Epsom and St Helier University Hospitals NHS Trust

Epsom General Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This is a report on a focused inspection we undertook at Epsom General Hospital on 29 and 30 October 2018. The purpose of this inspection was two-fold. Firstly, to follow up on concerns raised by Her Majesty's Coroner, in relation to patients being treated for hyponatraemia (low sodium blood levels), and the internal communication of abnormal pathology results. We also followed up on received concerns about the safety of mental health patients in the emergency department, nurse staffing levels in medical care wards and the safeguarding of patients being discharged from hospital. The concerns raised related to both Epsom General Hospital and St Helier Hospital.

Secondly, we followed up on the outstanding requirements from critical care and services for children and young people at Epsom General Hospital. As we had not inspected these services for more than two years, we inspected and rated them in their entirety.

Our key findings were as follows:

- Staff in the emergency department (ED) provided care and treatment based on national guidance and evidenced of its effectiveness. We saw recently adapted guidance on quality standards for the treatment of patients with hyponatraemia and these were embedded in practice.
- Medical staff across the ED, acute medical unit (AMU) and medical wards, received training in the management of patients with hyponatraemia.
- There was a trust wide standardised approach to the detection of deteriorating patients using the National Early Warning Score (NEWS) scoring system and staff knew what action to take when the score was above 4.
- Pathology results needed to deliver safe care and treatment were available to staff in a timely and accessible way. There was a trust wide standard operating procedure for communicating abnormal blood results to appropriate staff.
- Staff received effective training in safety systems, processes and practices. The trust trained staff in the Mental Health Act (MHA) and Safeguarding Adults.
- The design, maintenance and use of facilities and premises were satisfactory. There was a designated room for interviewing patients with mental health needs in the ED at Epsom General Hospital. The room had an emergency panic alarm strip and two exit points and there were no ligature points.
- ED staff identified adults at risk of causing harm to themselves. Patients assessed as being at risk of suicide or self-harm, received early referrals to the mental health liaison team. Policies and procedures were in place for extra observation or supervision of patients with acute mental health needs.
- The trust managed patient safety incidents well. Staff recognised incidents and reported them appropriately and learning was shared across the two sites. Staff gave us clear examples of when learning from incidents had resulted in changes to practice. This was an improvement since our last inspection.
- The trust monitored the effectiveness of care and treatment and used the findings to improve them. The trust regularly participated in national clinical audits and managers demonstrated a good awareness and understanding of the patient outcomes.
- Staff we spoke with described service leaders as visible and approachable. In critical care, the leadership worked to improve links between the two sites, including joint working and staff rotation.
- Managers of the critical care service promoted a positive culture, that supported and valued staff, creating a sense of common purpose based on shared values.

Summary of findings

- There was a clear drive from the clinical leadership to improve consistency and collaboration across the two sites in critical care and learning and development between sites had improved since our last inspection
- Safeguarding processes had improved since our last inspection across children and young people services. Staff had instant access to information, which was held electronically. This meant staff were immediately aware if a child was known to social services, was a looked after child, or subject to a child protection plan.
- Staff identified and responded appropriately to changing risks to children and young people, including deteriorating health and wellbeing and medical emergencies. Staff were able to seek support from senior staff in these situations.

However, there were also areas of poor practice where the trust needs to make improvements.

- The critical care service did not have suitable premises and the design of facilities did not meet the needs of patients. At the last inspection, there were several concerns about the facilities in critical care not being suitable for the patients including the unit not having any isolation rooms for patients and excessive temperatures during summer months. During our inspection, we saw these concerns remained, although they were identified on the service risk register.
- The critical care service did not always maintain an effective patient flow through the department. Delayed discharges remained consistently worse than the national average in the Intensive Care National Audit Research Centre (ICNARC) audit and this was graded as an extreme risk on the service's risk register.
- In the ED at Epsom General Hospital, people's individual care records were not always written and managed in line with best practice. This meant timely and available information was not available to the multi-disciplinary (MDT) team.
- Some medical wards did not use a checklist when discharging patients and this could result in parts of the process being missed.
- Some printed guidelines and policies we saw had passed their review date, or did not have a review date, which meant staff were at risk of not following the most up to date guidance.
- There was not a clear vision or strategy for critical care. While the service had defined plans to improve consistency of working between the two sites and had achieved some of these goals, it lacked a defined longer-term strategy.
- The critical care service had limited engagement with patients, staff, the public and local organisations to plan and manage appropriate services. Responses to the Friends and Family Test (FFT) were limited and there was limited active engagement of patients and relatives to provide feedback.
- In the children and young people service, medical staff did not meet the completion rate target of 85% for nine out of the 11 mandatory training modules for medical staff. This meant that not all medical staff had received training essential to providing safe patient care.
- In the children and young people service, staff did not consistently record the temperature of the fridge in the clinical room in the neonatal unit, which was used to store breast milk. This meant that there was a risk that breast milk could be exposed to abnormal temperatures, which could cause the milk to deteriorate.
- Locum medical staff did not have access to the full information technology systems and could only use a generic log on to access the trust's systems. This meant locum staff could not easily access important information such as handover lists, transfer letters and up to date guidelines.

Importantly, the trust must:

- Improve the environment and facilities on the critical care unit to reduce the infection control risks to patients.

Summary of findings

- Improve systems and processes in critical care so that patients are not delayed from being discharged.

In addition, the trust should:

- Consider an outreach service to support patients whilst they are waiting to be admitted to the critical care unit.
- Consider ways to increase engagement and feedback from patients in critical care and those close to them to improve the quality of the service.
- Develop an agreed vision and strategy for the critical care service and that staff are involved in the process.
- Ensure that guidelines and processes have adequate version control and are regularly reviewed, so staff have access to the most up to date guidance.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		• The service provided care and treatment based on national guidance and evidence of its effectiveness. We saw recently adapted guidance on quality standards for the treatment of patients with hyponatraemia, and these were embedded in practice. • Medical staff across the emergency department (ED) received training in the management of patients with hyponatraemia. • There was a trust wide standardised approach to the detection of deteriorating patients using the National Early Warning Score (NEWS) scoring system and staff knew what action to take when the score was above 4. • Pathology results needed to deliver safe care and treatment were available to staff in a timely and accessible way. There was a trust wide standard operating procedure for communicating abnormal blood results to appropriate staff. • Staff received effective training in safety systems, processes and practices. The trust trained staff in the Mental Health Act (MHA) and Safeguarding Adults. • The design, maintenance and use of facilities and premises was satisfactory. There was a designated room for interviewing patients with mental health needs in the ED at Epsom General Hospital. The room had an emergency panic alarm strip, two exit points and there were no ligature points. • ED staff identified adults at risk of causing harm to themselves. Patients assessed as being at risk of suicide or self-harm, received early referrals to the mental health liaison team. Policies and procedures were in place for extra observation or supervision of patients with acute mental health needs. However: • In the ED at Epsom General Hospital, people's individual care records were not always written and managed in line with best practice. This meant timely and available information was not available to the multi-disciplinary (MDT) team.

Summary of findings

Medical care (including older people's care)

- The service provided care and treatment based on national guidance and evidence of its effectiveness. We saw recently adapted guidance on quality standards for the treatment of patients with hyponatraemia, and these were embedded in practice.
- Medical staff across the acute medical unit (AMU) and the medical wards, received training in the management of patients with hyponatraemia.
- There was a trust wide standardised approach to the detection of deteriorating patients using the National Early Warning Score (NEWS) scoring system and staff knew what action to take when the score was to above 4.
- Pathology results needed to deliver safe care and treatment were available to staff in a timely and accessible way. There was a trust wide standard operating procedure for communicating abnormal blood results to appropriate staff.

However:

- Some wards did not use a checklist when discharging patients and this could result in parts of the process being missed.

Critical care

Good

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately and learning was shared across the two sites. Staff could give us clear examples of when learning from incidents had resulted in changes to practice. This had improved since our last inspection.
- The service had sufficient nurses to ensure patients received safe care and treatment. The unit followed the Guidelines for Provision of Intensive Care Services (GPICS) for registered nurse to patient ratios in level two units.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. The trust regularly participated in national clinical audits and managers demonstrated a good awareness and understanding of the patient outcomes of the unit.

Summary of findings

- Mortality rates in the unit were within the expected range and unplanned readmission rates to the unit within 48 hours of discharge to a ward were better than the national average.
- Staff took the time to interact with people in a respectful and considerate way and were supportive to patients. During ward rounds and other interactions, staff answered patient concerns, explained symptoms and reassured patients.
- The service took account of the individual needs and choices of patients. Staff discussed patient needs and made reasonable adjustments to support patient requests where possible.
- Staff described service leaders as visible and approachable. Since the last inspection, the leadership had worked to improve links between the two sites, including joint working and staff rotation.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There was a clear drive from the clinical leadership to improve consistency and collaboration across the two sites; and learning and development between sites had improved since our last inspection.

However:

- The service did not have suitable premises and the design of facilities did not meet the needs of patients. At the last inspection, there were several concerns about the facilities not being suitable for the patients including the unit not having any isolation rooms for patients and excessive temperatures during summer months. During our inspection, we saw these concerns remained, although they were identified on the service's risk register.
- Some printed guidelines and policies we saw had passed their review date, or did not have a review date, which meant staff were at risk of not following the most up to date guidance.
- The service did not always maintain effective patient flow through the department. Delayed discharges remained consistently worse than the

Summary of findings

national average in the Intensive Care National Audit Research Centre (ICNARC) audit and this was graded as an extreme risk on the service's risk register.

- The trust did not have a clear vision or strategy for the unit. While the service had defined plans to improve consistency of working between the two sites and had achieved some of these goals, the service lacked a defined longer-term strategy.
- The service had limited engagement with patients, staff, the public and local organisations to plan and manage appropriate services. Responses to the Friends and Family Test (FFT) were limited and there was limited active engagement of patients and relatives to provide feedback.

Services for children and young people

Good

- Safeguarding processes had improved since our last inspection. Staff had instant access to information, which was held electronically. This meant staff were immediately aware if a child was known to social services, was a looked after child, or subject to a child protection plan.
- Staff identified and responded appropriately to changing risks to people who use services, including deteriorating health and wellbeing and medical emergencies. Staff were able to seek support from senior staff in these situations.
- People received safe care and treatment. Vacancy rates for nursing staff had improved significantly since our last inspection.
- Staff understood their responsibilities to raise and record safety incidents, concerns and near misses. Learning from incidents was routinely shared with staff across the service in several ways, such as regular ward meetings.
- The service used a range of evidence-based guidance, legislation, policies and procedures to deliver care, treatment and support to patients.
- From June 2017 to May 2018, the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma.

Summary of findings

- Staff treated patients and their families with kindness, dignity, respect and compassion. We saw that staff took the time to interact with people who use the service and those close to them in a respectful and considerate way.
- The trust provided timely and accessible services for children and young people which reflected the needs of the population served. Trust leaders had worked collaboratively with trust staff, external bodies and children and young people, and their relatives to do so.
- The trust listened and responded to people's concerns and complaints about services for children and young people, and used these to improve the quality of care. The service received a very low number of complaints.
- Leaders had the required skills, knowledge, experience and integrity to carry out their roles effectively.
- There were clear and effective systems of governance and management across services for children and young people at Epsom General Hospital, in close liaison with St Helier Hospital, the other trust's site.

However:

- Medical staff did not meet the completion rate target of 85% for nine out of the 11 mandatory training modules for medical staff. This meant that not all medical staff had received training essential to providing safe patient care.
- Staff did not consistently monitor the temperature of the fridge in the clinical room in the neonatal unit which was used to store breast milk. This meant there was a risk that breast milk could be exposed to abnormal temperatures, which could cause the milk to deteriorate.
- The trust paediatric policies we looked at were not all up to date. For example, one of the policies we looked at, had expired in September 2017.
- Locum medical staff did not have access to the full information technology systems and could only use a generic log on to access the trust systems. This meant locum staff could not easily access important information such as handover lists, transfer letters and up to date guidelines.

Summary of findings

- Some staff told us they would use other staff members to translate for parents or relatives. This was outside of best practice and trust policy.

Epsom General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Critical care; Services for children and young people.

Detailed findings

Contents

Background to Epsom General Hospital

Epsom General Hospital is part of Epsom and St Helier University Hospitals NHS Trust and provides acute hospital services to population of around 166,257. Services are commissioned by Surrey Downs Clinical Commissioning Group.

The hospital has 352 beds, including;

• 27 children's (excluding cots)

There are also 92 daycase beds.

Epsom General Hospital operates 24 hours per day and has an accident and emergency department. The hospital has approximately 59,026 emergency attendances each year. For December 2017 to November 2018, there were 47,132 admissions (including the South West London Elective Orthopaedic Centre (SWELEOC)) and 237,314 outpatient attendances (including SWELEOC).

Our inspection team

Three CQC inspectors, five specialist advisors (emergency care, critical care, children and younger person) and an assistant inspector.

The inspection was overseen by Helen Rawlings – Head of Hospital Inspection.

How we carried out this inspection

This inspection was unannounced and triggered by a series of concerns raised by HM Coroner in relation to the treatment of patients with hyponatraemia and the internal communication of abnormal pathology results. We also received concerns about the safety of mental health patients in the emergency department, nurse staffing levels and the safeguarding of patients being discharged from hospital. The concerns related to both Epsom General Hospital and St Helier Hospital. Both sites were visited during the inspection.

We also followed up on the outstanding requirements from critical care and services for children at Epsom General Hospital. As we had not inspected these services for more than two years, we inspected and rated them in their entirety.

During this inspection, we visited the emergency department, acute medical unit (AMU), medical wards, the critical care unit, paediatric services and the pathology laboratories.

Detailed findings

Before our inspection, we reviewed a range of information we held including a previous site visit, the HM Coroners reports, safeguarding notifications, whistle-blower concerns, as well as the trust's action plans.

We observed how patients were being cared for and reviewed over 30 patient records. We spoke with 60 members of staff including doctors, nurses, laboratory staff, managers and a director. We also spoke with 12 patients and 10 carers/relatives. We attended meetings, safety briefings and handovers.

Urgent and emergency services

Safe	
Effective	
Overall	

Information about the service

Epsom General Hospital provides urgent and emergency care services, 24 hours, seven days a week. Services are provided to the local populations within areas of north east Surrey.

The Emergency Department (ED) at Epsom General Hospital is not a trauma receiving unit, and does not treat patients who may need emergency surgery. Patients who present into the ED at Epsom and need emergency surgery were transferred to St Helier Hospital for further assessment and treatment.

The hospital receives emergency adult, paediatric and maternity patients.

For December 2017 to November 2018, 60,437 patients attended the ED at Epsom General Hospital. Of these, 16,215 (26.8%) were ages 17 years or under.

During 2016/2017 the ED 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 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, triage and treatment cubicles. The ED also has a separate Ambulatory Care Unit.

Summary of findings

- The service provided care and treatment based on national guidance and evidence of its effectiveness. We saw recently adapted guidance on quality standards for the treatment of patients with hyponatraemia, and these were embedded in practice.
- Medical staff across the emergency department (ED) received training in the management of patients with hyponatraemia.
- There was a trust wide standardised approach to the detection of deteriorating patients using the National Early Warning Score (NEWS) scoring system and staff knew what action to take when the score was to above 4.
- Pathology results needed to deliver safe care and treatment were available to staff in a timely and accessible way. There was a trust wide standard operating procedure for communicating abnormal blood results to appropriate staff.
- Staff received effective training in safety systems, processes and practices. The trust trained staff in the Mental Health Act (MHA) and Safeguarding Adults.
- The design, maintenance and use of facilities and premises was satisfactory. There was a designated room for interviewing patients with mental health needs in the ED at Epsom General Hospital. The room had an emergency panic alarm strip, two exit points and there were no ligature points.
- ED staff identified adults at risk of causing harm to themselves. Patients assessed as being at risk of suicide or self-harm, received early referrals to the mental health liaison team. Policies and procedures were in place for extra observation or supervision of patients with acute mental health needs.

However:

Urgent and emergency services

- In the ED at Epsom General Hospital, people's individual care records were not always written and managed in line with best practice. This meant timely and available information was not available to the multi-disciplinary (MDT) team.

Are urgent and emergency services safe?

