the doctor looking after the patient was included in records we viewed. Enhanced care plans were available for various surgical procedures, for example, colorectal surgery.

Patients observations were collected electronically on hand held devices and uploaded to the electronic system and patient bedside notes contained nurse’s observations on the patient’s welfare. We found these notes had been completed in a timely manner. Access to electronic notes were password protected and patient notes were kept in a secure unit next to the nurse’s station.

Our mental health inspector reviewed three patients’ Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records on Swift ward. Staff said that one of the patients lacked capacity to consent to do not attempt DNACPR, but there was no mental capacity assessment form in the patient’s files, and staff could not locate an assessment on any other system. Two patients had capacity and the DNACPR forms recorded that a clinician had a discussion with the patient regarding the decision to not attempt resuscitation, but there were no details of the discussion in line with good practice as stated by the Resuscitation Council and in line with the trust’s own policy on mental capacity.

Overall records we viewed were, legible, timed, dated, and contained the full history of the patient’s journey through the hospital.

Medicines

Medicines were stored securely and within the recommended temperature range. Controlled drugs (CD) were stored and managed appropriately. Our pharmacist inspectors looked at prescription and administration charts for three people. Patient’s allergies were documented appropriately and there were no missed doses. The pharmacist had also clinically screened the charts to ensure people’s medicines were optimised.

We reviewed the CD registers and found records were correctly countersigned by to signatures to confirm who had removed drugs and who had checked drugs.

Records demonstrated fridge temperatures were checked on a daily basis and medication storage areas were kept clean and tidy. Pharmacy support was available to the surgical wards and to nursing staff for advice on medically complex patients.

At our last inspection, we raised concerns regarding the storage of local anaesthetics in theatres. We found local anaesthetics were stored with anaesthetic drugs in the same cupboard, which contravened good practice guidelines. During this inspection, we saw local anaesthetics were stored separately and were satisfied surgical services were following best practice.
The hospital used red bands, which identified those patients with allergies, and we found these were recorded on patient notes.

Clinical updates, discussions on individual medicines and patient safety alerts were discussed at the Medicines Management Committee Business Group meeting which was held every eight weeks.

**Incidents**

Staff reported incidents through the trust’s electronic system and we found from all staff we spoke with they felt confident to report incidents and they had good knowledge of what and how to report. However, some staff told us that there were occasions when they had not reported low-level incidents, as they did not always receive feedback on actions taken. For example, staff did not always report the shortage of sterile instruments being returned from the reprocessing service as it happened so often, that staff told us it had become part of their normal working environment.

Staff told us they received good feedback on serious and moderate incidents, but not always on the low-level incidents. Feedback was sent in the form of e-mails and discussions in team meetings. We saw through a selection of meeting minutes ranging from surgical governance meetings and local level team meetings incidents were discussed. Theatre staff we spoke with were able to tell us about the never event and the mitigating actions the hospital had taken since.

**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 October 2016 to September 2017, the trust reported one incident classified as a never event for surgery.

![Graph showing surgical invasive procedure and incident meeting](Source: Strategic Executive Information System (STEIS))

There was one reported never event which occurred three weeks prior to our inspection, and was therefore, still under investigation by the trust. The incident involved retained swabs in a patient who returned to the hospital after a surgical procedure. After the never event, the head of quality attended theatre to look at how swab procedures were undertaken. They identified stickers from the swabs were being mixed up with stickers from the count. This has since been rectified by changing the colour of the stickers. All staff we spoke with told us there had been discussions and actions taken fed back at their respective meetings.

**Breakdown of serious incidents reported to STEIS**
In accordance with the Serious Incident Framework 2015, the trust reported for serious incidents (SIs) in surgery, which met the reporting criteria set by NHS England from October 2016 to September 2017. Of these, the most common types of incident reported were:

- HCAI/Infection control incident meeting SI criteria with one (25% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (25% of total incidents).
- Treatment delay meeting SI criteria with one (25% of total incidents).
- Slips/trips/falls meeting SI criteria with one (25% of total incidents).

Patient mortality and morbidity was managed well by the hospital. There were regular monthly meetings and the trust had a lower hospital standardised mortality ratios (HSMR) than expected (for February 2016 to January 2017 it was at 92 across the whole trust), which was statistically better than expected for all trusts and in the top quartile of acute trusts in the country.

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. Staff we spoke with understood their responsibilities in relation to DoC and understood it was about being open and transparent when things went wrong. The trust held information on when the DoC had been applied, and we saw between January to December 2017 the DoC had been applied approximately 18 times within the surgical division across the whole trust.

**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 13 new pressure ulcers, one fall with harm and 15 new catheter urinary tract infections from October 2016 to October 2017 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Epsom and St Helier University Hospitals NHS Trust**

![Safety Thermometer Graph]
Is the service effective?

Evidence-based care and treatment

Care and treatment was delivered in line with nationally recognised evidence based guidelines and current legislation. Policies we reviewed were developed in line with the Royal College of Surgeons, Royal College of Anaesthetists, and National Institute of Health and Care Excellence (NICE) guidelines. Staff could access these policies on the provider’s intranet and were able to demonstrate this to us.

Surgical services had a clinical audit programme to ensure staff compliance with trust policies and these were conducted on a monthly basis. For example, we viewed the WHO surgical safety checklist, VTE rates and NEWS scores. From speaking to staff and viewing staff meeting minutes, results of audits were feedback to staff with actions set for areas of improvement.

There was an enhanced recovery programme for surgery such as colorectal. An enhanced recovery nurse worked within the surgical ward. The programme followed recommendations by NHS for Innovation and Improvement. Enhanced recovery is an evidence based approach that has proven to help patients recover more quickly after surgery by receiving the best possible care during surgery and while recovering.

The Trust was in the process of receiving Anaesthesia Clinical Services Accreditation from the Royal College of Anaesthetists. The approval process is based on set standards and criteria accreditation confirms trust is committed for achieving and maintaining a standard of good practice set by the professional body. The trust scored highly for most standards, such as excellent guidelines for the handover to the high dependency unit, the excellent training from the simulation human factors training centre and pre-assessment nurses providing call back to patients to name a few.

Nutrition and hydration
Patients waiting for surgery were kept ‘nil by mouth’ in accordance with national safety guidance. A staggered system was used which meant patients were treated in a timely manner and not kept waiting for too long.

Staff used the Malnutrition Universal Screening Tool (MUST) to assess patient's risk of malnutrition. Records we reviewed demonstrated staff had used the tool and were referred to the dietician for review if required.

**Pain relief**

Following surgical procedures, staff assessed patient’s pain. Pain was assessed using the Bolton Pain Assessment Scale, which included observing the patient and identifying any behaviour that indicated pain. This scale was included in the early warning scores assessment. Staff had access to the acute pain team on site.

Staff asked patients about their pain during the intentional rounds on wards and there were visual aids to assist patients who had difficulties communicating. Patients we spoke with said they were not in pain, comfortable and that staff had regularly checked to see if they required pain relief.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From July 2016 to June 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

- Trauma & Orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

All patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing elective admissions for different specialties]

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 – Trust Level

*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 (01/07/2016 - 30/06/2017))

### Epsom Hospital

From July 2016 to June 2017, all patients at Epsom Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at Epsom Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Epsom Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at Epsom Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

All patients at Epsom Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at Epsom Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at Epsom Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Ophthalmology patients at Epsom Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

### Elective Admissions - Epsom 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 trust based on count of activity

### Non-Elective Admissions - Epsom 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 trust based on count of activity

**Hip Fracture Audit**

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 3% which was a positive outlier. The 2015 figure was 6.5%.

The proportion of patients having surgery on the day of or day after admission was 92.1%, which was better than the national standard of 85%. The 2015 figure was 87.9%.

The perioperative medical assessment rate was 98.4%, which met / failed to meet the national standard of 100%. The 2015 figure was 96.6%.

The proportion of patients not developing pressure ulcers was 96.4%, which falls in the middle 50% / of trusts. The 2015 figure was 98.7%.

The length of stay was 24.7, which falls in the in the middle 50% of trusts. The 2015 figure was 21.7 days.

In September 2017, a dedicated hip fracture discharge co-ordinator was appointed to manage complex discharge hip fracture patients. The hip fracture unit manager was in the process of establishing a cohort of nurses led by a Band 6 nurse to act as a pressure ulcer champion team. The team would have overall responsibility for management of pressure ulcers, including education, training and guidance for all hip fracture team staff.

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 69.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 68.

The risk-adjusted 90-day post-operative mortality rate was 3% which was within expected range. The 2015 figure was 3.7%.

The risk-adjusted 2-year post-operative mortality rate was 17.6% which was within expected range. The 2015 figure was 19.6.

The risk-adjusted 30-day unplanned readmission rate was 10.3% which was within expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 38.5% which within expected range. The 2015 figure was 31.4%

(Source: National Bowel Cancer Audit)

The trust report produced in response to the audit, showed there may have been inaccuracies in the data as some parameters may have been missed, due to shortage of staff in producing and inputting the data. The measures taken since 2017 included improving data accuracy. The form
was now completed within the theatres post-operatively to provide more accurate data to cancer auditors and an additional member of staff had been employed within cancer services to facilitate the audit data.

**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 30.1%. This placed the trust within bottom 25% of all trusts for this measure. However, the trust provided further information and told us that data for this audit was reported from the London Cancer Alliance and that the trust led only on aspects of the diagnostic pathway, stenting and palliative care. Another hospital delivered and coordinated other aspects of care for the patient cohort. The trust was better than national aggregate for case ascertainment. The trust was above the national aggregate (higher than 20%) for the metric: Age and sex adjusted proportion of patients diagnosed after an emergency admission. For 2016 report the percentage was 30.1%. There was an additional strategic clinical network level metric of crude proportion of patients treated with curative intent, for which the network was significantly higher than the national aggregate.

The trust was not eligible to provide data against the 90-day post-operative mortality rate.

The proportion of patients treated with curative intent in the **Strategic Clinical Network** was 42.2%, significantly higher than national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker 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)*

**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

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2015/16 performance on groin hernias was about the same as the England average. For hip replacements, performance was better than the England average. For Knee replacements was better than as the England average.
(Source: NHS Digital)

Competent staff

Appraisal rates

As at September 2017, 58.5% of staff within surgery at the trust had received an appraisal compared to a trust target of 80%.

A split by location can be seen in the graph below:

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The trust had an annual appraisal cycle. All managers within the surgical division had a responsibility to complete staff appraisals by the end of March 2017. We were told managers were
scheduling reviews into their diaries for those areas that did not meet compliance. The appraisal figures provided included non-clinical staff, and therefore did not provide a true representation for the clinical areas within the surgical division. Further details provided showed theatre staff had achieved a 100% compliance for appraisals and this corroborated with the feedback we received from staff within theatres who all said they had recently received an appraisal. All staff in Swift Ward had received a recent appraisal as well as nursing staff in the day procedure unit. Northey Ward had a compliance of 58% against the trust target of 80%, and this reflected the difficulties the ward had experienced with a recent high turnover of staff.

During appraisals, development and training opportunities were discussed and staff told us the appraisal discussions were beneficial, but due to staff shortages, there had been occasions when they were unable to attend courses.

Staff we spoke to within Swift Ward had been promoted during their time at the hospital and there were opportunities for staff to work at the trust’s other site if they wanted to.

There was access to the trust’s training simulation centre. At this centre, staff undertook human factor training for the deteriorating patient and a number of other clinical scenarios. Staff gave us excellent feedback on the benefits of the training and how realistic the scenarios were. The course leader had sat on several serious incident panels to provide the trust with the human factor aspect with relation to serious incidents.

There was an induction programme for all staff. Bank staff were provided with induction training for the area they were working in. All new registered nurses undertook a preceptorship programme as part of their induction. Line managers had the responsibility of completing an induction checklist and this had to be completed within six weeks. The checklist included areas such as health and safety, policies and procedures and learning and development needs.

**Multidisciplinary working**

We observed good collaborative multidisciplinary working across surgical services. We saw surgical and nursing staff attending daily ward rounds together with physiotherapists and occupational therapists. Patient records were co-ordinated with involvement from a range of different staff involved in the patient’s journey.

We observed various handover and huddle meetings during our inspection and a hospital wide multidisciplinary team meeting, which involved members of staff from across the hospitals different core services. The purpose of this meeting was for the senior team to have oversight of all the different divisions’ operational requirements and patient flow.

From all the multidisciplinary meetings we observed the patients welfare and care plans were discussed at length.

**Seven-day services**

Acute and emergency surgical services were available seven days a week across the trust. Out of hours, cover for surgery patients at Epsom was provided by the acute medical service seven days a week from 8am to 8pm. The surgical team provided on-site presence seven days a week from 8am to 8pm. Any out-of-hours surgical issues were discussed with the on-call surgical team at St Helier who were able to travel to Epsom if required. In the event of a patient presenting acutely to Epsom with a life or limb threatening condition and being too unstable for transfer, emergency theatre and acute surgery could be safely undertaken at the hospital. This system had been in place since 2006.

**Health promotion**
Those people requiring additional support to improve their health and wellbeing were identified during pre-operative consultations. There was a smoking cessation team and the trust held diabetes and vascular referrals.

Following surgery, staff helped support patients to manage their own health, care, and wellbeing following surgery. The use of enhanced recovery programmes helped enable patients to be actively involved in their recovery following surgery. The pathway included encouraging patients to be as healthy as possible before their planned operation. Staff in the pre-assessment unit discussed eating well, exercise, and relaxation prior to surgery.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that as of October 2017 their mental capacity act (MCA) and deprivation of liberty training (part of their Safeguarding Adults (Level 2) had been completed by 59.8% of staff within surgery.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

The trust had a Consent and Mental Health Capacity policy, which was available to staff through the trust’s intranet. Most staff told us they had completed their mandatory training for MCA and DoLS. Staff understood their responsibilities in relation to consent. Patients we spoke with said treatment and care was explained and staff sought consent before treatment. Patients told us they had been provided with the associated risks to their treatment. All records we viewed had completed signed and dated consent forms and consent was conformed before treatment as part of the WHO safer surgery checklist.

Mental health nurses (RMN) on the wards supported patients with mental health needs where necessary. The trust did not hire mental health nurses and relied on NHS bank or agency RMNs. The trust gave inductions to RMNs coming to the hospital, and each ward supported the RMNs on the necessary procedures and policies. The psychiatric liaison team also provided a RMN to support patients in the hospital.

Ward nursing staff were able to describe situations when they felt they were able to assess patients capacity but said they would always seek advice from the on call consultant.

**Is the service caring?**

**Compassionate care**

**Friends and Family Test performance**

The Friends and Family Test response rate for surgery at Epsom and St Helier University Hospitals NHS Trust was 41% which was better than the England average from October 2016 to September 2017.

A breakdown of response rate by site can be viewed below.

**Friends and family Test response rate at Epsom and St Helier University Hospitals NHS Trust, by site.**
Staff were kind, caring and spoke to patients by their preferred name. Even though some patients had a relatively short stay at the hospital, we observed that staff had built a good rapport with them. Staff were able to identify the small details that made the patients stay more enjoyable. For example, the sister in Swift Ward told catering staff that they would make a cup of tea for a patient, as “she knew how they liked it”.

We spoke with five patients. Overall, they were happy with the care they had received. They were complimentary of all staff that had cared for them throughout their journey. Most patients commented on the immense pressure and how hard the nursing staff were working. Patients said their call bells were answered quickly but at night, it sometimes took longer. This corresponded with feedback from nursing staff, who told us night shifts proved to be more difficult due to the increased medical inpatients placed in the surgical ward, especially during winter. Some of the medical patients required more one to one care and nursing staff told us this had impacted on their ability to answer call bells as quickly as they would have liked.

Even though staff were faced with increased levels of pressure and had worked increased hours to support the hospital through difficult times, we observed staff throughout surgical services placing patients care and wellbeing at the forefront of their priorities. They were kind, compassionate, and treated patients with dignity. The goodwill of all staff and their professional nature was evident throughout the inspection.

Comments from patients included, “They work so hard, yet still have time for me” “They explained everything about my treatment,” and “they are always smiling when they talk to me.”

Patients gave good feedback on the consultants and how they felt confident in their ability to treat them. We observed that staff paid attention to patients dignity and respected their privacy. Patients curtains were drawn when hygiene procedures were completed and doors to consultancy rooms were closed during pre-assessment and pre-operative discussions.

**Emotional support**
A chaplaincy and pastoral care service was available to provide spiritual, emotional, and religious support to all patients. This was seen as part of the holistic care to help people recover or sustain them in times of distress.

We observed a member of staff help a patient who was anxious in a calm and kind manner. They were able to reassure them and relay their fears.

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 told us they had been involved in all aspects of their care. One patient told us staff had kept them updated on their procedure and kept them informed when they were moved to another ward.

Staff and patients knew each other’s names, which made for a more relaxed and informal environment. We observed good relationships had been made between staff and patients, so informal discussions could take place. Patients told us they felt they had been treated like an individual.

The surgical wards displayed a wide range of information for patients and their families on large notice boards and leaflet racks at the entrances and around the ward.

**Is the service responsive?**

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

Epsom Hospital provided elective surgery. Emergency surgery was delivered at the trust’s larger site St Helier.

Since May 2017, pre-assessment for both of the trust’s locations was now completed at Epsom. The purpose was to provide a ‘one stop’ service, to benefit the patient’s experience. The advantages meant all pre-assessment checks that were completed at other departments were now completed in the one unit. The unit could now complete electrocardiogram (ECG) and blood tests that were usually completed elsewhere.

At our last inspection in 2015, we found theatre utilisation was sub-optimal. The trust commissioned an external company to introduce a scheduling model across theatres. The model was rolled out across all specialities to ensure there were individual profiles for each consultant. They have since seen an increase throughout theatres. However, some consultants told us consideration for complex cases were not always taken into account. From the scheduling model, we saw all specialties for utilisation had improved apart from general surgery and urology. For urology, two urologists had been recruited to start in February 2018, so an improvement was expected for 2018. For general surgery, two orthopaedic lists were being moved from the elective orthopaedic centre to general surgery, so an improvement was expected in this area for 2018.

There was a weekly operation scheduling meeting attended by theatre staff, x-ray and service managers. The function of the meeting was to ensure theatres was working as much as possible with filled lists. A new information technology dashboard was due to be implemented a few weeks after our inspection and this dashboard would show how full each list was. A funding stream had been agreed to appoint an information analyst to the division of surgery. There were weekly theatre utilisation meetings but these meetings were not formally recorded.

The hospital had increased theatre sessions to three a day; however, this was not working as well as expected due to bed capacity issues, so other options of conducting theatre lists at the weekend were being considered.
Average length of stay
Trust Level – elective patients

From August 2016 to July 2017, the average length of stay for all elective patients at the trust was 3.2 days, which was as expected compared to the England average of 3.3 days.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 7.0 days, which was higher compared to the England average of 5.1 days.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Epsom Hospital - elective patients

From August 2016 to July 2017 the average length of stay for all elective patients at Epsom Hospital was 2.3 days, which was lower compared to the England average of 3.3 days.

- The average length of stay for General Surgery elective patients at Epsom Hospital was 2.9 days, which was lower compared to the England average of 3.3 days.
- The average length of stay for Urology elective patients at Epsom Hospital was 1.8 days, which was lower compared to the England average of 2.0 days.
- The average length of stay for Trauma & Orthopaedics elective patients at Epsom Hospital was 1.9 days, which was lower compared to the England average of 3.3 days.

Elective Average Length of Stay - Epsom Hospital
Epsom Hospital - elective patients

The average length of stay for all non-elective patients at Epsom Hospital was 4.4 days, which was lower compared to the England average of 5.1 days.

Meeting people’s individual needs

The hospital had made improvements to the patients experience with the new surgical care suite. This was a dedicated pre-operative suite to prepare patients for treatment. Before patients were prepared on the surgical ward and there had been a lack of sufficient space to provide a dignified service. The new suite was spacious and had reclining chairs and private consultancy rooms.

Staff were able to support those patients with dementia and have received dementia training for the trust. There were dementia linked nurses to support nursing staff within the hospital.

Bariatric equipment was available to accommodate patients through surgery. Hoists, two beds, four armchairs, and two wheelchairs were available throughout the trust.

At the time of our inspection, due to the increased ‘winter’ pressures, elective surgery was being cancelled on a daily basis to accommodate those patients with emergency medical conditions. A member of staff told us, they spoke with patients on an individual basis before cancelling their procedures and took into account an overall review of the impact the cancellation would have on them. For example, staff accommodated a patient who was a teacher. The patient had spent considerable time getting cover and changing their teaching schedule to accommodate their surgery date and recovery time. The hospital went ahead with the planned surgery, as the effect of the cancellation would have affected the patient’s welfare.

Psychiatric support was available for all patients on wards with staff being able to refer patients to the psychiatric liaison nurse. Staff we spoke with reported they were responsive to needs and that
in most cases they were alerted to any patients who required psychiatric support through pre-operative assessments.

There were suitable arrangements in place for people who needed translation services. Translators could be booked at the time surgery was arranged by the bookings team or via a phone call by the wards.

