Care Quality Commission

# Epsom and St Helier University Hospitals NHS Trust

# Epsom General Hospital

## Quality Report

Epsom General Hospital
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Date of inspection visit: Announced visit 10 and 13 November 2015. We also undertook unannounced visits to the hospital on 21, 23 and 27 November 2015.
Date of publication: 27/05/2016

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

## Ratings

| | |
|---|---|
| **Overall rating for this hospital** | **Requires improvement** |
| Urgent and emergency services | Requires improvement |
| Medical care (including older people's care) | Good |
| Surgery | Requires improvement |
| Critical care | Requires improvement |
| Maternity and gynaecology | Requires improvement |
| Services for children and young people | Requires improvement |
| End of life care | Good |
| Outpatients and diagnostic imaging | Good |
| Elective orthopaedic centre | Outstanding |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Epsom General Hospital is part of Epsom and St Helier University Hospitals NHS Trust. The trust provides local acute services for people living in the southwest London and northeast Surrey. Epsom General Hospital provides acute hospital services to population of around 180,000.

Epsom General Hospital is home to the South West Elective Orthopaedic Centre (SWLEOC), which is one of the largest hip and knee joint replacement centers in the UK. Most of the trust's elective surgery is undertaken at Epsom General Hospital and the majority of emergency surgery is carried at the trust's other location, St Helier Hospital and Queen Mary's Hospital for Children.

Epsom and St Helier University Hospitals NHS Trust employs around 5024.8 whole time equivalent (WTE) members of staff with approximately 705 staff working at Epsom General Hospital. We carried out an announced inspection of Epsom General Hospital between 10 and 13 November 2015.

We also undertook unannounced visits to the hospital on 21, 23, 25 and 27 November 2015. Overall, this hospital is rated as requires improvement. We found urgent and emergency care, surgery, critical care, maternity and gynaecology, services for children and young people required improvement. We found medical care, outpatients and diagnostic services and end of life care were good. We have rated the South a West London Elective Orthopaedic Centre as outstanding.

We found the care of patients was good, but the safety, effectiveness, responsiveness and leadership and management required improvement.

Our key findings were as follows:

**Safe**

- Systems and processes were in place for reporting and investigating incidents but learning from incidents and complaints was inconsistent.
- Low nurse staffing levels on some surgical and children wards meant there was a risk to the quality of patient care. There was also a large number of vacant medical staff posts and high use of locum doctors in paediatrics. However, the hospital had recently undergone a recruitment drive which had enabled it to fill some of its nursing and medical vacancies.
- Cardiac monitors used in the majors area in ED were not fit for use and this had been an ongoing risk for over a year, without an adequate solution. Major incident equipment we observed was out of date and not ready for use in the event of a major incident.
- Mandatory training completion rates were low.
- The hospital was visibly clean. However data supplied by the trust indicated that wards repeatedly fell short of the infection prevention control compliance threshold. Staff reviewing patients on the unit did not always comply with infection control practices such as being bare below the elbow and hand washing.
- Appropriate procedures and staffing were in place to prevent harm.
- We identified gaps in record keeping and safe storage of medicines management in some areas.

**Effective**

- Patient outcomes were good across most specialties and the trust performed well in national surgical audits. In the SWLEOC, patient outcomes and patient satisfaction consistently exceeded national averages.
- We found staff appraisal completion rates were low.
- There was a lack of clarity amongst some staff with regard to how the Deprivation of Liberty Safeguards should be used

# Summary of findings

- There was a lack of agreed guidelines specific to the critical care unit and no system to ensure consistency of care, even though three different consultants cared for patients in one day. The unit had a larger number of delayed discharges compared to similar units.
- There was good multidisciplinary teamwork and collaborative care.

**Caring**

- Patients and their relatives commented positively about the care they received and the attitude of the staff. Staff provided care in a compassionate and kind way that preserved patients' dignity. Patients felt supported and involved in their care and treatment.
- Whilst Family and Friend Test feedback was positive, the response rate was notably low.
- Patients were kept informed of their treatment, given detailed information about their diagnosis, and given time to ask further questions.

**Responsive**

- At Epsom ED for the 12 months between November 2014 and October 2015, 94% of patients were seen, admitted, transferred or discharged within four hours.
- In all but neurology and dermatology, the medical directorate achieved the 18 week referral to treatment standard. The average length of stay at Epsom was slightly longer for non-elective care than the England average.
- The medical directorate was slow to respond to complaints, achieving an 8% response rate within designated timescales.
- Not all women received one to one care in labour.
- National waiting times were met for outpatient appointments and access to diagnostic imaging although the wait for MRI services had increased.
- A higher percentage of patients were seen within two weeks for all cancers than the national average, but the cancer waiting times for people waiting less than 31 days from diagnosis to first definitive treatment and the proportion of people waiting less than 62 days from urgent GP referral to first definitive treatment were both below the national average.

**Well-led**

- Vision and strategy within departments were not well developed or known by all staff.
- There were good local governance structures and reporting mechanisms in place, however we found a lack of responsiveness to some known challenges and concerns.
- In critical care, the strategy for the unit had not been agreed due to difficulties in reaching an agreement among the critical care workforce across the two sites and staff were not aware of the vision for the unit. Not all risk had been identified on the risk register and some risk had been on the register for some time and senior staff were still unclear on the timescale to address these risks.
- The trust monitored maternity services based on merged data from both maternity units. This was misleading because the units were very different, with different staff and serving different populations.
- The hospital had a number of innovative projects underway, including some related to patients living with dementia. We saw several areas of outstanding practice including:
- The leadership of the outpatients and diagnostic imaging teams was outstanding with staff inspired to provide an excellent service, with the patient at the centre.
- The diagnostic imaging department worked hard to reduce the patient radiation doses and had presented this work at national and international conferences. However, there were also areas of poor practice where the trust needs to make improvements.

We saw several areas of outstanding practice, including:

# Summary of findings

- The leadership of the outpatients and diagnostic imaging teams was outstanding with staff inspired to provide an excellent service, with the patient at the centre.
- The diagnostic imaging department worked hard to reduce the patient radiation doses and had presented this work at national and international conferences.
- The safety and leadership of the SWLEOC, where outcomes for patients were consistently excellent and based on national guidelines.

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

Importantly, the trust must:

- Ensure there are adequate numbers of nurses and midwives to deliver safe and quality care.
- Implement agreed guidelines specific to the critical care units.
- Ensure the management, governance and culture in the critical care units, supports the delivery of high quality care.
- Obtain feedback from patients/relatives in the critical care units, so as to improve the quality of the service.
- Identify, analyse and manage all risks of harm to women in maternity services
- Ensure identified risks in maternity services are always reflected on the risk register and timely action is taken to manage these risks.
- Improve the quality and accuracy of performance data and increase its use in identifying poor performance and areas for improvement.

In addition the trust should:

- Ensure cardiac monitors used in the majors area in ED and major incident equipment are fit and ready for use in the event of a major incident.
- Ensure the target for 85% compliance for mandatory training is met.
- Ensure staff always comply with infection control practices.
- Ensure child protection notifications from the trust are up to date.
- Ensure staff appraisals are completed as required.
- Ensure all relevant staff are clear about how the Deprivation of Liberty Safeguards should be used.
- Ensure there are agreed guidelines specific to the critical care unit and that there are systems to ensure consistency of care.
- Improve the response times to complaints in the medical directorate.
- Ensure all women receive one to one care in labour.
- Improve the 31 day cancer waiting times for people waiting from diagnosis to first definitive treatment and the 62 day waiting time for people waiting from urgent GP referral to first definitive treatment.
- In critical care, ensure there is an agreed strategy for the unit that includes the critical care workforce across the two sites and that all risks are identified and on the risk register.
- In maternity, ensure monitoring data is separated by location.
- Improve and strengthen governance within the ED.
- Develop the leadership skills of labour ward coordinators to prepare them for this role and hold them accountable for their performance.
- Monitor action plans to ensure timely response to risk actions.
- Ensure the consultant hours in the emergency department meet the RCEM recommendation of 16 hours a day, seven days a week of clinical consultant working.
- Ensure that the paediatric emergency department complies with Royal College of Paediatric and Child Health staffing guidelines.
- Ensure all staff working with children are adequately trained to an agreed and measureable standard.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.

# Summary of findings

- Increase the number of sonographers in radiology.
- Improve compliance with all stages of the World Health Organization (WHO) Surgical Safety Checklist across all surgery services.
- Ensure local anaesthesia drugs are stored separately from general anaesthesia drugs in all operating theatres.
- Take further steps to update and improve operating theatre infrastructure and equipment.
- Improve scheduling of surgical procedures to improve theatre utilisation and efficiency.
- Ensure all reported risks in surgery services are addressed in a timely way.
- There is access to seven day week working for radiology services.
- Staffing is improved in radiology for sonographers.
- Improve the response rate of patient feedback.
- Ask patients and relatives for feedback on critical care.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- There are appropriate processes and monitoring arrangements in place to improve the 32 and 61 day cancer targets in line with national targets.
- There is improved access for beds to clinical areas in diagnostic imaging.

Professor Sir Mike Richards

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Urgent and emergency services | Requires improvement  | The ED at Epsom General Hospital was not meeting the Royal College of Emergency Medicine (RCEM) recommendation that an emergency department should provide medical emergency cover 16 hours a day, 7 days a week. The ED was reliant on using bank and agency nursing staff and locum doctors to fill vacant staffing posts. In the children's ED, the staffing levels did not comply with the Royal College of Paediatrics Child Health (RCPCH) guidelines and there were periods of time when there was no paediatric nurse on duty thismeant there was a risk to patient safety.<br>The adult and paediatric ED were often overcrowded. Patient flow through the department required improvement and was often blocked by internal capacity issues within the trust. Walk in patients waited long periods to be triaged within the department. Clinical priority was assessed at reception by a receptionist who assigned a red sticker to patients' notes if they deemed them a priority. Patients often waited for long periods in the department after the decision to admit (DTA). Surgical patients often had the longest wait with limited access to surgical reviews by specialist doctors. During our Inspection, we observed the use of the ambulatory care unit (ACU) to care for patients awaiting a bed on the ward. We saw significantly increased waiting times for patients being admitted compared with patients who would be discharged.<br>Cardiac monitors used in the majors areas required updating and this had been an ongoing risk for over a year, without an adequate solution. This may cause clinicians to be unaware of unwell and deteriorating patients within the department. Major incident equipment we observed was out of date and not ready for use in the event of a major incident.<br>The current nursing vacancy rate of 27% meant that bank and agency staff were used on a regular basis. |

# Summary of findings

Between April 2014 and March 2015, the average percentage of shifts covered by bank and agency staff was 28% in the adult ED and 29% in the paediatric department.
We observed on two occasions that when the department was busy, there was no effective shift coordination as the nurse-in-charge had no clear visualisation of the overall department, for example, the number of patients and types of patients in the paediatric department and the minors area. We saw nurses from the paediatric department had to come out of the department to inform the nurse-in-charge of the pressures they were under and give an updated status of the department.
During our visit, we observed four walk in patients waiting between 40-45 minutes to see the triage nurse. Data provided by the trust for the month of October 2015 demonstrated that patients could wait up to 59 minutes to be seen by the triage nurse. The four-hour waiting standard requires all EDs to see 95% of attending patients within four hours of their arrival. At Epsom ED for the 12 months between November 2014 and October 2015 94% of patients were seen within this target.
Vision and strategy within the department were not well developed or known by all staff working within the department. There were mixed views about the departments future and staff were unaware of trust values.
There were positive comments from patients and their relatives about the care received and the attitude of the staff. Patients were kept informed of their treatment, given detailed information about their diagnosis, and given time to ask further questions.

**Medical care (including older people's care)** — **Good**

We rated medicine as good for effective, caring, responsive and well led; and good overall, but as requiring improvement for safe. Wefound mandatory training and staff appraisal completion rates were low; some wards repeatedly fell below the trust's infection control thresholds' and patients were able to access areas of wards that might compromise their safety.

# Summary of findings

The hospital had recently undergone a recruitment drive which had enabled it to fill some of its nursing and medical vacancies. This had helped address the 23% nursing and 11% medical vacancy rate it had carried over the past financial year.

We reviewed seven patients' records and almost all were well completed, legible and evidenced multidisciplinary input.Staff were aware of how to reportincidents and demonstrated the learning that hadbeen taken from a recent Never Event at another site within the trust. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.)

On this inspection we found the hospital to be visibly clean. However data supplied by the trust indicated that wards repeatedly fell short of the infection prevention control compliance threshold. Sluice rooms on wards were not lockable, and provided easy access to hazardous substances.

The service had systems to review performance and disseminate the results to staff. The hospital participated in national audits with mixed results compared to the England average. The hospital had a mandatory training programme in place however for most staff groups the completion rate was low, as was the completion rate for staff appraisals. Staff spoke of pressures of work, particularly low staffing numbers that prevented them attending training days.

There was a lack of clarity amongst staff with regard to how the Deprivation of Liberty safeguards should be used.

Staff provided care in a compassionate and kind way that preserved patients' dignity. Patients felt supported and involved in their care and treatment. Staff also felt supported by their line managers to provide high quality care. We observed a culture that focused on meeting the needs of individual patients and their families, although staff expressed concerns at the staffing levels which they felt were detrimental to patient care.Service leaders had systems to assess how well they were doing and were aware of any challenges they faced.