Mandatory Training

- Staff received effective training in safety systems, processes and practices. 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 (ED) as a priority. Staff we spoke with in ED told us they had received level one and level two adult safeguarding training, which covered the Mental Capacity Act and Deprivation of Liberty. This meant staff were aware of the potential needs of people with mental health conditions. We saw evidence that 85.83% of ED staff had received Safeguarding Adults Awareness training, which is above the trust target of 85%.
- Medical staff across ED, AMU and the medical wards told us they had received training in the management of patients with hyponatraemia as part of their training programme. We saw evidence of this in the form of the Foundation doctors training schedule.

Environment

- The design, maintenance and use of facilities and premises of the ED at Epsom General Hospital kept people safe. During this inspection, we noted that there was a separate room designated for interviewing patients with mental health needs in ED. The assessment room had emergency panic alarm strips, there were no ligature points and there were two exits from the room.
- During our last inspection, we noted that 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 and had the potential to injure person using the area. However, during this inspection, we noted the door had been secured, minimising the risk of injury to others.

Assessing and responding to patient risk

- ED staff identified adults at risk of causing harm to themselves. During the inspection, we saw all patients assessed as being at risk of suicide or self-harm, received early referrals to the mental health liaison team. Staff worked in partnership with the mental

health team to ensure patients were helped, supported and protected. A mental health nurse was available at Epsom General Hospital through the psychiatric liaison service 24 hours a day, seven days a week.

- Staff supported patients with mental health needs through the psychiatric liaison service and by hiring bank and agency mental health nurses. Staff we spoke with told us that on the Epsom site, there were delays in assessing mental health patients overnight due to the mental health team not being on site. This meant there could be delays in patients with mental health problems getting the support needed. However, during the hours of 8am-10pm, the mental health team responded within an hour of referral.
- There were policies and procedures for extra observation or supervision of patients. Staff we spoke with in ED at Epsom General Hospital, told us patients who required extra observation or supervision received this. Staff told us registered mental health nurses were not always available to nurse patients on a one-to-one basis. We were told that on these occasions, trust staff would supervise the patients, with security support as required. This meant the patients who required one-to-one nursing were supervised at all times. Staff felt they were able to escalate the need for additional staff. We were told that out of hours, the site manager utilised nursing staff within the hospital to provide the additional support in line with the trusts safe staffing policy.
- We saw risk assessments completed by the mental health liaison team in line with national guidance. Risk assessments flagged whether a patient was at risk of suicide, self-harm or absconding and what action to take in response to these risks. For example, one set of notes we reviewed stated a patient was at risk of leaving the hospital before receiving a formal mental health assessment and staff should call the police if the patient left the hospital. However, ED told us they did not use a formal risk assessment tool for patients waiting to see the mental health liaison team, and were reliant on personal judgement to assess if someone was at risk. This meant that some patients at risk of harm may not be correctly assessed or referred to mental health services in a timely way. Following the inspection, the trust told us staff completed risk assessments electronically, for all patients in the Emergency Department at Epsom General Hospital, who were referred to the Liaison Psychiatry Service.
- Staff identified and responded appropriately to changing risks to people who use the service. We reviewed 12 sets of notes that showed staff used the National Early Warning Score (NEWS) system to detect deterioration in adult patients. Patient observations were recorded frequently and a NEWS score above 4, resulted in nurses escalating the patient to the medical team for review.
- We saw a hospital wide standardised approach to the detection of the deteriorating patient. We saw recently updated trust policies on managing the acutely unwell patients including those with hyponatraemia, as well as a handbook of emergency medicine. Medical staff we spoke with were fully aware of the policies and guidelines, and told us that they were easily accessible to all staff, including locum staff, through the trust's intranet. We saw the escalation of patients, including those with hyponatraemia, clearly documented in both medical and nursing notes, and discussed at handover.

Records

- People's individual care records were not always written and managed in line with best practice. Care records for two people living with mental health challenges in ED did not have any information recorded in them by nurses during the night shift on 29 October 2018. We looked in the patients cas cards and did not see any information documented by nurses, including regular observations. We spoke with the assistant head of nursing for emergency care, who confirmed they were unable to find any record of patients care by nurses during the night shift in question. This meant timely and available information was not available to the MDT team.
- Staff we spoke to in ED told us they did not use behaviour charts to document the behaviour of mental health patients who were being nursed on a one-to-one basis. This meant timely and available information about patients' behaviour were not available to the MDT team.
- We highlighted the issues of recorded keeping to the trust management at the time of inspection. Senior

managers told us immediate action had been taken as a result of our findings. We were shown guidance for the observation of patients being cared for in Majors, which detailed the minimum levels of observations and documentation required. Senior managers told us a number of actions were being undertaken in ED at both sites to strengthen the management of mental health patients. This included the introduction of written guidance on the management of mental health patients and will include the level of observation required. We were told the guidance would be developed with the input of the local mental health trusts.

- Pathology information needed to deliver safe care and treatment was available to staff in a timely and accessible way. Staff we spoke with in the laboratories told us they did not have difficulties in notifying clinicians of abnormal results. We were shown all pathology requests had a documented extension and bleep number for the requesting clinician. Laboratory staff told us in the event of an abnormal blood result, they would try to contact the requesting clinician using both their phone number and bleep number. If they failed to contact the clinician, they would contact the relevant consultant via the trust's switchboard. We were shown a three-screen computer system, which prompted the staff to call the clinician before the results could be released onto the general results system. We were told that in the event a clinician could not be contacted, the result would be released into the general system, and they would continue to try and contact the clinician. We saw a standard operating procedure that highlighted the steps needed to be taken when telephoning results, including steps to take if unable to contact the clinician. The current procedure was more robust than previously and minimised the risk of clinicians not being notified of abnormal blood results in a timely manner.
- Information needed for ongoing care was shared appropriately, and in a timely way when people moved between teams and services. We observed the handover between ED staff and medical clinicians when transferring the care of patients. On reviewing medical notes, we saw advice from specialists was documented, including recommendations for treatment, and saw these recommendations were followed up by the treating clinicians.

Are urgent and emergency services effective?

(for example, treatment is effective)

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. We saw recently adapted guidance on quality standards for the treatment of patients with hyponatraemia. We reviewed two sets of notes for patients who had been admitted for treatment of hyponatraemia and found their medical management followed the guidance. Staff we spoke to were aware of the new guidelines and had received training on its use. We found medical plans were clearly documented in line with the guidance, including fully completed fluid balance charts.
- We saw evidence of a recently updated handbook of medical emergencies. Staff told us the handbook had recently become more easily accessible, and was available to all staff though a one click process on the intranet. This meant the guidance was able to be located quickly and easily by all staff, including locums. Staff we spoke with were aware of the new handbook and were able to show us how to access it.

Medical care (including older people's care)

Safe	
Effective	
Overall	

Information about the service

Epsom and St Helier University Hospitals NHS Trust provides a comprehensive medical service incorporating all the key medical specialties including diabetes and endocrinology, rheumatology, elderly care, cardiology, stroke, gastroenterology, dermatology, haematology, oncology and respiratory medicine.

Summary of findings

- The service provided care and treatment based on national guidance and evidence of its effectiveness. We saw recently adapted guidance on quality standards for the treatment of patients with hyponatraemia, and these were embedded in practice.
- Medical staff across the acute medical unit (AMU) and the medical wards, received training in the management of patients with hyponatraemia.
- There was a trust wide standardised approach to the detection of deteriorating patients using the National Early Warning Score (NEWS) scoring system and staff knew what action to take when the score was to above 4.
- Pathology results needed to deliver safe care and treatment were available to staff in a timely and accessible way. There was a trust wide standard operating procedure for communicating abnormal blood results to appropriate staff.

However:

- Some wards did not use a checklist when discharging patients and this could result in parts of the process being missed.

Medical care (including older people's care)

Are medical care services safe?

Nurse Staffing

- On some medical care wards, there were not always enough nursing staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. On AMU at Epsom General Hospital we saw that 8 staff nurses should have been on duty for the day shift, including a nurse in charge, but there were only 6 on duty. This meant the nurse in charge needed to care for a cohort of patients instead of attending to managerial duties. Nursing staff told us that this occurs regularly. We saw medical care wards had a nursing vacancy rate of 24%. However, this vacancy rate had improved in the previous 12 months, when there was a 31.4% vacancy rate.
- Staff told us the trust mitigated the risk to patients through the use of bank and agency staff. However, we noted that in September 2018, 49% of the bank and agency shifts were unfilled, and in October 2018, 42% of the bank and agency shifts were unfilled, meaning patients were being put at risk of harm.
- Managers were aware of the nurse staffing issues within medical care wards. We saw evidence of nurse staffing being highlighted in the trusts' risk register. We saw the trust's action plan to increase nurse staffing.
- We saw there was an ongoing rolling recruitment drive for both nurses and healthcare assistants. The chief nurse told us the trust had recently recruited 80 healthcare assistants, with an aim to recruit 100 in total. We were told of monetary incentives being offered to substantive staff to help recruit other nurses into full time posts. We saw a senior nurse rota to deal with staffing issues had been recently introduced. This meant that there was a senior nurse on site out-of-hours with a focus on supporting the wards with staffing out-of-hours. Staff we spoke with told us this had helped to fill staffing gaps.

Assessing and responding to patient risk

- We saw a hospital wide standardised approach to the detection of the deteriorating patient. We saw recently updated trust policies on managing the acutely unwell patients including those with hyponatraemia, as well as a handbook of emergency medicine. Medical staff we spoke with were fully aware of the policies and guidelines, and told us that they were easily accessible to all staff, including locum staff, through the trust's intranet. We saw the escalation of patients, including those with hyponatraemia, clearly documented in both medical and nursing notes, and discussed at handover.

Records

- Pathology information needed to deliver safe care and treatment was available to staff in a timely and accessible way. Staff we spoke with in the laboratories told us they did not have difficulties in notifying clinicians of abnormal results. We were shown all pathology requests had a documented extension and bleep number for the requesting clinician. Laboratory staff told us in the event of an abnormal blood result, they would try to contact the requesting clinician using both their phone number and bleep number. If they failed to contact the clinician, they would contact the relevant consultant via the trust's switchboard. We were shown a three-screen computer system, which prompted the staff to call the clinician before the results could be released onto the general results system. We were told that in the event a clinician could not be contacted, the result would be released into the general system, and they would continue to try and contact the clinician. We saw a standard operating procedure that highlighted the steps needed to be taken when telephoning results, including steps to take if unable to contact the clinician. The current procedure was more robust than previously and minimised the risk of clinicians not being notified of abnormal blood results in a timely manner.
- Information needed for ongoing care was shared appropriately, and in a timely way when people moved between teams and services. We observed the handover between ED staff and medical clinicians when transferring the care of patients. On reviewing medical notes, we saw advice from specialists was documented, including recommendations for treatment, and saw these recommendations were followed up by the treating clinicians. However, on the medical wards, we saw discharge documentation was not always completed. Some wards we visited did not use a discharge checklist when discharging patients. Staff told us they relied on individual knowledge of

knowing what tasks needed to be completed to facilitate a safe discharge. This meant that steps in the discharge process could be missed, which could lead to patients being unsafely discharged.

Are medical care services effective?

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. We saw recently adapted guidance on quality standards for the treatment of patients with hyponatraemia. Staff we spoke to were aware of the new guidelines and had received training on its use. We found medical plans were clearly documented in line with the guidance, including fully completed fluid balance charts.
- We saw evidence of a recently updated handbook of medical emergencies. Staff told us the handbook had recently become more easily accessible, and was available to all staff though a one click process on the intranet. This meant the guidance was able to be located quickly and easily by all staff, including locums. Staff we spoke with were aware of the new handbook and were able to show us how to access it.

Critical care

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

Information about the service

The High Dependency Unit (HDU) at Epsom General Hospital has eight beds used for level two patients. This meant the unit was able to care for patients requiring more detailed observation or intervention, including support for a single failing organ system or post-operative care, and those 'stepping down' from higher levels of care. Patients who were classified as level three and requiring a greater level of care were stabilised at the unit and then transferred to the intensive care unit at St Helier Hospital.

In 2017/18, the unit had over 650 admissions, the majority of which were for post-operative care following elective surgery.

Our inspection was a focussed inspection, which looked at the areas identified as requiring improvement at our inspection. At our previous inspection in 2015, the provider had a breach of Regulation 17 HSCA (RA) Regulations 2014 Good Governance; this related to the critical care service as follows:

- There were not agreed guidelines specific to the critical care units.
- The management, governance and culture in the critical care units, did not support the delivery of high quality care.
- Feedback from patients was not always obtained in the critical care units.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. During the inspection, we spoke with fourteen members of staff, including doctors, nurses, allied health professionals and ancillary staff. We spoke with five patients and three relatives. We checked six patient records and a number of pieces of equipment including the resus trolley, syringe drivers and a ventilator.

Critical care

Summary of findings

Our rating of this service improved. We rated it as good because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately and learning was shared across the two sites. Staff could give us clear examples of when learning from incidents had resulted in changes to practice. This had improved since our last inspection.
- The service had sufficient nurses to ensure patients received safe care and treatment. The unit followed the Guidelines for Provision of Intensive Care Services (GPICS) for registered nurse to patient ratios in level two units.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. The trust regularly participated in national clinical audits and managers demonstrated a good awareness and understanding of the patient outcomes of the unit.
- Mortality rates in the unit were within the expected range and unplanned readmission rates to the unit within 48 hours of discharge to a ward were better than the national average.
- Staff took the time to interact with people in a respectful and considerate way and were supportive to patients. During ward rounds and other interactions, staff answered patient concerns, explained symptoms and reassured patients.
- The service took account of the individual needs and choices of patients. Staff discussed patient needs and made reasonable adjustments to support patient requests where possible.
- Staff described service leaders as visible and approachable. Since the last inspection, the leadership had worked to improve links between the two sites, including joint working and staff rotation.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There was a clear drive from the clinical leadership to improve consistency and collaboration across the two sites; and learning and development between sites had improved since our last inspection.

However:

- The service did not have suitable premises and the design of facilities did not meet the needs of patients. At the last inspection, there were several concerns about the facilities not being suitable for the patients including the unit not having any isolation rooms for patients and excessive temperatures during summer months. During our inspection, we saw these concerns remained, although they were identified on the service's risk register.
- Some printed guidelines and policies we saw had passed their review date, or did not have a review date, which meant staff were at risk of not following the most up to date guidance.
- The service did not always maintain effective patient flow through the department. Delayed discharges remained consistently worse than the national average in the Intensive Care National Audit Research Centre (ICNARC) audit and this was graded as an extreme risk on the service's risk register.
- The trust did not have a clear vision or strategy for the unit. While the service had defined plans to improve consistency of working between the two sites and had achieved some of these goals, the service lacked a defined longer-term strategy.
- The service had limited engagement with patients, staff, the public and local organisations to plan and manage appropriate services. Responses to the Friends and Family Test (FFT) were limited and there was limited active engagement of patients and relatives to provide feedback.

Critical care

Are critical care services safe?

Good

Mandatory training

- Staff received effective training in safety systems, processes and practices. Staff we spoke with told us mandatory training was booked by either their manager or the practice development nurse, and it was easy to book when needed. All staff had access to the trust online training record system, which clearly showed the modules that were due to expire or overdue. Staff told us they were able to be released for training courses and were supported by managers to keep their training up to date.
- As of October 2018, qualified nursing staff in Epsom HDU met or exceeded the trust target of 85% for completion of all mandatory training modules. This was good practice.
- As of October 2018, medical staff in Epsom HDU met or exceeded the trust target of 85% for eight of the 10 mandatory training modules.
- Low completion for venous thromboembolism (VTE) training had been identified as an issue at the last inspection for both medical and nursing staff. While training rates for nursing staff had improved and now met the trust target of 85%, medical training completion remained low at 57.1%. This meant there was a risk that patients would not be properly risk assessed for VTE, although all six patient records we reviewed during the inspection had completed VTE assessments. Resuscitation training for medical staff was also low and well below the trust target of 85%.

Safeguarding

- The trust had arrangements to safeguard adults and children from abuse and neglect and staff understood their responsibilities to report safeguarding concerns. Staff we spoke with could describe the steps they would take if they identified a safeguarding concern, and demonstrated a good understanding of how they would identify patients at risk, or suffering abuse or neglect.
- The trust set a target of 85% for completion of safeguarding training. As of October 2018, qualified nursing staff in Epsom HDU met or exceeded the trust target of 85% completion of all safeguarding training modules. This was good practice.
- We observed a nursing handover where safeguarding concerns were highlighted. The nurse-in-charge alerted staff to possible safeguarding risks for patients, and staff demonstrated a good understanding of safeguarding risks for patients in the unit and safeguarding plans that had been put in place for vulnerable patients.
- As of October 2018, medical staff in Epsom HDU had met or exceeded the trust 85% target for completion for two of the three safeguarding training modules. Although the target had not been met for Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training, medical staff we spoke with had a good knowledge of MCA and deprivation of liberty safeguards and were aware of how they could access advice if required.