Meal times were protected on all the surgical wards to enable staff availability to help patients with eating and drinking. Patients were able to have snacks in-between meal times and hot and cold drinks were provided. There was a choice of meals, which included lighter options and meals, which supported cultural and religious choices, as well as special diets, such as renal menu for those patients who had renal disease. A red tray system was used to highlight those patients who required help at mealtimes.

**Access and flow**

At the time of our inspection the trust were experiencing increased patient demand due to ‘winter’ pressures, so patient access and flow was not operating at a usual pace. Nationwide, trusts were given authorisation to cancel elective operations to accommodate the influx of emergency medical patients. Therefore, the demand of attending to emergency medical patients meant the hospital were cancelling elective operations on a daily basis. The hospital were able to carry out elective procedures, but the situation changed on an hourly basis. We found the trust had good processes in place and oversight in managing the situation. Day surgery was operating at a normal pace.

Due to the increased demand over the winter period the theatre recovery area were experiencing delays in releasing patients to the surgical wards and this had created a ‘bottle neck’ effect. The elective orthopaedic centre were accepting surgical patients to their wards to help the hospital during the pressures, but they required all the correct and necessary patient documentation to be completed before patients were admitted. Under normal circumstances, some of the documentation would have been completed once the patient was admitted to the hospitals main surgical ward. At the time of our inspection, we were told senior managers were in the process of dealing with the issue.

Surgical patients were being accommodated in the elective orthopaedic centre wards and the discharge lounge had been moved to a ward to accommodate those patients needing bed discharge.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From September 2016 to August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average the most recent data for August 2017 found the trust with 72% of this group of patients were treated within 18 weeks versus the England average of 70%.
Referral to treatment (RTT) (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, three of specialties were above the England average and two of specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>67%</td>
<td>62%</td>
</tr>
<tr>
<td>Urology</td>
<td>65%</td>
<td>77%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>86%</td>
<td>83%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>97%</td>
<td>74%</td>
</tr>
<tr>
<td>ENT</td>
<td>63%</td>
<td>65%</td>
</tr>
</tbody>
</table>

We reviewed the RTT action plan and saw for urology, a substantive consultant was starting in post in January 2018, which meant further clinics could be booked and the trust expected recovery time was April 2018. Extra clinics were scheduled including the weekend for ENT but these were dependant on staff support. The expected recovery time was April 2018.

Staff we spoke with told us bed capacity was an issue, particularly at weekends when medical outliers were placed in the surgical ward.

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.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Epsom and St Helier University Hospitals NHS Trust

Most recently in Q2 2017/18, this trust cancelled 174 surgeries, of the 174 cancellations 1% were not treated within 28 days.

Over the two years, the percentage of cancelled operations at the trust showed a trend of
decline, and was generally lower than the England average.

Cancelled Operations as a percentage of elective admissions - Epsom and St Helier University Hospitals NHS Trust

Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, and was generally higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

Summary of complaints

From November 2016 to October 2017 there were 32 complaints about surgical care out of 577 trustwide. The trust took an average of 90 days to investigate and close complaints. This is outside of their complaints policy, which states complaints should be resolved within 35 days or 45 days for more complex complaints.

- Epsom Hospital: There were 11 complaints, the main theme relates to all aspects of clinical treatment with seven complaints.

The trust had a clear escalation process for complaints. For those complaints that required a longer investigation, the patient was informed of the extra time required.

All nursing staff and senior staff told us they attempted to resolve all verbal complaints as soon as possible. Patients could be referred to the Patient Advice Liaison Service (PALS), which was based in the hospital. Staff received conflict resolution training as part of their mandatory training.

Is the service well-led?

Leadership

Since our previous inspection in 2015, the leadership within the surgery division had changed and roles were clearly defined. There were now clear roles of responsibility and staff knew who they reported to and who led their part of the service.

Staff told us they had confidence in their local management team across surgery services. From the senior team staff were particularly complimentary of the Chief Executive’s (CEO) leadership
style. Clinical directors within surgery told us the CEO was supportive of their ideas and had an open door policy. They did not feel stifled but were able to be open and honest with their ideas and concerns and felt listened to. There was mixed views on the presence and visibility of the leadership team.

On the whole most nursing staff were positive about the senior team, and although most staff recognised the shortage of nursing staff was of a national problem, they felt the trust were relying on the goodwill of staff to work overtime to ensure the service operated.

The hospital had recently recruited a new theatre matron and we received positive feedback from theatre staff. They were confident the matron had the capabilities and leadership style to support and drive the service forward. Staff within the surgical ward and day surgery described the matron as approachable, professional and worked hard to help the team as a whole.

Staff who worked within the discharge lounge told us they found their immediate line management to be one of a top down heavy approach. They felt disconnected and not involved with any decision making processes. Two members of staff told us they did not feel there was anyone they could share their concerns with. The communication methods mostly involved e-mails, the tone of which they found terse.

**Vision and strategy**

The trust’s mission “to put the patient first by delivering great care to every patient every day” was underpinned by a set of values. Staff we spoke with were engaged with the trust’s vision and strategy. Staff were able to tell us of the future plans and public consultation with regards to the trust moving forward.

Staff at Epsom could tell us of the surgical plans across both sites. Staff told us of the plans for a new surgical unit at St Helier to provide ambulatory care, rapid assessment in hub, intensive care.

**Culture**

Most staff we spoke with felt supported, and part of a team. Staff were proud to work at the hospital. However, at the time of our inspection, staff told us they felt tired and overstretched due to staff shortages. Many staff were working overtime to help the hospital tackle the increased levels of demand.

Staff we spoke with enjoyed working at the trust and some had been employed by the trust for several years. They told us they had been developed and promoted to different roles throughout their time at the trust. However, some told us they were starting to feel demoralised by the range of patient conditions they were expected to look after.

Junior doctors told us they were overstretched due to staff shortages. They were constantly being ‘bleeped’ by nursing staff, sometimes excessively for reasons that did not necessarily require their input.

**Governance**

The governance structure within the surgery division had improved since our last inspection. There were clinical director consultant leads for general surgery, trauma and orthopaedics and anaesthetics and service managers for each surgery division.

There were regular surgical governance meetings, which monitored clinical performance and patient safety. They were attended by senior staff, including medical and nursing staff and governance leads. We viewed a selection of meeting minutes, which showed a set agenda item of incidents, clinical audits, complaints, and health and safety updates were discussed with action plans with an accountable person. There was good oversight for the mortality and morbidity and meeting minutes demonstrated each consultant had their cases were discussed in an open forum.

There were monthly theatre meetings where theatre related topics were discussed and attended by all staff, including operating department practitioners (ODP), nurses, and theatre assistants.

**Management of risk, issues and performance**
There were systems to identify, monitor, mitigate, and cope with risks. The surgery division had a risk register and we saw high risks were fed into the corporate risk register, which ensured the senior team had oversight and scrutiny of the surgery division’s risks. There were 48 risks identified on the surgical risk register and they corroborated with the risks staff identified within surgical services. Top risks included staffing, equipment and instruments that needed replacing, failure to meet RTT and interruption of main power supply to certain services. The risk register provided actions taken and updates on the risk itself. There had been a regular review of the register and risks were discussed in monthly divisional surgical meetings. We saw risks relating to each department within the surgery division was discussed during local level team meetings. Staff we spoke with were able to tell us of risks relating to their department and were able to tell us of updated progression in relation to each risk.

We noticed the risk relating to missing instruments from sterile packs had been on the risk register for over a year. Although in November 2017, the risk register stated that meetings conducted with senior members from the hospital and the external company would be set up, at the time of our inspection, no arrangements had been made.

Daily huddle meetings and staff handovers meant patients risks were discussed at length and staff had a good understanding of mitigating actions to take to help support patients. For example, those patients with a risk of falling were discussed at length in the meetings and staff were able to describe the coping mechanisms to help the patient.

Patient safety performance was displayed on a notice board at the ward entrance and the information was up to date and available for patient’s staff and visitors to see.

**Information management**

There was a monthly divisional scorecard, which provided details on operational performance. The scorecard gave performance indicators for areas such as, harm free care, RTT, mortality and morbidity data and dementia screening. The senior team had oversight of this information and this was disseminated to departments. The surgical ward displayed harm free care information at the entrance of the ward. Information on harm free care was displayed for patients, staff, and visitors to see.

Various staff told us the trust’s system of storing mandatory training data was flawed. Mandatory modules staff had completed were taking a long time to upload into the system, (some staff told us it had taken several months), and this distorted the compliance figures.

**Engagement**

Patients and relatives views were taken into account to improve services. Patients could comment through the NHS Friends and Family Test. We saw feedback cards were available in all patient wards and information was displayed to encourage feedback. Patients were able to express their views through a variety of channels; you tube, e-mail, telephone, and twitter. The trust’s board meetings were open to the public and people could sign up the Patient First newsletter through the NHS website.

Staff were encouraged to contribute to the staff surveys every year. For the 2016 staff survey, the trust had the best staff response rate than previous years with 56%. The trust had developed an action plan to address the findings in 2016 staff survey. Staff received updates and feedback through the trust’s intranet system and through team meetings.

**Learning, continuous improvement and innovation**

In March 2017, the trust won British Journal of Nursing Award for Innovation for the Perfect Handover methodology developed by three senior nurses at the trust. This was a new method of conducting nurse’s handover between shifts to eliminate inconsistency and lack of appropriate information. The new methodology resulted in a reduction of falls, improved safety huddles, improvements in chart accuracy by 21% and less duplication of handover and more bay to bay handovers. Eighty six percent of handovers now take place by the bedside. The trust were trialling a new hand hygiene monitoring system.
Patient pre-assessment checks for the trust’s both locations are now completed at Epsom Hospital. The department was now able to complete all the necessary tests in the same department, whereas before the patient had to visit different areas of the hospital.

Epsom and St Helier Hospital were one of the first trusts in London to commit to mandatory multiprofessional simulation training for all medical and surgical nurses, healthcare assistants, and foundation doctors. The overarching aim of the project was to improve deteriorating patient outcomes. Through the implementation of the Care, Recognition and Initial Stabilisation in Simulation, CRISIS course, learning objectives focused on improving participants’ skills and knowledge around the recognition and management of the deteriorating patient. The course involved looking at human factors characteristics, which can influence behaviour at work in a way, which can affect health and safety. Staff highly praised the training and how this had benefited them in their working environment. However, there was uncertainty of the courses future due to funding issues.
Maternity services and ultrasound scanning are provided at both sites in the trust. An assisted conception unit is run at St Helier Hospital. There are 80 maternity beds across the two sites.

The maternity service is delivered on two sites, in two different NHS regions and with two host clinical commissioning groups. Epsom Hospital is in the Surrey Heartlands Better Births Early Adopter project.

Both hospitals provide consultant-led obstetric units and midwife-led birth centres. Epsom has a level one Special Care Baby Unit and St Helier has a level two Neonatal Unit. Pre-term births before 34 weeks are undertaken at St Helier Hospital.

An early pregnancy assessment unit operates Monday to Friday on both sites, staffed by midwives, gynaecologists and sonographers.

The trust provides a community midwifery service for Sutton, Merton and Surrey Downs CCGs and community midwives undertake the majority of antenatal and postnatal care. The hospitals offer specialist pre-conception and antenatal services, including teenage pregnancy, diabetes, mental health, obesity, perineal trauma, antenatal workshops and classes, foetal medicine and substance misuse.

There is a named midwife for safeguarding and a specialist team. *(Source: Trust Provider Information Return – Acute sites)*

From July 2016 to June 2017 there were 4,651 deliveries at the trust.

A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below.

Number of babies delivered at Epsom and St Helier University Hospitals NHS Trust – Comparison with other trusts in England.

![Graph showing trends by quarter for the last two years](image-url)

Trends by quarter for the last two years can be seen in the graph below.
Epsom hospital maternity service serves the population of North Surrey.

From September 2016 to August 2017 there were 1937 births: 309 midwife-led births; 1623 obstetric-led births and five still births at Epsom hospital. Trust wide there were 127 home births.

The hospital has one obstetric theatre, five delivery rooms and two recovery beds. One delivery room has a birth pool. The midwife led birth unit has two delivery rooms with birthing pools and a postnatal room.

The combined antenatal and postnatal ward has 19 beds including six single rooms. Two rooms are for private patients. The trust offered a private maternity package.

A three-bed antenatal Maternity Assessment Unit (MAU) is for women needing day assessment to monitor foetal or maternal conditions.

A new antenatal clinic is in a separate building on the hospital site. It has seven consulting rooms, three scanning rooms and a quiet room for confidential discussions. An appointment-only early pregnancy assessment unit (for women under 20 weeks of pregnancy) is based in this building and open on weekday afternoons. It offers women viability scans for any concerns in early pregnancy.

In the year to August 2017 there were 8 medical abortions and 7 surgical abortions, for foetal abnormality.

Community midwives provide antenatal care in community locations. Some specialist clinics are run in the hospital for diabetes, mental health, maternal medicine and foetal and maternal medicine.

During our inspection, we spoke to about 30 members of staff including midwives, maternity support workers, domestic staff, sonographers, consultants, junior doctors, domestic staff and the head of midwifery. We spoke to eight woman who used maternity services and three of their...
partners. We reviewed six sets of medical records and a variety of hospital data including meeting minutes, policies and performance data.

**Is the service safe?**

**Mandatory training**

Statutory and mandatory training covered fire, health and safety, patient handling, information governance, resuscitation and equality and diversity. The trust set a target of 95% for completion of mandatory training. All midwives trained together, whichever site they worked on, so managers did not usually split statistics by hospital site. There were three mandatory training days for midwives.

A breakdown of compliance for mandatory courses as at October 2017 for medical and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Mandatory training module</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>84%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>80%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>72%</td>
</tr>
</tbody>
</table>

The trust met the manual handling object training course compliance with 100% whereas four of the seven training modules did not meet the 95% trust target, the lowest with 72% was Venous Thromboembolism.

(Source: Trust Provider Information Return P14)

Midwives at Epsom Hospital had an 89% mandatory training completion rate at the time of the inspection. Four of the seven modules were below the 95% trust target. The lowest was 77% was Venous Thromboembolism. However, the deadline for training compliance was 31st March 2018.

In addition to the standard statutory mandatory training, all clinical staff working in the delivery suite were required to attend training in the use of cardiotocography (CTG) interpretation and foetal electrocardiogram (ECG) (known as STAN monitoring). STAN is a type of CTG that uses computer analysis of the baby’s heart rate and heart muscle function, to give clinicians an idea of how the baby is coping with labour, and assists in reducing the risk of unnecessary intervention. In June 2017, 90% of midwives and obstetricians had CTG/STAN training and 83% had achieved certification. The number of incidents where CTG interpretation was a factor had reduced since this training had started.

Basic neonatal life support was part of midwives mandatory training.

Not all consultants were up to date with all mandatory training, for example 11 consultants were not up to date with resuscitation training.
**Safeguarding**

The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as at October 2017 for medical and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Safeguarding courses</th>
<th>Trust Target (%)</th>
<th>Percentage of staff trained (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>69%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>37%</td>
</tr>
</tbody>
</table>

None of the safeguarding modules met the 95% trust target; the lowest was safeguarding adults (level 2) with 37%.

Epsom Hospital had a 65% safeguarding training completion rate at the time of the information return.

*(Source: Trust Provider Information Return P18)*

Level 3 Child Protection Update Training was incorporated into the midwives’ mandatory training programme and compliance was 88% at the time of the inspection. A manager explained that 100% was not achievable due to maternity leave, turnover and long term sickness. All staff had a two hour level 3 safeguarding refresher course each year.

The focus of the training during 2016-2017 was Child Sexual Exploitation, Female Genital Mutilation and PREVENT. Frontline staff had attended a training programme in domestic violence to raise awareness of the guidance and pathways for referring victims to local support services and the multi-agency risk assessment conference (MARAC).

The monthly maternity safeguarding forum provided multi-professional information sharing regarding vulnerable women and their families. During the PIR period, there was regular attendance by representatives from Sutton, Surrey and Merton Children’s Social Care. Information about safeguarding was circulated through the Risk Management Newsletter. For example, the February 2017 newsletter highlighted forced marriage, honour based violence and how to escalate concerns and the role of the MARAC.

Staff made use of community protection plans and safeguarding processes to ensure mothers and babies were kept safe. Staff held a monthly ante natal safeguarding forum, which includes social workers from the local authority, health visitors and the clinical lead. Staff created action plans for patients at risk during these meetings.

Midwives held weekly meetings to go through patient case notes to review women who need extra support. Staff used these meetings to review incidents and to share learning.

A small team of trained safeguarding supervisors delivered a reflective model of safeguarding supervision and work was continuing to embed safeguarding supervision in maternity in accordance with the trust Safeguarding Supervision Policy. The shortage of supervisors was on the risk register.

There were five adult safeguarding referrals in maternity in 2017 and 38 child referrals (some of which were not babies).

**Cleanliness, infection control and hygiene**

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Most areas we inspected were visibly clean and tidy, including sluices, linen cupboards and other storage areas. We inspected many areas of maternity services, the delivery suite and obstetric theatre, ward and birth centres. We did not inspect community locations where midwives gave antenatal and postnatal care.

We saw evidence that domestic staff followed guidance in regard to the required cleaning standards, practices and frequency of cleaning. Cleaning schedules and monthly cleaning scores were on display. We saw the overall results for November 2017 with scores of 98% for the ward and delivery suite. There were no scores for the antenatal unit which had only opened three weeks before the inspection. On the delivery suite, dedicated cleaners were available during the working day. Outside these times maternity staff would do this. Deep cleaning could be arranged within half an hour if required for infection control.

However, there were some areas that were less clean. At the last inspection the operating theatre walls and floor, and operating table were not clean. Staff told us that they had commissioned and passed a microbiology inspection of the theatre after that inspection. Although we saw improvements in theatre cleanliness at this inspection, there were a number of pieces of tape and tape residue on the theatre walls and large blobs of putty-like adhesive on the side of the resuscitaire. Both these residues could potentially host bacteria and were inappropriate in a theatre setting. Sticky tape is mentioned as a source of bacteria in the *Specification for the for the planning, measurement and review of cleanliness in hospitals* 2014. Theatre wall cleaning was not mentioned in cleaning schedules and good practice would suggest regular cleaning. Also a trolley had rust on it, which meant it could not be cleaned effectively. Staff told us they would remove the trolley immediately.

The whole maternity unit used cloth curtains rather than disposable curtains. As these were old it was unclear whether the stains we observed were new. In the MAU, the curtains were wrapped around equipment. This was not good practice. A full water jug was on a table in the MAU, presumably from the previous day as the unit was not in use on the day we saw this.

External windows throughout the maternity unit were not clean on the outside, possibly the result of building work taking place at the time.

All staff we met were ‘bare below the elbows’ to allow effective handwashing. Delivery rooms had dedicated hand hygiene sinks for staff to wash their hands before and after direct patient care.

Sanitising hand gel dispensers were available at the entrances to and within wards. Signs above gel dispensers encouraged staff and visitors to use the gel to clean their hands. We saw staff use hand gel appropriately. Gloves were available to protect staff and patients against infection. However, we saw staff handle blood samples without gloves. Policy recommended midwives, doctors and theatre staff should wear a mask and eye protection at all deliveries to avoid splashes of blood or amniotic fluid.

The two more expensive amenity rooms had some peeling wall paint and the TV screen and bedside table were not clean, after cleaning had apparently been completed.

We saw correct segregation of clinical and non-clinical waste. This was in line with Health Technical Memorandum 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that staff had labelled sharps bins and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks.
Community midwives were being trained to give whooping cough vaccines to pregnant women from 20 weeks up to 32 weeks to help protect babies from this disease. They were also training to administer BCG.

**Environment and equipment**

Access to all parts of the maternity service was secure and restricted to staff with swipe cards. However, we saw that there had been occasional lift breakdowns between the delivery suite and ward and staff told us that although access between the floors was possible by another route, its use broke the ‘security cordon’ around the unit. We were aware from documentation that the swipe access system was to be discontinued and staff did not know what would replace this.

Some of the signage on the ward was out of date – for example, a room labelled bathroom, next to the MAU was in fact a storage room. It was not locked so people could enter by mistake. The kitchen on the ward had two entrances. One door said ‘Staff only’, but access to the kitchen from the day room was open, which was confusing.

At the last inspection staff had reported a shortage of equipment, and that some equipment was old. The hospital had obtained some new equipment such as a mobile scanner, carbon monoxide monitors to evaluate and reduce smoking in pregnancy, and bilirubin meters. On this inspection staff told us there was enough equipment of adequate quality on the wards and delivery suite. However, community midwives seeing women at home or in community clinics had to share the three bilirubin meters (devices to measure the bilirubin (jaundice) level of babies without needing to do an invasive blood test). Staff said this was inconvenient given the emphasis on the importance of identifying the few babies who are at risk of developing serious complications of jaundice so doctors could treat them promptly. Visual identification was no longer regarded as accurate.

New blood gas analysers had been introduced to test umbilical artery blood (to determine if a baby has suffered oxygen deprivation). We saw there had been problems over the use of this in the first few months. Managers were confident that after training and regular reminders to staff about correct usage, correct readings were now obtained.