# Summary of findings

In all but neurology and dermatology, the medical directorate achieved the 18 week referral to treatment standard. The average length of stay at Epsom was slightly longer for non-elective care than the England average.
Whilst Family and Friend Test feedback was positive, the response rate was notably low. The medical directorate was slow to respond to complaints, achieved just an 8% response rate withindesignated timescales.
Governance arrangements in the medical directorate were satisfactory in some areas but could be improved in others. Staff commented on very good multidisciplinary teamwork; collaborative care and line management support. A number however commented on the dysfunctional cross site working. The hospital had a number of innovative projects underway, including some related to patients living with dementia.

## Surgery

**Requires improvement**

Epsom General Hospital provides a range of day case, elective and emergency surgical services to a mostly local population of patients from south west London and north east Surrey, including Epsom, Merton and Sutton. 13,100 surgical procedures were carried out in 2014. Epsom General Hospital is used mostly for day case and elective surgery, with 83% day case procedures, 16% elective procedures and 1% non-elective procedures in 2014.
There are eight operating theatres at Epsom General Hospital covering general surgery, orthopaedics, cardiovascular and urology. They operate Monday to Friday 8:30am-5:30pm, with additional availability for elective lists at weekends. The post-operative recovery facility has five bays. There are 22 inpatient surgical beds in the designated surgical wards and 15 day case only beds.
Surgical activity at Epsom General Hospital is managed by one directorate within the trust. This inspection focused on the services provided by the Surgery, Critical Care and Anaesthetics directorate. The Regional Services directorate within the trust was responsible for managing the South West London Elective Orthopaedic Centre and renal services, which are covered in separate sections of this report.

# Summary of findings

During our inspection, we visited Swift and Northey wards, the surgical admissions area, day surgery unit, main operating theatres and the recovery area. We spoke with 18 patients and their family members. We observed care and treatment and looked at care records. We also spoke with more than 40 staff members, including allied healthcare professionals, nurses, doctors in training, consultants, ward managers and senior staff. In addition, we reviewed national data and performance information about the trust.

## Critical care

**Requires improvement**

We rated the critical care unit as 'requires improvement' overall. We found that although staff were reporting incidents, there was no system in place to ensure that all staff were learning from these incidents. We identified gaps in record keeping and safe storage of medicines. The unit was bright and airy but there were no individual rooms so patient with infections could not be isolated. The unit used a high number of agency nursing staff to meet staffing requirements. Staff reviewing patients on the unit did not always comply with infection control practices such as being bare below the elbow and hand washing. Patients had to be escorted off the unit to access toilet facilities.

There was a lack of agreed guidelines specific to the critical care unit and no system to ensure consistency of care, even though three different consultants cared for patients in one day. The unit had a larger number of delayed discharges compared to similar units. This led to mixed sex breaches, although the unit was currently not recording these breaches.

The strategy for the unit had not been agreed due to difficulties in reaching an agreement among the critical care workforce across the two sites and staff were not aware of the vision for the unit. Not all risk had been identified on the risk register and some risk had been on the register for some time and senior staff were still unclear on the timescale to address these risks.

The unit had good outcomes for patient when compared to similar units and staffing was in line with national guidelines. The unit had lower out of hours discharges compared to similar unit and staff in other areas did not report difficulties in accessing

critical care. The unit managed booked beds for elective patients efficiently to ensure patients do not have their operation cancelled due to a lack of critical care beds. Staff, including agency, received a good induction and competency based assessment prior to caring for patients independently. Doctors in training received good teaching and support from consultants and patients and their relatives spoke highly of the staff and the care they received on the unit.

## Maternity and gynaecology

**Requires improvement**

We judged the maternity and gynaecology services as requiring improvement.

Systems and processes were in place for reporting and investigating incidents in maternity but dissemination of learning from incidents and complaints was inconsistent. In gynaecology incident reporting was very low. The service was slow to implement change. For example responding to failure to achieve its own or national performance targets in maternity services and despite limitations to restrict admissions of women in labour to lower risk women, some staff voiced safety concerns.

The trust mainly monitored maternity services based on merged data from both maternity units. This was unhelpful in terms of monitoring maternity performance at Epsom, which was smaller, less busy and served a different population and employed Epsom-based staff. Although we requested performance data specific to Epsom the trust was not able to provide this in many cases.

Most of the clinical guidelines had been reviewed recently in line with national guidance but not all staff were aware of key changes. There was limited evidence that national or local audits had an impact on practice.

Women and their partners were generally positive about the care they received. They understood and felt involved in their care. Women received the emotional support they needed.There was a mainly positive response to the Friends and Family Test, with a reasonably high response rate among woman who stayed in the maternity wards of 33%. The response on outpatient services were much lower.

# Summary of findings

Midwives were aware of the characteristics of the local population and responsive to their needs. However, it was less clear whether the pattern of medically led antenatal clinics met the specific clinical needs of the local Epsom population. There was limited engagement with either staff or with the local community about the design of the service.

Management of the maternity service was weak and obstetricians were not sufficiently engaged in the maternity service. Midwives felt Epsom hospital was low on the trust priorities. Managers did not identify, analyse and manage the risks of harm to women that were specific to Epsom and highlighted on the local maternity dashboard Staff provided little challenge to one another. The culture was hierarchical. Several staff said they had spoken up about concerns, but no action resulted. They felt the service was complacent.

Aside from the weaknesses in incident reporting, we had no concerns about gynaecology.

**Services for children and young people**

**Requires improvement**

Throughout the inspection, managers and staff told us they had concerns about staffing levels. We were told the trust had implemented the 'Safer Staffing' model for ensuring there were sufficient staff on duty to meet children's needs and the service met nationally recommended staffing ratios, but we found examples of staffing ratios falling below these levels. There was also a large number of vacant medical staff and high use of locums to cover for medical staff who were off sick or on maternity leave. There was a system in place for reviewing staffing levels if the dependency levels of children increased, but it was not always possible to allocate additional staff particularly if dependency levels increased.

Ward staff relied on information about safeguarding concerns being brought to their attention by emergency department (ED) staff if the child was admitted via ED, by checking manual records or by contacting social services. The information was not held on computer. There was a risk that the manual records were incomplete or could be lost and therefore there was a risk that staff may not always be able to identify and protect children at risk of abuse. It is important to note that these

arrangements were the adopted standard practice of the local authority who were responsible for maintaining the child protection database and was consistent across a number of acute services in Surrey.
Staff uncertainty about the future structure of the trust had contributed to difficulties recruiting and retaining staff resulting in staffing pressures on the ward. Developing a strategy for the service had also been problematic without clarity about the organisation's future. Managers had responded to the uncertainty by developing a five-year business and service strategy.
An executive director provided board level leadership for children's services. Paediatric services were part of the Women and Children's Directorate with clinical leadership from a consultant obstetrician and a consultant paediatrician. There was no governance lead for children's services.

## End of life care

**Good**

The Specialist Palliative Care (SPCT) team provided end of life care and support six days a week, with on call rota covering out-of-hours. There was visible clinical leadership resulting in a well-developed, motivated team.
The Director of Nursing had taken the executive lead role for end of life care, along with a Non-Executive Director (NED) to ensure issues and concerns were raised and highlighted at board level. Trust board received EOLC report outlining progress against key priorities within the EOLC strategy, including audit findings, themes from complaints and incidents, evidence of learning and compliance with end of life training requirements.
The SPCT provided a rapid response to referrals, assessed most patients within one working day, their services included symptom control, end of life care (EOLC), and support for patients and families, advised them on spiritual and religious needs and fast-track discharge for patients wanting to die at home.
Most of the nursing staff were complimentary about the support they received from the SPCT. Junior doctors particularly appreciated their support and

advice, and said they could access the SPCT at any time during the day. They recognised that the SPCT worked hard to ensure that end of life care was well embedded in the trust.
Nursing staff knew how to make referrals to the SPCT and referred people appropriately. The SPCT assessed patients promptly to meet their care needs. The chaplaincy and bereavement service supported patients' and families' emotional and spiritual needs when people were at the end of life. Referrals for patients who required support during end of life care were made electronically to the specialist palliative care team from clinicians throughout the trust. The specialist palliative care team had daily morning briefings to update on changes in patients' condition, assess new referrals and allocate work for the day.
The National Care of the Dying Audit 2013/2014 (NCDAH) demonstrated that the trust had not achieved three out of seven organisational key performance indicators. At the time of the inspection, the trust had not fully rolled out the replacement of the LCP, and this delay meant that staff were not fully supported to deliver best practice care to patients who were dying. The leadership failed to apply enough urgency to have an individual plan of care in place.

## Outpatients and diagnostic imaging

**Good**

Overall, we found that outpatients and diagnostic imaging were good. The service was rated as good for safety, caring, responsive and well-led. The effective domain was inspected but not rated. Patients, visitors and staff were kept safe as systems were in place to monitor risk. Staff were encouraged to report incidents and we saw evidence of learning being shared with the staff to improve services. There was a robust process in place to report ionising radiation medical exposure (IR(ME)R) incidents and the correct procedures were followed. The pathology department had a comprehensive quality management system in place with compliance targets set at higher than the national average to improve safety and quality. There was evidence of quality improvement in place following the restructure of pathology services. The focus on low radiation doses in radiology was excellent.

# Summary of findings

The environments we inspected were visibly clean and staff followed infection control procedures. Records were almost always available for clinics and if not, a temporary file was made using available electronic records of the patient. Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.

Nurse staffing levels were appropriate and there were few vacancies. The diagnostic imaging vacancies were higher, particularly ultra sonographers. There was an ongoing recruitment and retention plan in place.

There was evidence of service planning to meet patient need such as the contract for MRI services. National waiting times were met for outpatient appointments and access to diagnostic imaging although the wait for MRI services had increased. A higher percentage of patients were seen within two weeks for all cancers than the national average, but the cancer waiting times for people waiting less than 31 days from diagnosis to first definitive treatment and the proportion of people waiting less than 62 days from urgent GP referral to first definitive treatment were both below the national average.

Staff had good access to evidence based protocols and pathways. There was limited audit of patient waiting times for clinics, but patients received good communication and support during their time in the outpatients and diagnostics departments. Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005.

We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care. There was good support for patients with a learning disability or living with dementia. The outpatients department at Epsom hospital had good information display boards available for staff and patients to access.

Staff were aware of the complaints policy and told us how most complaints and concerns were resolved locally. The service had no open complaints at the time of the inspection.

The outpatients and diagnostic imaging departments had a local strategy plan in place to

# Summary of findings

improve services and the estates facilities. From December 2015, the current outpatient services that are in Clinical Services Directorate, will move to a new Outpatients and Medical Records Division. Staff expressed some concern over these changes. Governance processes were embedded across outpatients and diagnostics. The directorate was commended on its risk register in a recent review of risk registers in the trust. Senior managers told us the newly appointed Quality Manager had made significant improvements in making sure priorities, challenges and risks were well understood. Good progress was evident for improving services for patients.
We found good evidence of strong, local leadership and a positive culture of support, teamwork and innovation.

| | | | |
|---|---|---|---|
| **Elective orthopaedic centre** | **Outstanding** | ☆ | We rated this service outstanding as there was an open and transparent safety culture in practice and patient outcomes were amongst the best in the country. When things went wrong, there was thorough analysis and investigation owned by staff and changes weremade in a timely way. The approach to staffing and skill mix across all staff groups meant that highly skilled staff always cared for patients.<br>Patient outcomes and patient satisfaction consistently exceeded national averages. Innovative practice in recording outcomes was the basis for national guidelines. The lead surgeon used patient outcomes to validate and proactively change each consultant's performance. The service was proactively met the needs of the population it served, coordinating with referring hospitals, external and community providers to ensure the surgical pathway was appropriate.<br>Staff understood the ethos of the service values, and unequivocal in praising the support received from leadership team and there were measurably high levels of staff satisfaction. Patients who used the service were actively involved in the way the service operated. |

# Epsom General Hospital

## Detailed findings

**Services we looked at**

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging; Elective orthopaedic centre

# Detailed findings

## Contents



## Background to Epsom General Hospital

Epsom General Hospital is one of two registered acute hospital locations of Epsom and St Helier University Hospitals NHS Trust, which we visited during this inspection. The other hospital we visited was St Helier Hospital and Queen Mary's Hospital for Children.

Epsom General Hospital has 373 beds and is in the district of Epsom and Ewell, Surrey. The lead clinical commissioning group is Surrey Downs.

## Our inspection team

**Our inspection team was led by:**

**Chair:** Bill Cunliffe, Retired surgeon

**Head of Hospital Inspections:** Nick Mulholland, Care Quality Commission (CQC)

The hospital was visited by a team of 60 people, including: CQC inspectors, analysts and a variety of specialists. There were consultants in emergency medicine, medical care, surgery, obstetrics and renal. The team also included nurses with backgrounds in medicine, surgery, critical care, and palliative care. There were also midwives, specialists with board-level experience, a student nurse and two experts by experience.

## How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care

# Detailed findings

- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, NHS Trust Development Authority, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch. We also received information from the trust's council of governors.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospital, including doctors, nurses, allied health professionals, administration and other staff. We also interviewed senior members of staff at the hospital.

## Facts and data about Epsom General Hospital

### Context

- Epsom General Hospital is based in the district of Epsom and Ewell, Surrey and serves a population of around 180,000.
- Epsom General Hospital offers a range of local services, including: an emergency department, medicine, surgery, critical care, maternity, paediatric services and outpatient clinics. The hospital is also home to the SWLEOC which is an NHS treatment centre providing regional elective orthopaedic surgery services.
- In the 2011 census, the proportion of residents who classed themselves as white British was 79% in Epsom and Ewell.
- Epsom and Ewell ranks 308th out of 326 local authorities for deprivation (with the first being the most deprived).