Cleanliness, infection control and hygiene

- Staff maintained standards of cleanliness and hygiene in the unit. The department was visibly clean and bright. Personal protective equipment (PPE) was available throughout the unit. The ward had guidance on the appropriate use of PPE, with visual guides to ensure staff understood how to use this to prevent the risk of infection for patients. We saw staff appropriately using PPE before interacting with patients.
- Handwashing facilities and hand sanitiser dispensers were available throughout the department, and we saw guidance on the five moments of hand hygiene displayed above sinks. Displays within the ward showed hand hygiene compliance of 90% in September 2018. Hand hygiene was an item on the service “Big 3”, a newsletter which focussed on three key areas for the month, and we saw staff highlighting this at handover. Infection control training rates were above 90% for all modules for both medical and nursing staff. The service had planned an infection prevention and control (IPC) training day in November 2018 and managers were working with the IPC team to coordinate this.
- Infection control and hand hygiene audits were conducted on a monthly basis and discussed as part of the clinical governance meetings. Audits included hand hygiene, equipment cleanliness, and central venous catheter (CVC) checks for blood stream infections. Data supplied to the Intensive Care National Audit Research Centre (ICNARC) for 2017/18 for unit-acquired infections in blood per 1000 patient days was 0.4. This was a lower (better) rate than both the national average of 1.6 and the average for similar units, which had a rate of 1.3.

- The rate for unit-acquired infections in blood had improved in Q1 2018/19 to 0. This was better than both the national average, which had a rate of 1.6, and the rate for similar units, which was 0.7.
- The unit did not have any isolation rooms for patients who may be an infection control risk. Staff told us any patients with respiratory-based infections, who needed to be isolated, were not admitted to the HDU, and were transferred to the intensive care unit at St Helier Hospital.

Environment and equipment

- The service did not have suitable premises and the design of facilities did not meet the needs of patients. At the last inspection, there were several concerns about the facilities not being suitable for the patients. This included the unit not having any isolation rooms for patients, excessive temperatures during summer months and an old ventilation system. During our inspection, we saw these concerns remained, although they were identified on the service risk register.
- The unit did not have any isolation rooms for patients who may be an infection control risk. The service had some mitigations in place, including risk assessing patients on admission and transferring any patients who may be a risk to the intensive care unit at St Helier Hospital. However, the lack of isolation rooms meant the unit was not compliant with Health Building Notice HBN 04-02, which specifies a minimum of 20% of beds in a unit should be isolation rooms. Staff told us there had been some discussion about having temporary isolation rooms installed, but this had been halted as the lack of air conditioning on the unit would not support this. Despite this, information provided by the trust following the inspection outlined plans for purchasing temporary isolation rooms for the unit.
- Staff told us the lack of air conditioning on the unit resulted in excessive temperatures during hot weather. Staff we spoke with told us they were unable use a portable air conditioning unit due to the poor ventilation so had used fans during the hot weather. While this remained on the service risk register, there were no immediate plans identified to install any air conditioning.
- During the inspection, we saw one window on the unit was broken and had been boarded up. Staff told us this had been broken by a patient some months previously, and staff were unclear about plans to replace the window. However, information provided by the trust following the inspection gave assurances that the window replacement had been designed, and was due for installation before the end of January 2019.
- Despite the issues described above, the department was clean and bright. Staff kept the area clear of clutter and ensured there was space around patient beds to allow access for staff and equipment should it be required. Although the sluice was small, staff kept the area clean and tidy. Housekeeping staff attended the unit twice daily and when required and we were told they completed audits and other checks when required.
- The maintenance and use of equipment was in line with best practice and trust policies and procedures. Equipment we checked had been tested and cleaned. The unit had a regular equipment cleaning programme in addition to when a piece of equipment had been used and staff used 'I am clean' stickers to clearly indicate equipment that was ready for use. Staff kept the resuscitation trolley and airway trolley stocked and carried out regular daily and weekly checks to ensure that items were in date and suitable for use. We reviewed these checks back to February 2018 and found them to be complete.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Patient records we reviewed had comprehensive risk assessments which staff completed regularly using recognised tools, such as National Early Warning Score (NEWS) and the Glasgow Coma Scale (GCS), in line with national guidance. At handover, we saw staff discussing patient risks in detail and highlighting potential concerns for patients. During the inspection, we saw staff responded quickly to a patient who required urgent intervention, and took appropriate steps to treat them.
- Staff understood patient escalation routes and responded appropriately to changing risks in patients. All staff we spoke with were clear about what they would do if a patient deteriorated. The HDU was equipped to treat level two patients. This meant the service was able to care for patients requiring more detailed observation or intervention, including post-operative care, and those 'stepping down' from higher levels of care. Patients requiring a higher level of input, such as advanced respiratory support, were

transferred to the intensive care unit at St Helier Hospital. The unit had clear guidelines for stabilising and transferring patients out of the unit and had staff who were transfer-trained and capable of supporting patients during transfers to a level three unit.

- The hospital did not have an outreach team attached to the unit. Managers told us this was in the process of being formally established and would be trialled at St Helier Hospital in April 2019, before being implemented at Epsom General Hospital. However, the lack of a specific coordinated team meant the hospital was at risk of not being able to meet the requirements of patients needing critical care support in a timely manner.
- The unit was anaesthetist led, but managers had increased the level of input from intensivists at St Helier Hospital. This included intensivists being on site four days a week, and daily telephone ward rounds with the consultant intensivist at St Helier Hospital. This meant both sites were aware of patients who would potentially require a transfer, and staff at the HDU could access advice and support. Staff we spoke with were positive about these changes, and felt this had improved the relationship and communication between the two sites.

Nurse staffing

- The service planned and reviewed nurse staffing levels to ensure that patients received safe care and treatment. The unit followed the Guidelines for Provision of Intensive Care Services (GPICS) regarding registered nurse to patient ratios for level two units. On the days of our inspection, each shift had five registered nurses for eight patients, with one nurse being the nurse in charge and supernumerary. Night shifts had the same staffing arrangement. This was in line with the GPICS recommended staffing levels.
- During the inspection, the ward was fully staffed according to their planned staff levels, with five registered nurses on each shift. A newly qualified nurse had started on the unit; they were supernumerary, and were supervised by a substantive member of staff. This meant that the unit maintained the 1:2 nurse to patient ratio in line with GPICS guidelines. Nursing staff told us when the unit was fully staffed, the workload was manageable, and they could adequately care for the patients. However, some staff told us they struggled when there were staff shortages and the unit was fully occupied, as this required the nurse in charge to care for patients rather than perform in a supernumerary role.
- The service used bank staff to cover gaps in rotas and had developed good links with the level three intensive care unit at St Helier Hospital, so nursing staff could be flexed across the two sites where required. Agency staff completed an induction when on the unit for the first time and we saw the checklist included nursing responsibilities and mandatory training completion.
- Arrangements for nursing handovers and shift changes ensured patients were kept safe. We observed a nursing handover between night staff and the day shift. The handover was well-structured and communicated key information about the patients in the unit. Following the handover with the ward nurses, the nurses in charge from each shift had a more detailed handover, which also included information regarding staffing on the unit.
- Managers ensured nursing rotas included a nurse who was trained in being able to transfer a patient. This meant there was an appropriate skill-mix of nursing staff on site to support medical staff during patient transfers when needed.

Vacancy rates

- As of September 2018, Epsom General Hospital reported a nursing vacancy rate of 23.8% in critical care. Vacancy rates had increased slightly since October 2017, when nursing staff had a vacancy rate of 19.8%. This meant that the service was more reliant on bank and agency staff to fill vacant shifts. The fill rate had decreased slightly over the period, from 93.8% in October 2017 to 92.1% in September 2018.
- Nurse staffing remained a risk on the divisional risk register and the service had several mitigations in place to manage the impact on both staff and patients. Managers we spoke with were clear that if nurse staff numbers fell below what was safe for patients, they would close beds to ensure that nurse to patient ratios remained safe.

Turnover rates

- As of September 2018, Epsom General Hospital reported a nursing turnover rate of 0% in critical care. Turnover rates had fluctuated slightly since October 2017 but had remained generally low and were below 5% for the whole period. This was lower (better) than the trust threshold of 12%.

Critical care

Sickness rates

- Between October 2017 and September 2018, Epsom General Hospital reported a rolling nursing sickness rate of 5.9% in critical care. Sickness rates had increased slightly since June 2018, peaking in September to 9%. This was higher (worse) than the trust threshold of 3.8%

Bank and agency staff usage

- Between October 2017 and September 2018, Epsom General Hospital reported an average bank and agency usage of 15.1%. This was in line with the Guidelines for Provision of Intensive Care Services (GPICS), which recommended that units should have a bank and agency usage of less than 20%.

Medical staffing

- The service planned and reviewed medical staffing to ensure patients received safe care and treatment. The high dependency unit was primarily anaesthetist led, with input from intensivists from the St Helier intensive care unit. The service had recently introduced consultant intensivist presence on the unit four days a week, Monday to Thursday, with the rest of the week being covered by consultant anaesthetists.
- Medical staff conducted daily ward rounds followed by a telephone ward round with the consultant at St Helier Hospital. This occurred every day, including those where St Helier staff were present on the unit. This ensured there was a clear understanding across both sites of patients in the unit, and supported effective working relationships between the medical staff.
- Medical staff we spoke with were positive about the changes to the medical cover on the unit, and described good support from consultants and senior management. We spoke to one specialty doctor who was new to the unit, and they told us their introduction and induction on the unit had been well coordinated.

Vacancy rates

- As of September 2018, Epsom General Hospital reported a medical vacancy rate of 21.6% in critical care. Vacancy rates had improved since October 2017, when medical staff had a vacancy rate of 34.6%.

Turnover rates

- As of September 2018, Epsom General Hospital reported a medical turnover rate of 0% in critical care. Turnover rates had remained consistently at 0%, excluding rotation doctors, since October 2017. This was lower (better) than the trust threshold of 12%.

Sickness rates

- Between October 2017 and September 2018, Epsom General Hospital reported a rolling medical staff sickness rate of 0.8% in critical care. Sickness rates had fluctuated during the period, peaking in August 2018 to 4.9%, but was below the trust threshold of 3.8% for the rest of the period.

Bank and locum staff usage

- Between October 2017 and September 2018, Epsom General Hospital reported an average bank and locum usage of 1.6%, although for eight of the 12 months the usage was 0% and with the exception of August 2018, the unit consistently had over 90% of shifts filled by substantive staff.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Patient records were mainly paper-based, with some key information also stored electronically. We reviewed six patient records and found them to be detailed and comprehensive. Patient charts and observations which were paper-based were stored securely and we saw staff ensuring that computers were locked when not in use.
- Staff regularly recorded observations in line with national guidance and completed a daily assessment and evaluation, oral assessment, infection control risk, handling risk assessments, skin assessments, pressure ulcer risk assessment and falls risk assessment. Malnutrition Universal Screening Tool (MUST) scores were appropriately completed, as were pain scores and Richmond Agitation-Sedation Scale (RASS) scores.
- Input from therapists was clear and detailed. We saw patient records containing detailed reviews and care plans by physiotherapists, dieticians and speech and language therapists.
- The unit conducted documentation audits to review how well staff completed patient notes. In the most recent audit from October 2018, the unit had an overall

compliance of 82%. The lowest scoring criteria were for recording medical and nursing designation (0%), scoring the patient's pain or sedation at the same time as other observations (42.9%) and completing the MUST score (42.9%). The service identified areas for improvement and we saw an action plan to improve record completion. Records we reviewed during our inspection had pain and MUST scores adequately completed.

Medicines

- The service followed best practice when prescribing, administering, recording and storing medicines. Medicines and fluids were stored across several different cupboards across the unit due to its layout. All cupboards and stocked with medicines that were in date with the exception of one vial, which we highlighted to the nurse in charge.
- Controlled drugs were stored securely and record keeping was clear and in order. Pharmacists completed daily reviews of medicine and controlled drugs stock, to ensure medicines were appropriately stored and maintained.
- Patients received the right medication at the right dose, right time, and by the right route. The pharmacy team reviewed medicines, and patient records we checked were clearly signed and dated by relevant staff and reviewed by a pharmacist. While the rest of the hospital was using an electronic prescribing system, the unit was using a paper-based system, so patient medicines needed to be transferred to the electronic system on discharge. This meant there was a risk that patient medicines may not be accurately transferred when they left the unit.
- Storage temperatures for medication and medical gases were appropriate during our visit with fridge temperatures checked and recorded regularly. However, staff we spoke with told us during the summer the excessive temperatures on the unit could compromise medicines on the ward. While high temperatures were on the service risk register, there were no specific controls or mitigations relating to medicines stored on the ward.

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Staff we spoke with had access to the online incident reporting system, and understood their responsibilities to report incidents. While staff we spoke with could recall incidents they had reported, some staff told us they sometimes struggled to report incidents due to not having time during their shift.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff received feedback from incidents directly and as part of unit and divisional meetings. Learning was shared across the two sites and staff gave us clear examples of when learning from incidents had resulted in changes to practice. One example, which multiple staff told us had been given. As a result of this incident, the service had updated guidance, introduced a flagging system on patient records and at the patient bedside and emergency equipment boxes made available at patient bedsides.
- When things went wrong, staff apologised and gave patients honest information and suitable support. 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 relevant safety incidents. Staff and managers we spoke with understood their roles and responsibilities with duty of candour and did not identify any recent incidents where there was the need to implement the duty.

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 August 2017 to July 2018, the trust reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in critical care which met the reporting criteria set by NHS England from August 2017 to July 2018. The incident reported related to a delay in treatment.

(Source: Strategic Executive Information System (STEIS))

Critical care

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 four new pressure ulcers, one fall with harm and three new catheter urinary tract infection from May 2017 to May 2018. This information was data across the whole of critical care services. The HDU at Epsom General Hospital reported no pressure ulcers, falls or catheter-acquired urinary tract infections between May 2017 and May 2018 to the national patient safety thermometer.
- The service collected safety information regularly and displayed this in the ward. Displays on the ward showed that the last fall was in May 2018, and the last pressure ulcer in September 2015. This was good performance. Safety monitoring was also collected and reported on the divisional scorecard, although this was not broken down by department or clinical area within the division.

Are critical care services effective?

Good

Evidence-based care and treatment

- The service provided care and treatment based on national guidance. Guidelines we reviewed were in line with best practice and professional standards and legislation. Staff could access clinical guidelines in line with Intensive Care Society standards and National Institute of Health and Care Excellence (NICE) guidelines on the trust intranet and the unit also printed guidelines out for folders on the ward. However, some guidelines and policies had passed their review date, or did not have a review date which meant staff were at risk of not following the most up to date guidance.
- Updates on guidelines and changes to pathways were discussed as part of the service clinical governance meetings, and at the critical care and anaesthetics quality meetings. We saw evidence of guidelines and pathways being updated following incidents in the services, such as improvements in the treatment of patients with an altered airway. Draft guidelines we reviewed were detailed, in line with best practice and national guidance.
- The unit used recognised tools and care pathways in line with national guidance. Patient records we reviewed showed evidence of staff appropriately using and recording tools such as the Malnutrition Universal Screening Tool (MUST), the Richmond Agitation-Sedation Scale (RASS) and the central venous catheter (CVC) care bundle.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health. We saw water was available in the unit, and catering staff attended the unit and engaged with ward staff to ensure patients were receiving appropriate nutrition and hydration.
- Dietician input was available on the ward for patients requiring dietary assessments and support, and the service completed Malnutrition Universal Screening Tool (MUST) scores for patients. While we saw this evidenced in most of the patient records we reviewed, recent records audits identified this as an area which had been inconsistently completed. Managers had added this as an area for improvement in the documentation action plan.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain. Records we reviewed showed that staff had appropriately completed regular pain scores and administered pain relief as needed. Patients we spoke with raised no concerns about access to pain relief.
- Staff supported those unable to communicate they were in pain using suitable assessment tools. We saw tools available on the ward and staff could describe to us when they would use these to appropriately assess a patient's pain.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. The

trust regularly submitted data to the Intensive Care National Audit Research Centre (ICNARC), and employed an audit nurse at both sites to support this, and other audits in the service.
- The service compared local patient outcome results with those of other services. Managers we spoke with demonstrated a good awareness and understanding of the patient outcomes of the unit.
- The service participated in approved accreditation schemes and quality improvement initiatives. The service had recently gained their Anaesthesia Clinical Services Accreditation (ACSA) and used the enhanced recovery programme to improve patient outcomes following surgery.
- Data submitted to the ICNARC audit showed that unplanned readmission rates to the unit within 48 hours of discharge to a ward was lower (better) than the national average, having a rate of 0.2% in 2017/18 compared to a national average of 1.1%.
- The rate for unplanned readmissions within 48 hours of discharge had improved in Q1 2018/19 to 0. This was better than both the national average, which had a rate of 1.2, and the rate for similar units, which was 1.1.