There was appropriate emergency equipment on the delivery suite including drug boxes for specific emergencies such as sepsis. We saw the resuscitation trolley was fully equipped, with drugs in date, and staff checks were signed and dated. However, the resuscitation trolley in the newly opened antenatal unit was stored in a consulting room, which prevented ready access in an emergency if that room was either in use or locked.

The antenatal clinics were in a separate building and were bright and modern, with a waiting room, consulting rooms, offices and three scanning rooms, although only two scanners. We observed the cupboard containing cleaning chemicals in this unit was not locked. We drew this to the attention of staff.

If a woman needed emergency transfer from the antenatal clinic to the delivery suite or ward, the protocol was to call an ambulance. However, there was a direct route into the main hospital across the road from the antenatal unit through a service corridor. In theory only staff used this but in practice we saw patients and members of the public using it. The route was unsuitable for public use as there were trolleys of used linen in the area and the flooring was not level.

The single obstetric theatre was within the delivery suite and there was dedicated staffing. A two bed recovery room was next door to the theatre.
There was no second theatre. This had been on the risk register since 2009. One of the main theatres could be used in an extreme emergency and was not far from the maternity unit and on the same floor. At the last inspection we were told it would take an hour to prepare this theatre. Since then arrangements had been made to reduce the time to 45 minutes.

The special care baby unit was opposite the delivery suite. This meant that paediatricians could reach the delivery suite quickly in an emergency. The neonatal unit was a level 1 unit. Level 2 facilities were available within the trust at St Helier Hospital.

A midwife-led birth centre with two en-suite rooms and a postnatal room was on the floor above the delivery suite. The rooms had dimmable lighting and were equipped with birthing aids such as gym balls, birth pool and birthing couches. There was oxygen, gas and air and suction and an evacuation net in the event of maternal collapse in the birthing pool, and access to a hoist.

A manual register of births was maintained to mitigate IT problems. Staff said this allowed quick reference to key delivery information, although it was time consuming to complete by hand.

At the last inspection there was no STAN equipment at Epsom Hospital. This equipment was now available. However, there was central monitoring station allowing the combined display of CTG and/or STAN tracings. Managers told us there were technical difficulties to overcome although they hoped to provide this in due course.

There were five delivery rooms. There had been six at the previous inspection, but one was now used for storage. At the last inspection, one delivery room had a fire exit leading to lift lobby and staircase which was not locked, and therefore a security risk. The fire door was locked on this inspection.

The delivery suite did not have a high dependency unit (HDU). Women known to be high risk in pregnancy were advised to deliver at St Helier Hospital. In the event that a woman unexpectedly needed high dependency care at Epsom, staff would transfer the woman to the main HDU or to St Helier Hospital.

There was also no dedicated triage space. At present women telephoned the delivery suite for triage advice and if they needed examination out of hours, they came to the delivery suite where a midwife would carry out triage in a delivery room if one was free, the birth centre or on the ward.

There were two emergency grab bags available for use when babies were born before arriving in the delivery suite or on ambulance transfers to another hospital.

The fire extinguishers on the maternity unit had not been serviced in the past year, unlike others we saw on the hospital site. The next check was recorded as due March 2017.

Assessing and responding to patient risk

Risk assessments were carried out for women during antenatal care in line with national guidance. At the initial booking appointment midwives carried out a detailed risk assessment, in line with national guidance. For example, they assessed health, maternity history, multiple birth, previous caesarean section, weight and age, risk of venous thromboembolism (blood clots), blood pressure and conditions such as diabetes or high BMI. Midwives documented on-going risk assessments at subsequent antenatal visits. The criteria for women wishing to give birth in the birth centre or have a home birth, were in line with national guidance.

Midwives assessed women upon admission to the antenatal service to identify those who had extra needs. Staff triaged women into the mild to moderate pathway or moderate to severe
pathway depending on their needs. Women on the moderate to severe pathway had access to a mental health trained midwife.

Community midwives referred women who they identified as high risk for any medical reason to consultant-led clinics. A foetal medicine unit supported the identification of potential birth complications.

For the small number of women wanting a home birth, midwives undertook an environmental risk assessment of the home and birth space, lighting and equipment in the home. Midwives signposted women to Department of Health guidelines about equipment for home birth. A home birth pack was left at the home at 36 weeks. Women giving birth at home or in a birth centre were transferred to the delivery suite if midwives had concerns about foetal heart rate anomalies, failure for labour to progress and meconium in the waters. Meconium is baby’s first stool and its presence in the waters can sometimes be an indicator of foetal distress during labour.

Expectant mothers who were judged to have a clinical need for their labour to be induced came to the antenatal ward for induction. High risk mothers were induced on the delivery suite.

Smoking status was part of the risk assessment and midwives were encouraged to offer women smoking cessation because of the impact of smoking on the baby’s growth.

The dashboard recorded good evidence of compliance with an adapted Five Steps to Safer Surgery World Health Organisation (WHO) checklist, to prevent or avoid serious patient harm in the operating theatre, around 99%. However, on inspection we found that the ‘sign in’ stage had been completed in advance of the start of surgery, after which the doctors left the theatre, which was no good practice, and we saw from minutes of the maternity risk meeting that the checklist was not always used.

We attended a midwives ward handover on the delivery suite. Midwives followed a standard format reviewing women on the delivery suite and allocating staff as well as giving reminders on current safety issues. A multidisciplinary handover took place an hour later, for a wider group of staff so there was inevitably some duplication. A midwife took notes at that meeting and typed them afterwards for reference.

There were protocols to deal with obstetric emergencies within the delivery suite. We observed one emergency call and noted that some doctors responding did not know the location of the birth centre so went to the delivery suite.

Staff used the Modified Early Obstetric Warning Score (MEOWS) to monitor women on the delivery suite and ward. MEOWS charts are designed to give a clear visual record to help staff identify deterioration at a glance. There was an instruction to refer to a senior member of staff if a woman triggered a one red or two yellow scores at any time.

At the last inspection there were a large number of unexpected admissions of term babies to the neonatal unit (71). The number had risen in the period between April and December 2017. Nationally term admissions had shown an increase and Epsom was no different.

At the last inspection midwives did not adhere to their induction of labour policy which sometimes put pressure on the unit if too many women were induced on the same day. A quality improvement project was in hand to reduce induction. However, the rate had risen from 23.4% to 26.3%. Staff said there were pressures to induce women reporting reduced foetal movement or who had large babies. The target was to reduce inductions to less than 25%.
A test for detection of amniotic fluid in vaginal discharge of pregnant women had been introduced to check for premature rupture of membranes and an indication of when they might deliver their babies.

At the last inspection there was a lack of evidence of fresh eyes (having another midwife review the CTG trace and give a view, had yielded improvements in CTG interpretation, helping counteract the effect of fatigue, familiarity or limited knowledge) in interpreting the CTG. At this inspection we found midwives aimed to carry out this check hourly. The reviewing midwife signed it had been done, or documented reasons for a delay. Managers considered the practice was well-embedded.

There was no dedicated telephone triage line. This meant patients did not always get to speak to a midwife straight away and sometimes had to wait for a member of staff to answer their call. There was a detailed telephone triage form but delivery suite staff did not always have time to complete it during phone calls.

**Midwifery and nurse staffing**

The trust has reported their staffing numbers below as at September 2017.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing Staff</td>
<td>201.2</td>
<td>191.1</td>
</tr>
<tr>
<td>Total</td>
<td>201.2</td>
<td>191.1</td>
</tr>
</tbody>
</table>

The trust had 10.1 less WTE staff than they had planned to provide safe care in September 2017. Bank staff were used and if none were available, bank staff were employed.

*(Source: Routine Provider Information Return (RPIR) – P16 Total numbers – Planned vs actual tab)*

From April 2016 to March 2017, the trust overall reported a vacancy rate of 5.8 in maternity;

- Epsom Hospital: 10.7%

*(Source: Routine Provider Information Return (RPIR) P17 Vacancies)*

We were told that recruitment to midwife posts was to the trust rather than the hospital, with the expectation that staff could work at either of the trust’s maternity units. This should mean vacancies could be borne equally across the two units, but during inspection it appeared that there was a higher vacancy level at Epsom Hospital.

From April 2016 to March 2017, the trust reported a turnover rate of 16% in maternity;

- Epsom Hospital: 9%

*(Source: Routine Provider Information Return (RPIR) P18 Turnover)*

From April 2016 to March 2017, the trust reported a sickness rate of 6.5% in maternity;

- Epsom Hospital: 4.5%

*(Source: Routine Provider Information Return (RPIR) P19 Sickness)
From April 2016 to March 2017, the trust reported a bank and agency usage to cover 2,805 bank shifts, as well as 597 agency shifts there was a total of 1,408 shifts unfilled.  
(Source: Routine Provider Information Return (RPIR) P20 Nursing – Bank and Agency)

We were told, and saw on inspection, that agency staff were used to cover sickness when bank staff were not available.

As of July 2017 the trust had a ratio of one midwife to every 26.89 women. This was quoted against establishment.  
(Source: Electronic Staff Records – EST Data Warehouse)

On inspection we were told the service had a planned ratio of one midwife to every 28 women across the trust. This was in-line with evidence-based guidance set out in the intercollegiate document, Safer Childbirth (2007): Minimum Standards for the Organisation and Delivery of Care in Labour.

More accurate information would be provided by reporting the ratio against actual staff available at each site rather than funded establishment. The frequency of staffing being below establishment at Epsom was obscured by using a trust wide figure.

The trust had used a nationally recognised acuity tool in 2016 to calculate the required number of midwives needed in the service including that needed to maintain one to one care for women in labour. The tool indicated a ratio of 1:24 but this was not affordable. Trust data showed that in June 2016 the ratio was 1:27.

Trust wide the ratio of senior midwives to midwives was 0.47 compared to a national average of 0.24. This is likely to result from the fact that the trust has two maternity sites rather than one. There were three consultant midwives for public health (cross site) and normality. There were also specialist midwife roles for risk (cross site) and practice development. Midwife sonographers worked in the two ultrasound rooms.

There appeared to be enough midwives to ensure safe service on our inspection as the service was not busy. There were seven midwives on duty which managers regarded as safe staffing. However, the planned establishment was to have eight midwives on every shift in the maternity unit; one in the birth centre, two on the ward, four in the delivery suite and one floating to work as needed. Rotas indicated it was normal to have only seven midwives – two thirds of days in December 2017 did not have full staffing.

As at the previous inspection, delivery suite coordinators at Epsom were rarely supernumerary which could present a risk when all units were busy. This appeared safe in relation to the level of activity and acuity of women we saw during the inspection, but it was not recommended practice.

Community midwives were recruited to establishment, but four were on maternity leave.

A policy on delivery suite staffing, combined with reporting "red flag events", such as delayed care, or inability to provide one to one care could act as a trigger for considering increasing staff numbers. The recent introduction of a safety huddle of nurses also provided a daily opportunity to look at skill mix in relation to the acuity of women. However, there was no escalation flow chart on display and the escalation file on the ward contained two different paper versions of the delivery suite staffing policy (one of which was very out of date).
One midwife staffed the MAU. On one day of our inspection the MAU was closed because of staff absence. Women with appointments were postponed to the next day but all women with reduced foetal movement were asked to attend the delivery suite which put additional pressure on the delivery suite staff.

As at the previous inspection midwives scrubbed for emergency caesarean sections. This further reduced the number of midwives available, particularly as the caesarean section rate was quite high. A scrub nurse was only employed on the two days a week that planned caesarean sections took place. This nurse was off sick at the time of the inspection and no additional cover was sought.

Daily records of any differences between the number of midwives needed and those available for each day or shift were not displayed.

At the last inspection we found that some Band 7s did not work flexibly. At this inspection we saw managers had introduced rotation so that Band 7 and some Band 6 Epsom based midwives spent time at the St Helier maternity unit, to broaden their skills and build relationships across the trust.

**Medical staffing**

Trust wide there were more consultants than average 45% compared to a national average of 41%. There were 22 consultants in obstetrics (trust-wide) in July 2017, and another consultant was due to start in February 2018. Of these, 10 consultants worked a rota at Epsom that provided 98 hours cover a week on the delivery suite.

Most consultants within the maternity and gynaecology service worked in both obstetrics and gynaecology (O&G). There were some cross site sub specialities. Fatal and maternal medicine consultants were Epsom-based. At the last inspection the full time medical cover on the delivery suite and wards was provided by a Senior House Officer and a Registrar covering both maternity and gynaecology. Cover was the same at this inspection but doctors on the delivery suite did not cover the emergency department.

Junior doctor staffing was a mixture of clinical fellows and deanery trainees. There were 8.5 registrars and 7 SHOs. There was one post completion of training (CCT) specialist fellowship in the unit. The hospital had one trainee doctor from the Medical Training Initiative (MTI) scheme that allows International Medical Graduates (IMGs) to come to the UK for a maximum of two years to train within the National Health Service (NHS). The maternity unit was new to this scheme and, as is common elsewhere, staff told us there had been some initial challenges, but the arrangement was now working well.

A duty anaesthetist was available to the to the delivery unit 24 hours. This was a dedicated consultant for elective caesareans, and out of hours a consultant or staff grade plus a trainee out of hours.

In August 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

<table>
<thead>
<tr>
<th>Staffing skill mix for the 51.5 whole time equivalent staff working in maternity at Epsom and St Helier University Hospitals NHS Trust</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Although doctors had a base site, some worked shifts at the other site to ensure cover was maintained but other doctors said they only worked at Epsom maternity unit. The doctors felt the medical team worked well together.

**Records**

The unit used the national colour coded national maternity notes: green for antenatal care, yellow for labour and delivery and purple notes for postnatal care. The service also held its own set of ‘pink’ antenatal notes.

Mothers were given a Personal Child Health Record (commonly known as the Red book). Health professionals used the red books to record information on baby’s birth and health, including feeding assessments, newborn and infant physical examination checks and newborn hearing screening. After the transfer to an electronic patient record system, parents would be able to record and manage information about their child’s health and development online or by smartphone.

We looked at six sets of postnatal records for women who had used maternity services at Epsom Hospital. The overall quality was sound. Notes were legible; entries were signed, dated and timed in line with best practice guidance. There was adequate use of the venous thromboembolism score checklist, partogram (a composite graphical record of key maternal and foetal data during labour), World Health Organisation checklist, charts for growth and early warning scores. We were told there was no routine audit of maternity notes to monitor whether all key elements were included, in line with good practice. However, that specific areas were audited such as medication. If an issue was identified, we were told that a manager would discuss this with the individual at supervision.

Women carried their own notes and there was a protocol in place should these be lost.

We had no concerns about secure storage of records at the last inspection, and we saw notes continued to be stored securely, although they were readily accessible to staff.

**Medicines**

An Electronic Prescribing and Medicines Administration (EPMA) system was used to improve patient safety by reducing prescribing and administration errors that could result in medication errors and adverse drug events.

Midwives wore red tabards on the wards when dispensing medicine to indicate they should not be interrupted.

Medicines requiring cold storage were stored in dedicated fridges in locked treatment rooms.

Medicines were stored securely. We found that the controlled drugs register, whilst accurately completed, was falling apart so that pages could be easily lost. We looked at prescription and
administration charts for four women. We found that people’s allergies were not always documented appropriately.

Weekly checks on the pre-eclampsia treatment box had not always been undertaken. We found an out of date medicine in this box; staff replaced it immediately.

At the last inspection midwives were to be trained in prescribing. On this inspection we saw that midwives had had the appropriate training to prescribe certain medicines covered by midwives’ exemptions in the course of their professional practice without the need for prescription from a doctor. This allowed them to give timely medication, such as pain relief, to women. After training midwives gave the flu and pertussis (whooping cough) vaccine. They also had training in anaphylaxis (a sudden and serious allergic reaction).

We reviewed the medicine policy for home births. Midwives attending home births carried Entonox, oxygen and an appropriate range of drugs for management of the third stage of labour and in the treatment of post-partum haemorrhage.

**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 November 2016 to October 2017, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with six (67% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only with one (11% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (11% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with one (11% of total incidents).

(Source: Strategic Executive Information System (STEIS))
At the last inspection the maternity board rather than the Trust SI panel reviewed serious incidents. The maternity board had been replaced by a Maternity Risk meeting that reviewed the incidents and other issues. At this inspection we were told a multidisciplinary SI team investigated reviewed incidents and then presented findings to the SI panel. Incidents did not have input from an obstetrician external to the trust in line with best practice. An obstetrician at the other hospital site reviewed investigations. This was not compatible with the trust view that two maternity units comprised one service.

There had been four serious incidents at Epsom Hospital in 2017. We reviewed the root cause analyses of two of the incidents and were satisfied they were appropriately carried out. The results were presented to the local and directorate risk teams, the Labour Ward Forum, the bi-monthly quality meeting and the trust SI panel. Learning points were also available within the clinical areas in a designated folder for staff to access. The main themes of SIs, as identified in November 2017, were staff knowledge, communication, escalation and documentation.

At the last inspection staff reported receiving little feedback from incidents. Staff were also unaware of incidents at the other trust site. At this inspection we saw there was more effective sharing of learning from incidents cross site. We saw presentations to staff on all the serious incidents on both sites with clear analysis of care and service delivery concerns and contributory factors. The risk team produced a list of incidents monthly. A monthly risk newsletter was distributed to all midwives with short articles to share learning from incidents and copies were placed on risk noticeboards. Midwives told us they found this useful and were able to give examples of learning, for example, the importance of documenting all contacts with women, and in the delivery suite documenting the rationales for CTG, episiotomy and shorter passive second stages. This process ensured there was a better system of sharing learning from incidents amongst staff to help prevent recurrences. Obstetricians also produced monthly lists of incidents.

However, there were recurrences of incidents and there was still work to do here. For example, at the last inspection there had been a campaign to ensure accurate blood labelling. Staff told us practice had improved but slipped again early in the year. Correct labelling was critical because the risk of making a mistake with patient identification could lead to patient death. Managers had tackled the challenge in a variety of ways: presentations, national competency training and assessment and flow charts were displayed in clinical areas to remind staff of correct procedures. As a result there had only been two incidents in the six months to October 2017. However, on inspection we noted a member of staff marking up samples in the nurses’ station rather than the woman’s room.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds (Duty of Candour). The policy was to place a duty of candour sticker in the notes for all incidents reported on the electronic reporting system as evidence the woman had been informed and debriefed, as well as for cases where a woman needed debriefing for a traumatic birth not recorded as an incident.

Staff we spoke with knew that for serious incidents a senior clinician should speak with the family in person, record this in writing and explain what enquiries would be undertaken, offering an apology where applicable. This was to be audited.

**Major incident awareness and training**
Staff said they knew how to access the trust’s major incident information. A major incident policy was in a folder on the ward, but it was not the current version.

There was guidance on the ward on actions staff should take if the internal paging system failed or if the inter-site linked failed. There were also guidelines for temporarily closing the unit because of insufficient staff or beds.

Staff showed awareness of the action to take in the event of fire.

Staff were trained to use Situation, Background, Assessment and Recommendation in reporting incidents or escalating concerns.

Safety thermometer

The maternity safety thermometer is a measurement tool for improvement that focuses on: blood loss over 500ml, perineal tears (tears to the area between the vagina and rectum during birth), maternal infection, the psychological well-being of the mother and the baby’s health scores in the first 10 minutes after birth.

At the last inspection the trust was collecting safety thermometer data although not actively using it. The trust did not complete the national maternity safety thermometer at the time of this inspection, but most of the data was reported on the maternity dashboard.

The ward displayed ‘harm free care’ information from the standard safety thermometer. The number of staff planned and actual was also displayed.

Is the service effective?

Evidence-based care and treatment

Guidelines were developed in line with the recommendations of National Institute of Health and Care Excellence (NICE) and those of the Royal College of Obstetricians and Gynaecologists (RCOG). A maternity guideline committee developed guidelines in the light of new evidence. Doctors told us there were slight variations in guidelines across sites for practical reasons but most guidelines were now common to maternity services in both hospitals in the trust. The guidelines we reviewed were in date, for example, recently revised guidelines obstetric haemorrhage and antibiotics for Group B streptococcal disease.

We did not find guidelines for some new practices such as the use of the foetal pillow.

Midwives working in the MAU had access to fact sheets on key conditions such as hypertension in pregnancy and management of reduced foetal movements. These had flow charts to assist quick decision making.

At the last inspection there was little evidence that staff were following guidance in national and trust policies. This time we saw better information systems to communicate changes in national guidance and policy through monthly risk management newsletters, flash alerts and presentations to staff to communicate best practice on topics such as sepsis, to alert staff to updated guidelines such as the changes to the NICE recommendations on neonatal jaundice or the updated anaemia guideline. However, the practice of printing hard copies of policies meant not all staff looked at the most up to date guidance.
At last inspection there was little evidence that national audits impacted on practice. This time there was more evidence of learning from outside the hospital.