### Activity

- The hospital has approximately 455 beds including seven critical care beds and 82 SWLEOC beds.
- Many staff work across both sites, so it is not possible to assign an exact number of staff for each site. The workforce was supported by bank/agency staff and locum medical staff between March 2014 to April 2015.
- There were approximately 38,450 inpatient admissions at Epsom General Hospital and 5,214 at the SWLEOC in 2014/15.
- There were approximately 222,576 outpatient appointments at Epsom General Hospital and 830 at the SWLEOC between July 2014 to June 2015.
- The emergency department saw 56,652 patients in 2014/15.
- There were 641 deaths at the hospital between April 2014 and May 2015.

### Key intelligence indicators

#### Safety

- Between August 2014 and July 2015 there were 43 serious incidents at Epsom General Hospital; there were no never events.
- Between August 2014 and July 2015, there were 35 cases of pressure ulcers at Epsom General Hospital.
- Trust wide between August 2014 and July 2015, seven cases of MRSA, 18 of MSSA and 44 C diff cases were reported.
- There were 69 falls and 21 CAUTIs reported to the Patient Safety Thermometer between July 2014 and Jul 2015.

#### Effective

- HSMR rate is 90.9 trustwide with a rate of 90.3 during the week and 92.6 at the weekend. Epsom site is at 85.8 overall; during the week at 87.4 and weekends are at 80.3.
- The SHMI for this trust for August 2014 to September 2015 was 98.
- There were no mortality outliers in this trust.

#### Caring

- From the CQC inpatient survey 2014, this trust performed about the same as other trusts for 10 of the 12 questions.

#### Responsive

# Detailed findings

- Between April 2014 and March 2015, this trust received 523 complaints; 223 of which were at Epsom General Hospital; there are no significant outlying years from 2010/11 to 2014/15.
- Out of 23,843 patients waiting to start treatment at the end of September, 92.1% of patients were not waiting longer than 18 weeks. Half of patients were waiting less than seven weeks and 92 out of a 100 patients were waiting less than 18 weeks. The trust figures are in line with England figures.
- Half of patients who had to receive treatment that involved admission to hospital waited 12 weeks before being treated, longer than the England average wait of 9.6 weeks. 19 out of 20 patients started their treatment within 26 weeks, the same as the England average.
- Half of patients who had to receive treatment that did not involve admission to hospital waited nine weeks before treatment started. Patients waited roughly three weeks longer to start treatment than the England average of 6.1 weeks. 19 out of 20 patients waited 23 weeks to begin treatment roughly three to four weeks longer than the England average.
- The trust has met the operational standard for 93 % of cancer patients to wait less than 31 days from diagnosis to first definitive treatment between April 2013 and March 2015 for most quarters of the period**.**The trust consistently failed to meet the standard for 85% of cancer patients to wait less than 62 days from urgent GP referral to first definitive treatment from quarter four 13/14 to quarter four 14/15.

**Well-led**

- Staff sickness absence rates in this trust for the period April 2014-May 2015 was 5.7% and there was a turnover rate of 13.8% over the same period.
- Results from the staff survey in 2014 showed that this trust performed better than average for four questions, worse than average for 14 and in the bottom 20% of trusts for three questions. For the remaining eight questions analysed, the trust had a similar performance to other trusts. The response rate in this trust was 39%, which was lower (worse) than the national average.

### Inspection history

This is the first comprehensive inspection of Epsom General Hospital.

## Our ratings for this hospital

Our ratings for this hospital are:

# Detailed findings

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

# Urgent and emergency services

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

## Information about the service

The accident and emergency department is also known as the emergency department (ED).The ED at Epsom General Hospital is open 24 hours a day, 365 days a year. It treats patients who have suffered a serious injury or accident, and those who have developed a sudden serious illness or medical condition.

The ED at Epsom General Hospital serves a population, which is multi-cultural and diverse, covering a large catchment area of residential, rural and industrial communities in Northeast Surrey.

Epsom ED is not a trauma receiving unit, and it does not treat patients who may need emergency surgery. The ambulance services will not bring these patients to Epsom ED; however, these patients may present themselves at triage. Patients who present into the ED at Epsom and need emergency surgery are transferred to St Helier Hospital for further assessment and treatment.

A nurse triages all walk-in patients once they have registered at reception. Patients with minor injuries or illnesses are treated in the minors area of the department by emergency nurse practitioners or Doctors. Patients with more serious conditions are seen in the majors or resus area of the department.

The majors area includes ten trolley cubicles, one woman's health room, one psychiatric interview room, a rapid assessment cubicle, a decontamination cubicle, clean utility and a relative's room. The resuscitation area had four trolley bays and one of these bays is set up for paediatric emergencies. There are four trolley bays in the minors area, one ENT cubicle, one eye cubicle and one plaster room. The paediatric area was made up of three cubicles one triage area and a paediatric waiting area.

From April 2014 to March 2015 there were 55,502 attendances in the ED. 35% of these patients were aged 0-16 years old.

There was a separate children's area within the main ED. Paediatric trained nurses staffed this area during the day. After 2am, children were seen and treated in the minors area of the ED. All children, other than those who either have open access or are GP referrals, are seen by an ED doctor first, and if necessary, referred to a paediatrician and admitted to the paediatric unit. For emergency surgery and trauma, children are sent to Queen Mary's Hospital for Children at the St Helier hospital site.

We visited the ED over two days during our announced inspection and returned unannounced during a Monday evening. We observed care and treatment and looked at 29 patient records. We spoke with 28 members of staff including nurses, consultants, doctors, receptionists, managers and support staff. We also spoke with 14patients and relatives who were using the service at the time of our inspection. We received comments from out listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

# Urgent and emergency services

## Summary of findings

The ED at Epsom General Hospital was not meeting the Royal College of Emergency Medicine (RCEM) recommendation that an emergency department should provide medical emergency cover 16 hours a day, 7 days a week. The ED was reliant on using bank and agency nursing staff and locum doctors to fill vacant staffing posts. In the children's ED, the staffing levels did not comply with the Royal College of Paediatrics Child Health (RCPCH) guidelines and there were periods of time when there was no paediatric nurse on duty thismeant there was a risk to patient safety.

The adult and paediatric ED were often overcrowded. Patient flow through the department required improvement and was often blocked by internal capacity issues within the trust. Walk in patients waited long periods to be triaged within the department. Clinical priority was assessed at reception by a receptionist who assigned a red sticker to patients' notes if they deemed them a priority. Patients often waited for long periods in the department after the decision to admit (DTA). Surgical patients often had the longest wait with limited access to surgical reviews by specialist doctors. During our Inspection, we observed the use of the ambulatory care unit (ACU) to care for patients awaiting a bed on the ward. We saw significantly increased waiting times for patients being admitted compared with patients who would be discharged.

Cardiac monitors used in the majors areas were not fit for use and this had been an ongoing risk for over a year, without an adequate solution. This may cause clinicians to be unaware of unwell and deteriorating patients within the department. Major incident equipment we observed was out of date and not ready for use in the event of a major incident.

The current nursing vacancy rate of 27% meant that bank (mainly own staff) and agency staff were used on a regular basis. Between April 2014 and March 2015, the average percentage of shifts covered by bank and agency staff was 28% in the adult ED and 29% in the paediatric department.

We observed on two occasions that when the department was busy, there was no effective shift coordination as the nurse-in-charge had no clear visualisation of the overall department, for example, the number of patients and types of patients in the paediatric department and the minors area. We saw nurses from the paediatric department had to come out of the department to inform the nurse-in-charge of the pressures they were under and give an updated status of the department.

During our visit, we observed four walk in patients waiting between 40-45 minutes to see the triage nurse. Data provided by the trust for the month of October 2015 demonstrated that patients could wait up to 59 minutes to be seen by the triage nurse. The four-hour waiting standard requires all EDs to see 95% of attending patients within four hours of their arrival. At Epsom ED for the 12 months between November 2014 and October 2015 94% of patients were seen within this target.

Vision and strategy within the department were not well developed or known by all staff working within the department. There were mixed views about the departments future and staff were unaware of trust values.

There were positive comments from patients and their relatives about the care received and the attitude of the staff. Patients were kept informed of their treatment, given detailed information about their diagnosis, and given time to ask further questions.

# Urgent and emergency services

## Are urgent and emergency services safe?

**Requires improvement**

At the time of our inspection, the nursing vacancy rate within the department was 27%. The department was reliant on using agency and bank staff (mainly own staff) to fill these vacancies with 27% of shifts covered by bank (mainly own staff) and agency staff in the 12 months from April 2014 – to March 2015.

The department was not meeting the Royal College of Emergency Medicine (RCEM) recommendation that an emergency department should provide emergency consultant cover 16 hours a day, 7 days a week. The emergency medicine consultants were on duty in the department between 8 am until 10.45 pm on weekdays and a minimum of eight hours cover at weekends with 'on-call cover outside of these hours.

In the children's ED, we found that there were periods of understaffing that did not comply with the Royal College of Paediatrics and Child Health (RCPCH) guidelines, as they did not always have two paediatric-trained nurses on duty. Nursing staff told us there was a children's nurse on duty seven days a week until 2am only.

Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children, however there were gaps in the system to engage with local safeguarding processes and staff do not always respond quickly when referring patients who may be at risk or harm.

Necessary equipment in the department was not always adequate for use or kept in date. Cardiac monitors in the majors area of the department were either broken or not tested making them unsafe for use. Equipment in the major incidents cupboard was out of date.

### Incidents

- All incidents at Epsom ED were reported through a trust wide electronic reporting system called Datix. This allowed for management overview of incident reporting and an ability to analyse any emerging themes or trends. Since the trust changed to Datix reporting in July 2014, there has been a constant increase in incident reporting.
- Information provided by the trust for the period of May 2015 to August 2015 showed there were 229 reported adverse incidents in the ED at Epsom. Of these 46 incidents specifically related to the children's ED.
- ED incidents reviewed prior to our inspection for the period May 2015 to August 2015 showed the highest number of incidents related to care and treatment (50) where care/treatment was not completed or where treatment had been delayed. On discussion with staff, we were told treatment delays in the children's ED often occurred due to adult trained nurses not having competencies to administer medication to children.
- In the medicines directorate quarterly report, which reported on the period January 2015 to March 2015, the top sub-category of incidents was noted to relate to care and treatment not being completed; 22 incidents were relating to this. Out of these 22, 15 of these incidents related to ED at Epsom.
- There were no Never Events reported between Aug 14 and July 15 (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented). We were told about one Never Event, which had recently happened within the trust. Staff were able to tell us about this incident and learning that had occurred. This demonstrates learning had been disseminated about this Never Event.
- All staff we spoke with including agency and nursing students told us they were encouraged to report incidents and were aware of the procedure to do so. Staff we spoke with felt supported by their team leaders and manager to raise concerns and report incidents and near misses when these occurred.
- There was evidence of learning from incidents within the department. Staff told us incidents and learning from incidents was discussed as part of the Top Ten Topics at handover each morning or were communicated via email if staff had reported the incident. Top Ten Topics had been introduced to improve communication in the department. More detailed discussions of lessons learned were discussed within mentor groups led by a band seven nurse, although we were told these groups did not have designated meeting times and these meetings were sporadic depending on how busy the department was.

- We looked at ED governance meeting minutes from the previous six months and the trust wide Risky Business Bulletin newsletter covering the period January to March 2015. This demonstrated shared learning of trust wide serious incidents (SI) within the meeting. However, nursing staff we spoke with working within the department were not aware of any incidents or any learning from SIs that had happened outside of the ED department.
- An SI which had occurred on the 5 February 2015 with an Root Cause Analysis (RCA) report date of 10 April 2015, noted concerns in the ED around equipment, however nurses we spoke with were not aware of this. We noticed both the equipment issues reported within the RCA had been resolved, however no learning had been discussed or disseminated down to the staff using the equipment.
- There were three serious Incidents (SI) in the department in 2014/15 and the department has investigated the SI. We reviewed the RCA data for Serious Incidents requiring Investigation (SIRI) relating to Epsom ED within the last 12 months, in which there were three. One of the RCA had documented learning and action plans including dates for these to be implemented or tasks to be completed. This included the improvement in the documentation of paediatric early warning scores (PEWS). During the inspection, we observed evidence of ongoing audits and training in relation to PEWS.
- An RCA completed in March 2015 noted action points to review the current design of the NEWS chart; resize and position escalation recommendations adjacent in the clinical record. We asked two band 5 nurses and a band 7 nurse who had been in the department during the time that this incident took place. None of the staff we spoke with knew of any changes or were aware of any teaching that had taken place around this. Another action point listed within one of the RCA was to complete quarterly nursing document audits of NEWS, however the most recent audit provided was completed in 2012/13 and none had been completed since actioned in the RCA.

### Duty of Candour

- Information received from the trust indicated there were four incidents in the department from November 2014 to September 2015 dealt with under the Duty of Candour. Two of the investigations had been completed, one was currently being investigated. One investigation from March 2015 was pending; and an RCA had not been completed. It was not documented if relatives had been contacted. All the incidents had been rated as moderate to severe in terms of severity.
- Staff we spoke with had good knowledge of Duty of Candour and were able to demonstrate how this was applied in practice. One nurse we spoke with who had been in post for three weeks told us Duty of Candour training had been provided as part of her induction.