ICNARC Participation

- The trust has two units, one at St Helier Hospital and one at Epsom General Hospital, 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. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (all patients)

- For the High Dependency Unit at Epsom General Hospital, the risk adjusted hospital mortality ratio was 1.2 in 2016/17. This was within the expected range. The figure in the 2015/16 annual report was 1.2.
- The risk-adjusted hospital mortality rate had improved in 2017/18 to 1.13 and in Q1 2018/19 to 0.98. This was similar to the national average of 1.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low risk patients)

- For the High Dependency Unit at Epsom General Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.2. This was within the expected range. The figure in the 2015/16 annual report was 1.3.
- The risk-adjusted hospital mortality rate for patients with a predicted risk of death of less than 20% had improved in 2017/18 to 1.14 and in Q1 2018/19 to 1.11. This was similar to the national average of 1.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Competent staff

- The service made sure staff were competent for their roles. Managers completed staff appraisals to provide support and monitor the effectiveness of the service. All staff we spoke had completed their appraisal and described the process as beneficial.
- Staff had appropriate training to meet the needs of patients using the service. The unit met the standard set by the Guidelines for the Provision of Intensive Care Services (GPICS) which required a minimum of 50% of registered nursing staff to hold a post-registration award in Critical Care Nursing, with 16 of the 23 nursing staff (69.6%) holding the certificate.
- Managers supported staff to access non-mandatory training and develop their skills, to enable the delivery of effective care and treatment. Staff could rotate shifts with the level three intensive care unit at St Helier Hospital. This meant staff were able to maintain their skills through caring for patients with more complex needs. Staff we spoke with told us they had been able to access non-mandatory training, such as an assessment skills course at other hospitals.

Appraisal rates

- The trust conducted an annual appraisal cycle for nursing staff with appraisals completed in quarter four of each financial year. As of the end of 2017/18, the trust reported that all nursing staff on the HDU had completed their appraisal.
- Medical staff completed their appraisal as part of the annual revalidation process. As of October 2018, 82% of medical staff had completed their appraisal, although

the trust informed us only one appraisal was overdue and there were extensions for the remaining staff without a completed appraisal. Overall, this meant that medical staff were receiving timely appraisals.

Multidisciplinary working

- Staff worked together to provide consistent and coordinated care for patients. The unit had improved links with the intensive care unit at St Helier Hospital, and had started having intensivists on the Epsom unit from Monday to Thursday. Every day following the ward round, the consultant on the unit would have a telephone ward round with the lead intensivist at St Helier to review all the patients, to ensure the service was aware of all patients and those who may need transfer between the two sites.
- Nursing staff had also improved links with the St Helier site. Nurses who wanted or needed training in caring for level three patients (those patients with greater critical care needs) could rotate shifts at St Helier Hospital and nursing staff usually based at St Helier would cover the post on the HDU at Epsom.
- Doctors, nurses and other healthcare professionals supported each other to provide good care. Patients received input from a range of therapists including physiotherapists, speech and language therapists and dieticians. While this staff group was not specific to the unit and did not currently attend ward rounds, we saw good interactions between staff and detailed input into patient care.
- Staff and teams worked together to deliver effective care and treatment for patients. Staff could access support from specialist input, such as the psychiatric liaison team for patients with mental health needs. Patients who might require any additional input were discussed at handover so staff were aware of patient needs and care could be coordinated.

Seven-day services

- The service could access support to ensure care was delivered seven days a week. Consultant cover was present 24 hours a day with either an anaesthetic or intensivist consultant present on site, and access to intensivist advice from St Helier Hospital throughout. Over the weekend the service was covered by a consultant anaesthetist on site, and patient records we reviewed had detailed medical notes documented for weekend ward rounds.
- The unit had access to on-call input from therapies, such as physiotherapy, and pharmacy services over the weekend and out of hours.

Health promotion

- The service provided some information to patients to manage their own care and wellbeing. Staff provided patients admitted to the unit with information on their stay, access to chaplaincy support and patient information on venous thromboembolism. However, we did not see any information relating to national priorities to improve patient health, such as smoking cessation, weight loss, and support for patients with alcohol or drug dependency.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with could clearly describe the steps they would take if they had concerns about a patient's capacity, and knew how to access advice if needed. Staff knew how to access trust policies and guidance and demonstrated an understanding of the principles of the Mental Capacity Act (MCA) and deprivation of liberty safeguards.
- Staff discussed capacity during handover and updates on the MCA guidelines were highlighted as part of the service "Big 3", a newsletter which focussed on three key areas for the month. During ward rounds and patient interactions, we saw staff asking for patient consent before proceeding.
- Training for MCA and deprivation of liberty safeguards formed part of the Safeguarding Adults Level 2 training. As of October 2018, 89% of nursing staff and 76.2% of medical staff had completed this training, compared to a trust target of 85%.

Are critical care services caring?

Good

Compassionate care

- Staff understood and respected the personal, cultural, social and religious needs of each individual and how this related to their care. Patients were able to access multi-faith chaplaincy services and staff would liaise

with family and friends for the patient's own faith leader to visit. We saw a male staff member checking if a female patient was happy for them to assist with intimate care or would they rather have a female nurse.

- Staff took the time to interact with people in a respectful and considerate way and were supportive to patients. During ward rounds and interactions with patients, we saw staff answer patient concerns, explain symptoms and reassure patients. Staff checked on the comfort of patients and patients told us that staff were attentive and friendly. We saw therapy staff working with patients, supporting them during their treatment and encouraging patients to continue with their stretches once the session had ended.
- Staff raised concerns about disrespectful, discriminatory or abusive behaviour. During nursing handover, we observed staff discussing concerns for patients, their relatives and friends, and staff members, looking at where potential risks might be and how to mitigate them. In one instance we heard how a safeguarding referral had been made having identified a possible risk to a patient's welfare. Staff openly raised concerns with the lead nurse and these were acted upon.
- Staff maintained patients' privacy and dignity on the unit. Staff used the curtains around the bed before completing care tasks and during ward rounds and we saw staff check with patients before entering the curtained off area. When visitors entered the unit, staff would ask them to wait by reception and checked whether the patient wanted and was able to have a visitor.
- When patients were experiencing pain, discomfort or emotional distress, staff responded in a compassionate and timely way. Patients we spoke with on the unit had no concerns about access to pain relief. Each patient had a call bell within reach. Two patients told us they hadn't used it as staff were always accessible and patients who had pressed the bell told us the staff responded immediately.

Emotional support

- Staff understood the impact of a person's care and treatment had on their wellbeing and of their friends and family. The service sought the views of patients, relatives and friends and participated in the Friends and Family Test (FFT). The unit displayed results and comments on a notice board, however for September 2018 there had only been two responses.
- The unit kept previous FFT results and we saw these dating back to 2013. However, the responses were limited. The service received nine responses for July and August 2018 and six thank you cards. Under the display board was a comments box and slips for people to complete with their feedback. Whilst this was visible on the wall, the wall was to the side of the reception and might not be obvious for visitors to the unit. We talked with two patients and three relatives who told us they had not been asked to provide feedback.
- Looking at the responses kept in a file, there were consistent themes regarding lack of air conditioning and washing facilities but we did not see any evidence that these concerns had not been acted upon. Although the unit displayed a "You said, we did" poster to show action from patient comments, this listed only one item and was dated September 2017.
- Staff supported and gave information to patients and those close to them regarding their treatment and support services they could access. Staff showed us the information pack given to patients when they were admitted to the unit. This included useful information about car parking and a number of leaflets for patients to look through covering privacy and dignity, infection control, feedback, complaints and information about the High Dependency Unit (HDU). A visitor's room was available for people to use as private space to provide comfort for relatives. Staff had access to leaflets about bereavement and would provide these in the appropriate circumstances. However, these leaflets were only available in English and staff said they access the translator service if needed.
- Patients and visitors could access the chaplaincy service upon request. The chaplain also visited the unit daily to provide support and was visible and accessible. The service was available 24 hours a day and had volunteers from different backgrounds who were also able to support patients.

Understanding and involvement of patients and those close to them

- Staff communicated well with patients ensuring they understood their care and treatment. We spoke with patients and relatives, all felt involved with care plans and information was explained clearly. One patient commented that they felt that staff were 'doing their best' and felt confident with the care received. Timelines for treatment were explained and patients knew what to

expect and when. We saw these teams supporting patients in a friendly collaborative way. Staff could access translation services when required and we saw the communication tool staff used for patients with learning disabilities.

- Patients were supported to access advocacy services and support networks. We spoke with the Chaplain who told us they provided support to anyone that requested it irrespective of faith. They provided an adaptable service so people without religious beliefs were also able to feel supported. The Chaplain could arrange for patients to receive a visit from their own community religious leader and would update patients so they knew that a visit had been arranged. They would also assist patients in arranging a denomination-specific visit if it was requested.
- Friends and family were considered an important partner in the delivery of care and visitors were welcome on the unit. Patients and relatives were kept informed of their care and one patient we spoke with told us that they felt treated as 'a person not a bed number'. The visitors room could be used for families to access and staff told us this would be used for children visiting. It was recognised that children visiting was important for the patient recovery but that the unit was often not an appropriate environment. The unit had set visiting hours but these could be flexible if a patient was acutely unwell.

Are critical care services responsive?

Requires improvement

Service delivery to meet the needs of local people

- The service did not always plan and provide services that met the needs of the local population. The HDU was an adult unit but several staff we spoke with told us patients under 16 years were occasionally admitted to the unit; this included patients from a local residential rehabilitation service for children with learning disabilities. Service managers we spoke with acknowledged while the service was able to support these patients, there was a lack of clarity regarding the service provision and level of paediatrician engagement for these patients.
- While most of these cases would be unplanned admissions, staff told us of one instance where an elective surgical patient was admitted to the unit for post-operative care. While the patient and their family had consented to this arrangement and the service mitigated any risks to the patient, some staff we spoke with raised concerns about the level of input from paediatric services during the patient's stay on the unit.
- Following the inspection, the trust provided additional information regarding provision for paediatric patients requiring critical care support. The trust had clear processes for paediatric admissions to the unit and the support required from paediatric staff during any admissions. The trust supplied information on the paediatric admissions to the unit between October 2017 and November 2018 and provided assurances that these admissions were in line with their policies and the regional pathway for paediatric patients and 16 to 18 year olds who require critical care.
- The facilities and premises did not always meet the needs of the patients and those close to them. The service did not have any isolation or side rooms for patients. This meant patients who might require an isolation room had to be transferred to St Helier Hospital or managed in the main ward area. This was not responsive practice, and meant patients with an infection might have had to receive treatment further away from their home or in a higher acuity setting than necessary.
- The service had a family room near the ward where patient's visitors were able to stay in a more comfortable setting. The room was kept locked unless needed and drinks were available to visitors on request.

Meeting people's individual needs

- The service took account of the individual needs and choices of patients. Staff had access to interpreting and translation services for patients and relatives who did not speak English and staff knew how to make use of these services when needed.
- The unit had communication tools and aids for use with patients with a learning disability. This included information on how to support patients with a learning disability, a care passport for patients and carers or family members, contact details for the learning disability nurse and information on how to make a referral to the local mental health provider if needed.
- Staff discussed patient needs and made reasonable adjustments to support patient requests where

possible. During handover, we saw staff discussing patient needs and preferences. For example, one patient had been placed in a particular bay as they were more comfortable in the middle of the ward.

- However, the service did not have toilet facilities on the unit which meant that patients who were able to use toilets needed to be escorted from the unit by a member of staff. This meant the unit would be down a member of staff for this period of time.
- The hospital chaplaincy service was available to patients, those close to them and staff and provided a multi-faith service and support. We saw patient menus on the unit had a range of dietary choices, including halal and kosher food.

Access and flow

- The service did not always maintain effective flow through the department. Delayed discharges remained consistently worse than the national average in the ICNARC audit, and this was graded as an extreme risk on the service risk register. Ward staff and managers monitored the patients in the unit, identifying patients who were able to, or likely to be able to, be discharged to the ward. At handover, we saw managers discussing any planned incoming patients and likely admissions to the unit. However, all staff we spoke with told us discharging patients to hospital wards was an ongoing pressure and challenge to maintaining flow in the unit.
- Staff we spoke with described bed availability on the wards as the primary challenge to maintaining flow. Patients waiting for admission to the HDU were managed by the consultant in charge or on-call anaesthetist, however the service did not have a designated outreach team at the time of the inspection. This meant there was a risk that patients were not adequately supported while waiting for admission to the HDU.
- The service reported mixed-sex breaches as an incident. National guidelines for critical care services state that a mixed-sex breach occurs once the patient is ready for ward care. The trust reported 117 mixed-sex breaches between October 2017 and September 2018. This was an average of 10 breaches per month.
- Mixed-sex breaches were on the service risk register and a draft escalation process was awaiting review by senior nursing staff at the trust, however the continued difficulties in discharging patients from the unit meant the service was at risk of incurring mixed-sex breaches.

Bed occupancy

- From May 2017 to April 2018, Epsom and St Helier University Hospitals NHS Trust has seen adult bed occupancy consistently above 80%, above the England average for the last six months. (Source: NHS England)
- 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.
- It should also be noted that bed occupancy information was available only at trust level and was not included as part of the service performance report.

Delayed discharges

- For the High Dependency Unit at Epsom General Hospital, there were 2829 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 15.5%. This compares to the national aggregate of 4.9%. This meant that the unit was within the worst 5% of units. The figure in the 2015/16 annual report was 16%.
- The percentage of bed days occupied by patients with discharge delayed more than eight hours had improved slightly in 2017/18 to 15.1% and worsened in Q1 2018/19 to 16.6%. This was consistently worse than both the national average (4.9% for 2017/18) and performance for similar units (5.9% for 2017/18).

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-clinical transfers

- For the High Dependency Unit Epsom General Hospital, there were 659 admissions, of which 0.3% had a non-clinical transfer out of the unit. This was within the expected range. The figure in the 2015/16 annual report was 1.4%.
- In 2017/18, the percentage of admissions who had a non-clinical transfer out of the unit had improved to 0% and remained at 0% in Q1 2018/19. This was slightly better than the national average in 2017/18 of 0.3% and comparable to similar units (0.2%).

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-delayed out of hours discharges to the ward

- For the High Dependency Unit Epsom General Hospital, 0.7% of admissions were non-delayed, out-of-hours

discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within the expected range. The figure in the 2015/16 annual report was 0.9%.

- In 2017/18, the percentage of non-delayed patients who were discharged out-of-hours increased to 1.3% and was 1.1% in Q1 2018/19. This was slightly better than the national average in 2017/18 of 2% and comparable to similar units (0.9%).

(Source: Intensive Care National Audit Research Centre (ICNARC))

Learning from complaints and concerns

- Patients had access to information on how to raise a complaint or concern about the service. Staff we spoke with told us they would look to resolve any concerns locally in the first instance but did provide information on how to make a formal complaint if requested. We saw information in the ward for patients on how to contact the patient advice and liaison service (PALS) for patients and relatives who wanted to raise a complaint.

Summary of complaints

- Between October 2017 and September 2018, the trust reported no complaints in relation to the High Dependency Unit at Epsom General Hospital. This was consistent with our previous inspection in 2015 where the provider reported no complaints for the service in the 12 months prior to the inspection.

Are critical care services well-led?