At the last inspection the hospital was not meeting national targets for screening compliance particularly for thalassaemia and sickle cell where 44% were screened for these conditions (target 95%). At this inspection data showed that the overall screening target of 95% was exceeded in October 2017 (97.5%) and November 2017 (98.8%). The average for the year 1 April 2016 and 31 March 2017 had been 92%. Screening performance had therefore considerably improved since the previous inspection. There was no screening midwife and deputy. Staff analysed the reasons for why some women were not screened. Seven women were not able to be booked by 10 weeks due to lack of appointment slots, 31 were referred over 9 weeks gestation so could not be booked before 10 weeks and seven women were late GP referrals. Two women chose not to attend before 10 weeks.

Where there was a risk of breaching targets for scanning women in pregnancy the hospital arranged extra clinics at evenings and weekends. The need for this was reviewed weekly.

The hospital was contributing to seven external research projects such as a trial to prevent pre-term birth, organisation of early pregnancy assessment to optimise outcomes and treatment of women with preëclampsia (a placental condition affecting the mother’s blood vessels and the baby’s blood supply which can herald more serious illness).

The hospital took part in national maternity audits such as the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK). They also took part in initiatives such as NHS England’s Sign up to Safety campaign from which they had obtained funding for CTG interpretation and the introduction of the STAN foetal monitoring system.

There were 28 maternity-related audits on the Women’s health division health tracker on a range of topics from compliance with the NICE recommendations of intrapartum care (CG190) to audits of the management of hyperemesis (sickness in early pregnancy) and audits of areas of concern on the risk register such as third and fourth degree tears and caesarean sections. During 2018 there would be audits of the newly introduced BCG vaccination of babies and of enhanced recovery for women having planned caesarean sections. (Enhanced recovery encouraged early mobilisation, eating and drinking and enabling women to go home the next day if she was ready.)

At the last inspection a new clinic system had been introduced by ‘medical condition’ but not necessarily staffed by an expert in that condition. We were told at the last inspection that the clinics would be audited but no audit had taken place.

There was an emphasis in publishing data from audits to share learning for example a diabetes audit was published in July 2017. The hospital contributed data from the GROW (Gestation Related Optimal Weight) charts, customised antenatal charts for plotting fundal height and estimated foetal weight as part of the co-ordinated growth assessment programme (GAP).

There was no dedicated triage midwife, contrary to NICE guideline CG190. A telephone triage log book was kept but we were aware from a recent serious incident that these were not routinely audited. An audit was being undertaken.

A 24 hour regional triage line, staffed by midwives was due to start in April 2018.

**Nutrition and hydration**

Breastfeeding was a priority. The hospital had full re-accreditation by UNICEF baby friendly 2017, level 3 in March 2017 and was now aiming for Achieving Sustainability Gold award in 2018. The
standard of breastfeeding initiation was high. The rate in Surrey for continuation after six to eight weeks was 57.8%, higher than the England average of 43%.

Breastfeeding specialist midwives and maternity support workers helped support new mothers with breastfeeding. The hospital planned to train more breastfeeding champions. Ward staff carried out a structured assessment of breast feeding before mothers and babies went home to ensure that feeding was well-established. A woman we spoke with who was staying with her baby for breastfeeding support told us she received lots of help from staff. Woman received a guide to feeding and caring for their baby as part of their antenatal information and midwives gave new mothers further guidance before discharge from the postnatal ward.

Breast pumps were available for mothers to rent or to buy. If tongue tie affected a baby’s feeding there was an assessment and referral service.

The postnatal ward also had bottles and sterilising equipment for women who chose to bottle-feed their babies. The policy was to teach mothers responsive bottle feeding.

If babies were readmitted to hospital because of jaundice or feeding related issues the Infant Feeding team were informed so they could support mothers. This team also advised mothers how to spot issues including weight loss. The policy was to involve the neonatal unit if weight loss was over 12.6%. An audit had shown the readmission rate was well below the national average.

We reviewed patient menus. We saw that there was a range of choices, including options for people with special dietary needs such as diabetes. Women could request a meal out of hours too, with nine choices. This allowed women labouring during the night to have a meal if they wanted one; however, we found catering staff were not happy about making meals outside normal mealtimes.

The antenatal/postnatal ward had a day room, where women and their partners could spend time outside the ward and have snacks at any time of the day or night.

**Pain relief**

Women considered pain relief as part of their birth plan and received information about options in the antenatal period. Women told us that they were able to obtain pain relief during and after birth, usually in a timely way.

At the last inspection there was no data collected on the epidural rate (national average 30%). This data was now collected and the rate was 28%. We were told that epidurals were available to women on the delivery suite within 30 minutes the nationally recommended time. If there was a delay this was reported as a ‘red flag’ incident. Anaesthetists provided 24 hour cover for epidurals for pain relief.

The birth centre had a birthing pool for pain relief and water birth. Some women used birth pools at home. Pain relief in the birth centre included massage, breathing and relaxation techniques mobilisation and Entonox (a mixture of nitrous oxide and air). Some women used hypnotherapy. For home births a woman was able to have pethidine (a morphine-based injection) if prescribed by her GP.

Some alternative therapies such hypno-birthing or aromatherapy were available.

Women who continued to have pain on the second day after childbirth were not discharge without the agreement of a doctor.

**Patient outcomes**
The RCOG Good Practice guideline No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity clinical dashboard to monitor outcomes in a maternity service.

At the last inspection there was little evidence that data collected to maintain a site dashboard was used to monitor and improve patient outcomes. It did not include some information that might impact on outcomes such as details of staff sickness, use of agency staff or actual ratio of midwives to deliveries. At this inspection we found managers were taking action to address some of the areas concern on the dashboard and additional information was shown. However, the Epsom dashboard was not on display in the delivery suite or postnatal ward to give women an overview of maternity performance. It was also not displayed in staff areas, which was a missed opportunity for sharing information. However, one issue of the maternity risk newsletter compared aspects of trust-wide maternity performance in 2016-17 with performance in the previous year.

We reviewed the dashboard for the previous year and found there were a number of areas where the service was not meeting national goals.

At the time of the last inspection, the rate for episiotomy was 40%. However, there are no regional national or international expected rates. An episiotomy is a procedure performed during labour, in which a clinician cuts the area between a woman's vaginal wall and perineum (the area between the vagina and anus) in order to allow the baby to pass through the vagina more easily.

Episiotomy is not recommended without clinical need as it is generally more painful for the woman, leads to greater blood loss and takes longer to heal. The current rate had fallen to 25.6%.

The previous inspection had shown higher than expected rates of severe post-partum haemorrhage (PPH), or excessive blood loss during childbirth, which is a significant cause of morbidity and mortality. At this inspection we found the hospital was responding to these higher than expected rates on several fronts. There was with a literature review, an audit into the accuracy of blood loss measurement associated with deliveries with greater than 1500 mls. The results of the audit would be reported to the Board Patient Safety and Quality Committee. The drug carbetocin was being trialled to see whether its use was more effective at preventing PPH. In addition, the service had started to use a foetal pillow, a balloon device designed to elevate the foetal head when it is deep in the pelvic cavity during a caesarean section, making the delivery safer, easier and less traumatic for the mother and baby. An obstetrician told us it was too early to assess fully the impact of these changes. However, there was evidence of decline over the year 2017, and data for February 2018, provided by the trust after the inspection, showed a continuing fall.

The percentage of third and fourth degree tears during birth (also known as obstetric anal sphincter injury – OASI) had increased since the last inspection (5.1%). The hospital were taking action to address this and was part of a formal pilot of to use a hands on technique at the time of birth and communication with the women about achieving a slow controlled birth of both the baby’s head and shoulders. The trust had adopted the use of episcissors which have been found in research studies to reduce the incidence of anal sphincter injury by 43%. The preliminary indications were encouraging and had reduced third and fourth degree tears so the OASI techniques were to be used at the St Helier site too, even though that was not part of the national pilot. An audit in 2016-7 had identified there was no postnatal physiotherapist at Epsom, however, a perineal midwife had recently been appointed. It was too early to show the impact of this. The third or fourth degree tear rate was 2.7% of women, which about the same as the national rate of
2.9%. The trust aim was to keep the tear rate between 1.5 and 3.5%. We saw that the practice development newsletter for April 2017 focussed on promoting techniques to avoid injury to the anal sphincter as recommended by RCOG and there was a care bundle to support this.

The unit had a 64% uptake of vaginal birth after caesarean section (VBAC) which was a sound level of success. Clinics were held for women as part of birth choices.

At the previous inspection the hospital was only achieving one to one care for 91% of women. The rate of one to one care in labour had now improved to 99.7%.

Managers now prioritised one-to-one care of labouring women, which appeared not to have been a priority at the previous inspection.

We saw that staff advertised the use of the enhanced recovery programme in the antenatal and postnatal ward, although not in the antenatal clinic. An audit was planned.

Very few women were smoking at the time of birth – the rate of 5% was below the national figure of around 10%.

In the 2016 National Neonatal Audit, Epsom and St Helier Hospitals performance was as follows:

Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?

**Epsom Hospital**
There were 2 babies born at <32 weeks included in this audit measure for the unit. 100% of these babies had their temperature measured within an hour of birth; this was above the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

**Epsom Hospital**
There were 13 eligible mothers identified for inclusion in this audit measure for the unit. 69% of these mothers were given a complete or incomplete course of antenatal steroids; this was below the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

What proportion of babies < 33 weeks gestation at birth were receiving any of their own mother’s milk at discharge to home from a neonatal unit?

**Epsom Hospital** did not enter 2016 data for this NNAP audit measure.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Epsom Hospital did not normally accept women below 34 weeks gestation for birth the neonatal unit was level one, the simplest level of care for babies who need continuous monitoring of their breathing or heart rate, additional oxygen tube feeding, phototherapy recovery (to treat neonatal jaundice) and convalescence from other care. A unit of this kind would not take very premature babies so women likely to give birth prematurely were transferred to another unit.

From July 2016 to June 2017 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections as expected.
More up to date figures at the time of the inspection showed the average rate of caesarean section had increased from 26% in 2015-6 to 32% in 2016-7. The rate was 36.0% in November 2017.

The rate of emergency caesarean was 17.5% in October 2017 and 23.8% November 2017. This was high by comparison with the national rate of about 15% and the London rate of 17%. Doctors acknowledged the recognised difficulties in defining emergency caesarean sections.

The rate of failed instrumental deliveries leading to caesarean section was about 3%.

A consultant reviewed all caesarean sections in Category 2 (those where there was a threat to the mother’s or baby’s condition which was not life threatening). They also reviewed Category 3 caesarean sections, that is, those where there was failure to progress with labour when the baby was well and there was no maternal or foetal compromise, but needed early delivery, or where a caesarean was planned but the mother had gone into labour, or a bay was unexpectedly found in the breech position. An obstetrician reviewed caesarean sections daily and there were also quarterly reviews to assess whether all these procedures were necessary.

In relation to other modes of delivery from July 2016 to June 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections³</td>
<td>1,328</td>
<td>28.6%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>705</td>
<td>15.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>2,610</td>
<td>56.1%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>8</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
Normal (non-assisted) delivery rates were lower than the England average and instrumental (vacuum) delivery rates were higher than the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

At this inspection we saw there had been an audit of management of ectopic pregnancy which had shown 94% of ectopic pregnancies were managed in accordance with local and national guidelines. Diagnosis and follow up was adequate in medically managed patients with a success rate of 83%.

The unit held Perinatal Morbidity and Mortality meetings but they were not cross site.

Birth centre births were below the 20% target in October: 14.9% and in November 16.5%.

As of November 2017 the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

The trust acknowledged that it was a national outlier for caesarean sections in the middle to low category, (GIRFT) Getting It Right First Time (GIRFT) programme. Staff were exploring the reason for this, although they said, defensively, that caesarean section rates were increasing nationally through increased maternal age, diabetes and greater use of induction for reduced foetal movement.

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.1. The comparator group was 5.19. The previous year's score was 4.49.

(Source: MBRRACE UK)

On inspection we found from Board papers that the trust aimed to make more progress and was to offer all women post mortems and send placenta for examination after all losses, as well as improving data recording.

Staff told us the still birth rate was falling. There were a variety of actions that had influenced this, including the programme to monitor foetal growth and uterine artery Doppler scan to check that enough blood was reaching the placenta. The Perinatal mortality rate (hypoxic-ischaemic encephalopathy) in 2016/17 financial year was 0.8 deaths per 1,000 births which was significantly lower than the MBRRACE-UK benchmark of 3 deaths per 1,000 births (trust-wide figures).

**Competent staff**

A one year preceptorship programme supported newly-qualified band 5 midwives in gaining skills to practice. This lasted about a year while staff gained their competences. They had a buddy system where the band 6s acted as a buddy for band 5s.

There were specialist midwives for antenatal screening, diabetes, infant feeding, risk management, governance and bereavement as well as midwife sonographers. Some of the specialist midwives worked clinically one day a week.
Midwives we spoke with were complementary about the practice development midwives. Band 7 away days had been introduced and staff said they valued these.

Some midwives were trained in the New-born and Infant Physical Examination (NIPE). Hospital paediatricians were also carrying out NIPE checks. A new NIPE clinic had been started for which appointments were available to ensure babies had the check within 72 hours of birth and then again (by the health visitor) at 6-8 weeks of age.

Band 7 midwives had neonatal advanced life support (NALS) training. We noted on the occasions when there was no band 7 labour ward coordinator; there would not be a midwife with NALS. The home birth team also had NALS training. We were told most midwives had training in adult intermediate life support.

Only one midwife was trained in HDU level 2 care. This was not enough to ensure there was always someone with this training on every shift. There had been eight transfers to HDU care in 2017.

Midwives attended annual "PROMPT" study days. These involved scenario-based training covering emergency obstetric situations such as post-partum haemorrhage (excessive bleeding after childbirth), shoulder dystocia (where baby’s shoulder becomes stuck in the birth canal after delivery of the head) and cord prolapse. Cord prolapse is when the cord comes out before the baby during labour, which can cause a reduced supply of blood and oxygen to the unborn baby. Midwives told us they found these sessions useful and attending allowed them to keep their skills up-to-date should an emergency happen. There were also regular unannounced ‘skills and drills sessions’. At the last inspection some midwives had not experienced unannounced drills but on this inspection midwives we spoke with reported having this training.

Improved simulation kit for perinatal mortality and neonatal issues, followed by the uses of the ‘Diamond debrief’, a standardised approach to high-quality debriefing on non-technical skills had improved training of obstetricians and midwives, and there were new models for training perineal repair IV cannulation and neonatal resuscitation.

Some midwives were having MDT training in perinatal mental health.

The trust had also adopted human factors training and was training the trainer. Human factors training supports safety by helping staff gain better understanding of the behaviour of individuals, their interactions with each other and with their environment to help prevent accidents).

Midwives felt rotation into the risk role was helping to embed safety, and midwife rotation across sites had been valuable for their development and enabled the units to work better together as well as influencing the culture.

Junior doctors reported active support from senior doctors, and some regular and some ad hoc teaching as well as opportunities for involvement in audit.

The trust had an annual appraisal cycle. End of year reviews were completed in quarter four each year. The most recent data therefore is for quarter four 2016-17 and there is no year to date information to provide.

From December 2016 to March 2017, 59.2% of staff within the maternity at the trust had received an appraisal compared to a trust target of 80%.

A split by unit group can be seen in the graph below:
| Maternity unit                                      | Percentage of
<table>
<thead>
<tr>
<th></th>
<th>Number completed – last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal (Epsom) - Nursing</td>
<td>22.2%</td>
</tr>
<tr>
<td>Antenatal Pod (Epsom)</td>
<td>0.0%</td>
</tr>
<tr>
<td>Community Midwifery (Epsom) - Nursing</td>
<td>46.7%</td>
</tr>
<tr>
<td>Maternity/Labour Pay (Epsom)</td>
<td>38.6%</td>
</tr>
<tr>
<td>Midwifery Management - Trust Wide</td>
<td>83.3%</td>
</tr>
<tr>
<td>SCBU (Epsom) - Nursing</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Return (RPIR) P43 Appraisals)

Some staff we spoke with had not yet had an appraisal in 2017 but said they would have one before the end of March 2018. The pattern was for Band 6 staff to appraise band 5s and Band 7 staff to appraise Band 6.

Junior medical described feeling well-supported by the consultants with opportunities for learning.

The arrangements for support to midwives to replace the former supervisors of midwives on-call, since statutory supervision had ceased to exist in April 2017 was provided by senior managers. An experienced midwife had recently been appointed to support supervision.

**Multidisciplinary working**

Staff we spoke to reported good working relations between obstetricians, midwives, midwifery support workers, and other staff. Midwives told us they contacted consultants if they needed advice, for example, around risk assessments, and found consultants approachable.

The handovers on delivery suite were not multidisciplinary. There was an 8.30am huddle on the delivery suite with doctors, and midwives from throughout the unit. This was helpful for obstetricians and the wider ward staff, although the handover did not mention women who required review on the wards. From the perspective of staff on the delivery suite the process duplicated the 7.30 am handover for midwives on the delivery suite for delivery suite staff.

Managers said that if the unit was exceptionally busy, the huddles would take place at lunchtime and the end of the day.

Many women had their antenatal care from midwives in GP surgeries. No problems were reported about communications with GPs during antenatal care and discharge. We saw that midwives completed the child health record (Red book) to handover care to health visitors. There was a process for midwives to inform health visitors of all pregnancies and to alert them to post-natal issues at discharge.

The maternity service demonstrated good external multidisciplinary working. Where necessary, staff referred women to a psychiatric mother and baby unit so that expectant mothers received the care they needed during and after childbirth. Staff held biweekly meetings with a liaison psychiatrist and an officer from Public Health England to discuss the referrals that were made for patients with extra needs. This ensured that women with extra needs benefitted from a coordinated approach from different agencies.

We were told a consultant midwife was involved with the area health visitor forum, and arrangements for sharing information with health visitors before and after birth were well-established.
On the Epsom site there was a monthly multi-disciplinary meeting to discuss women with screening results which may impact their pregnancy and plans are made for delivery. There was a weekly meeting at the other site.

Epsom hospital worked with Surrey Heartlands Local maternity services transformation plan for 2017-2021. Although the hospital was part of the Epsom and St Helier Universities Trust, maternity services were commissioned by Surrey Downs Clinical Commissioning Group and of necessity the hospital’s external relations were in Surrey. There was a regional dashboard in development for Surrey. This was not the same as the dashboard used in West London region.

**Seven-day services**

Consultants covered the delivery suite every day including weekends between 8am and 9pm (98 hours a week). Each consultant covered a full day 8am to 5pm and all consultants took part in the rota. At the last inspection cover had been unevenly spread over the week but on this inspection the hours of cover were the same each day. The level of cover exceeded the recommendations of the Royal College of Obstetricians and Gynaecologists for a maternity unit of this size. A consultant was always on call and could attend within 30 minutes.

Ultrasound was not available at the weekend apart, from a mobile mini scanner.

The maternity assessment unit (MAU) was not open at weekends, but from 8am to 6pm Monday to Friday. Appointments were made for women referred by GPs or a community midwife, but women could refer themselves because of reduced foetal movement. Outside these hours, women with urgent concerns could telephone the delivery suite for advice.

The early pregnancy assessment unit (EPAU) was not open at weekends. This had not changed. Women below 20 weeks gestation were advised to attend the emergency department out of hours.

Scanning clinics were usually only open on weekdays. Routine blood tests were done by maternity support workers. Scanning was available 8.30am to 4.30pm. Staff told us that out of hours it was possible to arrange to scan women to check fetal growth in an emergency in the main hospital X-ray department. The mobile scanner on the ward could show the presentation of the baby but not growth.

Community midwives ran clinics for antenatal and postnatal women on Saturdays.

The delivery suite at the hospital had not closed in the past year. However, we were told there were sometimes not enough staff for the birth centre to be open.

Home birth services were available 24 hours a day every week.

**Health promotion**

A consultant midwife for public health had been recruited. This had led to changes such as a tuberculosis (TB) vaccination offer for all new-borns and better coordinated mental health provision for pregnant woman and mothers, with referral to psychiatric input if needed.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust reported that as of October 2017, Mental Capacity Act (MCA) and Deprivation of Liberty training part of the module called safeguarding adults (level 2) had been completed by 38% of staff in within maternity.

(Source: Trust Provider Information Return P14/P49)

Arrangements were in place to seek consent for surgery and other procedures, including screening. Forms were appropriately signed in the maternity notes we reviewed.
At the last inspection there had been no audit of consent in maternity.

We reviewed six sets of records and saw staff obtained and recorded verbal consent where appropriate, such as before a vaginal examination and written consent was recorded for procedures such as caesarean section.

**Is the service caring?**

**Compassionate care**

We saw evidence of care being delivered that was kind and compassionate. The Friends and Family Test is a measure of patient satisfaction. The hospital had question cards on display in units and also encouraged online completion.

**Friends and Family Test performance (antenatal), Epsom and St Helier University Hospitals NHS Trust**

![Graph showing Friends and Family Test performance (antenatal)](image)

From October 2016 to September 2017 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average with a seasonal drop during winter months. However, the response from women was very low – on average six per month.