### Cleanliness, infection control and hygiene

- The ED department was clean in all areas. There were sufficient hand-washing facilities and alcohol gels available throughout the department. Equipment and areas checked included patient trolleys, monitoring equipment, wheelchairs, commodes, curtain rails and bed spaces. These were mostly clean however, we did notice a split in the mattress of a patient trolley in the minor's area and some dried blood on the cot side of another.
- Staff we spoke with were aware of infection prevention and control (IPC) procedures and policies. There was signage reminding people of the importance of hand washing over hand basins. We observed that staff generally washed their hands in line with the World Health Organisations guidance 'Five moments of Hand Hygiene'. All staff we observed including doctors, nurses, porters, domestic staff and support staff were 'bare below the elbows' in line with trust policy.
- Hand hygiene observation audits were undertaken on a quarterly basis to ensure that monitoring of hand hygiene techniques are maintained within departments. These audits were undertaken by the three infection control champions within ED. Audits provided for May 2015 showed 90% staff compliance with hand hygiene.
- 84% of nursing and medical staff working in the ED had received IPC training against the trust target of 95%. However, all staff we spoke with told us they received annual IPC training.
- In the ED survey 2014 the trust scored about the same as other trusts (8.8) for how clean was the ED. This was for both St Helier and Epsom General Hospital.

- In the National Cleanliness Audit for October 2015, the department scored 98% and in the Patient-led assessment of the care environment (PLACE) in 2015, the department scored 98% for cleanliness.
- Two side rooms were available within the department. One was used as a women's health room and the other is a decontamination room used for infection purposes. During the inspection, we observed there was insufficient space available for patients who needed a side room. We observed a patient with a potential infectious condition who needed a side room, however none were available.

### Environment and equipment

- During our inspection, doctors and nurses told us and we observed the environment of the ED was not fit for the number of patients being seen. On several occasions, doctors and nurses told us that space in the department caused delays in the assessment and treatment of patients.
- There was sufficient seating in the adult waiting room where reception staff had a good line of sight of patients. The paediatric waiting room was small, with space for one child and adult only before it appeared over crowded.
- Entry to the department from the waiting room was restricted and a separate buzzer system was used to access the paediatric area of the department.
- Paediatric patients were assessed and treated in the adult minor area of the department, when the paediatric area was full. We did not note this on the department's risk register and there were no reported incidents referencing this. During our visit, we observed two occasions where children were brought into the adult area. The RCPCH states that children's departments should have audio and visual separation from adult patients.
- A separate room was designated for interviewing patients with mental health needs. We observed that this room had only one exit did not have an emergency call button and a ligature point was noted. This room did not meet the standards set by the psychiatric liaison accreditation network.
- Cardiac monitors in the majors area of the department were in the process of being replaced and required updating. This was on the department's risk register and we were told this had been an on-going issue for over one year. We were told that of the ten monitors, only seven were functioning. The seven monitors we saw in use during our inspection were due to be portable appliance tested (PAT) as these were out of date. We were told if capacity allowed, all patients requiring monitoring and had the potential risk of further deterioration, were transferred to the resuscitation area of the department. The consequence of monitors not being available was a high risk of patients with cardiac arrhythmias not being identified early enough. This can cause loss of life and also clinicians may be unaware of unwell and deteriorating patients.
- We examined the record of daily checks for the resuscitation trolleys within the department. Equipment was not checked on several days in the resuscitationarea of the department. There were six omissions for the month of October 2015 and four omissions since the 1st November 2015 to the time of our inspection.

### Medicines

- Medicines were secured in the clean utility accessed by keypad access within the ambulatory care unit (ACU) and the majors area of the department. Medicines for children were in a locked cupboard above the nurse's station with no available clean space for medicine preparation.
- Intravenous (IV) and oral medication were kept separately to avoid medication errors. All medicines were stored A-Z and drugs checked were within date. We observed pharmacy assistants checking stock levels during our visit.
- We checked the records and stock levels of controlled drugs in the majors and paediatric area. All stock records were accurate, showing the correct amount of stock stored at the time of inspection. The controlled drug (CD) register was completed with two signatures for each drug that was administered to patients.
- Daily checks of controlled drugs in the majors area had omissions. Four omissions were noted in the daily checks from 1st November to the date of our Inspection and four omissions were noted for the month of October.

- Medication fridges were locked and temperatures were within the desired range. There were omissions in the daily checks of fridge temperatures in the resuscitation area. Daily checks were omitted five times in the week prior to our inspection.
- We observed one nurse during our inspection preparing IV paracetamol whilst walking towards the patient. This is not recognised as good practice as it meant the medication was not being prepared in a clean environment.

### Records

- Paper records were used within the ED department at Epsom. Reception staff generated paper records registering the patients' arrival time in the department, personal details including next of kin and the reason for attendance. All healthcare professionals involved in the patients' care, recorded care and treatment using the same paper document.
- The trust's policy is that staff must complete Information Governance (IG) training once within each financial year and compliance starts at 0% as at April and increases through the year until the end of the following March. For the previous year April 2014 to March 2015, the compliance for IG training for the Medicine Directorate as a whole was 82% against the trust target of 95%. Since April 2015, 46% of staff had completed IG training.
- The records were kept in pigeonholes at the nurse's station, numbered by bed space in the majors department. In the minors area, we observed records stored in a holder on the wall above the nurse's station. This raised concerns regarding the security of these records, as there were often times when no visible staff were in this part of the department and records could easily be accessible to the public.
- Within the department, there was no live updated electronic tracking system of patients. This may lead to risk to patient care, as there was no 'live' register of patients clinical priority to be seen medically, thus leading to a risk of failing to allocate clinical resources safely and consistently. A white board was used to record patients who were currently within the department and updated regularly however there was no clinical priority recorded on this board. We observed the nurse in charge having to regularly check different areas of the department to update the white board.
- During our inspection, we looked at 29 care records including four children's and found they were clear and easy to follow. We found health care professionals recorded information in these notes signed and dated them accordingly.

### Safeguarding

- Reported incident logs received prior to our inspection raised concerns around the safeguarding of adults and children within the ED department. We reviewed incidents from May 2015 to August 2015 and noted seven occasions where potential safeguarding opportunities and early identification of concerns had been missed. These incidents were reviewed as part of the inspection process and we found the appropriate team followed up these patients after discharge and safeguarding referrals made retrospectively.
- Training data provided by the trust demonstrated that 93% of all clinical staff in the department had received up to date level 2 child safeguarding training against the trust target of 95%. RCPCH guidelines state that all nursing and medical staff working with children in urgent care settings should be trained in level three safeguarding. Data provided demonstrated that 87% of band five nurses, 100% of band six nurses and 92% of band seven nurses had received training in child safeguarding level three. 100% of consultants, 73% of middle grade doctors and 100% of foundation year doctors had received level three child safeguarding training. As children were seen within the adult minors area at night, all nursing and medical staff should be trained up to level three.
- Safeguarding vulnerable adults and learning disabilities training, continues to be part of trust induction for all nurses and midwives. 72% of staff had completed this training against the trusts own target of 95%
- Safeguarding policies and protocols were available and up to date. A notice board in the corridor outside the paediatric area had clear advice about recognising children at risk and actions to take.
- We learnt that there were no current flag systems in use within the ED. This meant staff did not have access to an up to date "At Risk" register. We were informed that if staff had concerns about a child, there was a referral centre, which was always manned within working hours. Out-of-hours, the duty social worker took these calls. Therefore, local safeguarding teams would only be

contacted if staff had a current concern and there was a risk that information would not be shared. No reliable systems were in place to notify staff if the child was on a current child protection plan or if there had been previous concerns that would guide clinicians' assessment around a child's needs and safety. This was not noted on the departments risk register.

- During our inspection, it was brought to our attention that two children from the previous week had gone home without adequate safeguarding procedures being implemented and we saw safeguarding referrals being made in retrospect. This could mean that staff were lacking in the adequate knowledge needed to recognise and respond appropriately to signs of potential patient safeguarding needs. This added to the risk of there being no flagging system and the potential that children at risk of significant harm were not recognised in a timely manner.
- The children's ED held weekly safeguarding meetings, which were attended by an ED paediatric consultant, clinical nurse specialist, a representative from the local authority multi-agency safeguarding team and the ED safeguarding administrator. Minutes demonstrated that concerns were discussed, actions were identified and outcomes were recorded.

### Mandatory training

- Mandatory training included infection control, resuscitation, safeguarding children and vulnerable adults, blood transfusion, equality and diversity, health and safety, patient handling, conflict resolution, fire and information governance.
- All staff we spoke with had either completed their mandatory training or were in the process of doing so, if they had recently joined the trust. Staff told us they were given adequate study leave necessary to complete this training.
- 84% of staff in the department had completed basic life support training (BLS); however, the trust was unable to break these figures down to supply information on levels of training within the ED department. Across the trust, 86 staff had completed advance life support (ALS), 25 staff had completed advance paediatric life support (APLS) and ten staff had completed advance trauma life support (ATLS).
- 84% of staff had completed Infection control training (target 95%) 80% had completed blood transfusion training (target of 95%) 94% had completed equality and diversity training (target 95%) and 88% of staff had completed health and safety training (target 95%)
- We were advised there was a training programme for safeguarding vulnerable adults, the mental capacity act, deprivation of liberty safeguards and caring for people with complex needs i.e. learning disabilities. There were various levels of training available, from level 1 to 5.

### Assessing and responding to patient risk

- The department monitors the time from arrival by ambulance to initial assessment. The national standard is 15 minutes. Data provided by the trust showed the department was achieving this 15-minute target. A median time to triage in the children's ED was two minutes in August 2015, three minutes in September 2015 and three minutes in October 2015. In the adults ED, the median time to initial assessment was 18 minutes in August 2015, 15 minutes in September 2015 and nine minutes in October 2015.
- Nurses took the handover from the ambulance crew and assessed patients arriving by ambulance. Based on the information received, a decision was made regarding where in the department the patient would be seen.
- We were advised during a walk around of the department that ambulatory patients who attended ED were initially assessed using an 'adapted' version of the Manchester Triage Guidelines. We looked at five sets of notes of patients waiting to be seen in the minors area of the department after triage. There was space on the triage proforma to record presentation, treatment to date, past medical history, medications, pain scoring, initial observations and next of kin information. We found on all five sets of notes, information was incomplete or missing.
- As part of our inspection, we tracked the pathway of three ambulatory patients who were assessed in the emergency department. We observed the initial assessments of these patients' conditions were established in detail by the triage nurse, incomplete vital signs recording, NEWS and pain scoring was observed. Therefore, the full clinical picture of patient's stability had not been established and clinical priority was not established. We also observed patients with certain conditions were being streamed through the

department when space allowed this. Such practice facilitates the triage nurse to apply their own 'subjective assessment' rather than an 'objective assessment' that an evidenced base triage tool affords. For example, we observed the triage nurses judgement to establish an ECG on a patient as an immediate clinical priority. There was a delay in 10 minutes in performing an ECG due to the delay to assign a cubicle in minors for this patient. This would ultimately have an impact on the patient being medically reviewed in a timely manner.

- We saw evidence of rapid assessment and treatment (RAT) by a designated RAT team of one consultant and one nurse. The RAT team would assess patients arriving by ambulance and walk in patients who were seen in majors. There was one RAT cubicle available between the majors and minors area of the department, however, we were told the RAT team worked throughout the majors department as a mobile team, rather than working in one designated bay, which might delay assessments due to space. The RAT team worked between 12pm to 8pm
- Children attending the ED during the hours of 8am and 2am were directed to the children's ED department where a paediatric nurse undertook triage. One-registered children's nurse had been allocated to the children's ED on the morning of our visit. We observed two patients in cubicles awaiting medical assessment and one child waiting to be triaged by the nurse. The nurse was required to leave the department on three occasions for up to five minutes to alert medical staff that patients needed assessment, which meant paediatric patients were left unattended by clinical staff.
- Median time to treatment for patients from October 2014 to September 2015 was between 66 and 84 minutes for adults and between 64 and 83 minutes for children. This meant, the department exceeded the national guidelines and did not meet the target of 60 minutes to treatment. From October 2014 to September 2015 45% to 59% of adult patients were not treated within this 60-minute target.
- During our inspection, we were told and observed that time to treatment was significantly less for patients being admitted compared with patients who were discharged home. Data provided for the week beginning 05 November 2015, showed the median time to treatment for admitted patients was 55 minutes and non admitted patients was 76 minutes. For the week of the 16 November, admitted patients waited on average 70 minutes to be treated and non-admitted patients waited 136 minutes.
- We observed good evidence of national early warning scores (NEWS) in use throughout the department. NEWS scoring was recorded in 13 out of the 16 sets of patient notes we looked at in detail.
- The trust had introduced an electronic early warning system (VitalPAC) in some areas of the hospital with the aim to provide safer hospital care using technology to semi-automate the consistent and standardised capture of nursing observations. Staff in the ED told us they were keen to have it implemented within the department as this may improve patient outcomes.
- We saw paediatric early warning scores (PEWS) in use in the paediatric department, however these were not accurately completed in all of the three sets of notes which were available to look at. Ongoing audits were currently in place to facilitate improvement in the use of PEWS scoring in the department. Between April 2015 and September 2015, 57% to 95% of charts were accurately completed.
- Risk assessment documentation was available to assess falls and pressure ulcer risk. These assessments could be added to patients' notes. Risk assessments were not completed in any of the patient records we reviewed.
- Patient pathway algorithms for adults and paediatric patients presenting with suspected sepsis were available in the department. These had been updated in 2015 and were based on the UK sepsis trust guidelines. These were clear and concise with time critical treatment advice and antibiotic guidelines.
- There were no black ambulance breaches in the previous 12 month to our inspection at the Epsom site. When we inspected we found patients who arrived by ambulance were handed over quickly at the nurses station with minimal delay. Data provided showed that patients who arrived by ambulance had a considerably less waiting time to initial assessment, (2-3 minutes) compared with ambulatory patients (14-19 minutes).