Good

Leadership

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. At the last inspection, staff told us nursing leads were not always present or visible on the unit. While the main matron for critical care was based primarily at the St Helier site, the service had recently appointed a matron to support the nursing leadership and managers on-site. Nursing staff on the unit told us the liaison between the two sites worked effectively, particularly with regards to staffing cover and rotation to support skills development at the St Helier unit. This was an improvement upon our last inspection.
- Staff we spoke with and felt they could raise concerns if they had them. Staff could approach managers directly, and add items to the agenda for discussion at the unit meeting. Minutes of the unit meeting would then be printed and available on notice boards for staff who were unable to attend the meeting.
- Staff we spoke with described service leaders as visible and approachable. At the last inspection, staff told us senior management and leaders of the service were not always visible, as the service was largely focussed on the level three unit at St Helier Hospital. Since the last inspection, the service leadership had worked to improve links between the two sites, including joint working and staff rotation. Staff we spoke with described a much greater collaborative approach and visibility of leadership on the HDU. However, some staff on the ward told us that there was less visibility from the executive team and while they felt assured in service and local leadership, they felt there was less focus on the Epsom site.

Vision and strategy

- The trust did not have a clear vision or strategy for the unit. While the service had defined plans to improve consistency of working between the two sites, and had achieved some of these goals, the service lacked a defined longer-term strategy. This meant there was a lack of shared understanding amongst staff and managers about how the service could develop in the future.
- While most staff had some understanding of the trust strategy to focus certain acute services on a main site, some staff we spoke with were uncertain about the long-term plans for the unit. Staff told us they felt the focus was on the redevelopment and changes at the St Helier site.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Most staff we spoke with felt supported by managers, and described an open and friendly unit. However, while most nursing staff we spoke with felt while the culture was generally positive, some staff felt there was a lack of recognition from some managers. For example, one staff member told us that managers hadn't acknowledged or

recognised contributions when staff left the department and another told us that there was limited acknowledgement of staff working extra time once their shifts had ended.
- All staff we spoke with described and demonstrated a patient centred culture which was focussed on the needs of people who used the services. We saw staff interacting positively and supportively with each other and patients on the unit.

Governance
- The service had clear responsibilities, roles and systems of accountability to support good governance and management. The service had monthly clinical governance meetings held at St Helier Hospital, and with attendance from medical and nursing staff from both sites. These meetings discussed incidents, complaints, performance, the risk register and any service updates and fed into the divisional risk and governance meetings.
- Critical care was part of the Surgery, Critical Care and Anaesthetics Division. There were specific clinical governance meetings for critical care which fed into divisional meetings and then the trust-wide Clinical Quality and Assurance Committee. Clinical leads for the service spoke positively about the executive team and told us that the governance framework from ward to board worked effectively and that issues raised were addressed.
- Staff we spoke with were clear about their own roles and responsibilities and the structure of the management and governance oversight. Within the HDU, the service had a monthly team meeting where staff could add items to the agenda for discussion and managers relayed information from service governance meetings. Minutes from these meetings were circulated via email to staff and printed copies were also made available.

Management of risk, issues and performance
- The service had systems for identifying and managing risks. Risks were escalated through local management and fed into the divisional risk register which was reviewed at divisional risk and governance meetings. Meeting minutes we reviewed showed evidence of discussions about service risks.
- Risks on the register were aligned with what managers told us was on their 'worry list', particularly staffing and estates. All risks had controls outlined and review dates, however some controls lacked specific deadlines and some risks on the unit, such as the broken window, did not appear on the risk register. Although the immediate impact of the broken window had been mitigated by boarding it up, this remained an ongoing risk for the environment and patients.
- The trust had performance measures and monitoring, however these were not specific to the service. Critical care formed part of the surgery division, and performance was monitored through a divisional performance dashboard. This meant that measures were not specific to the critical care service and there were no measures on the performance dashboard which related only to the service, such as the number of delayed discharges from the unit.
- While management we spoke with could discuss service performance and regularly collected information and submitted this to ICNARC, we did not see evidence that the trust conducted their own internal analysis of specific service performance information and management. This was not best practice. Some staff we spoke with felt critical care services were sometimes overshadowed or did not receive the same level of attention as other parts of the division.

Information management
- The trust collected, analysed, managed and used information well to support all its activities. Patient records were primarily paper-based on the unit, with some key information also stored electronically. Staff, including bank and agency staff, had access to relevant patient information systems and records.
- The service had effective arrangements to ensure performance information was accurate. Performance and patient outcome information was submitted regularly to ICNARC by the audit nurse. The service had two audit nurses, one based at each site, and they provided a level of peer support and assurance regarding audit collection and processes. The information submitted to ICNARC was then checked by the audit body and validated again by the audit nurse to ensure the data was accurate and robust.

Engagement
- The trust had limited engagement with patients, staff, the public and local organisations to plan and manage appropriate services. While there was no specific

follow-up clinic for discharged patients on the Epsom site, patients who had received input from the St Helier intensive care unit had access to the follow-up clinic run at that site.

- Patient feedback and engagement was limited. Feedback from patients and those close to them was not routinely sought or encouraged, and response rates to the friends and family test were consistently low. While the unit had a patient feedback box available, it was not prominently displayed or immediately apparent to visitors to the unit.
- The service did not actively engage with staff regarding service planning and development. Staff we spoke with told us while some development plans were discussed at team meetings, most information was circulated via email, and there was a lack of active engagement and participation from staff in service developments.

Learning, continuous improvement and innovation

- The trust was committed to improving services by learning from when things went well and when they went wrong. There was a clear drive from the clinical leadership to improve consistency and collaboration across the two sites, and learning and development between sites had improved since our last inspection. Staff we spoke with were able to give us clear examples of instances where the service had made improvements, as a result of incidents or learning identified at one site.
- The service participated in approved accreditation schemes and quality improvement initiatives and had recently gained their Anaesthesia Clinical Services Accreditation (ACSA). The service used the enhanced recovery programme to improve patient outcomes following surgery, and staff we spoke with were positive about this programme and the impact it had for patients.
- While we did not see any evidence of standardised improvement tools or methodology, staff we spoke with felt supported to offer suggestions for improvement and this would be done through the local unit meetings.

Services for children and young people

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

Information about the service

Services for children and young people 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 Epsom General Hospital.

Epsom General Hospital has a 16 bed children's inpatient ward. The ward is a level one paediatric oncology shared care unit (POSCU) which means staff care for children with cancer. There is an 11-bed assessment unit, which opens from 7.30am until 5.30pm five days a week. The dedicated children's outpatient department has several clinics in various specialities such as urology, general paediatrics, cardiology and multidisciplinary 'one stop' clinics for conditions such as allergies. At the time of our inspection, there was no paediatric surgery being carried out at the Epsom site. A children's community nursing team was based in the hospital, providing care for children following discharge from their original point of care. There was a special care baby unit (SCBU) with six cots providing care for babies born prematurely or who were unwell. Babies requiring more intensive care could be transferred from Epsom to the level two neonatal intensive care unit at St Helier Hospital, nine miles away.

The trust had 6,424 spells from March 2017 to February 2018.

Emergency spells accounted for 69% (4,401 spells), 30% (1,939 spells) were day case spells, and the remaining 1% (84 spells) were elective.

Summary of findings

Our rating of this service improved. We rated it as good because:

- Safeguarding processes had improved since our last inspection. Staff had instant access to information, which was held electronically. This meant staff were immediately aware if a child was known to social services, was a looked after child, or subject to a child protection plan.
- Staff identified and responded appropriately to changing risks to people who use services, including deteriorating health and wellbeing and medical emergencies. Staff were able to seek support from senior staff in these situations.
- People received safe care and treatment. Vacancy rates for nursing staff had improved significantly since our last inspection.
- Staff understood their responsibilities to raise and record safety incidents, concerns and near misses. Learning from incidents was routinely shared with staff across the service in several ways, such as regular ward meetings.
- The service used a range of evidence-based guidance, legislation, policies and procedures to deliver care, treatment and support to patients.

Services for children and young people

- From June 2017 to May 2018, the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma.
- Staff treated patients and their families with kindness, dignity, respect and compassion. We saw that staff took the time to interact with people who use the service and those close to them in a respectful and considerate way.
- The trust provided timely and accessible services for children and young people which reflected the needs of the population served. Trust leaders had worked collaboratively with trust staff, external bodies and children and young people, and their relatives to do so.
- The trust listened and responded to people's concerns and complaints about services for children and young people, and used these to improve the quality of care. The service received a very low number of complaints.
- Leaders had the required skills, knowledge, experience and integrity to carry out their roles effectively.
- There were clear and effective systems of governance and management across services for children and young people at Epsom General Hospital, in close liaison with St Helier Hospital, the other trust's site.

However:

- Medical staff did not meet the completion rate target of 85% for nine out of the 11 mandatory training modules for medical staff. This meant that not all medical staff had received training essential to providing safe patient care.
- Staff did not consistently monitor the temperature of the fridge in the clinical room in the neonatal unit which was used to store breast milk. This meant there was a risk that breast milk could be exposed to abnormal temperatures, which could cause the milk to deteriorate.
- The trust paediatric policies we looked at were not all up to date. For example, one of the policies we looked at, had expired in September 2017.
- Locum medical staff did not have access to the full information technology systems and could only use a generic log on to access the trust systems. This meant locum staff could not easily access important information such as handover lists, transfer letters and up to date guidelines.
- Some staff told us they would use other staff members to translate for parents or relatives. This was outside of best practice and trust policy.

Services for children and young people

Are services for children and young people safe?

Good

Mandatory training

- Staff received effective training in safety systems, processes and practices.
- Staff told us mandatory training was managed well by ward managers on an electronic system, and they received email alerts to remind them when they were due to attend training. Staff told us they did not have any difficulties attending training, and were released from their duties to allow them to attend.
- Staff received training in paediatric life support through the annual paediatric resuscitation module and paediatric 'Care, Recognition, Initial, Stabilisation in Simulation' (CRISIS) study days.

Mandatory training completion rates

- The trust set a target of 85% for completion of mandatory training.
- As of October 2018, the 85% target was met for all of the 14 mandatory training modules for which qualified nursing staff working on site in children's services at Epsom General Hospital were eligible. This meant most staff had received training essential to providing safe patient care. Community nursing staff are not included in these figures as we did not directly inspect community health services for children.
- As of October 2018, the 85% target was not met for nine out of the 11 mandatory training modules for medical staff working on site in children's services at Epsom General Hospital. Community medical staff are not included in these figures as we did not directly inspect community health services for children. This meant that not all medical staff had received training essential to providing safe patient care. However, we spoke to three medical staff who told us they were up to date with their mandatory training. It should be noted that the trust's training year ran from April to April, so the period for completion of training had not yet expired. For the information governance module, staff had until 31 March 2019 to complete the training.

(Source: Provider Information Request - DR24)

Safeguarding

- There were appropriate safeguarding systems, processes and practices to protect adults and children from abuse and neglect. Staff knew how to identify and report abuse and neglect, and were confident to do so.
- Safeguarding processes had improved since our last inspection. On our last inspection, we found ward staff relied on safeguarding concerns being brought to their attention by the emergency department, who manually checked records or contacted social services. The information was not held electronically and therefore was not easily accessible. It should be noted that, at the time of our last inspection, these arrangements were the adopted standard practice of the local authority, who were responsible for maintaining the child protection database.
- On this inspection we found the service was mostly compliant with NHS England's Child Protection Information Sharing Project. This meant that relevant staff had instant electronic access to information, which informed them if a child was known to social services, was a looked after child or subject to a child protection plan. We viewed the trust's Safeguarding Children Annual Report 2017-2018, published July 2018, which confirmed this was the case. However, the report recognised that full implementation and consistent checking of children against records was yet to be achieved. This was also corroborated by staff we spoke to. Overall, this was an improvement upon our last inspection.
- Staff were competent and confident in their knowledge of safeguarding. Safeguarding information, including contact numbers and details of the trust lead were easily available on wards, and most staff were aware of how to access support. Staff gave examples of safeguarding concerns they had identified, and when they had made referrals. Staff could access safeguarding supervision and ad-hoc advice from the trust safeguarding team. However, some staff we spoke with were not sure who they could contact for safeguarding advice out of hours.
- Staff worked well in partnership with other agencies to ensure people were helped, supported and protected. 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, GPs and local authority social workers regarding a baby or child. Staff

were also aware of the next steps in the process after they reported a concern, which was that social services would allocate a key worker to the case and hold a strategy meeting.
- The trust participated in local safeguarding children's boards and with other partners in local health and social care services. The trust had developed an adults' and children's safeguarding hub 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 the 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. For example, this could include pregnant young women receiving care from the maternity service.

Safeguarding training completion rates

- 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. Other non-clinical staff completed level two safeguarding training.
- The trust set a target of 85% for completion of safeguarding training.
- As of October 2018, the 85% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible. This meant that most nursing staff had received training essential to protecting patients from abuse and neglect. Community nursing staff are not included in these figures as we did not directly inspect community health services for children.
- As of October 2018, the 85% target was met for two of the four safeguarding training modules for which medical staff were eligible. Community medical staff are not included in these figures as we did not directly inspect community health services for children. This meant that not all medical staff had received training essential to protecting patients from abuse and neglect.
- However, we spoke to three medical staff on inspection, who told us they were up to date with their safeguarding training. It should be noted that the trust's training year ran from April to April, so the period for completion of training had not yet expired. The trust was aware of the low completion rates for the Safeguarding Adults Level 2 (MCA and DoLS) module, and the lack of compliance was being monitored at the Safeguarding Children Committee.

(Source: Routine Provider Information Request (RPIR) – DR24)

Cleanliness, infection control and hygiene

- The trust had effective systems to maintain standards of cleanliness, and prevent and protect people from healthcare-associated infections.
- The areas we visited were visibly clean. However, there was some clutter on Casey Ward, which meant the ward was not always tidy. Staff told us this was due to a lack of storage space, which would be resolved when the new Ebbisham Ward was opened, on the same floor as Casey Ward, later in November 2018.
- Hand sanitisers were available throughout the wards and at the point of entry. There were several handwashing sinks in side rooms and the main ward areas. We observed staff washing their hands prior to, during and after patient contact. 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. Staff adhered to the trust bare below the elbow policy.
- Staff escalated any issues with cleaning to the contracted cleaning agency, and told us these were resolved quickly. Cleaning staff recorded completion of cleaning tasks in a checklist document. We viewed the checklist and saw it was consistently completed, signed for and dated.
- Staff used 'I am clean' stickers to indicate whether items of equipment had been cleaned and when the next clean was due. We looked at four items of equipment and saw all had an up to date 'I am clean' sticker.
- Staff told us that healthcare assistants or play specialists were responsible for cleaning toys, depending on the clinical area the toys were in. Toys were cleaned twice a week, and we saw that cleaning was recorded in a log book. Staff told us that they would all contribute to cleaning toys where needed, and on an ad hoc basis, particularly where toys had been used by a child with an infection. Children who were receiving care in side rooms received a box of age-appropriate toys for their sole use, which would be cleaned thoroughly when the child was discharged.