**Friends and family Test performance (birth), Epsom and St Helier University Hospitals NHS Trust**

![Graph showing Friends and Family Test performance (birth)](image)

From October 2016 to September 2017 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

Most recently in September 2017 the trust performance was 98% recommended compared to 96% of the England average. On average 8 women a month commented, which was low. The response rate from women using the birth centre was higher and almost universally positive.
From October 2016 to September 2017 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally better than the England average.

Performance of the postnatal ward at Epsom was 97% for the trust compared to 94% of the England average based on responses from 53 women a month.

Friends and family Test performance (postnatal community), Epsom and St Helier University Hospitals NHS Trust

From October 2016 to September 2017 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

Performance of the postnatal community was 89% for the trust compared to England average score of 98% in September 2017. We were not given response rates for these women.

(Source: NHS England Friends and Family Test)

We were told the Maternity Friends and Family Test response were lower than the London average and at a relatively low level compared to 2017. For 2018 the trust aimed for response rate over 30% and scores of 95%. Staff were seeking to identify options for improvement, including working with the Patient Experience Team.

Women and their partners we spoke with on the postnatal ward during the inspection reported that midwives had been supportive, although CQC had some mixed feedback from women before the inspection.

The trust performed similar to other trusts for all most questions in the CQC maternity survey 2017.

In the CQC maternity survey 2017 the trust performed better than other trusts in two questions:
‘Did the staff treating and examining you introduce themselves?’ (9.6/10)
(9.6/10)
‘Did you have confidence and trust in the staff caring for you during your labour and birth?’
(9.4/10)

The trust also used the feedback gathered by the maternity voices partnership to gather feedback from women.

**Emotional support**

We spoke with two mothers in the antenatal clinic. They described receiving clear and helpful advice and reassurance. Women could access support for specific health issues such as diabetes or mental health needs. Midwives assessed women’s mood during antenatal visits in line with NICE clinical guideline 192 and were able to signpost women to sources of help for anxiety and depression.

A specialist bereavement midwife provided sensitive and compassionate care to women or couples, as well as practical support while they were in the hospital. One of the more attractive delivery rooms was used, where possible, as a room for women with pregnancy loss. Although not specifically a bereavement room, staff would remove the resuscitaire and other relevant items when this room was being used for the purpose. We saw that the bereavement midwife attended to give support to families following stillbirth or neonatal death.

Trained screening midwives counselled pregnant women undergoing screening tests to check for genetic anomalies. This process ensured women were fully informed about the test and the possible implications before going ahead. Midwives or consultants provided de-brief appointments for women whose antenatal screening results identified anomalies. As well as providing the opportunity for emotional support, these meetings allowed women to discuss their results, the implications, and to plan the next steps.

Staff considered that women had very supportive care in the early pregnancy unit. We did not speak with women using this service as no one was using the service at the time we inspected.

Women’s partners were allowed to stay overnight with them after they had given birth. This enabled women to receive support from their partners as they recovered from birth and adjusted to the demands of a new baby. Not all partners stayed and staff were aware that some women would prefer not to have men stay on the ward overnight. We noted a sign addressed to men about staying overnight on the ward, which might more appropriately have been addressed to ‘partners’.

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

We were told women had continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationship. The target was for a woman to have two midwives. However, information on this was not yet collected centrally. The trust offered women an option pay the trust for personalised midwifery care, in which case continuity of care was assured before and after birth.

Women we spoke with said midwives had supported them in making decisions about their care. They felt able to ask staff if they were unsure about something. A woman from outside the area said she had not had a named midwife but was confident in the advice midwives had given, both in appointments and over the phone. Women we spoke with reported staff were really helpful.
A diabetes specialist midwives worked alongside women with diabetes to support them in the management of their condition during pregnancy.

A woman who had recently given birth told us staff fully explained things throughout her pregnancy and labour. She felt staff listened to her concerns and gave her enough information to make informed decisions about her care, such as place of birth.

The consultant midwife led one to one debrief/birth reflections for women who wanted to obtain a greater understanding of events surrounding the birth, why possible intervention was necessary, and the possible implications for future births. We did not see this advertised in the postnatal ward or the delivery suite. One woman told us she had clearer advice from staff on her pregnancy this time compared to her experience over a year ago.

**Is the service responsive?**

From April 2016 to September 2017 the bed occupancy levels for maternity were generally lower than the England average, with the trust having ~40% occupancy in Q2 2017/18 compared to the England average of ~60%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Staff were aware of the cost of low bed occupancy but there was no short term solution.

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

Women could refer themselves to the hospital from nine weeks of gestation. There was a booklet for mothers: Your parent journey starts here: What you can do to meet your baby’s needs. A baby buddy app was also advertised.
Community midwives offered antenatal booking appointments in community premises, mainly GP surgeries. We were told a system of community hubs was planned as part of Surrey’s medium term maternity plans. These would be located in places with good transport links. The aim was to provide continuity of care to women, ideally with two midwives but in practice very few women had their baby delivered by their named midwife. Many women saw three or four midwives for antenatal clinics.

The hospital antenatal clinic saw women who needed to see a consultant during pregnancy and also women from out of area. The clinic had moved three weeks before the inspection. A few women had received letters directing them to the former location, in error. One woman who had transferred from another service said she was impressed by the clinic organisation. On the days we inspected the antenatal clinics were running to time. Two women told us that it was easy to reschedule appointments if they needed to cancel.

Antenatal classes were run to increase the knowledge, confidence and aspirations of expectant mothers and their partners. These were run by midwives. These included an antenatal infant feeding workshop.

On weekdays, the hospital provided an early pregnancy assessment unit. This was for women under 20 weeks gestation who had concerns about their pregnancy. While co-location of an EPAU with the antenatal clinic and ultrasound facilities was not ideal, there was no gynaecology department at Epsom Hospital. A separate waiting area for women with EPAU appointments was provided, but women had to go to the antenatal waiting room to get a drink, and would also be likely to pass pregnant women in the waiting area for ultrasound scans. While the arrangement was convenient for staff, women had not been consulted. A patient satisfaction survey was planned when the clinic area had been open for some months. The opening of the new clinic had happened very quickly and although staff had input, plans changed as work progressed.

Women over 20 weeks attended the MAU for assessment for pregnancy specific concerns including reduced fetal movement, presentation scans, CTG monitoring or for concerns about pre-eclampsia. This was in the main maternity unit with easy access to the delivery suite or the antenatal/postnatal ward.

A midwife led birth centre in the main maternity unit had facilities for women with low-risk pregnancies to give birth to their babies. There was also an option of home birth. The women who used the birth centre loved it because of the relaxing ‘spa feel’.

The obstetric led delivery suite provided for women over 34 weeks gestation. Women were able to tour the whole maternity unit in advance of giving birth.

Visiting hours on the ward were 24 hour for partners.

The trust had an active Maternity Voices Partnership (MVP). We also saw evidence of engagement between maternity services and a local Health watch group. This was a significant improvement in engagement with local stakeholder groups since our previous inspection in 2015.

Information was on display in the antenatal/postnatal ward about breast feeding, patient property, discharge information, and the bathrooms displayed information about contacts for domestic abuse which as appropriate. We noted some commercial adverts on the noticeboards for women, for example, about personalised prints for children, and some maternity services for which there was a charge, such as hypnobirthing and classes. The Trust was working with the Plain English Campaign to review and improve the information provided to patients, carers and visitors.
The Trust had recently (September 2017) appointed an Equality, Diversity and Inclusion Manager. This was a new post at the Trust and is part of the organisation’s commitment to ensure that it continues to meet the diverse needs of the communities it serves.

Information on the trust website and in the hospital was all in English. Staff told us information could be provided in other languages. However, women could obtain translated maternity information documents through the hospital including braille and audio. The service was publicised and there was access to interpreters both in person and through telephone support, although the percentage of women needing an interpreter was low, on average under 2%.

**Meeting people’s individual needs**

There were a series of leaflets which midwives could give to women to whom they were relevant, for example, on breech presentation, pre-term birth (before 37 weeks), pain relief options in labour and the advantages and disadvantages of these, and infant feeding. Women were given leaflets at different stages of antenatal care. However, the leaflets were not available on line as in many hospitals.

There was no written information for parents in the ward about the ward routine. This was left for midwives to explain.

There were 10 reclining chairs for partners to stay overnight. There were some amenity rooms for women. Amenity rooms are single rooms, common in maternity, for which women can pay to have greater privacy after birth. There were two price ranges. Some women commented that if they had to stay longer than planned for medical reasons the rooms were very expensive.

Women with mental health issues or learning disabilities were supported by hospital services and by social care. A specialist midwife had responsibility for perinatal mental health and substance abuse. As at the last inspection there was no specialist consultant for perinatal mental health at Epsom nor a named perinatal psychiatrist, however, staff now worked with mental health services to ensure that women with mental health needs were supported.

Women whose labour started before 34 weeks were transferred to St Helier Hospital which had the higher level of neonatal support that premature babies might need.

A new dedicated home birth team started in November 2017. They offered home birth to mothers who chose to give birth at home and were assessed as safe to do so. Community midwives provided the second midwife on call. The team ran quarterly home birth workshops and the service was being advertised widely. About 2% of births in the Epsom area were at home at the time of the inspection.

The trust offered various private services such as Hypno-birthing workshops (fee £185) and private midwifery services. The private services were offered in conjunction with the NHS provision. Women’s blood tests and routine scans were undertaken as part of their NHS booking and delivery would be in either the birth centre or delivery suite at the trust. A number of midwives qualified in aromatherapy and could support women who wished to use this.

High risk NHS funded women were offered the SAFE test (a non-invasive prenatal test (NIPT), which evaluates whether a pregnancy is at risk of certain chromosomal conditions antenatally. However, if a mother was assessed as a low risk and still wished to have the SAFE test, then she could pay for this.
Face to face breastfeeding support was available daily within the area covered by the trust. These were in antenatal clinics and GP surgeries, and infant feeding support workers also gave advice to women after birth.

**Access and flow**

The Epsom maternity dashboard showed 95% of women receiving antenatal care saw a midwife for their booking appointment by 12 weeks and six days of pregnancy between April 2017 and December 2017. National targets are to increase the proportion of women accessing maternity services by 10 weeks to avoid delays and ensure most women were able to access screening that could only take place in early pregnancy.

At the last inspection the trust did not collect data on women attending for first appointments at 10 weeks but now did do. We saw from the dashboard that 84% of women attended before 10 weeks.

The trust did not routinely audit many maternity processes, such as waiting times for patients seen in the antenatal clinic, waiting times to see a doctor in the MAU or telephone triage logs.

The maternity unit did not close in 2017; however, there were occasions when the birth centre was not available because the unit was short-staffed. This meant some women’s choice of place of birth may not have been met.

Births in the birth centre were now 17%-18%. The hospital aimed for 40% of deliveries in birth centre. If more women used it two midwives could be stationed there. The transfer rate of women from the birth centres averaged 20.4% during 2017: 81 transfers out of 384 women. This was a significant reduction from the previous year when the transfer rate was 36% and demonstrated the influence of the midwife for normality.

There was capacity on the delivery unit for six elective caesareans a week on two mornings. Elective caesareans could be performed in the afternoon as emergency caesareans took precedence and there was only one theatre. This meant that sometimes a woman awaiting an elective caesarean section had to wait until later in the day after an emergency case was completed.

**Learning from complaints and concerns**

We saw information on how to make a complaint available to people who used services in the antenatal clinic and ward as well as on the trust website. We asked three women whether they knew the procedures for raising complaints and concerns. All were aware of the processes and the availability of the trust’s patient advice and liaison services (PALS).

From October 2016 to September 2017 there were 45 complaints about maternity. The trust took an average of 86 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be 35 days for completing a complaint or 45 days for more complex ones.

Epsom Hospital: There were 11 complaints, six of which related to all aspects of clinical treatment during that period.  
(Source: Provider Information Return P55)

On inspection we found the number of complaints had risen. There were 19 between April and December 2017. We were told senior midwives were proactive in mitigating complaints in meeting women quickly on the ward to discuss any concerns.
Trust wide themes from complaints were clinical care and treatment; attitude; communication and information. There had been complaints about heat in the antenatal/postnatal ward at Epsom and we were told the trust was purchase air conditioning units later in the year.

Dissemination of learning from complaints was inconsistent at last inspection. From April 2015, the divisions have been provided with an action plan which has to be completed for all upheld complaints. Work is in progress to improve the process for the recording of actions and then using these to improve services. Once the new process is brought in, the team will be focussing on improving the way we currently use feedback from our complaints. Staff told us lessons learned were shared at team meetings and that such meetings now took place at Epsom. There had not been regular band 7 team meetings at the time of the previous inspection.

The Patient Advice and Liaison service (PALS) was open five days (open 10am to 4pm) and there was a dedicated phone number for Epsom hospital and an email address through which people were able to contact PALS. There were leaflets in clinic and ward areas. Staff in the PALS team said there were not as many complaints in maternity as in some other areas. They told us midwives were willing to meet women who had complaints to resolve issues face to face if possible.

Is the service well-led?

Leadership

There had been leadership changes with the appointment of a new head of midwifery and a new clinical director for obstetrics, shortly to become the clinical director for obstetrics and gynaecology. This had improved leadership and we saw evidence of clinical leadership displayed and recognised by others in escalation of a concern. There was a delivery suite lead at each site, and a consultant lead for risk and quality in obstetrics.

Maternity was part of the Women’s and Children’s Division. A clinical director for Women’s health had been appointed as well as a Divisional Director for Women’s and Children’s Health and a Director of Midwifery and Gynaecology. These covered both sites in the trust.

All staff we spoke to felt supported by their line manager. Staff also felt the newly appointed head of midwifery and the clinical director were visible and approachable. The head of midwifery was supported by three consultant midwives, one for public health and two who promoted normal births. Hospital midwives and maternity support workers (MSWs) reported to staff in the band above, and then to the consultant midwife who reported to the trust’s head of midwifery. Community midwives reported to the site community midwife lead.

Consultants provided leadership to junior doctors.

Vision and strategy

At the last inspection there was no shared strategy or vision. Epsom maternity services were part of a Better Births project in conjunction with two other Surrey hospitals, and building on improved provision of safe local maternity care for local women and increasing the proportion of women having normal births. We still felt individual leaders staff had specific aspects of the service that they wanted to improve rather than a shared vision.

The Women and Children’s Division Operational Plan for 2018-19 set out the strategic objectives. The major project for the year ahead was implementation of Maternity Information System.
The trust had committed to the Caring for You Campaign (The Royal College of Midwives); they had constructed an action plan for maternity services to deliver the charter which was about caring for staff well so staff could provide good care to women and families.

We were aware of a long term plan, now at consultation stage, to gain support for investing in a new specialist acute unit for the trust on a new site. For maternity this would mean a larger delivery suite and an alongside birth centre on one site, enabling 168 hours of consultant cover as opposed to the 98 hrs a week that was currently in place. Antenatal and postnatal clinics would continue at all sites and in the community. Both Epsom Hospital and St Helier Hospital would continue to provide 24/7 for maternity until 2020.

Culture

Managers we spoke with knew the trust’s values and we saw staff demonstrate the values of putting the woman first, working as a team and showing mutual respect. However, a number of staff told us that although many managers worked cross-site, the two maternity units continued to feel separate entities.

At the last inspection some new midwives told us it was difficult to integrate because midwives worked in cliques and were not always welcoming to those from other backgrounds. This was less obvious on this inspection. The trust had recently created a new role for an Equality, Diversity and Inclusion Manager. A manager was appointed to the role in September 2017 and aimed to develop an equality, diversity and human rights strategy by April 2018.

The presence of new consultants in the unit had influenced the medical culture and brought in new ideas. We saw doctors and midwives working well together and the culture appeared less hierarchical than at the previous inspection. There was evidence that the unit was more outwardly focused and learned from other trusts and other areas and examples of good practice.

Staff told us there was a no blame culture in relation to incident reporting.

Governance

Maternity sat within the Women and Children’s services division, and the management structure included gynaecology. Governance was mainly cross site. The lead midwife for clinical governance held responsibility for managing risk within the maternity services, including monitoring Datix and compliance with learning outcomes, and action resulting from serious incident review. Two part time risk midwives (one for each site) supported the lead.

The governance processes ensured quality, performance and risk were well structured. The top level governance meeting was the bi-monthly divisional review meeting covering Women’s and Children’s Division attended by senior staff. The clinical lead provided both site specific and combined reports through the Quality and Risk Lead. The meeting reported to the Clinical Quality and Assurance Committee (CQAC) and the Health, Safety and Risk Committee. External scrutiny was provided by the Clinical Quality Review Group (CQRG) and through the Maternity Voices group.

There were quarterly directorate meetings chaired by the divisional director. A bi-monthly guideline meeting reviewed and updated guidelines. Following any updates, newsletters were sent to staff to ensure they were aware of the updates.
A labour ward forum was led by the lead midwife for inpatient services. This was open to all staff to attend. There was a lead midwife for antenatal care and community midwives at Epsom.

At the last inspection obstetrician engagement was considered to be relatively weak. There was now evident clinician engagement in governance. Senior staff said commissioners challenged the dashboard results, but we saw less evidence of internal challenge to results outside the expected pattern.

At the last inspection, the maternity dashboards presented information without national comparisons and contained little information about staffing. At this inspection we saw that staffing information was included but only at trust wide level. While we understood that this was part of the attempt to manage the units as one entity, there were differences between the sites which were obscured by this approach. For example, staff shortage at Epsom had led to a reduction in birth centre births in one month. We considered staff might take more ownership of performance at their own site if the local dashboard was more actively used.

Management of risk, issues and performance

At the last inspection the management of risks was reactive rather than proactive. Most of the risks we identified on this inspection were on the maternity risk register and we saw that action to manage risks was in hand.

The head of midwifery chaired monthly risk meetings. The meetings reviewed performance at both sites. The meetings covered a standard agenda including incidents, staffing and safeguarding. The maternity dashboard was reviewed quarterly.

However, there were two risks not on the risk register, staff retention which many staff mentioned as a concern. The second risk was fractured relations between some groups of staff and grievances of some staff about opportunities and support. A black and ethnic minority network was being set up but some staff had felt it was taking a long time for the hospital to embed the NHS Workforce Race Equality Standard.

The risk midwife reviewed all maternity incidents and ran weekly meetings to review significant incidents. A monthly risk newsletter shared learning from incidents and complaints. We saw copies on display on noticeboards.

Further work was needed to improve performance. Although the hospital had better data than at the previous inspection, outcomes for women remained, as at the last inspection, below national expectations and analysis and changes had not yet shown an impact on performance.

An audit schedule was in place with focus on a number of areas of risk. Findings were fed back to staff through clinical quality half days. On these days all elective clinical activity was cancelled to enable most staff to attend.

On the risk register was the risk of unauthorised removal of babies. We saw good physical security on the site, and evidence that the trust learned from other hospitals where labelling was an issue. However, on inspection we found one baby with only one label whose mother was not aware that she should tell staff about the missing label. There was no information on the noticeboards about this.

We also saw that the hospital had reviewed its response to the Kirkup report of the Morecambe Bay investigation, to provide assurance that key issues identified there could not occur at the trust. They had reviewed this in April 2017 after Supervision of Midwives arrangements, on whose shoulders many of the actions fell, had ended, and reviewed it again in December 2017. They had appointed an experienced midwife to manage supervision in January 2018.
Information management

Staff at the previous inspection commented on slow computer speed, and also that community midwives had no IT access outside the hospital. This was still the case at the time of this inspection, and on the risk register as an extreme risk, but plans were advanced for a new IT system for maternity information in April 2017. The new system would allow easier analysis of data and would also allow real-time recording of all events in the community, or home. Staff hoped the infrastructure would support faster intranet access through the new system. Community midwives would have remote access to the new system through a tablet.

Guidelines were stored in an electronic resource on the trust’s intranet, known as VICTOR – All things clinical. Those we reviewed were up to date but the widespread use of paper copies in clinical areas meant we found out of date version in use.

Engagement

As at the previous inspection, many staff considered the maternity units were separate rather than one service operating across two sites. This was partly the result of different commissioning arrangements but also because most doctors were Epsom based.

The trust had been creative in improving the spread of information among staff at handovers, risk meetings, newsletters, risk alert, skills and drills and ward meetings.

The unit celebrated success both in highlighting staff good practice and performance results such as high levels of assessment for the risk of blood clots. Managers praised named individuals publicly in newsletters for good case management. A team brief highlighted the achievement of 17% birth rate at Epsom birth centre in 2017. Trust wide maternity outcomes were also celebrated. We found staff were proud of their service, the quality of audits, involvement in research and the changes that had been made during 2017

A challenge was midwife cover for the birth centre. With current birth centre numbers, only one midwife worked in the birth centre, but many midwives felt isolated working on their own in the birth centre as it was on a different floor from the delivery suite.

At the last inspection there was limited evidence of local involvement in design of service. There was now an Epsom and St Helier Maternity Voices Partnership (MVP), an advisory group made up of professionals and parents working in partnership). We were told members ‘walked the floor’ to elicit feedback from women and held the service to account.

Feedback from the maternity network and from our observation showed a good level of satisfaction amongst the midwives and staff we met.