### Nursing staffing

- The nursing establishment for the ED was 49 whole time equivalent (WTE) staff. The current vacancy rate at the time of our inspection was 10.45 WTE.
- The planned nurse to patient ratio in the department was as follows; the resuscitation area was two registered

nurses for an area, which can take up to a maximum of four patients (1:2). Majors had a planned nurse patient ratio of 1:5 / 1:6. We were told in information received before our inspection that Royal College of Nursing (RCN) recommendations were followed regarding nurse/patient ratios. However, there was no mention or evidence of the RCN Baseline Emergency Staffing Tool (BEST) in use during our discussions with staff. The function of BEST is to assist the workforce planning process within emergency departments. The tool does not recommend minimum staffing levels.

- In the children's ED, we found staffing levels did not comply with the RCPCH; as there were not always trained children's nurses on duty 24 hours a day. After 2am children were looked after by adult trained nurses in the main department. We were advised that this model of care was currently under review by the Paediatric Emergency Board.
- Data provided by the trust showed that for October 2015 95% of planned registered nurse hours were covered 77%, of ENP hours and 82% of paediatric nurse hours were covered. During inspection we observed a junior doctor covering the minors area of the department due to no ENP being available that morning.
- The current nursing vacancy rate of 27% meant that bank (mainly own staff) and agency staff were used on a regular basis. Between April 2014 and March 2015, the average percentage of shifts covered by bank (mainly own staff) and agency staff was 28% in the adult ED and 29% in the paediatric department. The trust average for the same period was 14%.
- Three months of nursing rotas were reviewed. The rota provided for four weeks of October/November 2015 noted 53 different temporary staff working shifts throughout this period within the ED department.
- Initiatives were ongoing to improve nurse-staffing levels. We were told about a recent recruitment day at the trust in which the department had recruited two registered nurses and the oversees recruitment drive in which five registered nurses had been allocated to the department.
- When we visited the department, there were three agency staff on duty. Nursing staff told us agency staff were mostly long-term agency workers and knew the department. We observed one bank nurse in the department on her first "shadow shift" being inducted to the ward using the trust induction checklist.
- Agency staff told us they had a good induction to the department and had key skills, which were observed by senior staff.
- Over the last 12 months, the sickness rate amongst nursing staff was 7.1%. This was above the national average of 4% reported in 2014/15. High sickness rates amongst staff can be linked to a decrease in patient satisfaction and reduced performance outcomes.
- The trust had recently employed nursing staff from oversees including Spain and Italy. Three of the staff we spoke with had recently started in post from this program. They told us they had good inductions and worked three weeks in a supernumerary capacity, where they were able to shadow staff in different areas of the department.
- When talking with staff within the department, nurse staff levels were mentioned as an area of concern on a number of occasions. They told us that often they were too busy to care for patients and the high use of agency can sometimes added to workload as they were not always trained to work in the ED.

### Medical staffing

- Fourteen consultant doctors were employed at the time of our visit for both Epsom and St Helier ED. Of these two were locum doctors and one an associate specialist. These doctors covered both the Epsom and the St Helier site including the children's ED at Epsom but not the children's ED at St Helier.
- The department did not have any specialist trainee (ST) doctors, all the ST doctors worked at the St Helier ED site only. We were told that filling middle grade doctor posts was a challenge. Data provided by the trust demonstrated a 7% vacancy rate in consultant doctors and a 12% vacancy rate in doctors of other grades. This resulted in a high use of locum staff of 33%.
- Emergency medicine consultants were on duty in the department between 8am until 10.45pm on weekdays and a minimum of eight hours cover at weekends. This meant the trust did not meet the RCEM recommendation that an ED should provide emergency

consultant cover 16 hours a day, seven days a week. We were told by senior management teams that increases to consultant cover throughout the trust was part of the trusts five-year plan. The consultant on call covered both the Epsom and St Helier EDs meaning there was only one consultant to cover both sites.

- We were told the night shift in the ED was covered by one middle grade doctor and two foundation year doctors (FY2). We were told there had been an agreement to increase the number of middle grade doctors to two for the winter period.
- Two of the consultants who worked in the department had sub-speciality recognition for paediatric emergency medicine (PEM). There were paediatricians on site at Epsom to see children in the ED if needed. It is recommended that in EDs seeing more than 16,000 children per year, there should be at least one PEM consultant.
- There were plans to increase the number of paediatric emergency consultants across both sites and we were told four new consultants were currently being employed to increase this number. We were told by one consultant that once these doctors were in post they would work across sites at both the children's departments.
- Sickness rates amongst medical staff in the department were 2.3% within the last 12 months, which was lower than the national average for 2014/2015
- A consultant told us recruiting medical staffing into permanent posts had been difficult due to Epsom ED not having trainee level doctors and this created a gap in the staffing of middle grade doctors.

### Major incident awareness and training

- The trust had a major incident plan in place, which was last updated in October 2014. This was available for all staff on the trusts intranet pages. However hard copies of the major incident plan in red folders around the department were found to be out of date in the majors area. We brought this to the attention of the ED clinical lead and we saw updated copies in place the following day.
- The major incident equipment cupboard was found to have numerous pieces of equipment out of date. We brought this to the attention of the ED clinical lead and we saw that all out of date equipment had been removed and re stocked by the following morning.
- Nurses we spoke with had limited knowledge of the trust major incident plan apart from where the plan was located on the intranet and in the red folders. One nurse told us they would report to the nurse in charge.

### Security

- We visited the security staff office and spoke with two members of the team. Security staff working in the hospital were provided under contract from a commercial company and were present in the hospital 24 hours a day. Security staff told us they made regular checks on the ED during their patrols, but did not have a specific agreement for frequency of patrol in the ED. They were on-call at any time if the department required assistance.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Patients were not always administered timely pain relief and pain-scoring tools were inconsistently used to assess or monitor patients' pain throughout the department.

Staff followed accepted national and local guidelines for clinical practice, however, we observed some of these in use were out of date and due for renewal.

We observed staff upheld the principles of the Mental Capacity Act 2005 (MCA); however. The mental capacity of patients was not recorded in any of the 16 records we reviewed in detail. We saw no evidence of documentation of a 'best interest' decision-making process for patients who did not have capacity to consent for example, the notes of two patient's recorded reduced conscious levels on arrival in the ED.

A psychiatric liaison service provided by the local mental health NHS trust was available on site, adjacent to the ED. The service is available 8am to 3am daily then the 'home treatment team' responds to referrals. We were told patients were only referred to the team once the patient was medically well. During our inspection, staff from the psychiatric liaison service informed us that ED staff did not always involve them in the care of patients who may require their service.

# Urgent and emergency services

## Evidence-based care and treatment

- The children's and adult ED guidelines were available on the trust intranet; not all the guidelines had been updated by the review date. Senior staff stated they reflected best practice, however we found they did not reference the national guidelines of professional bodies; such as the Royal College of Nursing & Midwifery (RCN), the RCEM and the National Institute for Health and Care Excellence (NICE). Adherence to clinical guidelines was encouraged through the development of illness-specific algorithms for the management of sepsis, stroke and low risk acute coronary syndrome.
- Guidelines were easily accessible on the intranet and we were shown a folder which had been developed in October 2015 for junior doctors for the management of common medical emergencies and the use of antimicrobial drugs.
- We observed the trust guidelines in use for pulmonary embolism, sickle cell and acute coronary syndromes were out of date and had been due for renewal in 2011; this meant treatment guidelines may not have reflected current best practice.
- There was a patient pathway in place for neck of femur fractures, including iliaca fascia block equipment stored in a box ready for use to aid the patient pathway. However, when we initially asked a junior doctor, they were not sure where this box was.
- We saw guidelines available in the children's department for bronchitis dated 2015, however the patient pathway was due for renewal in 2013. Other guidelines in use within the department-included guidelines for self-harm which were due for renewal in 2014.
- We were told clinical audit half days took place six times a year, to allow presentations of audits, which could show improvement within the organisation, and areas of good practice can be shared, with actions agreed for improvements where required. We were told that junior doctors and nursing staff were not involved in the clinical governance meetings.

## Pain relief

- Clear analgesia guidelines for the assessment and management of pain were available for use within the department. These guidelines had been developed to guide staff in the suggested route and type of analgesia and the timely re-evaluation of pain in accordance with the patients pain score.
- We observed staff checking pain levels in different areas of the department. Records used graded pain scores of 0-3 however; we observed staff using scales of 1-10. This could lead to inconsistency in the assessment of patient's pain as different scoring systems were in use. For example, a score of three would mean something different in a scoring system of 1-10 then it would in a scoring system of 0-3.
- We looked at five sets of patient notes in the majors area of the department and noted that pain scores had been assessed quickly and pain medication prescribed and administered in a timely fashion. We did not see any evidence of re-assessment of pain for these five patients in line with trust guidelines.
- We looked at five sets of notes of patients in the minors department and noted that pain scores had been assessed at triage in all five patients using a score of 1-10. We saw one patient with a pain score of seven and two patients with a pain score of four. We saw no evidence of pain medication being offered and there was no documented pain relief administered for these patients.
- On request there were no available pain audits to demonstrate compliance of pain management within the department. Clinical audit is a way to find out if care is being provided in line with standards and can help improve quality of care.
- We saw a poster around the department which prompted patients to speak to staff if they were still in pain 30 minutes after receiving pain medication
- We observed nurses who triaged walk-in patients had to get doctors to prescribe pain relief as nurses were not currently trained to use patient group directives (PGDs) and we were told some of the PGDs needed updating and therefore could not be used. Doctors were observed prescribing pain relief without seeing the patient.
- The trust scored about the same as other trusts in the A&E survey (2014) for patients not having to wait long to receive pain relief and for patients feeling that hospital staff did all they could to help control their pain

## Nutrition and hydration

- During our inspection, we observed volunteer staff offering patients drinks and sandwiches if clinically safe to do so.
- The trust scored about the same than other trusts in the A&E survey (2014) for patients being able to access suitable food and drink while in the ED.

- Following assessment by a doctor, intravenous fluids were prescribed if necessary and we saw this documented appropriately in the ED notes.
- We did not see any evidence of malnutrition universal screening tools (MUST) used in the department. A nurse told us these would be completed on the ward if the patient was admitted.

### Patient outcomes

- The department currently contributes to 2015/2016 national RCEM audits. These include vital signs in children, procedural sedation in adults and VTE risk in lower limb immobilisation in plaster cast. These audits can be used to benchmark performance against best practice.
- The ED at Epsom had mixed results in the RCEM 2013/2014 audit for severe sepsis and septic shock. The department scored better than the national average for vital signs measured and recorded, capillary blood glucose measured and antibiotics administered within one hour. The department was in the lower quartile for evidence for obtaining blood gases.
- In the RCEM audit of consultant sign-off in 2013, the trust performed worse than the national average. The audit looked at three patient groups that should be reviewed by a consultant prior to discharge. These include adults with none-traumatic chest pain, febrile children less than one year old and patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Consultant sign-off for these conditions was below the national average with 4% of the audited patients being seen by a consultant and 4% being discussed with a consultant.
- In the RCEM 2014-2015 clinical audit for assessing for cognitive impairment in older people the ED scored worse than the national average and below RCEM standards for early warning score assessment which is a fundamental standard where there should be zero tolerance of breaches.
- In the RCEM, clinical audit for the management of mental health in the ED the department scored better than the national average in one element of care about average for five elements of care and worse than the national average in two elements of care.

### Competent staff

- The department did not comply with nursing and clinical staffing guidance published by the Intercollegiate Standards for Children and Young People in Emergency Care Settings particularly as there was not a children's nurse on duty after 2am.
- We were advised there was currently no competency framework in place for adult nurses who were working within the children's ED and therefore we were concerned that staff did not have the skills and experience to enable them to deliver good quality care. During our visit, we observed an adult trained nurse working without the support or supervision of a children's trained nurse due to staff pressures in the resuscitation area of the department.
- We discussed training and development with a senior paediatric nurse who advised us competency packs were currently in development for adult nurses. There were also four study days a year planned for adult nurses, which will aim to cover a range of skills required. We looked at training logs and observed that out of 51 nurses, 30 had yet to complete any form paediatric skills training.
- Information provided by the trust showed that 36% of nursing staff had an appraisal completed within the current year. Staff we spoke with in the department told us there was often a lack of adequate time to complete appraisals as often senior members of staff were leading the department.
- We were provided with revalidation data for all doctors who worked within the ED department at Epsom. Of 24 doctors, 16 had an up-to-date appraisal, five were in progress and one was overdue. Two of the doctors listed had started within the last three months and therefore no appraisal data available
- Data provided demonstrated that not all staff were up to date with relevant resuscitation training. Data provided showed medical and nursing staff of all grades without any level of resuscitation training recorded.

### Multidisciplinary working

- Medical and nursing staff worked across the ED to provide care within the department. Medical and nursing staff of all grades that we spoke with all described excellent working relationships between healthcare professionals. We observed the healthcare team worked well together to provide care to patients.