- We saw information displayed on Casey Ward showing there had been no cases of methicillin resistant staphylococcus aureus (MRSA) or clostridium difficile (C diff) in the 12 months prior to our inspection. Furthermore, there had been no cases of C diff on Casey Ward since April 2016. This was good practice, and demonstrated that practices on the ward protected patients from such infections.
- We saw infection prevention and control information displayed on Casey Ward, which informed patients and relatives about handwashing techniques, and to tell staff immediately if they had a loose dressing or a wound or intravenous drip site became painful. We observed staff advising parents and carers of children and young people on Casey Ward about infection prevention and control practices. For example, if a child with an infection was receiving care in an isolation room, staff advised parents to remain with their child in the room and not walk around the ward unless necessary. Patients and relatives we spoke to told us they felt the ward areas were sufficiently clean.
- In the CQC Children and Young People's Survey 2016 the trust scored 8.86 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 and Young People's Survey 2016, RCPCH)

Environment and equipment

- The design, maintenance and use of facilities were mostly in line with trust policies and procedures, and with best practice.
- We saw fully equipped resuscitation trolleys on Casey Ward, Ebbisham Ward and children's outpatients. We saw that staff checked the resuscitation trolleys and their contents daily, and kept a record of their checks. These checklists were overseen by senior nursing staff, who ensured action was taken if the checklists identified problems with the resuscitation trolley.
- We also checked the resuscitation trolley in the Special Care Baby Unit (SCBU). We found that this contained all items on the checklist, but the checklist did not specify the required numbers of each item. This meant that the checklist did not always reflect the contents of the trolley, and we found that there were multiple numbers of the same item in the trolley. This also meant there was a risk that in the event of an emergency, there may have been fewer items of equipment in the trolley than required, meaning staff may have to source the equipment during an emergency.
- On Casey Ward, resuscitation trolleys were unlocked and turned to face the wall, to prevent unauthorised access. Service leaders told us this had been reviewed and approved by the hospital resuscitation lead, who had confirmed that this was compliant with the Resuscitation Council guidelines. However, staff told us they found the resus trolley awkward to access, and worried that it would be difficult to use in the event of an emergency.
- The trust provided an up to date list of all equipment currently on the children's ward and outpatient areas. We saw that all equipment, including electrical equipment, was regularly tested and serviced to ensure it conformed with relevant safety standards.
- Staff were aware of the procedure to follow in the event of broken equipment. Staff told us the hospital estates team were very efficient, and they rarely had to wait more than 24 hours for equipment issues to be resolved. Staff also told us matrons, or the infection prevention and control link nurse, could intervene to speed up solutions to environment or equipment problems.
- We saw that there were appropriate arrangements for managing waste and clinical specimens. We saw that sharps bins were signed and dated when brought in to use. The sharps bins we viewed were not overflowing. We saw that when sharps bins were full, staff sealed the bin and alerted the nurse in charge, who would arrange for it to be collected by the hospital's estates team.
- There were robust arrangements for entry and exit to ward areas, and to children's outpatients that kept people safe. Entry to all areas we visited were controlled by a buzzer call system. Exit to Casey Ward and the SCBU was also controlled in this way. To gain entry to the ward, visitors would have to press a call bell which would be answered by a member of staff, who would confirm the visitor's identity and authorise their entry to the ward. We saw this in practice, and staff rightly asked us who we were and asked for our identification.
- However, staff did not consistently record the temperature of the fridge in the clinical room in the SCBU, which was used to store breast milk. We found that in September 2018, the fridge temperature was not recorded on 21 out of 30 days. By contrast, in October 2018, the fridge temperature was consistently recorded.

Nevertheless, for both September and October 2018, staff had only been recording the current temperature of the fridge, and not the minimum and maximum temperatures. The inconsistency of recording of fridge temperatures meant that there was a risk that breast milk could be exposed to too high or too low temperatures, which could cause the milk to deteriorate. We raised this with the nurse in charge of the SCBU at the time of our inspection, who confirmed that the fridge temperatures were checked every day, but recognised that the temperatures should be recorded, regardless of whether there was breast milk in the fridge.

Assessing and responding to patient risk

- Staff identified and responded appropriately to changing risks to people who use services, including deteriorating health and wellbeing and medical emergencies. Staff were able to seek support from senior staff in these situations. There was a dedicated hospital-wide resus team and staff were aware of how to contact them.
- Staff also received paediatric 'Care, Recognition, Initial, Stabilisation in Simulation' (CRISIS) study days. We viewed the training records which showed the trust had held 15 such study days between 2016 and the time of our inspection in 2018. We saw that the CRISIS study days were well attended by a variety of nursing staff, medical staff of various paediatric specialities, and students. Staff commented that these study days were useful, and increased their confidence in their ability to care for acutely unwell patients in an emergency.
- Staff carried out comprehensive risk assessments for patients. Staff managed risks positively. We viewed the paediatric nursing admission form which included risk assessments for manual handling, pressure ulcers, infection control and specific adolescent risk assessments. Risks such as a patient having a known infection or allergy were flagged through a tick box at the front of the admission form, which would make these risks immediately clear to any member of staff caring for that patient.
- Children and young people were monitored for signs of deterioration using a paediatric early warning score system, the 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. The trust regularly audited the use of COAST. Staff received training and updates on the use of COAST through practice development nurses and CRISIS training days.
- There were plans to roll out a new electronic mobile observations system in the children and young people's service, which would calculate early warning scores automatically. This meant deterioration would be detected and escalated earlier, as there was less risk of the scores being calculated incorrectly. At the time of our inspection this was not yet in place, as the mobile observations system was not yet able to support COAST scores. The trust had a steering group that was continuing to meet to resolve the issue and progress towards implementation of the electronic mobile observations system.
- The service also used the 'sepsis six' pathway for sepsis management, and most staff we spoke with were aware of this. We saw 'sepsis six' pathway flowcharts in all areas we visited, for staff to refer to.
- In the SCBU, staff used the newborn early warning trigger and track tool to identify babies at risk of deterioration. We inspected three newborn early warning trigger charts and found that these were completed appropriately. In the charts we looked at, the observations had not triggered an elevated early warning score.
- We viewed the transfer policy for acutely ill children who required specialist intervention and saw this contained clear criteria for transfer and a flowchart for staff to follow. However, when we asked medical staff who they would contact if they were transferring out a baby to a neighbouring acute trust, they were not sure of who they would contact.
- We attended a morning nursing handover on Casey Ward and found this to be well-structured and informative. There was detailed discussion regarding the medicines management, diagnostic test results, recent COAST scores, risk factors, and specific needs. This meant that all staff had sight of key information about patients on the ward, and therefore were better prepared to assess and respond to patient risk.
- In the CQC Children and Young People's Survey 2016 the trust scored 7.86 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

- In the CQC Children and Young People's Survey 2016 the trust scored 9.71 out of ten for the question '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)?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Nurse staffing

- Nurse staffing levels and skill mix were planned and reviewed so that people received safe care and treatment.
- Staff used the 'safecare' tool to determine ward staffing levels and skill mix. This was an evidence-based tool that enabled nurses to assess patient acuity and dependency, and match this to numbers and skills of nursing staff needed on the ward. 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 how much care and intervention patients needed from nursing staff. This would then determine if there were enough nursing staff to meet patient need. A report on staffing was circulated twice daily to the senior nursing team using 'safecare' criteria.
- We saw nurse staffing, as well as any current sickness or recruitment plans, was discussed at matron's meetings. In these meetings, matrons could arrange for staff to work flexibly across areas and sites, when staffing was short.
- There were appropriate escalation arrangements in place when staffing fell below required levels, including a safer staffing policy. Staff escalated to the site team and would reduce the bed base, if it was considered that staffing posed a risk to patient safety. Staff also told us that practice development nurses frequently attended the wards to check up on staffing, and assist staff clinically if appropriate.
- 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

Vacancy rates

- The trust provided us with the average monthly registered nursing staff vacancy rates in children's services from November 2017 to October 2018. The trust reported that in October 2018, the vacancy rate for registered nursing staff was 5.3%. This was lower (better) than the trust threshold of 10%, and was a notable reduction from a vacancy rate of 21.6% in November 2017. This meant there were sufficient levels of nursing staff to care for patients in children's services.

(Source: Provider Information Request – DR62)

Turnover rates

- From October 2017 to September 2018, the trust reported an average turnover rate of 1.2% for nursing staff in children's services. This was notably lower (better) than the trust threshold of 12%. This meant that there were good levels of nursing staff retention.

(Source: Provider Information Request - DR22)

Sickness rates

- From October 2017 to September 2018, the trust reported an average sickness rate of 1.11% for nursing staff in children's services. This was lower (better) than the trust threshold of 3.8%. This meant that fewer nursing staff were off sick, and more staff were available to care for patients.

(Source: Provider Information Request - DR23)

Bank and agency staff usage

- Vacant shifts were submitted to bank and agency. From October 2017 to September 2018, the trust reported that an average of 5.7% of shifts were filled by bank nursing staff. None of the shifts were filled by agency nursing staff.

(Source: Provider Information Request – DR33 & DR65)

Medical staffing

- Medical staffing levels and skill mix were planned and reviewed so that people received safe care and treatment.
- Consultant medical staff reviewed children's care twice daily during the weekdays, and once during a daily ward round over weekends. We saw consultants undertaking ward rounds, and medical handovers happened twice a day. All new admissions were seen on every ward round.
- Medical staff we spoke with felt there were adequate numbers of medical staff at the hospital during the day and night. There was a consultant paediatrician on site at the hospital from 8am until 10pm seven days a week. After 10pm, staff contacted the consultant on call. Staff

gave examples of when consultants attended the hospital out-of-hours. Staff told us they felt that staffing at night was safe, and they felt supported by consultants.
- Leaders recognised that medical staffing could be a challenge in the winter months, and in response had secured winter pressure funds to recruit locums to fill rota gaps in 2018/2019.

Vacancy rates

- The trust provided us with the average monthly medical staff vacancy rates in children's services from November 2017 to October 2018. The trust reported that in October 2018, the vacancy rate for medical staff was 5.9%. This was lower (better) than the trust threshold of 10%. This meant there were sufficient levels of medical staff to care for patients in children's services.

(Source: Provider Information Request – DR62)

Turnover rates

- From October 2017 to September 2018, the trust reported an average turnover rate of 1% for medical staff in children's services. This was notably lower (better) than the trust target of 10%. This meant there were good levels of medical staff retention.

(Source: Provider Information Request - DR22)

Sickness rates

- From October 2017 to September 2018, the trust reported an average sickness rate of 1.11% for medical staff in children's services. This was lower (better) than the trust target of 3.8%. This meant that fewer medical staff were off sick, and more staff were available to care for patients.

(Source: Provider Information Request DR23)

Locum staff usage

- Vacant shifts were submitted to locum agencies. Medical staff told us they were not always successful in obtaining locum staff to fill shifts, but most locums who were booked worked at the hospital regularly.
- Staff and leaders confirmed that foundation year one or two doctors and speciality registrars covering paediatrics were never both locums at the same time.
- Vacant shifts were submitted to bank and agency. For the period of October 2017 to September 2018, the trust reported that an average of 9.9% of shifts – both desirable and essential – were filled by bank medical staff, and 3.6% were filled by agency medical staff.

(Source: Provider Information Request – DR33 & DR65)

Staffing skill mix

- In December 2017, the trust reported 73 whole time equivalent staff working in children's services at Epsom and St Helier University Hospitals NHS Trust. The proportion of consultant staff reported to be working at the trust was the same as the England average at 41% and the proportion of junior (foundation year 1-2) staff was about the same at 5% compared to the England average of 6%.

Records

- People's individual care records, including clinical data, were mostly written and managed appropriately. In the areas we inspected, staff used paper records.
- In children's outpatients, we looked at three sets of patient notes for clinics and found that these were well organised, with no loose paper, and most entries legibly signed and dated, in line with national professional guidelines. On Ebbisham Ward, we looked at two sets of patient notes and found that these were consistently completed.
- On Casey Ward, we looked at 11 sets of patient notes and found that these were mostly complete, legible, signed and dated. Of the records we looked at, all contained up to date children's observation and severity tool (COAST) scores and appropriately completed drug charts. However, three sets of patient notes did not include evidence of child or parent involvement in care planning, and two did not contain safeguarding information. This meant there was a risk that staff caring for children may not have been able to access all the information they needed.
- However, this risk was mitigated by regular documentation audits, carried out by leaders on Casey Ward at least every two months. We viewed a sample of these audits. The audits assessed a sample of records for completion of patient identification information, manual handling assessments, patient observations, and drug charts, and whether records were signed, dated and written in a timely manner. The audits we reviewed showed that records were mostly complete,

however scores had not been calculated. Leaders told us any issues identified from the documentation audit were addressed with relevant members of staff on the day of the audit. The results and any themes identified from the documentation audit were reported at the monthly senior nursing meeting.

- We saw that patient records were stored in trolleys with code locks, and they were locked appropriately. This ensured the confidentiality of patient records was maintained, and prevented unauthorised access.
- Staff in children's outpatients reported that notes were always available for clinics, and the medical records team were helpful in ensuring this.

Medicines

- Medicines and medicines related stationery were managed safely and securely.
- Staff reported good access to the pharmacist who visited the wards. Paediatric pharmacists regularly checked prescription charts and controlled drugs (CD) books. On Casey Ward we looked at three prescription charts and found these were legible, signed and dated and allergies clearly recorded.
- We saw that patient's medication was discussed in detail during the nursing handover. If staff were involved in a medication error, the practice development nurse met with them to offer one to one training and support.
- Nursing staff were aware of the policies on the administration of controlled drugs (CDs); these are medicines requiring additional security.
- CDs were stored in lockable cupboards. 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.
- The trust policy was for the CD cupboard and associated log books to be checked once per shift. In the SCBU, we checked the CD stock levels documented in the stock books and found them to be accurate. We also checked a sample of medicines and found them all to be in date.

Incidents

- Staff understood their responsibilities to raise and record safety incidents, concerns and near misses.
- The trust used an electronic incident reporting system to report incidents and 'near miss' situations. Staff were aware of how to report incidents. Staff told us managers encouraged them to report incidents. Staff received an acknowledgement email when they submitted an incident report, and matrons provided individual feedback, if appropriate.
- Incidents and associated learning were discussed at monthly ward meetings. The meeting minutes were emailed to all relevant staff, and we saw copies were also available in each ward office. Staff confirmed that they were kept informed in this way, and could give examples of recent learning from incidents.
- Learning from incidents across both hospital sites was shared in staff newsletters. Staff could access learning from incidents in services for children and young people at the St Helier Hospital site through twice yearly paediatric study days, and routine updates from leaders and managers.
- There were effective arrangements amongst the senior leadership of the service to ensure that internal and external incidents, safety alerts and investigations were responded to appropriately, and learning and key information was shared amongst staff. We saw that incidents were discussed and analysed during cross-site divisional meetings. This included discussion on themes, and any changes in the number of incidents reported compared to the same time the previous year. When themes became prominent, these were escalated to the divisional risk register.
- Leaders also discussed learning from incidents and alerts such as National Patient Safety Alerts from NHS Improvement and Medical Device Alerts from the Department of Health and Social Care.
- Paediatric medical staff at the hospital attended quarterly cross-site 'Mortality and Morbidity' (M&M) meetings. Minutes of the meetings were recorded and circulated to staff via email. M&M meetings were incorporated into the teaching programme for medical staff. We viewed a sample of M&M meeting minutes, and saw that these included presentations. Leaders told us if there were no relevant mortality cases for discussion, the team would discuss other issues relating to end of life care and shared learning from the local children's hospice.
- 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 did not have any recent examples where they had needed to formally carry out the Duty of candour.

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 August 2017 to July 2018, the trust reported no incidents classified as never events for children's' services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in children's services which met the reporting criteria set by NHS England from August 2017 to July 2018.
- The incident reported was: Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with one (100% of total incidents).

(Source: Strategic Executive Information System (STEIS))

- We observed that leaders tracked the progress of any SI investigations during divisional meetings.

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 urinary tract infections in patients with a catheter from May 2017 to May 2018 for children's services. This was good performance.
- We saw that safety thermometer data was displayed on Casey Ward. These showed that in September 2018, 100% of patients had received harm-free care. We saw that leaders also discussed the level of harm in each area of the trust during the divisional meeting we observed.

(Source: NHS Digital)

Are services for children and young people effective?

Good

Evidence-based care and treatment

- The service used a range of evidence-based guidance, legislation, policies and procedures to deliver care, treatment and support to patients.
- The service participated in several accreditation schemes. For example, the SCBU had achieved Gold level 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 would support optimum health and development.
- The service followed relevant national guidelines and standards. Staff accessed policies and corporate information on the trust's intranet. Medical staff we spoke with gave examples of guidelines they had recently referred to, and told us they found them helpful. We reviewed seven policies including those for stabilisation of a deteriorating patient, bronchiolitis and assessment of fever in children. The policies we viewed 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.
- However, not all the policies were up to date. Of the seven policies we looked at, five were out of date at the time of our inspection. For example, one of the policies expired in September 2017. Two of these policies did not have an identifiable review date. This was not best practice, and meant staff may not have used the most up to date information to guide care and treatment of patients.

- 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 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. Action plans were also discussed at these meetings to monitor improvement.
- The service participated in several national audits, and conducted local audits. These are explained in more detail in the patient outcomes section of the report.

Nutrition and hydration

- Staff identified, monitored and met patient's nutrition and hydration needs.
- We saw that there was a section on eating and drinking in the paediatric nursing admission form. Staff recorded patient's special dietary requirements, as well as allergies and if the child was enterally fed. For babies, staff recorded whether they were breast or formula fed, and recorded the routine. 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, 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 support workers were available to support eating. Snacks were available between meal times, and patients and their relatives we spoke to were aware of this.
- Age appropriate nutrition was provided. There were different menus depending on the age group of the child or young person. 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 salt or smooth textured diets. There were also religious and cultural menus available.