Learning, continuous improvement and innovation

The trust considered maternal medicine strength, as well as the fact that women needing medical review were seen by named clinicians.

The sepsis toolbox developed in maternity containing the items required by the ‘sepsis 6’ protocol was now widely used throughout the hospital.

Reduction in the hierarchy between doctors and midwives was leading to better working.

Community and home birth midwives were working with the ambulance service to support paramedics with training in delivering babies.
The Home Birth Lead had won the Birthplace Matters ‘Home Birth Midwife of the Year’ award for 2017. The trust had set up a dedicated team of experienced and enthusiastic midwives, to offer home birth with individualised continuity of care for women and their families.
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.
A list of all hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of all hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epsom Hospital</td>
<td>Epsom Hospital&lt;br&gt;Dorking Road&lt;br&gt;Epsom&lt;br&gt;Surrey&lt;br&gt;KT18 7EG</td>
<td>South West London Elective Orthopaedic Centre (SWLEOC)&lt;br&gt;Specialist pre-conception and antenatal services</td>
<td>South west London and north east Surrey</td>
</tr>
<tr>
<td>St Helier Hospital and Queen Mary’s Hospital for Children</td>
<td>St Helier Hospital and Queen Mary’s Hospital for Children&lt;br&gt;Wrythe Lane&lt;br&gt;Carshalton&lt;br&gt;Surrey&lt;br&gt;SM5 1AA</td>
<td>Renal and Transplantation Unit&lt;br&gt;Specialist pre-conception and antenatal services&lt;br&gt;Children’s Hospital</td>
<td>South west London and north east Surrey</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Acute Context tab)

Epsom and St Helier University Hospitals NHS Trust has approximately 870 beds located across two acute locations; Epsom General Hospital which is located in Epsom and St Helier Hospital and Queen Mary’s Hospital for Children which is located in London Borough Sutton.

The trust has a further four locations registered with the CQC: Kingston Satellite Dialysis Unit; Leatherhead; Mayday Satellite Unit and Sutton Hospital. In addition to these registered locations, Epsom and St Helier University Hospitals NHS Trust is the host for the South West London Elective Orthopaedic Centre (SWLEOC) which is located on the Epsom General Hospital campus. SWLEOC is run in partnership with a number of local trusts. It is the largest hip and knee replacement centre in the United Kingdom and is one of the largest in Europe.

Additionally, St Helier Hospital is home to the Southwest Thames Renal and Transplantation Unit which provides acute renal care and dialysis and is integrated with the St George’s University Hospitals NHS Foundation Trust renal transplantation programme.

Epsom and St Helier University Hospitals NHS Trust provides district general hospital services to a population of approximately 497,000 people living across Southwest London and Northeast Surrey as well as more specialist services in particular elective orthopaedic, renal and level two neonatal intensive care units to a wider catchment area covering parts of Sussex and Hampshire.

The number of staff employed by the trust as of November 2017 was 6,219.

The trust services are commissioned by Sutton Clinical Commissioning Group, Merton Clinical Commissioning Group and Surrey Downs Clinical Commissioning Group.

The trust was previously inspected in November 2015 where it was found to require improvements in a number of areas. As a result we took regulatory action, which included serving the trust with eleven requirement notices.
Is this organisation well-led?

Leadership

Board Members

Of the executive board members at the trust, 10% were British Minority Ethnic (BME) and 30% were female.

Of the non-executive board members 14% were BME and 43% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>10.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>14.0%</td>
<td>43.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>12.0%</td>
<td>35.0%</td>
</tr>
</tbody>
</table>

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

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The trust board was made up of executive directors and non-executive directors (NEDs). The executive directors were the chief executive (CEO), two medical directors, chief nurse, chief operating officer (COO), and the chief financial officer. One of the joint medical directors was also the deputy chief executive. Managing risks around external engagement was important to the trust and the more time spent with external activities meant that business as usual (BAU) work was a challenge. The deputy CEO’s role was to manage quality and keep close oversight on this.

The non-executive directors were made up of the chair, five NEDs and one associate NED. There were four other executive directors without voting rights who attended board meetings; these were the director of people and organisational development, director of strategy, corporate affairs and information communications technology (ICT), director of estates, facilities and capital projects, and director of communications and patient experience. The trust board was stable and had been for a number of years with the longest serving executive in post for seven years. The most recent appointment was the COO, who had been appointed within the last year.

The chair led the board and was involved in appointing the current CEO. All members of the board were recruited into permanent roles. Each executive director held a portfolio of responsibilities that aligned to their job role and skills; however some executive portfolios included a large number of responsibilities which could be a challenge to their priorities.

The chair and NEDs were employed based on the skills and knowledge required for the trust. All had high profile jobs in the local geography of the trust and this enabled them to be visible on the sites. They had a variety of backgrounds and experience including accounting, finance and medicine. The chair and all executives had a good working relationship with mutual respect for each other. The NEDs who chaired the audit and finance and investment committees were both experienced in finance and both were clear on their role and the remit of their committees.

The chief nurse was also the director of infection prevention and control (DIPC). She was not responsible for the safety, quality and governance, as these were the responsibility of the trust’s joint medical directors. The chief nurse was accountable to the board and directly managed by the chief executive and was responsible for nurses, allied health professionals, therapists, chaplaincy...
and bereavement services, end of life care services and safeguarding. She was also the integrated lead for the community services provided by the trust.

The joint medical directors (MDs) had instituted six weekly quality meetings for which elective activity was cancelled. They discussed learning from serious incidents (SIs), learning from death reviews, mortality reviews, complaints etc. These meetings were trust wide and relevant consultants were expected to attend.

The chief finance officer (CFO) had been in role for around two and half years and was an experienced NHS finance professional, having had previous board-level experience. He demonstrated in his interview that he had a good grasp of the financial position of the trust, and his executive and non-executive colleagues expressed confidence in his financial leadership. Finance was identified as a high performing department with strong leadership and senior staff who had high quality skills and experience. This had been led by the chief finance officer who was recruited into the organisation based on his previous experience and background.

The trust delivered its control total in 2016/17, and was forecasting to achieve it in 2017/18 (before application of the Sustainability and Transformation Fund monies). The trust had consistently achieved financial plans in recent years, and the integrated performance reports used by committees and board meetings gave a clear view of the performance of the trust. However, as at end December 2017, the trust was not achieving all of its planned cost improvement plans for 2017/18 and it was expected to under-achieve against its annual efficiency plan but was expecting to achieve its control total.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience and there was a flat structure to the senior management. The divisional structure and management structure supported this. Underneath the board was a senior leadership team which included the head of corporate governance, deputy chief nurse, director of planned care, director of medicine and urgent care, clinical director of private patients, and director of workforce. There were eight associate medical directors who also held clinical roles at the trust, and a director of medical education.

The trust was made up of eight clinical and five non-clinical divisions, which were led on a day-to-day basis by executive directors. The eight clinical divisions were:

- Medicine
- Surgery
- Critical Care, Theatres and Anaesthetics
- Women and Children
- Renal
- South West London Elective Orthopaedic Centre (SWLEOC)
- Clinical Services
- Patient Services

The five non-clinical divisions were:

- Strategy, Corporate Affairs and ICT (including Performance)
- Communications and Patient Experience
- Finance
- Estates and Facilities
- HR and Transformation

There was flexibility of roles to make sure the right people were in the organisation, for example a job share for a divisional director. This approach also helped with succession. There were no vacant posts at any level of the senior and clinical leadership level and all posts were permanent except one general manager who was interim.
The trust had developed a leadership and management matrix that mapped leadership and management training and opportunities across five levels of management. The matrix and training had been shared with managers and throughout the year specific programmes coming up were shared. The training was a mixture of national programmes, academic programmes, as well as bespoke programmes.

The trust was a member of NHS Elect, which was used to deliver coaching based programmes at Levels 3 and 4 to senior staff. The trust had also recently developed an in-house mentorship register. The trust also had a training program for middle level managers to equip them with the necessary skills to make them more effective. Trust provides full funding and time for leaders to attend the training and courses required for their development.

The trust had leads for mental health, mental capacity and adult protection. The leads were in charge of the safeguarding hub, which covered both hospital sites. The hubs coordinated the efforts of staff in safeguarding, child protection, maternity, independent domestic violence and learning disabilities. The safeguarding hub had monthly meetings which included community leads in agencies supporting people within these various areas. The hub supported staff to complete levels one and two safeguarding training which covered the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Health training was delivered as a separate module and included suicide awareness.

There were two learning disability liaison nurses on site who supported staff to deliver care to patients with learning disabilities. The learning disability liaison nurses supported a referral management system to link with each GP in the local authority to make sure referrals of patients with learning disabilities had the appropriate care when they were admitted to the hospital.

Staff had links with autistic spectrum groups in the community to better support patients who have autism. The trust was in the process of developing a training module concerning autism so that staff had the skills they need to support patients.

We found there was no evidence that two out of the nine records of executives we checked, had a competency-based interview. However, following the inspection, the trust informed us that the directors in question were appointed following a full recruitment and selection day.

Other than those, all other FPPR checks had been completed for board members. Everyone with ‘director’ in their title was checked for the fit and proper persons requirement (FPPR). The check list was carried out on appointment and then every five years. The six mandatory employment checks, plus the FPPR checks were carried out on all appointed directors. References, enhanced DBS and all barred lists were checked. We were told of an example where the trust offered a post to an individual where all FPPR checks had not been satisfied. There was a clear understanding of why this was the case and actions were in place to support the individual into the role, until full clearance could be completed.

We undertook checks on eight board members individual personnel files. All executives were meant to have appraisals on their performance through an electronic appraisal system. The trust had an annual appraisal cycle and we were told the end of year reviews for 2017/18 will be completed in Q4. It was therefore not possible to provide accurate details of completed appraisals for the 2017/18 year. We were told that the CEO preferred to send personal letters to his reports rather than use the appraisal system. The director of transformation told us that they planned to move everyone onto the appraisal system and ensured that it was kept up to date in the future. Following the inspection, the trust confirmed that all directors had had an appraisal on their performance for the previous year.
Appraisals throughout the organisation, for medical staff, showed that 91% of medical staff had an appraisal on their performance between November 2016 and 31 October 2017. This was below the trust target of 95%, but better than the all staff percentage which was 80%.

The leadership team had taken action to develop capacity and capability throughout the organisation. We were told of examples such as the apprenticeship levy being utilised to develop staff with the skills and qualifications they needed in-house. This was utilised for nurses and allied health professionals for them to work at the organisation and gain their professional qualification. In addition capacity and capability had been developed in radiology where there were currently no staff vacancies and the service was able to deliver a comprehensive seven day service to patients. An operational managers’ programme had been designed and was running to support staff to move into vacant posts for operational managers. Surgical clinical leadership was being enhanced by recruiting more senior nurses. It was hoped that this would result in more visibility of clinical leaders for this division.

The leadership team we spoke with were aware that the current priorities and challenges of the trust. They all knew that staffing, the variability of care, poor estate and finance were the main challenges for the trust and spoke about the various strategies and measures to address them. The published strategies to address these challenges included developing a creative recruitment strategy, instilling a culture whereby staff worked to consistent, evidence-based operating practices across all services, agreeing a long term plan for the trust and its buildings and becoming more efficient, removing unnecessary duplication and reducing overhead costs.

The leadership team were visible. All board members undertook the 15 steps programme. This involved board members visiting clinical areas for 30 minutes. The clinician then went back with the executive team and fed back to the board about the experience in their services. For example, during the December 2017 board meeting, the chief nurse feedback that whilst hand hygiene measures were positive during her tour of St Helier Hospital, she did find empty hand gel dispensers, or dispensers which were not working, and undertook actions to ensure that improvements would be made.

Succession planning took place and assessed the readiness of junior staff to take over the role of their line managers, or at least act up for a limited time, without risk to the organisation's performance. Succession planning was focused on the very top of the organisation, in order to gain assurance on the continuity of director-level leadership. The trust was focussed on succession planning for Level 4 into Level 5 roles during the inspection. Each executive director was having succession conversations with the CEO about the resilience in their part of the organisation.

**Vision and strategy**

There was a clear vision and set of values for the trust. The trust’s values were grouped under five categories:

- **Putting the patient first**
  Patients were the number one priority for everyone at the trust.

- **Working as one team**
  It was important for staff to work together as they saw it as the only way of making sure they achieved the very best for patients.

- **Respecting each other**
  Through mutual respect, staff can appreciate and recognise everyone’s contribution through their hard work and commitment.

- **Protecting the environment**
Doing all that was possible to cut the trust’s carbon footprint, so as to help protect the environment and save money.

Striving for continuous improvement

It was essential for the trust to continue to perform well against quality and finance standards the government expected of the NHS.

Most staff were aware of the trust’s values and they were displayed through the trust’s premises and on its intranet.

The trust’s values supported its current strategy (2015-2020), which was called ‘Patients First. Great Care. Every Patient, Every Day. This strategy included the commitment for both its main hospitals to continue to provide consultant-led, 24/7 A&E, maternity and paediatric services; and working with GPs to provide more care in community settings, so that people only care to hospitals when it was absolutely necessary. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services.

The trust also had a current strategy to improve the estate that was in need of repair, this strategy had been approved by the board. The trust was not relying entirely on the long-term strategy to solve the issues with the estate, and it was currently implementing plans to improve the existing estate to avoid patient safety risk. St Helier Hospital was due to be re-designed with specialty areas close to each other in one block. Many more wards now had windows and CCU was due to be relocated into a purpose built unit.

There was extensive building work on the St Helier Hospital site during the inspection, which the trust was managing through. This was a challenge, but trust had managed the health and safety issues associated with noise and disruption. There was a senior nurse leading on this project.

The trust’s planned strategy for 2020-2030, was based on securing a sustainable future for its hospitals. It was proposing to combine six acute services on one site with community outreach. Outpatient activity will continue on both sites. The local community were widely consulted and around 25,000 people were involved. Over 1,000 questionnaires were completed and 37 stakeholders were in favour of its plans. 80% of respondents agreed to having a single acute site, as opposed to the two that the trust currently had.

The trust had recognised the challenges of providing duplicate clinical services on both sites were not productive or best for quality or finance. Changes were starting to happen and critical care and emergency surgery had been consolidated on one site.

The CEO was driven and passionate about the 2020-2030 strategy. When the CEO arrived, there was a lot of uncertainty around the trust’s future, especially consultant recruitment. The
CEO was focused on getting certainty on the trust long term strategy in order to improve recruitment and retention of staff.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans (STP). The trust’s strategy of aligning to the STP was described as ‘complicated’ by a senior board member. There are two STPs across two regions (South London and Surrey) and this was acknowledged as the only trust in England with this arrangement. As identified in the strategy, the trust was aiming for a single site new build hospital and this idea had a programme board. The commissioners were aligned to this idea and work was being completed to engage with other providers who had some concerns about the change. The STP was involved in canvassing views of the public on the changes throughout the process. Whilst the STP work was to give advice, the decision on the changes was to be made by the trust. The chairman explained how he met with other chairs of local STPs regularly and there was a South West London Chairs’ collaborative operating which he attended.

The trust had a strategic outline case (SOC) (2020-2030) that outlined plans for changing the clinical model. This included bringing the clinical services together to deliver better care. The trust was involved with the Sutton Vanguard and developing the Sutton Health and Care (yet to be implemented), that would mirror Epsom Health and Care, but for Sutton residents.

The trust had carried out work as part of the long-term strategy development to understand the causes of its underlying financial deficit. This showed that approximately two-thirds of the deficit related to the service configuration, but that the other half could be tackled through operational efficiencies. The trust had a robust process which started in the autumn of 2017 to develop cost improvement plans for 2018/19. This was based on both executive and divisional-level views of the required activity levels, cost pressures and opportunities for efficiencies. The trust had applied “priority-based budgeting” to a number of clinical areas, which had allowed it to challenge what resources were required to deliver a safe and effective service. This process was ongoing.

We reviewed information and were told about the clinical and workforce strategies. The trust struggled with recruitment and retention of nursing staff. We were told that this was getting better now. Vacancy rate was 30 to 40% before chief nurse took up post, but it had halved over the past three years.

The trust had a dementia strategy and a NED who led on dementia. It is a centre for dementia care, where experts developed their knowledge and experience in dementia care. The trust recently recruited three consultants in geriatric medicine with interests in dementia to drive the trust’s dementia friendly policy forward. The trust had implemented individual care plans for dementia patients and most nurses had been trained to care for people living with dementia and learning disabilities. Every newly recently refurbished ward in the trust, was made as dementia friendly as possible.
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 Origin</th>
<th>Medical and dental %</th>
<th>Nursing and midwifery registered %</th>
<th>Qualified Nursing and Health Visiting Staff %</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>4.8</td>
<td>3.3</td>
<td>9.7</td>
</tr>
<tr>
<td>White – Irish</td>
<td>0.2</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Any other white background</td>
<td>1.5</td>
<td>0.5</td>
<td>2.8</td>
</tr>
<tr>
<td>Mixed White and Black Caribbean</td>
<td>0.1</td>
<td>0.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Mixed White and Black African</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Mixed White and Asian</td>
<td>0.1</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>0.2</td>
<td>0.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Asian or Asian British – Indian</td>
<td>2.2</td>
<td>0.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Asian or Asian British – Pakistani</td>
<td>0.8</td>
<td>0.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Asian or Asian British – Bangladeshi</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>1.2</td>
<td>0.1</td>
<td>3.9</td>
</tr>
<tr>
<td>Black or Black British – Caribbean</td>
<td>0.0</td>
<td>0.2</td>
<td>0.9</td>
</tr>
<tr>
<td>Black or Black British – African</td>
<td>0.5</td>
<td>0.2</td>
<td>3.4</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>0.1</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.5</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>0.7</td>
<td>0.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Not stated</td>
<td>1.5</td>
<td>0.2</td>
<td>1.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity P6)

NHS Staff Survey 2016 – results better than average of acute trusts

The trust has two key findings that exceeded the average for similar trusts in the 2016 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>4.12</td>
<td>4.06%</td>
</tr>
<tr>
<td>KF3. Percentage of staff agreeing that their role makes a difference to patients</td>
<td>92%</td>
<td>90%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2016 – results worse than average of acute trusts

The trust has five key findings worse than the average for similar trusts in the 2016 NHS Staff Survey:
<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF9. Quality of appraisals</td>
<td>2.98</td>
<td>3.1</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.38</td>
<td>3.45</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.67</td>
<td>3.73</td>
</tr>
<tr>
<td>KF15. % of staff satisfied with the opportunities for flexible working patterns</td>
<td>46.94</td>
<td>50.51</td>
</tr>
<tr>
<td>KF21. % of staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>81%</td>
<td>86%</td>
</tr>
</tbody>
</table>

*(Source: NHS Staff Survey 2016)*

**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>Your Trust in 2016</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 29% BME 29%</td>
<td>27% 26%</td>
</tr>
<tr>
<td>KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 25% BME 27%</td>
<td>24% 27%</td>
</tr>
<tr>
<td>KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 86% BME 68%</td>
<td>88% 76%</td>
</tr>
<tr>
<td>Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 6% BME 12%</td>
<td>6% 14%</td>
</tr>
</tbody>
</table>

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

1. “KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion”

2. “Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader” or other colleagues”.

*(Source: NHS Staff Survey 2016)*
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 similar to the England average for recommending the trust as a place to receive care from September 2016 to August 2017.

(Source: Friends and Family Test)

Sickness absence rates

The trust’s sickness absence levels from June 2016 to May 2017 were similar to the England average.

(Source: NHS Digital)

The trust’s strategy, vision and values underpinned a culture which was patient centred. We met with different groups of staff including consultants, junior doctors, nurses, clinical and divisional leads and conducted all-staff focus groups. Several staff members working across both sites commented that support from managers was ‘really good’. Some said they were
given lots of development opportunities and understood strategic vision of their respective service. We were told that the practice development team were very supportive and provided the necessary learning materials.

We were told that most of the medical workforce felt well supported. The trust had recruited a high calibre of consultants recently, including two care of the elderly physicians, who were specialists in dementia care. Recruitment had helped the workforce feel supported.

However, some junior doctors felt they were not provided with sufficient information and supervision when working on the ambulatory care unit and in the early evening when working out-of-hours. Feedback from Health Education South London (HESL) stated that trust needed to improve the support given to junior doctors during twilight hours and find better support for the ambulatory care unit when open for admissions. In response and following the inspection, we were informed that the trust had strengthened senior clinical support with on-site consultant presence for both ambulatory care and early evening working in late 2017. We were also informed that there was provision of an advanced nurse practitioner in the evenings to assist the clinical on call team on ward cover. A subsequent visit from HESL in November 2017, had closed off the mandatory actions relating to these issues.

Board members described the trust culture as open, committed and passionate. Staff were honest when errors were made and we found that the majority of staff were able to raise issues with the CEO.

In the NHS Staff Survey of 2017, the trust had an engagement score of 3.77, which was average when compared with trusts of a similar type. Engagement scores range from 1 to 5, with 1 indicating that staff were poorly engaged (with their work, their team and their trust) and 5 indicating that staff were highly engaged.