- Emergency Nurse Practitioners (ENP) worked alongside the medical team to cover the minors area of the department seeing patients with minor illnesses/injuries for full episodes of care.
- The intercollegiate standards for Children and Young People in Emergency Care Settings recommend departments seeing more than 16,000 children per year employ a play specialist or have access to a play specialist. During the inspection we did not see any play specialists available to any of the children in the department.
- Staff informed us they had links with doctors at Chelsea and Westminster Hospital for the assessment of patients requiring burns or plastics assessment. They informed us a photograph would be sent to them and a decision on best treatment communicated usually within an hour.
- Staff in the paediatric department advised us the child and adolescent mental health service team (CAMHS) were available Monday-Friday only. We were told there was not an out of hour's service and that CAMHS will only see referrals on the ward and not in the ED department. This has the potential to delay patient assessment and treatment when children or young people had emotional, behavioural or mental health difficulties.
- A psychiatric liaison service provided by the local mental health NHS trust was available on site, adjacent to the ED. The service is available 8am to 3am daily then the 'home treatment team' responds to referrals. We were told patients were only referred to the team once the patient was medically well. During our inspection, staff from the psychiatric liaison service informed us that ED staff did not always involve them in the care of patients who may require their service.

### Seven-day services

- All areas of the ED were open seven days a week. X-ray, scanning and pathology services were available to support the seven-day working of the department.
- ED consultants were not in the department for the recommended time outlined by RCEM guidelines which state a consultant in emergency medicine to be scheduled to deliver clinical care in the department for a minimum of 16 hours a day 7 days a week. From rotas reviewed, we noticed that locum doctors often covered night and weekend shifts.
- The ambulatory care unit was open seven days a week, 24 hours a day, to receive patients referred by GPs.

### Access to information

- The department used a white board to communicate the patients currently in the department. We saw the whiteboard being updated by the nurse-in-charge on a regular basis; however when the department was busy, there appeared to be confusion about which patients were where, as the white board was not updated in real time.
- The white board recorded the patients who were in the resus area and majors area only. Patients who were in the minors, paediatric and ACU area of the department were not captured on the white board. We observed the nurse in charge at handover not being able to fully communicate the current number of patients in each area of the department.

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

- We observed consent was obtained for treatments and procedures undertaken by staff. Staff we spoke with were aware of different types of consent including written and verbal consent and were clear about their responsibilities in gaining consent from patients.
- While we observed staff upheld the principles of the Mental Capacity Act (MCA) during care and treatment, the mental capacity of patients was not recorded in any of the 16 records we reviewed in detail. Information in some of the records we looked at indicated patients may have had impaired mental capacity. For example, the notes of two patients recorded reduced conscious levels on arrival in the ED. An abbreviated mental test score (AMTS) was recorded in two out of the 16 notes we looked at. We saw no evidence of documentation of a 'best interest' decision making process for patients who did not have capacity to consent. For example, patients under the influence of drugs or alcohol, living with dementia or who had reduced conscious level.
- Concerns were voiced by specialist teams about the lack of understanding by staff of MCA, deprivation of liberty safeguards (DoLS) and mental health. We were told of a recent example of a patient with diminished capacity who was obviously detained (prevented from leaving) but no DoLS application had been made. Data provided by the trust demonstrated that there had been no DoLS applications made in the department within the last 12 months.

# Urgent and emergency services

## Are urgent and emergency services caring?

Good

Patients and their relatives gave us positive views and examples about the care they received.

We observed staff treating people with dignity and respect and staff using appropriate language to explain investigations, treatment and diagnosis. Staff provided emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.

### Compassionate care

- The Friends and Family Test (FFT) trust scores for patients recommending the service were better than the national average for all months from July 2014 – June 2015. During our inspection, we observed friends and family test data from September 2015 displayed in the waiting room. This showed that 93% of patients would recommend the ED service. This was an increase from 89% from the previous month.
- The FFT overall response rate for the department was low with only an 8% response rate for the adult ED and 10% response rate for the children's ED. From January 2015 the response rate had varied between 5% - 17%.
- In the A&E survey (2014), the trust performed better or about the same as other trusts for all questions relating to the care they had received.
- The trust performed better than other trusts in 8 out of 23 key questions focused on caring. This included doctors and nurses listening to what patients had to say, time given to discussions, explaining treatment in a way patients are able to understand and patients being involved in their care.
- We observed staff treated people with dignity and respect. For example, privacy curtains were drawn during interventions: discussions about care and treatment were sensitive and discreet to support patients' confidentiality and patients were addressed by their preferred names or formally with the use of 'sir' or 'madam'. The reception staff were particularly mindful of patient confidentiality when 'booking in'. We observed reception staff asking patients for reasons for attending, but then stopped the discussion when sufficient information had been obtained and told patients they could discuss their condition further in private when called in to see the triage nurse.
- During inspection in the minors area of the department, we observed examples of doctors and nurses using appropriate language to explain investigations, treatments and diagnosis in a way that the patient could understand.

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

- We saw examples of children being involved in the decisions regarding their care when it was appropriate to do so. Several parents attending told us they were happy with the treatment and care they had received while in the department. One parent mentioned that they attended on a regular basis with her child and commented that the nurses were always kind and caring.
- We saw a junior doctor working in minors communicating effectively with an anxious teenager about their treatment.

### Emotional support

- We observed staff provide emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.
- There was a relative's room where distressed relatives could sit in a private space.
- Patients told us they had been well supported by staff and were given good information about waiting times and treatment.

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

Requires improvement

The adult and paediatric ED was often overcrowded. Patient flow through the department required improvement and was often blocked by internal capacity issues within the trust. We observed patients who had been

admitted waiting for long periods for a bed to become available and we observed some of these patients being accommodated in the ACU area of the department, which was inappropriate for this purpose.

Initial assessment of patients arriving within the ED did not always occur in a timely way. We observed patients waiting up to 45 minutes to be seen by the triage nurse and reception staff providing initial clinical priority using a red sticker.

We observed patients arriving by ambulance were handed over to nursing staff and assessed quickly with minimal delay. We observed walk in patients having a significantly longer delay to be seen and triaged. Walk in patients also had a longer delay from initial assessment to treatment and spent longer in the department waiting for a decision about their care.

We listened to senior staff who were concerned about the pathways of surgical patients within the department as these patients' experienced extended waits to be reviewed by a specialist surgical team.

### Service planning and delivery to meet the needs of local people

- Patient information and advice leaflets were available in the adult and paediatric ED department in English but were not available in any other language.
- Reception staff told us the nurse-in-charge had a contact number to access a translation service for patients who did not speak English. In practice, staff said the service was not often used. We were told there were a number of staff in the department and in the rest of the hospital, who could speak; various languages and they were called to the department when necessary.
- Staff identified a diverse community was served by the ED and staff identified a large eastern European and traveller communities among the local population. There were no specific initiatives to address the specific needs of these, or other minority groups.

### Meeting people's individual needs

- When a patient with a learning disability was admitted to the ED, their electronic patient record 'flagged' their specific need and the trust's learning disability nurse was alerted to the patient's presence in the hospital.
- Staff had access to training in the needs of people living with dementia. The department did not use a system for identifying people with dementia. There were no specific care arrangements for meeting the specific needs of people living with dementia in the department.
- Children's needs were met by the provision of age appropriate toys and activities.

### Access and flow

- Capacity in both the children's and adult ED was an on-going problem within the ED at Epsom and we were told that this was often due to patients awaiting a hospital bed at either the Epsom site or waiting to be transferred to the St Helier site.
- Walk-in patients were registered at reception and then asked to take a seat to wait to be seen by triage nurse. We observed reception staff using coloured stickers on patient notes. We were told that red stickers indicated a patient who was a clinical priority. This meant that administration staff with no clinical training were making decisions on the clinical needs of the patients within the department and therefore unsafe.
- During our visit, we observed four walk in patients waiting between 40-45 minutes to see the triage nurse. Data provided by the trust for the month of October 2015 demonstrated that patients could wait up to 59 minutes to be seen and assessed by the triage nurse.
- The four-hour waiting standard requires all EDs to see 95% of attending patients within four hours of their arrival. At Epsom ED for the 12 months between November 2014 and October 2015 94% of patients were seen within this target.
- Data for the previous 12 months showed that on average 147 patients a month were in the department more than six hours. During our inspection, we were told and observed patients who had been waiting in the department for a bed to become available within the hospital. One patient who had been waiting for a bed for nine hours had been moved to the ACU area of the department. Staff informed us that the ACU could be used as an escalation bay for patients awaiting a bed on the ward and this happens on regular basis. During our Inspection, we saw four patients in the ACU three of these patients were awaiting beds on the ward.
- The specialities with longer lengths of stay in the ED were surgery and gynaecology patients. Staff told us surgical patients had to wait for an available bed before being transferred to St Helier Hospital. We were told this

could cause delays in patient care, as there was no surgical team to assess the patient until the patient arrived at St Helier. We were told patients could be transferred directly to St Helier ED if there were no beds becoming available on the wards. This could mean patients having a long wait in ED at both Epsom and St Helier Hospitals. We were told this was done in patients' best interests, as there were surgical teams that could assess patients at St Helier.

- In the 12 months up to August 2015, the unplanned re-attendance rate to the ED within seven days was 7.29%. This is about the same as the England average (between 7% and 7.5%) however this does not meet the RCEM recommended standard of 5%.
- The percentage of patients who left the department before being seen has been recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait to be seen. Between 2.1% and 3.5% of patients left the ED without being seen compared to between 0.2% and 3% nationally.
- There was a clear procedure in place for referring patients to the ACU area of the department. GPs could phone to refer patients and an up to date list of expected patients was kept in reception.

### Learning from complaints and concerns

- Information about how to complain was displayed throughout the department. Information leaflets were available at reception and in the relative's room. Leaflets contained information about how to access the Patient Advice and Liaison Service (PALS).
- Staff we spoke with told us how they dealt with patients complaints. We were advised that patients who wanted to make a complaint were directed to the nurse in charge and that if the concern was not able to be resolved within the department they would direct the patient to PALS.
- Information we received before our inspection demonstrated some concerns around the response time in which complaints were being dealt with. Senior management told us this was an area for improvement and were currently working on initiatives to improve response times. This included setting time aside for nurse managers and consultants to phone patients to discuss concerns and inviting patients back to the department to discuss their concerns in person.
- Information received showed 55 complaints had been received by the trust in the last 6 months, 11 of these were still under investigation. The top area of complaint was clinical care and treatment (33).

## Are urgent and emergency services well-led?

Requires improvement

Vision and strategy within the department was not well developed or known by all staff working within the department. There were mixed views about the departments future and staff were unaware of trust values.

The arrangements for governance within the department were not inclusive of all staff groups and grades and staff felt there was little support from directorate leaders.

Senior nurses we spoke with felt they were not included within discussions and plans about the future development of the department and were not always informed of changes or planned changes.

### Vision and strategy for this service

- There was a five-year strategy in place for the development of the ED. These included plans to maintain the environment, increase consultant cover to 16 hours seven days per week and increase the number of middle grade doctors. The senior management team told us they wanted to improve cross-site working and improve unity with St Helier's ED.
- We heard mixed views from staff and patients about the future of the ED at Epsom. Patients told us they were unsure what the future for the ED was and some patients we spoke with informed us the ED at Epsom would probably be closing. Staff were unsure of any planned vision for the department as a whole, were unaware of the trust's vision of 'Put the Patient First, and provide great care to every patient every day'.
- Consultants and nurses in the department told us there were plans to move the children's ED, as this would create more space, improve collaborative working and improve oversight of the department by the nurse-in-charge. Opinions on when this was likely to happen and how the department would run as a whole if this move were to take place differed considerably between the different staffing groups.

- There were various recruitment strategies in place to improve staffing throughout the department. This included regular recruitment days and the recruitment from overseas programme. Senior management told us staffing within the department had been a problem due to the uncertain future of the department.
- Staff we spoke with felt there was no overall direction for the department and felt there were short-term improvement considerations only.
- Staff had mixed feelings and concerns about the ACU department that had previously been the observations ward for the department. Staff felt the ACU had been developed without consideration of patient flow through the department and that too often the ACU was still being used as an observation ward which it was now not set up to do.

### Governance, risk management and quality measurement

- The department held a risk register, which identified risks within the department. Senior management were able to tell us what was on the risk register at the time of Inspection. At the time of inspection there were eight risks highlighted including insufficient air conditioning, broken monitoring equipment and shortage of middle grade doctors. However, the risk register did not mention children being seen in the adult area of the department, problems with space to see patients or the use of agency and bank nursing staff, which, were all current concerns amongst staff, we spoke with. This demonstrated the risk register did not reflect key concerns amongst the staff and that there was an inconsistency between what frontline staff and senior managers thought were the key challenges the department faced.
- National audits that the department took part in indicated that they were benchmarking themselves against the England average, however there was a limited range of evidence from local audits. Some audits requested were not current or had not been carried out. There were no audits available for the management of pain, no patient flow audits and no current audits on NEWS scoring that had been suggested in a recent RCA.
- Governance within the department was arranged so that the adult and paediatric ED fell under the leadership of the medicine directorate.
- The schedule of clinical governance meetings included directorate meetings once monthly and specific ED meetings once every two months. We noticed a disconnect between the directorate management team and the ED management team. We noticed from the three medicine directorate governance meeting minutes issued that neither the ED clinical lead or matron were in attendance at these meetings. We also noticed limited communication between the ED management team and the medicine directorate management team when meeting with them. This was not indicative of a fully functioning or effective governance, risk and quality measurement processes. It worth noting that none of the staff we talked with working within the department had ever attended, or been invited to a governance meeting, or received feedback from regular meetings. This suggested the governance function within the department was not an inclusive process.
- The department did not hold mortality and morbidity meetings. We were informed that this was because small numbers of patients die in ED; and either died before reaching the hospital or die within another area of the hospital following transfer from ED. The benefits of these meetings can provide learning opportunities and opportunities to improve patient safety and quality care collaboratively with different members of the multi-disciplinary team.