Pain relief

- Staff assessed and managed patient's pain effectively.
- Staff completed a pain assessment for every patient upon admission, and recorded this in the paediatric nursing admission form. Children over three years were asked to rate their pain on a scale of zero to ten, and staff used a pain assessment tool with illustrations of faces, to help children identify their pain level. For children aged one month to three years, or for children who were unable to communicate their pain, staff used a scale which included observations of the child's face, legs, activity, cry and whether the child could be easily consoled by comfort or distraction.
- Staff used both of these scales to calculate an overall pain score for the child. This was recorded and if the pain score was above two, staff were required to take appropriate action. For example, staff could refer the child to the hospital pain team, who provided a consulting service for chronic and acute pain across the hospital. Parents we spoke with told staff had managed their child's pain effectively.

Patient outcomes

- The service routinely collected and monitored information about the outcomes of patient's care and treatment. 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. We viewed an updated action plan from October 2018, which gave assurances that the vast majority of the actions had been completed. This was effective practice, and showed the trust's commitment to improving patient outcomes.

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 diabetes audit the trust performed better than the England average on one measure and worse than the England average on one measure.
- The proportion of patients receiving all key care processes annually was 62.9% which was a positive outlier compared to a national aggregate of 35.5%, the previous year's score was 72.9%.
- HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. Higher values indicate poorer control. Gender, ethnicity, age and deprivation are known to impact upon the level of diabetes control typically achieved by patients, as reflected in mean HbA1c levels. Case-mix adjusted mean HbA1c levels are presented so that trust's performance can be fairly represented, taking these factors into account. The trust was an outlier in this measure, which meant it was outside of the expected range of performance.
- The average HbA1c value (adjusted by case-mix) at the trust was 76.3 mmol/mol which was a negative outlier compared to a national aggregate of 68.3 mmol/mol, the previous year's score was a negative outlier.
- The trust provided information which showed an improvement in the mean case-mix adjusted HbA1c for paediatric patients with Type 1 diabetes, in response to the NPDA 2014/15 and 2015/16 results. For 2016/17, the mean adjusted HbA1c value for the Trust was 72.9 mmol/mol. This was a reduction on the 76.3 mmol/mol reported for 2015/16 and the 80.0 mmol/mol reported for 2014/15.
- The trust provided us information which showed for 2016/17, the median HbA1c value for the Trust was 69.0 mmol/mol. This was a reduction on the 70.0 mmol/mol reported for 2015/16 and the 73.3 mmol/mol reported for 2014/15. This showed the trust had improved upon the median HbA1c for paediatric patients with Type 1 diabetes.

(Source: National Paediatric Diabetes Audit 2015/16 and Provider Information Request - AC3 & AC4)

- At the time of our inspection, we spoke to leaders about the trust being a negative outlier for case-mix adjusted average HbA1c. It should be noted that there was a significant delay in the paediatric diabetes audit reports being published compared to data collection and submission, which was a national issue. We also viewed a trust action plan from September 2018. Leaders were confident that appropriate steps were being taken and they were making progress to improve upon the outlier.
- The Paediatric Diabetes Team were fully informed of the audit reports which were also shared at the Paediatric Quality Half Days and at the Paediatric Diabetes Network Meetings. Leaders told us the outlier was complex as the performance was not solely dependent on input from the hospital but relied to a large extent upon patient compliance with diabetes treatment and testing outside of the hospital setting.
- Since the early notification of negative outlier status in March 2018, the paediatric diabetes team had reviewed and audited their 'high HbA1c' policy for the last quarter of 2017-18. The team had amended their 'high HbA1c' pathway and introduced real time monitoring of performance at every clinic, which was kept on the shared drive with information available for the whole team. The trust reported these showed an overall trend in improving the HbA1c of each clinic (calculated by comparing each child's HbA1c at that visit compared to their last clinic attendance and calculating a clinic mean).
- Leaders told us there were also plans to introduce sensor technology, which patients could use to monitor their HbA1c levels in the community, which gave much more accurate readings.

Emergency readmission rates within two days of discharge

- The data shows that from May 2017 to April 2018 there was a similar percentage of patients aged 1-17 years old readmitted following an elective paediatric admission compared to the England average, with the trust having a readmission rate of 0.8% compared to an England average of 0.9%.
- During the same period, the trust had a similar percentage of patients aged 1-17 years old readmitted following an emergency paediatric admission compared to the England average, with the trust having a readmission rate of 2.2% compared to an England average of 2.8%. the trust had a higher (worse) readmission rate for emergency admissions in accident and emergency compared to the England average, with the trust having a readmission rate of 3.1% compared to an England average of 2.1%.

- Readmission rates by specialty for patients under one year old could not to be calculated due to low numbers.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

- From June 2017 to May 2018 the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma, with the trust having a rate of 9.8% compared to an England average of 16.1%.
- From June 2017 to May 2018 the trust performed about the same as the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for epilepsy, with the trust having a rate of 25.5% compared to an England average of 27.4%.
- Readmission rates by specialty for patients under one year old could not to be calculated due to low numbers.
- The trust's performance for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma was an improvement upon our last inspection. This was an improvement we told the trust they should make in our report of the inspection of the St Helier Hospital site.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

National Neonatal Audit Programme

- In the 2015 National Neonatal Audit, Epsom General Hospital's performance was as follows:
- Do babies with <32 weeks gestation who have temperature taken within an hour of admission that was between 36.5ºc and 37.5ºc? Data was suppressed due to low numbers.
- 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? Data was suppressed due to low numbers.
- Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? Out of 131 eligible cases identified for inclusion, 99.6% had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. This made the hospital a positive outlier when compared to the national aggregate of 90.5%.
- Do all babies with gestation at birth <30 weeks receive documented follow-up at two years gestationally corrected age? Data was suppressed due to low numbers.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

- In addition to the 2015 data, the trust also provided the results from the 2017 National Neonatal Audit at Epsom General Hospital. These are listed below.
- The audit showed that 85% of mothers who delivered babies between 24 and 34 weeks gestation were given antenatal steroids, compared to a national rate of 89%. This is recommended to help prevent breathing problems in the baby.
- In 99% of cases there was a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of a baby's admission, which was better than the national rate of 95%.
- The proportion of admissions where parents were present on at least one consultant ward round during a baby's stay was 63%, which was worse than the national rate of 74%.
- Babies who were born weighing less than 1501g, or were born at less than 32 weeks gestation received on-time screening for retinopathy of prematurity in 80% of cases, which was worse than the national rate of 94%. However, it should be noted that the SCBU at Epsom General Hospital did not routinely deliver babies below 34 weeks. Instead, in such cases the mother would be transferred to the neonatal unit at St Helier Hospital.
- The number of babies born at less than 30 weeks who had received documented medical follow-up at two years of age was 100%, which was notably better than the national rate of 63%.

(Source: Provider Information Request – DR60)

Competent staff

- Staff had the right skills and knowledge to meet the needs of patients.
- The service had placed strong emphasis on education for staff. The trust ran paediatric nursing update days

twice per year. Staff confirmed that they were able to attend these and found them useful, and leaders listened to their suggestions on what they would like to be included.
- Consultants provided teaching for junior doctors every Thursday afternoon.
- At the time of our inspection, the trust was developing a comprehensive programme of evidence-based mental health training and guidance for staff, to equip them with the skills and abilities to care effectively for patients with mental ill health. This was in response to an increase in children presenting at the hospital with mental health problems, and was driven by senior leaders in the service alongside the paediatric mental health liaison nurse. The paediatric mental health liaison nurse had delivered several teaching sessions to staff, including the use of case studies.
- The trust had been successful in securing funding from Health Education England to provide face to face 'We Can Talk' training for all staff from November 2018. This training included the use of a competency framework, which staff could embed in to their practice. The trust told us external trainers would initially provide the training sessions, and the trust would take over the training after three sessions had been provided.
- The paediatric mental health liaison nurse told us of plans to establish staff members who were mental health champions on each ward, who staff could approach for advice and support. Staff we spoke to across the service confirmed this was the case and felt that the increased training was a positive development.
- Managers encouraged staff to take up development opportunities. Most staff we spoke to, of all bands and disciplines, told us they felt they could access development opportunities and their managers were supportive of this.
- Nursing staff did not receive formal clinical supervision. The trust provided us with information which stated that instead of formal clinical supervision, nursing staff met their managers regularly as part of the appraisal process, had regular one to one meetings, and worked closely with the practice development team and their mentors. However, this was not best practice and this was highlighted as action the trust 'should' take to improve in our inspection report of services for children and young people at St Helier Hospital in May 2018.
- All staff received a structured induction programme when they commenced their employment with the trust. We spoke with three members of staff who had recently joined the trust and they had received a corporate trust induction as well as a local induction to their area of work. Local inductions included a period of shadowing. Staff were positive about the induction they had received.
- We saw that locum medical staff received a generic induction pack. Locum medical staff could use a generic log on to access the trust IT systems. Following the inspection, the trust told us locum medical staff could access handover lists, transfer letters, and up to date guidelines through the generic log on.

Appraisal rates

- The trust had an annual appraisal cycle for non-clinical and nursing staff. End of year appraisals were completed in quarter four. The trust provided us with information which showed, of 96 eligible staff, 88 had received an appraisal in the 2017/18 year, giving a completion rate of 92%.
- Medical staff received appraisals annually as part of the revalidation process. The trust provided information which showed, of 18 eligible staff, 15 had received an appraisal, giving a completion rate of 83%. The trust explained that the three staff who had not yet received an appraisal due to maternity leave and recently commencing employment at the trust.
- All staff we spoke with about appraisals told us they had an appraisal and it was useful.

(Source: Provider Information Request – DR25)

Multidisciplinary working

- The service involved all necessary staff, including those in different teams, services and organisations, in assessing, planning and delivering care and treatment. The trust provided us with information which stated each ward had a weekly multidisciplinary (MDT) meeting where the team discussed patients in depth, and made plans for those with complex discharge planning needs.
- Consultants worked closely with the nurse in charge on each ward and had daily discussions including a safety debrief and escalation of any immediate issues.
- We saw that allied health professionals, such as play therapists and dietitians, were present on Casey Ward

and interacted well with nursing and medical staff. Paediatric pharmacists were available on site during normal working hours, and available on call out of hours.
- There was evidence of effective multidisciplinary partnership working with external agencies and professionals. 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. For example, paediatric epilepsy plans were developed between the child or young person, their carers and the multiprofessional team responsible for their care. Plans were shared with the child's GP.
- The children and young people's service met twice a year with the South Thames Retrieval Service (STRS), an intensive care service, transporting critically ill children from local hospitals to intensive care units (PICUs).
- Staff reported good communications with local GPs. Discharge summary letters were sent to the patient's GP and community school nurses where relevant, as well as to parents, carers and patients. Staff encouraged patients to attend their GP shortly after discharge.
- In the CQC Children and Young People's Survey 2016 the trust scored 8.96 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

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 days per week.
- Medical staff we spoke with confirmed a consultant paediatrician was available until 10pm seven days per week. After 10pm, there was an on-call consultant rota.
- Staff reported that physiotherapists were available during normal working hours, and then available on call 24 hours a day, seven days per week. Medical staff told us they could obtain assistance from physiotherapists within 60 minutes, including during the night.
- Services such as diagnostic scanning were available seven days per week.
- The paediatric pharmacist attended paediatric inpatient wards every day including weekends, and there was 24 hour on call paediatric pharmacy support.

Health promotion

- The service supported children and young people and their families to live healthier lives, through several initiatives.
- Staff identified children, young people and their relatives who may need extra support and arranged that support for them. For example, the clinical nurse specialist for asthma visited patients in their homes to support with inhaler technique. The clinical nurse specialist for diabetes visited patients in their homes to encourage compliance with blood sugar monitoring.
- Throughout the areas we inspected we saw leaflets were available on a wide range of health promotion topics, such as support for young carers, and smoking cessation for teenagers and their relatives or carers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and the Children Act 1989 and 2004.
- Staff we spoke with were aware of the requirements of their responsibilities as set out in the 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, and were supported by their managers to do so. Staff told us they knew who to contact for advice in cases where a patient may require support including the safeguarding team and the child and paediatric mental health liaison nurse. The clinical staff we spoke with were knowledgeable about guidelines and 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.

Mental Capacity Act and Deprivation of Liberty training completion

- The trust reported that as of October 2018, Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) training (part of safeguarding adults level two) had been completed by 64 of 112 eligible staff, giving a completion rate of 57% of eligible staff within the children's service. This was below the trust threshold of 85%, and meant that not all staff had completed

training to assist them in dealing with MCA and DoLS issues. However, it should be noted that the completion rates for nursing staff, ranging from 100% to 66%, were much higher than the completion rates of medical staff.

(Source: Provider Information Request - DR24)

CQC Children and Young People's Survey 2016 Data

- The trust performed better than other trusts for one question, asking whether different staff gave parents and carers of children in the 0-7 age group conflicting information. The trust scored 8.6 out of 10. The trust scored about the same as other trusts for the remaining five questions relating to effectiveness in the CQC Children and Young People's Survey 2016. This included questions on: feeling that staff knew how to care for individual or special needs, staff playing or doing activities with the child during the hospital stay, staff working well together and staff playing with or distracting the child during any operations and procedures.

(Source: CQC Children and Young People's Survey 2016)

Are services for children and young people caring?

Good

Compassionate care

- Staff treated patients and their families with kindness, dignity, respect and compassion.
- We saw that staff took the time to interact with people who use the service and those close to them in a respectful and considerate way. For example, we saw the ward clerk on Ebbisham Ward explaining the setup of the ward over the telephone in a reassuring and kind manner.
- We saw positive feedback from patients and relatives displayed on wards across the service. In ward offices we also saw lots of cards from patients and relatives, thanking staff for caring for them.
- We spoke to nine children and young people and their relatives who were positive about the care they or their child received. Parents told us that 'staff are warm and friendly' and 'staff introduce themselves and are nice.' All parents we spoke with told us they would feel happy to leave their child under the care of the staff on the ward.
- Staff appropriately respected patient privacy and took steps to preserve their dignity. We saw that staff drew curtains around the bed when they were providing treatment to patients, to protect their privacy.
- Staff responded compassionately to children who were frightened, anxious, or phobic. Staff gave examples of how they would explain the procedure in a way the child could understand, and where possible would involve a play therapist to help with a role play exercise.
- There were signs throughout the ward areas and outpatients advising patients that they could request a chaperone should they wish to.

CQC Children and Young People's Survey 2016

- The trust performed about the same as other trusts for the 10 questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

(Source: CQC Children and Young People's Survey 2016)

Emotional support

- Children and their families could access appropriate and timely support and information from the trust, to help them cope emotionally with their care, treatment or condition.
- Children and their families who were dealing with a cancer diagnosis could visit the Macmillan Butterfly Centre on the hospital site. There was a bereavement specialist link nurse that relatives could access support from. The trust held an annual memorial service for babies and young children, in emotional support of parents and relatives who had been bereaved.
- There was a team of play specialists who provided play preparation, distraction and emotional support to paediatric patients. The trust told us the play specialists also provided emotional support to the parents and carers of children receiving treatment.
- Staff understood and placed emphasis on the effect a patient's care, treatment or condition would have upon them and their relatives. One parent told us that medical staff had shown their child a constructed image of what the results of their surgery would look like, which helped to ease their child's distress and anxiety.

Services for children and young people

- Staff told us they would respond to parents and carers who were upset by offering them a hot drink, sitting with them to comfort them, and referring them to counselling services where appropriate.
- There was a multi-faith chaplaincy service which patients and relatives could access for support. The trust provided information which stated chaplains regularly provided support to bereaved parents, and could advise staff and relatives on funerals.

CQC Children and Young People's Survey 2016

- The trust performed about the same as other trusts for all five questions relating to emotional support in the CQC Children and Young People's Survey 2016.

(Source: CQC Children and Young People's Survey 2016)

Understanding and involvement of patients and those close to them

- Staff communicated with children and their families in a way which ensured they understood their care, treatment and condition.
- All parents, relatives and patients we spoke with told us staff had explained their condition, treatment or care in a way that they could understand. For example, some parents told us medical staff had drawn pictures and diagrams to explain a procedure to their child.
- Staff told us they would put themselves 'in the patient's shoes' to anticipate their worries and concerns, and try to reassure them by providing clear information.
- However, some patients and their families told us they felt they would like to be more involved and informed about the plan for their care. For example, some people we spoke to told us they felt they had been left alone for long periods of time without knowing what was going on.