In the same survey, the trust performed worse than it did in 2016 and below the average for acute trusts. In the questions related to ‘Staff recommendation of the organisation as a place to work or receive treatment.

<table>
<thead>
<tr>
<th>Trust score</th>
<th>Average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care of patients/service users is my organisation’s top priority</td>
<td>73%</td>
</tr>
<tr>
<td>• My organisation acts on concerns raised by patients/service users</td>
<td>70%</td>
</tr>
<tr>
<td>• I would recommend my organisation as a place to work</td>
<td>57%</td>
</tr>
<tr>
<td>• If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation</td>
<td>67%</td>
</tr>
<tr>
<td>• Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.71</td>
</tr>
</tbody>
</table>

After a gap of one year, the trust had recently held two years’ worth of long service awards to recognise staff’s contributions to the trust. We attended one of these award ceremonies whilst on our engagement visit during the year.
There was a freedom to speak up guarding (FTSUG) in post since September 2016, who did 22 hours/week in the FTSUG role and 15 hours/week in a clinical nurse specialist role in the trust. The role was advertised internally and the FTSUG wanted to make a difference. Training was provided by the National Guardian Office and the FTGUG also attended listening and learning events. The trust recently appointed another FTSUG for a further one day/week.

The FTSUG felt that the current resources were sufficient and had been allowed to help staff appoint their choice of FTSUG ambassadors or champions to help in raising concerns in each of the directorates. Senior staff including consultants had spoken to the FTSUG about their concerns. The FTSUG had monthly 1:1 meetings with their line manager, although not formally recorded. We were also told that the FTSUG had not had an appraisal since they were in post. The FTSUG travelled around the trust to see staff individually or in groups. They submitted ‘raising concerns’ reports to the board on a twice-yearly basis and presented them in person. The FTSUG was part of the FTSUG Regional Network and found these supportive as well as an opportunity to learn. Information about FTSUG was promoted through staff briefings. There was a FTSUG screensaver for staff to use on their computers as well as FTSUG posters in the trust. The FTSUG escalated staff concerns that could not be resolved locally to the National Guardian Office for case review.

We were told that the board listened to its staff. However, the opening of the ‘escalation areas’ had caused some unease amongst staff re-the suitability to staff those areas. The FTSUG was aware of the black midwives concerns in the maternity service at St Helier Hospital.

The trust had 37 whistleblowing cases in the past 12 months and the FTSUG was trying to promote people speaking up. We reviewed five whistleblowing cases and the FTSUG was used in four of those. We found that staff raised concerns about the safety on escalation wards. The board was fully aware of this concern, which had been raised in September 2017 and was not resolved or closed at the time of the inspection.

We found that the trust adhered to the duty of candour requirement appropriately. There were clear audit trails within the clinical case notes of the methods used for verbal and written communication, with accountable trust staff identified with dates recorded of when the Duty of candour actions were undertaken. Duty of candour letters to patients were written in an open and transparent manner, confirming processes of investigation, providing a nominated lead for the patient with an appropriate apology. There was clearly documented evidence with dates of when the outcome of the investigation report was made available to patients.

Most staff training was now online, so more flexible to access. There were challenges in giving staff time and access to computers and having time to be released. This was especially the case for nurses and HCAs, often due to staff shortages.

The workforce culture included areas for development which were being reviewed by leaders within the organisation and actions planned to improve this. There had been no external review of workforce culture in areas of concern, however external support was being arranged to deliver actions. Some black midwives at St Helier Hospital felt that equality and diversity were not promoted in their day to day work. Twelve percent of the trust board were from a BME background. We were told that some staff found it difficult to move into higher roles. The trust
was aiming to improve this with a series of initiatives, including mentoring and recruitment selection.

We reviewed the trust’s Workforce Race Equality Standard for 2016-17. BME staff were 1.73 times more likely to enter the disciplinary process and twice as likely to experience discrimination at work from a manager/team leader or other colleagues. The trust had an action plan and published this on its website.

We held a focus group for BME staff during the ‘Well-led inspection. Staff expressed some lack of clarity around WRES and its purpose. We were told that disciplinary action tended to be more punitive towards BME staff than their white colleagues. Some staff felt the trust needed more BME staff in senior positions and although a BME leadership programme was available, this needed to be publicised more. A trustwide BME network was launched the week before our inspection. Some staff stated that a similar group was launched in the past and it had no lasting impact.

Black midwives in the maternity service at St Helier Hospital expressed concern about staff leaving, disciplinary/performance being inconsistently managed, progression in to other roles, bullying and equality of treatment. They had submitted a collective grievance to the trust. An internal investigation was carried out and the report submitted during our inspection. Recommendations to improve the situation were made.

Some staff said they had seen improvements since the current chief nurse started in 2015, but many of the issues were longstanding. Staff had raised concerns with the FTSUG freedom to speak up guardian. One senior executive recognised that one of the trust’s main equality and diversity challenges was the BME representation amongst senior nurses. To help address this, a lead nurse had begun running programmes and offering career development support for BME nurses wishing to progress.

The trust had an equality and diversity (E&D) manager, toolkit and strategy. The manager started in September 2017 and although they had no team or members or staff working with them, they worked closely with the FTSUG. EDS1 had been completed at the time of the inspection. The E&D manager had been set detailed objectives and had set out an action plan for the period December 2017 to April 2018. The E&D manager’s immediate action was to set up the equality panel with Healthwatch.

**Governance**

The trust had structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. Reporting to the board were eight sub-committees committees, which focused on specific areas of work. The eight sub-committees were: trust executive committee, patient safety and quality, performance assurance and risk, audit, people and operational development, finance and investment, renumeration and charitable funds. These were chaired by a board member and reported to their outputs to the board.
Board meetings took place once a month and had a public and private part. Any member of the public could attend the public part of the board meeting. The trust had an integrated performance report (IPR), which it developed since the last inspection. This was reported to the board each month. The IPR highlighted the trust’s latest performance and covered the following areas; mortality rates, quality measures (stroke, transient ischaemic attack, venous thromboembolism and dementia, incidents, route cause analysis compliance, duty of candour, safety thermometer and falls), safe staffing, infection control, maternity care, friends and family test, PALS and complaints, cancer access, elective care pathways, workforce, communications and engagement and financial performance.

Each division had their own governance structure and reported to the relevant trust’s sub-committee. The chief nurse attended the governance committee meetings and worked closely with the medical directors who are responsible for governance and quality. There were also senior nurses represented on the governance committee.

We met with the divisional management team for surgery. We were told that this division was too big and too complex to have one clinical director (CD), so now had three. CDs met weekly with the divisional manager. There was clinical input into the management team and there was easy access to the executive team. The management team felt that the current system was functional and robust. There was a weekly workforce meeting where doctor’s capability, conduct and competence were discussed and challenged where necessary.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. Non-executive and executive directors were clear about their areas of responsibility.

There were appropriate governance arrangements in place in relation to Mental Health Act administration and compliance; and there were partnership arrangements with local NHS trusts for the provision of psychiatric liaison services with appropriate governance arrangements.

There was a structure for ward, team, division and senior trust meetings. However, the sharing of essential information such as learning from incidents and complaints was variable and can be improved. Most staff knew what to do to and felt confident to escalate concerns to a senior member of staff. However, in surgery, there was a lack of proactive leadership to address concerns identified within the risk register as well as lower level concerns escalated by operational staff.

The trust worked with third party providers such as other local trusts, GPs and the local authority to promote good patient care. Examples of this working together were through the South West London Elective Orthopaedic Centre and the Epsom Health and Care @Home service.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The trust ensured that when staff detained patients under the MHA, they filled out the correct paperwork and ensured that patients had their rights explained to them.
The trust worked closely with their two neighbouring mental health trusts, to provide care for mental health patients. There were initial operational issues in terms of referrals and accessibility of services, however, the provision of mental health services was much better now. An operational group was set up by the trust to look at mental health training. The group was tasked to improve staffing and training. The mental health team worked well with the learning disability (LD) team and staff were trained to care for people living with learning disabilities. There were four LD nurses employed by the mental health trust who were based at the trust.

Any patient subject to a section under the Mental Health Act (MHA) was allocated a mental health nurse throughout the 24 hour period. Acute Liaison Psychiatry on both sites assisted in the care patients to ensure that their physical and mental health needs were met with appropriate treatment. All staff had access to training provided by the two acute mental health trusts that provided liaison psychiatry services.

The trust had policies and procedures in place to meet the needs of people with mental health needs. There were Service Level Agreements with the local mental health trusts to help administer the documentation of patients detained under the MHA, to support staff in treating patients with a mental health illness, and to train staff.

There were regular governance meetings to oversee the work of the Liaison Psychiatry Services for the trust. We reviewed some of the minutes for these meetings and they covered relevant agenda items.

Staff knew how to report medicines errors and some gave examples of learning. Staff felt that the pharmacy team was responsive to their needs in terms of advice provision and chart screening. Staff felt that medicines supply from pharmacy to wards, happened in a timely manner. We saw and were told by staff on two wards (one at St Helier Hospital, one at Epsom General Hospital) that waste medicines were not always collected for return to pharmacy in a timely manner.

**Management of risk, issues and performance**

**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.

In 2017-18 a commitment was made to achieving improvements in response times for complaints.

Quarter one: 60% to be responded to within the agreed time frame (25, 35 or 45 working days).

Actual achieved = 45%.

Quarter two: 70% to be responded to within agreed time frame (either 25, 35 or 45 working days).

Actual achieved = 65%.

Quarter three: 75% to be responded to within agreed time frame (either 25, 35 or 45 working days).

Actual achieved = 68%.
Number of complaints made to the trust

The trust received 557 complaints from October 2016 to October 2017; medical care core service received the most complaints with 166. The biggest complaint subject was all aspects of clinical treatment with 245.

<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>166</td>
<td>30%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>129</td>
<td>23%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>113</td>
<td>20%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>45</td>
<td>8%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>32</td>
<td>6%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>20</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>3%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>16</td>
<td>3%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>13</td>
<td>2%</td>
</tr>
<tr>
<td>AC - End of life care</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>2</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

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

Finances overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£372,431</td>
<td>£392,162</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>-£25,780</td>
<td>-£12,813</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£398,211</td>
<td>£404,975</td>
</tr>
<tr>
<td>Budget (budget deficit)</td>
<td>£0</td>
<td>-£15,584</td>
</tr>
</tbody>
</table>

(Source: Trust additional information: Appendix WLAC4)

Epsom Health and Care risk register

The trust provided a document detailing their Epsom health and care risk register:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Existing Controls, gaps in controls and audit activity</th>
<th>Long-term mitigating action plan</th>
<th>Original risk rating</th>
<th>Current risk rating</th>
<th>End of FY Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staffing</td>
<td>The staffing issues relate predominantly to an inability to recruit and have the required staff in post within the services EHC are contractually responsible for in line with the delivery profile established in the Funding Agreement</td>
<td>15 (5 x 3)</td>
<td>15 (5 x 3)</td>
<td>10 (5 x 2)</td>
<td></td>
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<td>-------------</td>
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<td></td>
</tr>
<tr>
<td>1.1 Vacancy Rates</td>
<td>Rolling programme of place based recruitment Active identification of staff for secondment, bank, increased hours Agreement to use agency within financial envelope Ramp up plan in line with expected staffing profile Active prioritisation of workload across @home service</td>
<td>Development of EHC Workforce Strategy - new role; Creation of rotational posts and training posts</td>
<td>15 (5 x 3)</td>
<td>10 (5 x 2)</td>
<td>8 (4 x 2)</td>
</tr>
<tr>
<td>1.2 Competencies</td>
<td>Establish competency framework for @home service Establish required training programmes for all new staff Undertake individual planning sessions and agree plans Ramp up plan in line with expected competency profile Active prioritisation of workload across @home service</td>
<td>Ongoing competency assurance; Shared competencies across all professional groups</td>
<td>16 (4 x 4)</td>
<td>12 (4 x 3)</td>
<td>12 (4 x 3)</td>
</tr>
<tr>
<td>1.3 &quot;One team&quot; ethos</td>
<td>Organise launch event and ongoing communications and meeting structure Establish shared induction / onboarding programme Establish organisational development programme Establish leadership programme</td>
<td>Epsom Health and Care established and branded</td>
<td>12 (4 x 3)</td>
<td>8 (4 x 2)</td>
<td>6 (3 x 2)</td>
</tr>
<tr>
<td>2. Quality of Care</td>
<td>The risks relate to the potential to increase clinical risk of medical needs (e.g. exacerbation, adverse reaction) leading to safety risks and the potential that any increased demand placed upon community services results in bottlenecks and inability to cope. Overall that any clinical incident or never event undermines the whole of the integration programme and</td>
<td></td>
<td>16 (4 x 4)</td>
<td>12 (4 x 3)</td>
<td>12 (4 x 3)</td>
</tr>
<tr>
<td>2.1 Increased clinical risk</td>
<td>EHC as an alliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational specification with clear governance arrangements and escalation arrangements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escalation arrangements within and between partner organisations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service ramp up aligned to staffing and competency profile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily and weekly clinical review meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully integrated clinical strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 (4 x 4)</td>
<td>12 (4 x 3)</td>
<td>8 (4 x 2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.2 Increased demand on existing services</th>
<th>EHC as an alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational metrics incorporating onward referrals and resource requirements</td>
<td></td>
</tr>
<tr>
<td>Regular review of while system impact</td>
<td></td>
</tr>
<tr>
<td>Integrated activity, demand and capacity plans aligned with clinical strategy</td>
<td></td>
</tr>
<tr>
<td>12 (4 x 3)</td>
<td>12 (4 x 3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Outcomes and Finances</th>
<th>EHC as an alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risks relate to failure to achieve planned savings resulting in adverse financial position of ESTH and undermining the future viability of the programme; Inability to meet stretching outcomes within timescales resulting in adverse reactions to ethos and purpose of integrated work and EHC as an alliance; and that a focus on future strategic direction results in a lack of attention to delivery of @home service</td>
<td></td>
</tr>
<tr>
<td>16 (4 x 4)</td>
<td>12 (4 x 3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.1 Financial Savings</th>
<th>EHC as an alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of contingency fund and agreement to claw-back underspend to the contingency fund</td>
<td></td>
</tr>
<tr>
<td>Agreement to review operating model to address lack of delivery Provider 'whole organisation' escalation to support achievement of outcomes</td>
<td></td>
</tr>
<tr>
<td>Whole system care model with benefits over 3-5 year period; Accountable Care Partnership</td>
<td></td>
</tr>
<tr>
<td>16 (4 x 4)</td>
<td>12 (4 x 3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.2 Outcomes</th>
<th>EHC as an alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Performance Dashboard</td>
<td></td>
</tr>
<tr>
<td>Wider benefits realisation framework developed, agreed and implemented</td>
<td></td>
</tr>
<tr>
<td>Wider promotion of the</td>
<td></td>
</tr>
<tr>
<td>Whole system evaluation aligned to Surrey Heartlands Academy over 3-5 year period of</td>
<td></td>
</tr>
<tr>
<td>16 (4 x 4)</td>
<td>12 (4 x 3)</td>
</tr>
</tbody>
</table>
benefits of integrated, coordinated working

| 4. User and Carer Experience | Failure to involve wider community, voluntary organisations and carers results in reduced benefits and poorer outcomes | 5  
(5 x 1) | 5  
(5 x 1) | 5  
(5 x 1) |
|-------------------------------|-------------------------------------------------------------------------------------------------|---------|---------|---------|
| 4.1 Appropriate involvement of the wider community, voluntary organisations and carers | Co-design of operating model and specification with wider partners  
Inclusion of wider partners as part of operational delivery and evaluation  
Inclusion of carers’ needs as part of care planning process and documentation  
Improved capture of user and patient experience and outcomes | Whole system strategy aligned to prevention and carers strategy | 5  
(5 x 1) | 5  
(5 x 1) | 5  
(5 x 1) |

(Source: Board assurance framework – P113)

Board assurance framework

The trust’s submission includes the quarter one progress updates for the corporate objectives. These serve as the Board Assurance Framework as they focus on providing assurance on the delivery of the 25 corporate objectives.

For 2017/18 the trust’s six corporate objectives are:

- Delivering safe and effective care with respect and dignity
- Creating a positive experience that meets the expectations of patients, their families and carers
- Providing responsive care that delivers the right treatment, in the right place at the right time
- Being financially sustainable
- Working in partnership
- Ensuring highly engaged, patient centred and skilled teams that are well-led

(Source: Trust Board Assurance Framework)

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The trust’s complaints procedure and approach to managing patients’ complaints and concerns reflected the requirements of the Local Authority Social Services and National Health Service Complaints Regulations (England) Regulations (2009).

The trust received 606 formal complaints in 2016/17, which was a 3% decrease on the previous year. The chief nurse, chief operating officer, general managers, clinical directors and heads of nursing received copies of all new complaints, so there was senior clinical and management knowledge of them. We were told the CEO signed all complaint responses (except in periods of leave, when a designated executive director deputy signs responses).
The head of patient experience covered complaints, PALS, patient feedback and surveys, volunteering, the trust’s Patient First programme, and (in partnership with the head of communications and engagement) patient information and patient and public engagement. They reported directly to the director of communication and patient experience and managed eight WTE staff including the PALS officers. The head of patient experience provided quarterly reports to the trust board.

The complaints manager triaged and RAG rated complaints received and was responsible for assigning complaints to officers for investigation (with the division and drafting of responses). The complaints manager was also responsible for overseeing cases referred to the Parliamentary and Health Service Ombudsman. The complaints manager managed five WTE complaints officers, two administrators, and one operations coordinator. The director of communications and patient experience had board responsibility for complaints.

When written complaints were received, they were all acknowledged within the KPI of three working days. The complaint response timescale targets were 25 working days for minor, straightforward complaints, 35 days for more complex complaints and 45 days for the most complex cases. The trust had a performance target of 75% to meet all complaint timescales, but was performing lower at 70% and 69% in January and February 2018, respectively.

We reviewed five patient complaint files. There was awareness and support for patients to make complaints. However, three complaints were upheld; one was partially upheld; and three were rejected. One was not upheld following an investigation. The complaint process was simple and straightforward for patient and relatives to follow. There was involvement of PALS in all the records reviewed. There was not always clear evidence of complaint outcomes making any difference to the service on some of the complaints reviewed.

Categories of incidents were recorded and monitored through the trust’s risk management system (Datix). Each division was able to run reports on the categories of incident reported and associated trends. Learning associated with incident reporting was shared via a number of channels including, incident reporting, incident investigation, quarterly reporting, newsletters, investigation reports, serious incident panels. The top five themes of incidents reported across the trust were:

- Care and treatment
- Staffing issues
- Pressure ulcers (mostly the reporting of community acquired skin damage)
- Patient falls
- Maternity/ neonatal categories

The trust’s annual serious incidents report summarised the themes and learning as a result of serious incidents. The top five themes of serious incidents were:

- Lack of contemporaneous documentation
- Suboptimal medical review
- Compliance with trust policy/best practice guidance
- Medication
- Communication, medical

Measuring outcomes was monitored through the number of harm incidents, including serious incidents, reported each month in proportion with the total number of incident reported. This was reported through the trust's integrated performance report.

All incidents were investigated using Root Cause Analysis. Every serious incident (SI) investigation, including Duty of candour was signed by the medical Director.

There were appropriate governance arrangements for safeguarding adults and children.

**Safeguarding Adults**
There was a bi-monthly safeguarding adults committee which was jointly chaired by the chief nurse/Head of Education and Safeguarding lead. This committee was accountable to the trust executive committee (TEC) and provided the trust with assurance and monitoring of the safeguarding function.

**Safeguarding Children**
The chief nurse was the executive lead for safeguarding and reported to the TEC. The TEC ensured the trust was meeting its obligations in safeguarding children and promoting their welfare. Representatives from the CCGs attended these meetings. In addition, the trust had representation within the Sutton, Merton and Surrey Local Safeguarding Children Boards. An annual safeguarding children report was produced and gave assurance that the trust was effectively discharging its safeguarding functions for children.

Senior management committees and the board reviewed performance reports. The Board Assurance Framework (BAF) was how risks were presented at board level. The board checked whether there was assurance that risks were being managed. They also checked what was being done, what controls there were and who was accountable. We reviewed the BAF for Q3. The document outlined the trust’s performance against the 25 corporate objectives. The BAF outlined the domain, objective, current quarter and performance/progress. It also stated the performance by quarter and projected year end position. Rationale and further actions were also described. The summary at the top of the document allocated an executive owner to the corporate objective.

The BAF was a dynamic tool for re-assessing risk and identifying the risk level with a colour coding. One executive told us that what the BAF doesn’t do was expose unknown risks and there had been an improvement in the system since the last CQC.

We noted that it was not clear which sub-committee of the board was responsible for which corporate objective. Timescales were described in quarters rather than by exact date. The BAF did not describe links to the risk register. Risks to the delivery of care were not outlined and therefore not rated. Primary, secondary or tertiary controls were not described, which would demonstrate best practice; nor were assurances or assurances gaps.