### Leadership of service

- Leadership and management of the ED was shared as part of the medicine directorate across both hospital sites. The trust had recently appointed a clinical director with responsibility for ED services at St Helier and Epsom General Hospitals.
- Senior nurses at band seven level and above, voiced their concerns that there was not enough support from the clinical directors within the ED. The directorate team appeared to have a good awareness of the challenges the department were facing, however it was felt there was no communication or visible support for the staff working within the department.
- There was evidence of good visual leadership from the matron in the department and nursing staff of different grades told us they were well supported and felt able to discuss any issues. Staff told us that their immediate managers and mentors were always supportive in terms of clinical and personal needs.
- We observed on two occasions that when the department was busy, there was no effective shift coordination as the nurse-in-charge had no clear

visualisation of the overall department, for example, the number of patients and types of patients in the paediatric department and the minors area. We saw nurses from the paediatric department had to come out of the department to inform the nurse-in-charge of the pressures they were under and give an updated status of the department.

### Culture within the service

- Nursing and medical staff told us the ED was a very team-orientated and supportive department to work in. Junior staff told us they were well supported from the nursing management team including the matron and the band 7 nurses.
- During our inspection, we spoke with a new health care assistant and new band 5 nurses who told us they were happy in their jobs they had been given good support to develop their skills and experience.
- During our inspection, we saw staff treating each other with respect and there was a culture of mutual support across different staff members. We saw permanent staff members ensuring bank and agency staff were well supported and one consultant doctor we spoke with wanted to improve the support of the ENP nurses who worked in the minor area of the department.

### Public and staff engagement

- The department used the Friends and Family Test to capture patients' feedback however, response rate from patients was low. We viewed in governance meeting minutes the trust had introduced a text message service for friends and family test feedback however, this had not improved performance. During our visit, we did not see staff offering the Friends and Family test to patients. Posters demonstrating the departments' performance were available in the patient waiting areas.
- Senior nurses we spoke with felt they were not included within discussions and plans about the future development of the department. Staff felt they had received mixed messages and those we spoke with did not know about vision and strategy for the ED. One senior nurse told us that she had not been informed about any winter pressure plans and no information had been cascaded down to staff about this.
- Governance meetings were held once every two months for the ED department however, we were told managers attended these only and junior staff were not invited.

# Medical care (including older people's care)

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

## Information about the service

Epsom and St Helier Hospitals, medical care services are managed by the directorate of medicine. There are joint clinical directors, responsible for one site each. Specialties include gastroenterology, respiratory medicine, cardiology, endocrinology, elderly care and stroke.Medical care services provide 31,000 spells of care per year across both sites. Epsom Hospital serves the southern part of the catchment area.

To help us understand and judge the quality of care in medical care services at Epsom General Hospital, we used a variety of methods to gather evidence. We spoke with five doctors including consultants, 23 nursing staff including ward managers, matrons, specialist nurses and health care assistants; four therapists and a pharmacist. We spoke with support staff including ward clerks, cleaners and housekeeping staff. We also spoke with 14 patients and two relatives of patients. We interviewed the directorate management teams for medicine. We observed care and the environment and looked at records, including patient care records. We looked at a wide range of documents including audit results, action plans, policies and management information reports.

During our announced inspection we visited Chuter Ede, Alexander, Britten, Gloucester, Cardiac Care Unit, Croft and Buckley Wards. We also visited the discharge lounge.

## Summary of findings

We rated medicine as good for effective, caring, responsive and well led; and good overall, but as requiring improvement for safe. Wefound mandatory training and staff appraisal completion rates were low; some wards repeatedly fell below the trust's infection control thresholds' and patients were able to access areas of wards that might compromise their safety.

The hospital had recently undergone a recruitment drive which had enabled it to fill some of its nursing and medical vacancies. This had helped address the 23% nursing and 11% medical vacancy rate it had carried over the past financial year.

We reviewed seven patients' records and almost all were well completed, legible and evidenced multidisciplinary input.Staff were aware of how to reportincidents and demonstrated the learning that hadbeen taken from a recent Never Event at another site within the trust. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.)

On this inspection we found the hospital to be visibly clean. However data supplied by the trust indicated that wards repeatedly fell short of the infection prevention control compliance threshold. Sluice rooms on wards were not lockable, and provided easy access to hazardous substances.

The service had systems to review performance and disseminate the results to staff. The hospital

# Medical care (including older people's care)

participated in national audits with mixed results compared to the England average. The hospital had a mandatory training programme in place however for most staff groups the completion rate was low, as was the completion rate for staff appraisals. Staff spoke of pressures of work, particularly low staffing numbers that prevented them attending training days.

There was a lack of clarity amongst staff with regard to how the Deprivation of Liberty safeguards should be used.

Staff provided care in a compassionate and kind way that preserved patients' dignity. Patients felt supported and involved in their care and treatment. Staff also felt supported by their line managers to provide high quality care. We observed a culture that focused on meeting the needs of individual patients and their families, although staff expressed concerns at the staffing levels which they felt were detrimental to patient care.Service leaders had systems to assess how well they were doing and were aware of any challenges they faced.

In all but neurology and dermatology, the medical directorate achieved the 18 week referral to treatment standard. The average length of stay at Epsom was slightly longer for non-elective care than the England average.

Whilst Family and Friend Test feedback was positive, the response rate was notably low. The medical directorate was slow to respond to complaints, achieved just an 8% response rate withindesignated timescales.

Governance arrangements in the medical directorate were satisfactory in some areas but could be improved in others. Staff commented on very good multidisciplinary teamwork; collaborative care and line management support. A number however commented on the dysfunctional cross site working. The hospital had a number of innovative projects underway, including some related to patients living with dementia.

## Are medical care services safe?

**Requires improvement**

We rated safe as requiring improvement. Wefound mandatory training and staff appraisal completion rates were low; some wards repeatedly fell below the trust's infection control thresholds' and patients were able to access areas of wards that might compromise their safety.

The numbers of nurses, doctors, therapists and other staff on the wards were adequate at the time of our inspection, to meet patients' needs. Senior managers told us staffing levels were kept under review and changed in response to emerging concerns or circumstances. However some ward mangers expressed concern regarding their increased workload due to the number of patients with dementia and the negative impact this could have on patients' safety as staffing levels were not increased to reflect this.

Patient records we reviewed were legible, up to date and displayed a multidisciplinary input. However on several wards staff were not keeping food, fluid and patient weight charts up to date or accurate.

### Incidents

- The medical directorate reported no never events in the 12 months prior to this inspection.
- In the last five quarters (April 2014 – June 2015), 5355 incidents were reported by medical directorate across the trust. Data provided for quarter one of 2015 (April to June) indicated there had been 1221 incidents, equating to 407 each month. This was a slight increase on the previous quarter (1186 incidents). Five of these resulted in severe or permanent harm to the patient, three of which occurred at Epsom General Hospital.
- Staff of all grades on all the wards we visited were aware of the process to record and report incidents, however some staff said they could not access the computer system to record them. The trust policy stated that the reporting of incidents was 'the responsibility of each member of staff and not limited to, or exempt to any healthcare professional group'. All incidents should be reported using the trust's online incident reporting system, which could be accessed all trust PCs. Staff were not required to have a system log in, or user account to report incidents.

- Staff were able to tell us about incidents that had occurred and the learning taken from them. For example, onone ward,subsequent to a patient falling, staff had been reallocated to ensure that there was one member of staff in each bay.
- Information from incidents was shared via email or printed for discussion in ward meetings. Staff told us they requested feedback when they reported incidents and this was usually, but not always, forthcoming.
- We saw that the hospital employed a number of overseas nurses whose understanding of and training in incident recognition and reporting in the UK differed from their home country. This had been identified by senior managers and additional training, for example, on the use of restraint, had been provided.
- The medicine directorate had recently appointed a new quality assurance lead who was reviewing all medical mortalities to determine if there were any trends. This data would then be fed into regular morbidity and mortality meetings and learning points disseminated from them.

### Duty of Candour

- We spoke with a number of staff at all grades. Almost all were aware of the duty of candour and what the implications of it were.
- From its implementation date to July 2015, the medical directorate had made three duty of candour disclosures related to Epsom hospital.

### Safety thermometer

- Medical care services at Epsom General Hospital used the NHS Safety Thermometer to collect local data on specific measures related to patient harm and 'harm free' care. Ward managers and matrons were able to talk us through the data relevant to their ward(s) and the learning shared as a result.
- We saw that key elements of the data were incorporated into performance dashboards for the directorate, and details of, for example, the last fall, acquired infection and pressure ulcer were displayed on every ward we visited.
- Patient falls were the highest number of incidents reported. There were three falls in May 2015 at Epsom which resulted in moderate harm to the patient. There were none in June 2015 and two in July 2015.
- Between April and July 2015 the number of patients receiving a venous thromboembolism risk assessment at Epsom hospital was 95%, matching the trust threshold of 95% (venous thromboembolism (VTE) is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or PE).
- The trust's safety thermometer data indicated that the number of patients acquiring catheter-related urinary tract infections had remained constant until May 2015, when there had been an increase. This was a minimal increase which equated to less than 0.2 incidentsper 100 patients surveys however.
- Since April 2015 the numbers of patients experiencing pressure ulcers had decreased. There had however been one grade three hospital acquired pressure ulcers at Epsom in July 2015. Meetings had been held on the ward to review care standards and initiate any necessary remedial action.

### Cleanliness, infection control and hygiene

- We observed that the environment was visibly clean, tidy and organised. Patients told us they were satisfied with the standards of cleanliness. One patient said, "It's very nice and clean here.
- Ward managers told us that where they had a permanent cleanerthe level of cleaning was very good. However the consistency and quality dropped when agency staff were used.
- Cleaning staff told us they had received training in infection prevention and control (IPC) and were provided with appropriate equipment including personal protective equipment (PPE). There was an ample supply of clinical and general waste bins.
- We observed staff were bare below elbow and hand hygiene gels were visible in all areas we visited. We observed staff following handwashing guidelines however the hospital's own quarterly audits indicated that staff often fell below the compliant target (85%) for using correct hand hygiene techniques, on occasion scoring as low as 25% on Chuter Ede Ward (quarter two audit, July – September 2015).
- Wards were put into 'special measures' if they fell below the minimal complaint target which or <75%, or if they had a trust apportioned MRSA bacteraemia or C. difficile infection. For example, Alexandra ward was in 'special measures' for two weeks due to the outcome of its

quarterly MRSA (meticillin-resistant Staphylococcus aureus) audit. A re-audit after two weeks indicated improvements had been made and the ward achieved 86% compliance.

- We observed that clinical and domestic waste was segregated in different-coloured bags and that waste in ward areas was correctly stored.
- The cleanliness of commodes was audited by the hospital's IPC team. The quarter two audit (July – September 2015), showed the score for the commode cleanliness in the medical directorate was between 50 and 100%. We found commodes and sanitary ware to be visibly clean.
- The hospital's quarter two audit (July – September 2015) of the care of patients with diarrhoea indicated that on a number of occasions patients were not isolated; equipment such as blood pressure cuffs was not labelled with the patient's name so staff were not aware they should use it for just that patient; handovers did not always convey to staff coming on shift that a patient had diarrhoea and risk assessments were not always being completed. We saw staff were prompt in their request for assistance from the hospital infection control team when they suspected an outbreak of diarrhoea amongst patients.
- Quarter two audits (July – September 2015) of the management of patients with MRSA showed Chuter Ede and Gloucester wards had achieved minimal compliance with the trust's policy. On Gloucester ward, for example, a patient with MRSA was being nursed alongside a patient with a cannula in situ, thereby increasing the risk of cross infection.
- Since April 2015 there had been five cases of clostridium difficile reported in the medicine directorate. This equated to16.8 per 100000 bed days atEpsom hospital.
- The uptake of mandatory training in IPC amongst theclinical teamat St Helier for the year to date was just under 84% (target 95%).

### Environment and equipment

- The wards we visited were clean, tidy and generally free from unnecessary equipment, although some had limited storage space. The building itself is old but efforts were being made to refresh and refurbish it where possible.
- Medical equipment within the medical directorate was managed by the Trust electro-medical engineering department. They maintained a database of all equipment identified by individual asset numbers. We were told the medical devices committee had identified there were a number of weaknesses in the system and assurances could not be provided that all medical devices were being maintained to the required standard. Staff on the wards however told us that they felt their equipment was regularly maintained and serviced and there was no apparent shortage.
- We saw resuscitation equipment readily available in each clinical area. There were systems to ensureequipmentwas checked daily to ensure it was ready for use. We saw from records thatstaff complied with these systems.
- We saw that all portable electronic equipment had portable appliance testing labels attached, indicating that it had been safety tested in the previous year.

### Medicines

- We observed nurses administering medicines and found that overall, Nursing and Midwifery Council (NMC) standards for medicines management were being adhered to.
- We saw that management of controlled drugs met legal requirements. We checked order records and controlled drug registers and found these to be in order. We spot-checked some medicines and found that stock balances were correct. We saw there were arrangements for ward staff to check stock balances daily, and saw records of this being done.
- We found that medicines were stored securely in locked cupboards and trolleys.
- There was a ward-based pharmacy service. Patients' prescriptions were checked by a pharmacist to ensure their medicines treatments were safe, effective and met current guidance. We saw pharmacists' carrying out these checks, and ward staff told us that the pharmacists were readily available for advice and guidance.