CQC Children and Young People's Survey 2016

- The trust performed better than other trusts for two questions, had one 'No score' response and scored about the same as other trusts for the remaining 18 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016.
- The questions in which the trust performed better than other trusts were regarding whether parents or carers of children in the 0-7 age group staff communicated with their child in a way they could understand, scoring 8.4 out of 10, and whether parents or carers of children in the 0-7 age group felt that staff listened to them, scoring 9.2 out of 10.

(Source: CQC Children and Young People's Survey 2016 – Q36)

Are services for children and young people responsive?

Good

Service delivery to meet the needs of local people

- The trust provided services for children and young people which reflected the needs of the local population. Trust leaders had worked collaboratively with trust staff, external bodies and children and young people, and their relatives to do so.
- The trust provided specialist shared care for children with cancer through the Paediatric Oncology Shared Care Unit. This meant that children and young people could receive treatment closer to their homes. There were similar arrangements in place for children and young people with cystic fibrosis. This was good practice.
- Patients could access specialist care when they needed it. There were clinical nurse specialists in place for a range of conditions including diabetes and asthma. The trust offered a multidisciplinary 'one stop' allergy clinic, where children and young people could see multiple professionals in one clinic slot, rather than several different appointments on different days. This meant they could receive earlier diagnosis and treatment. This was responsive practice.
- The ward, clinic and assessment areas we visited were suitably child friendly. All areas we visited where children would be treated were decorated in bright welcoming colours. There was also a sensory room on Casey Ward. We saw that staff had placed considerable focus on providing a range of activities for children and young people of all ages. We saw that entertainers and a Pets As Therapy (PAT) dog regularly visited Casey Ward. Appropriate entertainment activities, such as arts and crafts, were available for older children and teenagers.
- There was a newly opened dedicated children's outpatient area, the Sunshine Clinic, which was located

separately from the main hospital building. This meant that children were seen separately from adults. Following feedback from the trust's Patient First programme, one of the clinic rooms in the Sunshine Clinic had been decorated by a local charity and there were plans to expand on this. Staff told us they would orientate patients and relatives to the layout of outpatients upon their arrival, and informed them of the process for being weighed and measured. Staff in the Sunshine Clinic also offered activities, such as seasonal-themed arts and crafts, to entertain children in the waiting area.

- There were facilities available for parents and relatives. On Casey Ward, parents could stay overnight with their child either on a camp bed or reclining chair. There were similar arrangements on the SCBU. There were kitchen facilities available for parents.
- The trust was responsive to the needs of the local population, and involved children, young people and their families in the design and running of the service. For example, the trust had responded to the increased number of children in the area presenting to the emergency department with mental ill health. The trust had introduced the role of the paediatric mental health liaison nurse and healthcare assistant with enhanced skills in caring for children and young people with mental health problems. Furthermore, the trust had sought the input of local youth groups and service users to gather feedback on how care for children and young people with mental health problems could be improved at the trust.

CQC Children and Young People's Survey 2016

- The trust performed about the same as other trusts for all 17 questions relating to responsiveness in the CQC Children and Young People's Survey 2016.

(Source: CQC Children and Young People's Survey 2016 – Q36)

Meeting people's individual needs

- The service was delivered and coordinated in a way which took account of the needs of different people, including those with protected characteristics under the Equality Act, and those in vulnerable circumstances
- We saw that the children's outpatient service booked longer clinic slots for children with complex needs or multiple conditions.
- Staff referred to the individual needs of each patient during handovers. For example, this included any concerns about the child's mental health, or nutrition and hydration requirements.
- The community paediatric team worked closely with Casey and Ebbisham wards, to share appropriate information and provide joined-up, person centred care. For example, when children who were under the care of the community teams were admitted to Casey or Ebbisham wards, community nurses visited that child on the ward regularly and worked in partnership with ward staff.
- The trust had placed emphasis on ensuring there were appropriate arrangements to ensure support for children with mental health problems, and improve their experience. There was a paediatric mental health liaison nurse who visited patients on the wards. The paediatric mental health liaison nurse also played a role in liaising with local child and adolescent mental health services (CAMHS) and educating staff. This helped to prevent delays in patients receiving the support they needed.
- Staff had sufficient access to appropriate translation and advocacy services to support patients and relatives who did not speak English. Translation services could be booked for telephone and face to face interactions, and we saw this was advertised in multiple languages through posters across the hospital. However, some staff told us they would use other staff members to translate for parents or relatives. This was outside of trust policy and best practice.

Access and flow

- The service was organised in a way that ensured patients had timely access to care and treatment.
- At the time of our inspection, Ebbisham Ward was being moved to the same floor as Casey Ward, which leaders told us would improve flow across the wards.
- A tracking system had been established in the trust. All children who accessed services in the trust were tracked daily through receipt of regular reports which contained details of the child, diagnosis and location in the hospital. The report was sent to the safeguarding team and was reviewed and monitored daily. This provided assurance that children coming into the trust were identified, and ensured that they were in appropriate

wards. There was daily tracking by the trust safeguarding team and matron of young people aged 16 to 18 years old who were outliers. Outliers are children who are inpatients in adult wards.

- Staff efficiently managed access and flow in children's outpatients. Each member of staff was assigned a clinic to manage on each day, and those staff members took responsibility for carrying out observations on those patients such as weight, height and blood pressure for older children. Staff built relationships with each clinic consultant to find out how and when the consultant would prefer each patient's observations to be recorded. Staff reported this worked well and facilitated an efficient flow of patients through outpatients. We saw that staff booked longer clinic slots for patients who had complex needs or multiple conditions. This was good practice, reduced the risk that clinics would overrun, and improved patient experience. The outpatients receptionist took receipt of patient clinical outcome forms (a document which indicated whether the patient required a follow-up appointment or could be discharged) before each patient left the outpatients department, and ensured this was processed appropriately.
- Patients and their relatives were kept updated on any delays or waiting times through a board displayed in the waiting area. Staff also provided verbal updates on any waiting times or delays, and patients and relatives we spoke to confirmed this was the case. Where possible, staff provided patients and relatives for a reason for the delay and a voucher to reduce the cost of their car parking, as a goodwill gesture.
- One relative told us they had raised concerns with the service about the length of time they had to wait for their child to receive an appointment. In response staff had found an earlier appointment, which was responsive practice.

Learning from complaints and concerns

- The trust listened and responded to people's concerns and complaints about services for children and young people, and used these to improve the quality of care.
- Patients and relatives we spoke to were aware of how to make a complaint. We saw that information regarding the Patient Advice and Liaison Service (PALS) was available throughout the areas we visited, in the form of leaflets and posters.
- Staff told us that they would try to resolve concerns and complaints informally when they arose, by speaking with the complainant and addressing their concerns immediately where possible.
- Staff discussed complaints and concerns during weekly ward meetings. Staff could give examples of improvements they had made to services in response to complaints and concerns.

Summary of complaints

- The trust provided us with information which showed between November 2017 and October 2018 services for children and young people at Epsom General Hospital had received seven complaints over the last year.
- 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.
- Out of the seven complaints received between November 2017 and October 2018, six were responded to before or on the deadline. This meant 85.7% of complaints were responded to within the required timeframe, which exceeded the trust target of 75%.

(Source: Provider Information Request – DR32)

Number of compliments made to the trust

- The trust provided us with information which showed between December 2018 and October 2018 services for children and young people at Epsom General Hospital had received 42 compliments about the service from patients and their relatives. Leaders identified the most common themes from compliments being communication, friendly and welcoming staff, and excellent care provided by staff.

(Source: Provider Information Request – DR37)

Services for children and young people

Are services for children and young people well-led?

Good

Leadership

- Leaders had the required skills, knowledge, experience and integrity to carry out their roles effectively. Leaders we spoke to had specific experience in paediatrics and received appropriate paediatric training. The leadership team of the service was established and stable.
- All staff told us their managers were visible, approachable and supportive. Most staff told us the divisional leadership were visible and approachable.
- Leaders understood the challenges to quality and sustainability in the children and young people's service, and could identify actions needed to address them. For example, leaders identified that medical staffing was a challenge during the winter months. In response to this, the trust had secured winter pressure funds to recruit locums to fill rota gaps, and built good relationships with health rostering teams to develop a hub of paediatric trained medical staff who could work at the trust. Leaders had also focused on increasing multidisciplinary education opportunities, such as the CRISIS training, to boost retention.
- There was clear representation of children and young people services at trust board level. This included an executive director 'children's champion'.
- The trust had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There was a trustwide leadership development programme, which leaders could access for support and coaching.

Vision and strategy

- There was an overall vision and strategy for the trust, which the trust were consulting on with staff and the public at the time of our inspection. This included plans to secure funding for a new acute hospital facility, which would provide specialist care for paediatric inpatients and babies born in hospital, from 2020 onwards. However, not all staff we spoke with were aware of this.
- The women and children's division had an operational plan for 2018/19. This included analysis of the strengths, weaknesses, opportunities, threats in the services across the division. The plan also looked at risks across the division and what the service had in place to mitigate the risks. For example, the plan recognised the risk of children receiving support from CAMHS absconding from inpatient wards. In mitigation, leaders set out requirements for such children to be admitted to places on the ward where they could be easily observed, and additional staff to be booked to provide one to one care for patients who required closer observation.
- The plan also reviewed arrangements in the division to strengthen leadership, and continue to improve staff engagement. For example, the plan expressed a commitment to promoting a climate of equality for all staff groups, and addressing concerns and issues raised by black and minority ethnic staff through thorough investigation.
- Staff were aware of the vision and strategy for their area of work, and some staff felt engaged in this. For example, in children's outpatients, staff were aware that there were plans to provide electrocardiogram (ECG) clinics. At the time of our inspection, there was work underway to move Ebbisham Ward to the same floor as Casey Ward, to improve patient flow, particularly during the winter months. Staff had been consulted about this. However, some staff said they did not feel their concerns, such as how infection prevention and control would be managed after the move, had been thoroughly listened to by the senior leadership team.

Culture

- Staff spoke of a culture of multidisciplinary professional respect and inclusion. Staff gave examples of how this culture had a positive impact on patients, as all staff worked towards the shared goal of putting the patient first and focussing on their needs. Staff told us there were often informal multidisciplinary debriefing meetings after difficult cases, including patient deaths, to check on the wellbeing of staff.
- Staff felt supported, respected and valued. Managers demonstrated recognition and understanding of staff wellbeing. Most staff told us they felt invested in by the trust and had access to development opportunities.
- Many staff we spoke with were proud to work for the trust and had been an employee for many years. This demonstrated a positive culture and good retention.

- The culture of the service encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution.
- Most staff we spoke with were aware of the concept of the Freedom to Speak Up Guardian (FTSUG), but were not aware of the name of or how to contact the FTSUG for the trust.

Governance

- There were clear and effective systems of governance and management across services for children and young people at Epsom General Hospital, in close liaison with St Helier Hospital, the trust's other site. Staff had clear responsibilities and roles, and there were effective systems of accountability.
- We viewed the governance structure, which was in the form of a flowchart. Services for children and young people at Epsom General Hospital were part of the cross-site women and children's division, which fed up to the board through the director of the division, to the trust executive committee.
- 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 matron meetings, and monthly senior nurses and matron meetings. This meant there were pathways for information to flow across sites, as well as from ward to board.
- We observed part of a divisional management meeting which covered operational performance. This included governance reports, learning from incidents, risk registers, implementation of national guidance. This was an effective and productive meeting, and leaders appropriately challenged one another and scrutinised information and data. We noted leaders sought assurance on how information about all items on the agenda would be or had been disseminated to ward staff, which demonstrated an established process of ward to board governance.

Management of risk, issues and performance

- There were comprehensive assurance systems across the service, and performance issues were escalated appropriately through clear structures and processes.
- There were processes to manage current and future performance. For example, we observed a cross-site matrons and head of nursing meeting and saw that this was a structured and efficient meeting, where current risks to the service were discussed. Matrons worked together collaboratively to mitigate risks such as staffing.
- There were robust and appropriate arrangements for identifying, recording and managing risks, issues and mitigating actions. We viewed the risk register for services for children and young people. The risk register contained 41 risks, which all had a future date for review. Identified risks included medical staffing and manual handling. Risks on the risk register were aligned to what staff told us was on their 'worry list'. Risks were reviewed monthly, and documentation submitted by the trust demonstrated clear action plans to address these risks.

Information management

- Service leaders had a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Leaders used information to measure for improvement and assurance.
- Leaders managed key performance information on the service through a dashboard, which covered the women and children's division. We saw that this contained comprehensive performance information on a variety of operational measures, such as referral to treatment times. The dashboard included an indication of how performance had changed, got worse or improved over time.

- 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. Leaders also checked the accuracy of these information and notice boards during ward documentation audits.

Engagement

- The trust gathered and acted upon people's views and experiences to shape and improve the service and culture.
- In children's outpatients there was a feedback form which could be filled in by both the child and their parent or carer. The trust took action in response to feedback. For example, the trust had sourced an electronic tablet for paediatric play specialists to help explain procedures such as MRIs to young people.
- The trust actively engaged staff so that their views were reflected in the planning and delivery of services and in shaping the culture.
- The trust maintained positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. For example, medical staff had developed links with specialists at large local teaching hospitals.The trust medical director was an honorary paediatric consultant at another trust, and provided clinics there. Similarly, the other trust provided clinics at Epsom General Hospital. Consultants from local teaching hospitals provided joint clinics in several specialties, including cardiology, endocrinology, neurology and rheumatology. Medical staff told us they felt this was highly beneficial for patients with specific needs, and fostered a sense of partnership with nearby trusts.

Learning, continuous improvement and innovation

- Leaders and staff strived for continuous learning, improvement and innovation.
- At the time of our inspection, the trust had recently opened two transitional care wards for neonates. This meant that new-born babies who were not well enough to be discharged, but who did not need the intensive care of the neonatal or Special Care Baby Unit, could receive care and treatment at their mother's bedside. This could include intravenous antibiotics and light treatment for jaundice. Although we did not inspect this specific service, as it falls under the maternity core service, this demonstrated a research and evidence-based approach to putting the child's needs first by keeping families together. The trust had taken this action in response to the neonatal peer review.
- The service had several quality improvement initiatives in progress which would assist the delivery of mental health care within the service, as detailed earlier in this evidence appendix. This was in response to an increased need from the local population and feedback from staff, demonstrated a commitment to continuous improvement. The trust monitored the impact of these initiatives through regular impact assessments.

Outstanding practice and areas for improvement

Outstanding practice

- Trust services for children and young people had placed emphasis on ensuring staff had the right skills and abilities to effectively care for children and young people with mental health concerns, and to improve the experience of those patients. This was aligned to the needs of the local population and feedback from staff. For example, the trust was developing a comprehensive programme of evidence-based paediatric mental health training and guidance, and had introduced the role of the paediatric mental health liaison nurse and healthcare assistant.
- The trust had developed an adults' and children's safeguarding hub and safeguarding team. In services for children and young people, the team enabled the monitoring of children and young people's safeguarding in other areas of the trust where children and young people attended. 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.

Areas for improvement

Action the hospital MUST take to improve

- Improve the environment and facilities on the high dependency unit to reduce the infection control risks to patients.
- Improve systems and processes so that patients are not delayed from being discharged from the HDU.

Action the hospital SHOULD take to improve

- Consider an outreach service to support patients whilst they are waiting admission to the HDU.
- Consider ways to increase engagement and feedback from patients and those close to improve the quality of the service on the HDU.
- Develop an agreed vision and strategy for the critical care service and that staff are involved in the process.
- Ensure that guidelines and processes in critical care have adequate version control and are regularly reviewed so staff have access to the most up to date guidance.
- Ensure that staff in services for children and young people consistently and accurately record temperatures of refrigerators containing breast milk, including minimum and maximum temperatures.
- Ensure medical staff in services for children and young people meet the trust target for completion of mandatory training by the end of the training year.
- Ensure all policy documents for services for children and young people are up to date, and have specified review date.
- Ensure nursing staff in services for children and young people have access to formal clinical supervision.
- Consider ways to ensure patients in services for children and young people, and their relatives, feel more involved and informed about plans for their care and treatment.
- Ensure staff in services for children and young people do not use other staff members to translate for patients or relatives who do not speak English, and ensure face to face or telephone interpreting services are used in these situations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and process were not established and operated effectively because: 1. The environment and facilities on the HDU was an infection control risk to patients. 2. Patients were delayed from being discharged from the HDU.