PLACE audit scores were being maintained, but the environment continued to score poorly. There was good feedback by patient on the quality of the food provided, but there was also a high turnover of hostesses. There were no complaints about the food in the past year. Food
management was part of the 15 steps that the trust board undertook prior to board meetings. This involved looking for evidence that observations were consistent with information.

The trust was slightly below the benchmark on the model hospital, but slightly above nationally. All medical devices were tracked electronically and will be linked to the financial asset register. This should be operational by the end of April 2018.

The audit committee had a structured agenda and external membership. The committee had three NEDs and also included the chief financial officer (CFO) and director of strategy. The NED lead for audit worked closely with the CFO. Outputs from the committee were reported to the board. The audit committee found that there was a large financial write off in the pharmacy secondary to a fire there. This resulted in the trust reviewing how it reported non-clinical serious incidents to the board.

The audit process had improved following recommendations from internal audit. New internal auditors were recently appointed. The NED lead for audit told us they had a voice at the board, when the BAF was reviewed on a quarterly basis.

The audit committee identified that there were fraud related to car parking and immigration statutes. Some staff were reporting sick and working elsewhere. As a result, NIS numbers were checked across the local health economy. The trust responded by training its staff on reducing fraud.

External audit did note an issue with the ability to track assets on the asset register, although this issue was not stated as material and the accounts were unqualified. Interviewees noted that this was now being addressed through the implementation of a tracking system.

The trust delivered its control total in 2016/17, and was forecasting to achieve it in 2017/18 (before application of the Sustainability and Transformation Fund). The minutes of the audit committee showed that internal and external auditors had not flagged any material concerns in the last year. Counter-fraud had supported the trust with a fraud case amounting to a £580,000 loss in 2016, and the audit committee minutes showed that the trust had taken account of the lessons learned from this case.

In the medicine division, during audit meetings, action plans from previous incidents were monitored. Staff from across the division were involved in audit meetings in order to share learning.

NEDs undertook hospital visits. One told us that they sat and talked with people about their experiences and that the trust prioritised quality of care over finance. From discussion with the surgical division, it was clear that operational and clinical management were appropriately supported by financial colleagues, including embedded finance managers, and that the operational and clinical team understand the implications on resource use of their actions. Both
operational staff and board members agreed that patient safety and clinical quality would not be compromised by financial restrictions.

The risk register had been re-written since the last inspection and the performance assurance and risk committee (PARC) was formed. We reviewed the risk management process and it was explained to us. Risks were identified, reported to the divisional management team (DMT), then to the performance committee and then to the trust executive committee (TEC), where corporate risks were discussed. All board members recognised that the trust’s top three risks were inadequate staffing, poor quality estate and finance. There was also universal recognition that inefficiencies were caused by running two full service district general hospitals, across a relatively small geography.

Risks were drawn from the integrated performance report (IPR) and divisional risk registers. Divisional risks over 16 were discussed amongst the executive team. The trust organised quality half days. This was a monthly program, where quality initiatives were discussed and action plans agreed on implementation of an identifiable quality initiative.

In 2015, governance and risk from ward to board was not managed, however clear action had been taken to improve this. Trustwide risks and service risks were now better understood. Risks were identified in three categories with short term and long term actions. Risk register was dynamic and reviewed regularly in the senior leadership team (SLT) and risk committee. This was all in the public domain and part of the performance report. If a risk was not scored right, then this was addressed. We saw some risks that were visible on both the divisional and organisational risk registers.

Recently, a specific clinical risk relating to colposcopy equipment was reviewed and actions were taken to reduce the risk immediately including putting extra equipment in place. The trust’s risk appetite was explained in the risk register ratings. Specific risk appetite was discussed; for example, the risk appetite for lifts was discussed as this was always high.

The trust had identified five objectives which were broadly categorised as; safe and effective care, positive experience; responsive care, financial sustainability and working in partnership. There were four identified challenges which were; strengthening staffing in key service areas, variability in the delivery of clinical care, the quality of the estate and infrastructure; and finance. There was a comprehensive list of 25 key priorities in six domains; safe, effective, caring, responsive, well-led; and money and finance.

The trust’s bandwidth had a high risk score of 25 i.e. its capacity to manage issues. Mitigation and controls were written as part of PARC. Internal risks were discussed at PARC, but none made it to the corporate risk register. The corporate risk register was reviewed monthly and executives were updated quarterly. Clinical risks included stroke services and elderly care. One senior executive told us that the trust was at its limit of what it could manage and this had impacted on non-delivery of the key standards of RTT and finance.

Divisions used their local risk register to report issues. Following the inspection, we were told that executives discussed what the risk score should be using the NPSA risk matrix and
dependent on the scoring agreed, risks would be presented at PARC. Risks were reported to the TEC meeting and also discussed at the monthly performance meeting.

A&E four-wait performance was better than the national average. We were told that contributing to this performance were the Surgical Assessment Unit, Ambulatory Care unit and Epsom Health and Care (EHC). At the EHC, GPs and social workers worked with the hospital and prevented patients from coming into hospital unnecessarily. However, medical cover in A&E at St Helier Hospital was often stretched and one senior executive told us the department was too small.

In the surgical division, risks were reported to the divisional manager and logged. Urgent risks were logged immediately by Chair’s action. Risks were discussed at all monthly divisional governance meetings (CQAG) and at PARC. All risks that were rated 15 and above were discussed. There were also bi-monthly risks meetings and risk owners had to attend. RTT performance was below the national average, based on the model hospital. The trust followed the National Planning Guidance i.e. what was done this year and what needed to be done next year.

We were told the trust was struggling to keep up for demand in services, so even though workforce has increased, resources remain tight. The trust had seen more extreme demand this winter season which meant more escalation areas opening. However, the practice of opening escalation areas with agency staff had ceased.

Junior doctor recruitment was a challenge. There was effort to understand rotations early and engage with junior doctors, so they felt involved in the trust. The trust was also looking to reduce junior doctors’ workloads through the recruitment of advanced nurse practitioners, physician associates and doctor administrative assistants.

During the inspection, the trust was experiencing winter pressures on its emergency departments, like elsewhere in the country. There were increases in both the number of attendances and the level of acuity. The trust had opened escalation ward areas in order to cope with the increase in demand for its acute services and showed that it had appropriate plans to ensure business continuity.

However, at Epsom General Hospital, the lack of community beds resulted in some delayed transfers of care (DTOC). Due to bed pressures, medical patients at times had to be admitted to SWLEOC, with is the regional elective orthopaedic centre. Nursing and clinical directors were involved in making these decisions.

**Information management**

There were gaps in the quality and sustainability of information received by the trust. We were told that there had an under investment in IT over several years. However, capital investment in IT had trebled as part of the trust’s digital strategy.
The trust was still using the ISOFT3 data management system, which was an outdated PAS system which took a lot of manual processing. For example, SITREP was collated by hand on an excel spreadsheet daily. This risk was being managed until the new hospital build. The trust was putting a lot of effort into making the data right. ESIS reviewed data and reported back that it was good quality. Manually tracking of 18 week RTT had meant good quality data. A&E data was scrupulously tracked and so correct.

The trust had invested in a number of core systems to maintain availability of existing infrastructure (such as PACS digital storage), a rolling PC replacement programme, network infrastructure replacement, better mobile working, electronic prescriptions and medicines administration, and deployed new tools to improve clinical care and management of the trust.

One senior executive told us they were not happy with the quality of the trust’s data, as they believed it did not give the detail of what the main issues were. For example, current data could not produce theatre efficiency. They also said that information throughout the local health economy needed to be better in order to alleviate some challenges around information sharing. However, following the inspection, the trust told us that data quality was not a significant issue for the trust. Availability of sufficiently granular theatre utilisation data had made it more difficult to undertake demand and capacity work and manage theatre utilisation effectively. The trust had invested in additional analytic staff to help support clinical divisions as well as other tools to address this challenge.

Following the inspection, we were told that the trust had supported a combination of face to face and on-line information governance (IG) training throughout the year. The trust achieved the 95% standard of all staff being trained in IG for the 2016/17 year, and achieved Level 2 in the IG toolkit.

The trust provided information to NHS Improvement and to its board on its financial position. Some executives told us that sometimes systems within the trust did not provide consistent information (e.g. between HR records and finance), but the trust has provided additional funding for analysts to work with divisions to ensure the information used by operational and clinical staff was as accurate as possible.

Performance measures were clearly collected and documented and information and data validated. There was work to be done to establish further information management and IT systems to improve data processes, whilst also considering the impact of the current estates.

Most data validation occurred daily, including waiting time data. For example, A&E datasets were validated by the emergency department team and the urgent care service leads daily and signed off by the director of urgent care. RTT data was reviewed by the trust operational performance group (consists of service managers from all divisions) twice every week. Cancer datasets were reviewed by the cancer services team. These were signed off by the director of planned care.
Most safety data were reviewed on a case by case basis. This included mortality review and infection control. The trust information team provided a series of reports that supported this review and validation process.

The trust’s board made a decision to continue using a mixture of paper and electronic records. However, it did recognise that the two main weaknesses in its records management systems were:

• Only having a partially electronic system available.
• The IT infrastructure.

The trust described one of its electronic clinical information systems as ‘often very slow to process electronic documentation’. Its poor IT infrastructure had a negative impact on the effectiveness of some of its electronic record management systems.

**Engagement**

The trust engaged with people who use services and their relatives/carers. For example, there was the Cancer Patient Forum whose role was to help support and improve services for those affected by cancer.

The wards and departments largely had access to feedback from patients and carers via the friends and family test. Although, the characteristics of the friends and family test data is not classed as official statistics, the trust scored similar to the England average for recommending the trust as a place to receive care from September 2016 to August 2017. In many areas, these results were used to make improvements.

We received positive comments from patients and their relatives via boxes we placed in the trust during the inspection, about their care and treatment. Comments included ‘I am very happy about the cooperation and treatment’; ‘Great care, great staff’ and ‘All staff have been really helpful, I have had no problems’.

The CEO’s weekly message was well received for those who had access computers regularly. Matrons delivered messages for those staff who did not have access to computers.

The trust undertook internal engagement with both clinical and non-clinical staff regarding service design and change. An engagement event called ‘Shaping the Future’ was led with 200 staff, to discuss and agree key success factors improve staff’s experience and deliver the organisation’s objectives. This led to each division reviewing the staff survey results with their staff and producing local action plans. The plans had been presented to the TEC.

An engagement taskforce was set up called ‘Daniel’s Taskforce’ to help engage with staff more effectively. There were monthly meetings and began in October 2017.

The trust was in the process of strengthening its engagement with staff. It introduced a major involvement event for all staff and formed a staff engagement group. There was a “Breakfast with the Boss”, where staff were able to speak with CEO and raise concern.

The trust had struggled with obtaining exit interviews. Attempts to improve this had not been successful. Feedback was more frequently received informally.

Healthwatch Surrey was actively engaged with the trust and provided feedback to trust from patients and relatives using Epsom General Hospital. The Healthwatches of Sutton, Merton and Surrey all took an active part in gaining feedback from local people on the trust’s proposal for 2020/2030.
As part of the development of the long-term plans for the organisation, the trust had also engaged extensively with local stakeholders including MPs, local authorities and the public. As the programme moves forward, the next stage was a formal public consultation led by its host CCGs.

The trust straddles two STPs (in two NHS regions) and the trust CEO took a lead role with engaging with these, supported by the director of strategy, corporate affairs and ICT. The chair also engaged with the STPs, and with the chairs of the other trusts in the area.

The trust was involved in an integrated provider alliance (with GP practices) around the Epsom area (Epsom Health and Care Alliance @home service) which delivered care for older people. This has resulted in better flow for example no 12 hour trolley waits in A&E and no corridor queues. At the time of the inspection, the trust was waiting to hear whether it was the preferred provider to deliver a similar service from the St. Helier Hospital site.

We were told by the trust that there were good relationships with the local CCGs. The focus was on what the trust was meant to deliver and the aim was to keep to a block contract. The CCGs provided us with feedback on the trust’s performance and were satisfied with the respective relationships they had with them.

**Learning, continuous improvement and innovation**

**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>Epsom Hospital was awarded full accreditation on 19th April 2017. St Helier Hospital has had accreditation deferred pending structural alterations.</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>The first ACSA inspection took place on 16-18th October 2017. The Trust are awaiting formal feedback.</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>All labs have been awarded ISO 15189 accreditation. The certificates have not yet been issued.</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>The Macmillan Butterfly Centre at Epsom Hospital achieved accreditation on 16th May 2013. The Cancer Information and Support Centre St Helier has not yet achieved accreditation.</td>
</tr>
<tr>
<td>Psychiatric Liaison Accreditation Network (PLAN)</td>
<td>St Helier Hospital Liaison Psychiatry Service. Accreditation was achieved on 14th December 2015 and is valid until 14th</td>
</tr>
<tr>
<td>December 2018.</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Peer Review of Paediatric Acute Care Services for Children and Young People</strong></td>
<td></td>
</tr>
<tr>
<td>The Healthy London Partnership visited Epsom Hospital and Queen Mary’s Hospital for Children, which is collocated with St Helier Hospital, on 21st March 2017. Feedback from the visit has been received.</td>
<td></td>
</tr>
<tr>
<td><strong>National Cancer Peer Review - POSCU</strong></td>
<td></td>
</tr>
<tr>
<td>A peer review was undertaken by the NHS England Quality Surveillance Team in April 2016. Feedback from the review has been received.</td>
<td></td>
</tr>
<tr>
<td><strong>UNICEF Baby Friendly Initiative (BFI)</strong></td>
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<tr>
<td>The Trust was visited by UNICEF from 22nd March to 24th March 2017. Full accreditation has been maintained.</td>
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<tr>
<td><strong>Antenatal and Newborn Screening Quality Assurance</strong></td>
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<td>The antenatal services and laboratory were quality assured by Public Health England on 8th and 9th February 2017. Feedback from the visit has been received.</td>
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<tr>
<td><strong>South London Adult Critical Care Network (SLACCN) Review</strong></td>
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<td>The SLACCN review of Critical Care took place on 26th June 2017.</td>
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<td><strong>South West London &amp; Surrey Trauma Network Peer Review</strong></td>
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<tr>
<td>The South West London &amp; Surrey Trauma Network peer review took place on 28th July 2016 and a follow up visit took place on the 24th April 2017. The Trust has retained the trauma unit status within the local trauma network.</td>
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<tr>
<td><strong>British Society of Echocardiography Departmental (BSE) Accreditation</strong></td>
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<td>The Department of Cardiology on both sites in the Trust (Epsom Hospital and St Helier Hospital) achieved British Society of Echocardiography Departmental Accreditation in October 2010. Re-accreditation was achieved in October 2015. The accreditation covers: Transthoracic Echocardiography and Training to BSE Proficiency Standard.</td>
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<tr>
<td><strong>Cervical Screening Programme - Quality Assurance Visit</strong></td>
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<tr>
<td>A quality assurance visit took place on 10th, 29th and 30th November 2016. A report has been received and an action plan created.</td>
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<td><strong>National Cancer Peer Review - Cancer of Unknown Primary</strong></td>
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<td>A peer review was undertaken by the NHS England Quality Surveillance Team in February 2016. A report has been received.</td>
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<tr>
<td><strong>London Clinical Networks Renal Services Peer Review</strong></td>
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<tr>
<td>The West Midlands Quality Review Service carried out a peer review of renal services on 29th and 30th June 2016. The final report was issued to the Trust on 23rd September 2016.</td>
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<td><strong>NHS England Emergency Preparedness, Resilience and Response Assurance Process</strong></td>
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<tr>
<td>A visit from NHS England South London EPRR Area Team took place on 10th November 2016. A report has been provided to the Trust.</td>
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<tr>
<td><strong>NHS England Chemical, Biological, Radiation, and Nuclear (CBRN) Assurance Process</strong></td>
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<tr>
<td>A visit from NHS England South London EPRR Area Team took place on 29th September 2017. Feedback has been provided to the Trust.</td>
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<tr>
<td><strong>Human Tissue Authority Inspection</strong></td>
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<td>An inspection of SWLEOC took place on</td>
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16th June 2016. The inspection report has been received. An inspection of the mortuaries at Epsom Hospital and St Helier Hospital took place on 7th-8th January 2017. The Trust are awaiting the report for the inspection of the mortuaries.

| Stroke Clinical Network - Acute Stroke Review | The Stroke Clinical Network undertook a review of the acute stroke service at St Helier in 2017. Accreditation has been achieved. |
| Getting It Right First Time (GIRFT) | Visits by GIRFT have taken place for the following specialties:  
  • General Surgery  
  • Orthopaedic Surgery  
  • Vascular Surgery  
  • Spinal Surgery  
  • Oral and Maxillofacial  
  • Obstetrics and Gynaecology  
  • Ophthalmology Surgery |

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

The trust actively sought to participate in national improvement and innovation projects. There was an associate medical direct for research and development, innovation and information technology. The trust had policies for the introduction of new and innovative devices and technologies and was building a portfolio of innovations that had been adopted and implemented throughout the trust. For example, the trust had adopted several of the first innovations that were selected by NHS England as part their new innovation and technology tariff. These innovations included episiotomy scissors, for women giving birth, together with other medical devices for patients with chronic lung problems, men having urological surgery, and acutely ill inpatients.

Innovative practice had been championed throughout the trust through roles such as the nurse catheter care champion dementia care specialist; and awareness specialist nurses and educators.

The trust had worked closely with the Health Innovation Network (HIN) South London, whose role is to identify, adopt and spread innovation across the health and care system in South London.

The trust had a policy for mortality reporting and mortality peer review process. The purpose of this policy was to state how the trust would implement the requirements of the Learning from Deaths Framework as part of the organisation’s existing procedures in order to learn and improve the quality of care for all patients.

One of the joint medical directors was the board lead responsible for learning from deaths. One of the associate medical directors was responsible for the implementation of the policy. Both the medical director and associate medical directors were trained investigators for RCA.

The trust was an early adaptor for learning from deaths and had three trained investigators who also trained others within the trust. The trust approach: Stage 1- all clinicians could
undertake the investigation; Stage 2- Structured Judgement Review (SJR), undertaken by trained clinicians only. Anyone who had a psychosis or learning disability automatically had an SJR. Mental health and learning disability deaths were reviewed and learning was shared locally and beyond. The safeguarding committee was involved where there were. Part of this review included going out to talk to the family in their own home. There was a template for all junior doctors to complete for deaths in parallel with SJRs; this was then reviewed by senior staff.

Every six weeks, all elective activities were cancelled, so that learning from deaths could take place (quality initiatives). Learning from deaths was discussed at CQRG and GPs could raise quality alerts with trust re-patients who die post discharge. Learning was also shared through webinars.

We were told that if concerns were found about the death of a patient, the Duty of candour procedure was implemented and recorded as a clinical incident. Duty of candour was audited on a monthly basis. If a family member had concerns about their relative’s death, they could request an SJR, where the death would be reviewed. Patient relatives could also request a mortality review, if they wished. Information on the process was contained in bereavement paperwork for families.

We were told the medical director always made direct contact with patient’s family, followed up with a formal letter. The family were usually invited them to come in for a meeting and they were involved in the RCA. They were also invited back for findings of the RCA. We were told the team lead on ‘learning from deaths’, had the resources to deliver its strategy, although it was ‘early days’.

We found the mortality review process was embedded into existing systems. Systems the trust found beneficial were RADAH- (Reducing Avoidable Deaths and Harm), RADAR (Reducing Avoidable Death Action Review) and simulation courses. The team also developed good links with quality half days, so these did not just focus on audits and SIs, but also deaths. Medical and nursing staff attending these.

The cardiac arrest panel found that the DNACPR process was unnecessarily being implemented with frail elderly process. As a result of the learning from this, the revised ‘Managing Acutely Ill patients’ policy was developed.

Deaths were picked up through Datix. Mortality reviews were the responsibility of associate medical directors. They met to discuss, investigate and share learning. Six doctors were trained to review all death in the trust to gather deeper understanding of what went wrong. Mortality rate had been reducing and was currently lower than the national average at 3.5%. Mortality and morbidity meetings were part of audit committee meetings. If death was felt to be avoidable, it was raised at the audit committee meeting.
Innovation and continuous improvement was evident through examples such as the transformation team and use of the PERFORM methodology. This was a bespoke performance improvement methodology and was supported by a large performance improvement team, staffed with substantive trust employees rather than relying on consultancy support. There was a focus of continuous improvement on important areas such as Accident and Emergency and this had an impact.

The trust had invested in a system of electronic whiteboards on ward areas. This was a plasma screen near the nurses’ station and included data including the patient’s name, whether VTE was completed, NEWS score, and dementia screen. The whiteboards gave a snapshot of what was happening with each patient on the ward.

The trust had a program of One Year Quality Sessions; this was where the doctors met to reflect and learn from each other. They discussed SIs, took lessons and learning from incidents. An example of changes as a result of this was the introduction of nasogastric tube insertion training for the doctors.

Another development was the “Governance Grand Round”. This was where teaching and learning sessions were shared with all medical staff, who then developed a teaching program and shared with all staff. An example was the development of the hypoglycaemic training session program that the diabetic team developed on hypoglycaemic prevention and management.