### Records

- We reviewed seven patient records on various wards, and found that generally they were legible, comprehensive, up to date, appropriately signed and reflected the care and treatment patients received. Patients' records were readily accessible to those who needed them. The trust told us that records were electronically tagged to make retrieval of them easier.
- Medical care services had integrated patients' records shared by doctors, nurses and other healthcare

professionals. This meant that all professionals involved in a patient's care could see the patient's full record. We evidenced multidisciplinary input in the records we reviewed.
- We found that some medical records were stored in notes trolleys in ward areas to which the public had access however we saw staff ensure that they were locked.
- Information governance training was mandatory for nursing staff. The percentage of nursing staff who hadundergone this varied from ward to ward. None had completed it in the diabetic unit whereas over 93% had done so on Alexandra ward.
- We saw that patients were generally risk assessed in key safety areas using national validated tools. For example, we saw that the risk of falls was assessed and that the risk of pressure damage was assessed using the Waterlow score. We noted that when risks were identified, relevant care plans that included control measures were generated. We checked a sample of these control measures and found them to be in place. We saw that risk assessments were reviewed and repeated within appropriate and recommended timescales. For example the stroke ward carried out a weekly 'breach' meeting to review if there had been any omissions. However we noted in two patient records that staff had not completed a nutritional assessment even though there were concerns regarding the patients food intake.

### Safeguarding

- Training in safeguarding children and adults formed part of the mandatory training programme. The level of staff training in safeguarding adults varied between wards. With the exception of the diabetic unit (50%) all other wards achievedover 96%. The number of staff who had completed level two child protection training ranged from 50% to 100% depending upon which ward they worked on.
- With the exception of cleaning staff, all other staff we spoke with were all aware of their responsibility to report potential abuse and knew how to do this.
- Staff gave us examples of how they managed safeguarding concerns that demonstrated that processes were followed and staff were engaged in the process.
- Staff told us that where possible safeguarding concerns were identified whilst the patient was in the Medical Assessment Unit, prior to any transfer to a ward. We observed a multidisciplinary meeting where several safeguarding concerns were discussed.

### Mandatory training

- In the medical directorate, completion of mandatory training at Epsom General Hospital averaged 84.1%. Trust wide, the target was 95%. Compliance with mandatory training in the medical directorate was below target in six out of ten of the mandatory courses, including resuscitation and health and safety.
- Staff were aware of the mandatory training they were required to undertake.
- Ward managers we spoke with demonstrated the systems they used locally to monitor attendance of their staff at mandatory training, to ensure training was completed or refreshed when necessary. Staff commented completion of mandatory training was sometimes difficult due to staffing levels.

### Assessing and responding to patient risk

- The medical directorate maintained a trust-wide risk register. The majority of identified risks were relevant across both sites and not specific to one location. The register had 37 entries. Eleven of these were assessed as presenting a moderate risk; 22 were high risk and four were deemed an extreme risk. The latter related to environmental issues; problems recruiting medics and nurses; patient falls which could result in severe harm or fatality and delays in discharge because of inadequate patient transport.
- There was a risk of unauthorised access into the sluice room on Buckley Ward, because it was not lockable and hazardous fluids were within easy reach. We also found one storeroom on Alexandra ward was open, giving access to needles and other clinical equipment.
- The trust identified there was a risk of delays between 5-9pmin acutely unwell in-patients being reviewed by a senior doctor.To address this a medical registrar twilight shift had been introduced.
- Staff used the National Early Warning System (NEWS) to assist them to recognise and respond appropriately to signs of deterioration. The trust was also in the process of introducing an electronic early warning monitoring system. Staff commented positively on the wards where it had already been introduced, although some did

highlight that the equipment was not always available in the quantity required and it had not yet been electronically linked to the doctors hand held electronic devices.
- Staff were able to undergo simulation and acuity training and we were told that new junior doctors were provided withacuitytraining within their first few days of employment.
- Management of the acutely ill patient was on the trust's risk register and outcomes fed into the regular mortality and morbidity meetings to identify if trends were emerging and to take learning from issues that may have arisen. The trust's NEWS audit indicated that the number of breached observations had steadily declined since May 2015. For the week of 23 August 2015 two wards at Epsom breached by more than 15% during the day; while five breached by between 10% and 15%.
- Advanced nurse practitioners were rostered at night to support junior doctors. Senior managers told us that where appropriate escalation plans were agreed in advance.
- We sawsome wards , such as Buckley,carried out safety huddles daily to discuss and monitor risk.
- Where patients were at risk from falls wards had introduced bed and chair sensors and provided patients with anti-slip socks.
- We reviewed six patient medical records and noted they contained completed risk assessments relating to, for example, pressure scores, falls, nutrition, catheter care, bedrail assessment and night-time activity.

## Nursing staffing

- The numbers of nursing staff planned and actually on duty were displayed at ward entrances in line with Department of Health guidance. We saw that the actual numbers on several of the wards we visited fell below the agreed templates.
- The trust told us it followedNational Institute for Health and Care Excellence (NICE)guidance in determining staffing levels (which state that while there is no single nursing staff to patient ratio that can be safely and adequately applied across the wide range of wards on the NHS the guideline recognises that if each registered nurse is caring for more than 8 patients during the day time on a regular basis, there is an increased risk of harm), and carried out the Safer Care nursing tool three times per year on all general medical wards. On the coronary care unit the ratio was 1:4 (one nurse to every four patients); whilst on general wards it was between 1:6 and 1:7; with a maximum of 1:8 excluding the nurse in charge. The medical assessment unit had a ratio of 1:6 excluding the nurse in charge.
- Data provided by the trust showed that in August, on the medical wards sampled at Epsom hospital the fill rate of nurses during the day was between 83.6% and 97.2%. At night it was between 87.1% and 98.1%.
- The trust had recently carried out a recruitment at Epsom which resulted in 24 appointments. The trust had also appointed a number from overseas. These nurses worked at band 4 level until they obtained their Nursing and Midwifery Council registration. Data supplied by the trust showed that for the last financial year, the medicine directorate was carrying a 23% nursing staff deficit.
- Trust data for April 2014 – March 2015 indicated the average use of agency and bank nurses by the medical directorate at Epsom hospital was always above the trust average of 14.3%. It ranged between 20.7% on Britten ward up to 42.6% on the escalation ward.
- Over the past 12 month, staff turnover varied from ward to ward. The highest turnover had been on Gloucester ward (24%). Two wards had not had any turnover during that period.
- Agency and bank staff told us they were made to feel welcome and part of team.
- We saw arrangements for nursing staff to hand over the care of patients between shifts. These arrangements were supported on some wards by printed handover sheets which contained relevant information on the specific needs and risks of patients that supported the delivery of safe care. Health care assistants did not receive copies of printed handovers but thought it would be beneficial if they did.
- Specialist nurses were available, for example in palliative care, stroke and diabetes care.
- Staff turnover in the directorate was 16% for nursing staff. The trust average was 14%.

## Medical staffing

- The trust was better than the England average formedical registrars (42% compared to the England average of 39%) and consultants (36% compared to 34%) WTE posts. It fell below the England average for junior (foundation year 1-2) doctors (17% compared to 22%).

# Medical care (including older people's care)

- Trust data for April 2014 – March 2015 indicated the average use of locums by the medical directorate at Epsom was above the trust average. It peaked at 23.9% in September 2014 (trust average 11.8%), and was at its lowest, 14% in December 2014 (trust average 10.9%).
- Over the last financial year the medical directorate had carried an 11% vacancy rate. The trust had actively recruited medical staff, from within the UK and overseas. Progress had been made. All middle grade posts had been recruited to and the number of junior doctors increased by five. Medical fellows recruited from outside the EU were assigned a mentor and a personal development plan. Nevertheless data for July 2015 showed vacancies existed for, for example, three specialist registrars; one junior doctor and a respiratory consultant. A consultant cardiologist post was beingfilled by a locum.
- A consultant on-call system operated in the evenings and at weekends. Junior medical staff told us they could access advice from a consultant at any time, and that, when required, consultants medically reviewed patients. Junior doctors told us they had good support and back-up from senior doctors.
- Depending on the ward, we found consultants did not review all patients every day, except where it was determined that not doing so would affect a patient's care pathway. However, the medical team reviewed patients daily during the week, and this was recorded in patients' notes. This meant that although patients were reviewed by a doctor, it was not necessarily a consultant; this had the potential to delay patients' progress through their treatment pathway.
- Nursing staff told us they were encouraged to upskill and become advanced nurse practitioners; and some were in the process of obtaining prescribing qualifications.
- We did not observe a shortage of allied health professionals such as therapists. Although staff did not raise concerns with us we noted that as of July 2015, the hospital had a 16% vacancy rate in this area.
- Staff turnover in the directorate was 18% for clinical staff. The trust average was 14%.

### Major incident awareness and training

- The trust had a major incident plan in place, which was last updated in October 2014. This was available for all staff on the trusts intranet pages.

## Are medical care services effective?

Good

Staff were able to demonstrate use of national guidance from, for example, the National Institute for Health and Care Excellence. They knew how to access the hospital's policies and procedures however the Trust's own audits reflected that compliance with these were sometimes low.Patients could access the expertise of the full range of healthcare professionals, and there were arrangements to ensure the multidisciplinary team worked well together with access to the information they required to care for patients effectively.

The medical directorate carried out a range of internal audits, and disseminated the results, action plans and learning from them. The directorate also participated in a number of external national audits. The results of these were mixed, with the hospital falling below the England average for some, but exceeding it in others.

None of the patients we spoke with during our inspection raised concerns related to pain relief howeverprior to the inspection we received feedback from four people who expressed concern at the pain relief provided to their relatives.

We observed wards had protected meal times and patients who needed assistance to eat were given it. On some wards staff were not accurately completing patients food, fluid and weight records.

Staff were positive about working at the hospital and said that they were able to access training and received regular appraisals. This was not supported by the data provided by thetrust however, as mandatory training levels were below the Trust's threshold in a number of areas, as were the number of appraisals carried out.

We observed competent and effective multidisciplinary ward meetings and all staff spoke highly of the positive collaborative working within the medicine directorate.

### Evidence-based care and treatment

- Staff were able to demonstrate how they used national good practice guidance, such as that from Department of Health and the National Institute for Health and Care Excellence (NICE). Examples were provided relating to

chest drains and the recommended duration and frequency of physiotherapy for patients recovering from a stroke. Staff talked confidently about the guidance and how they worked to ensure their practice was compliant.

- Staff were able to access the hospital's policies and procedures electronically. Although they demonstrated they knew where to find these, the trust's own audits indicated that compliance with these varied.For example, five wards at Epsom (Gloucester, Chuter Ede, Alexandra, Britten and Croft)were non-compliant with the management of patients with diarrhoea in August 2015.
- We saw that at Epsom hospital the medical directorate carried out its own internal audits on a quarterly basis, evaluating, for example pressure ulcers, infection control, privacy and dignity, nutrition and hydration. Results of these audits were documented and shared with staff alongside actions to take forward. Staff were able to talk knowledgeably about them and the goals they needed to achieve.
- In July 2015 an audit of blood culture collection standards was carried out by the trust. The medical directorate provided 20% of samples, and of that number staff had appropriately documented the collection of the blood in 83%. In 50% of samples from medical wards, documentation of adherence to care standards (when taking the sample) was absent. This information was distributed to clinical directors with a request it be discussed during phlebotomy/blood culture collection educational sessions scheduled for junior doctors and nurses during their trust induction.

### Pain relief

- Patients we spoke with said that staff gave them painkillers when they were required. We did not receive negative feedback during the inspection however four people fed back prior to the inspection that they felt their relatives pain relief needs had not been addressed.
- We found that staff had access to pain-assessment tools and they were able to explain how they would use these. The tools were not consistently usedacross the medical wards however.

### Nutrition and hydration

- We looked at patients' records that showed that patients were assessed for the risk of malnutrition using a recognised, validated tool – the Malnutrition Universal Screening Tool (MUST).
- When nutritional screening demonstrated a risk, we saw that appropriate actions, such as the maintenance of food charts, the provision of dietary supplements or referral to the dietician, were taken in most cases. On two wards we found that staff were not keeping accurate records and had not proactively linked notable weight loss or the provision of intravenous fluids to the need for food/fluid charts to be maintained.

### Patient outcomes

- There were 110 deaths in medicine in April 2015, four more than in March and an average of 108 per month. This was above the expected number.
- The standardised relative risk of non-elective readmission to Epsom hospital in general medicine was 7% worse than the England average. Elective re-admissions in general medicine were 7% better than the England average but higher for Clinical Haematology.
- The national heart failure audit in 2013 showed Epsom General hospital was worse than the average for all four in- hospital measures and in line or better than the national average against five of the seven discharge measures.
- In the Sentinal Stroke National Audit programme (SSNAP) the hospital had achieved a varied score across each quarterly audit since January 2014 ranging between A and E (on an A–E scale, where A is the best). Areas of particular concern identified as part of the audit were compliance with discharge processes and access to speech and language therapy. It had scored well in specialist assessments and occupational therapy, and it should be noted that it had not fallen to an E rating in any area since September 2014.
- In a national audit of care of patients with non-ST segment elevation infarction (a form of heart attack), as part of the Myocardial Ischaemia National Audit Project (MINAP) in 2013/14 the hospital performed above the national average in two indicators, and below average in the remaining four.
- In the National Diabetes Inpatient Audit (NaDIA) for September 2013, the hospital performed better than the England average in 13 of the 21 standards. These included staff knowledge and awareness of a patient's diabetes.Areas below the England average included patients being visited by a specialist diabetes team and foot risk assessments

# Medical care (including older people's care)

- Medical outliers (patients admitted to a ward different from a medicine ward) were not unusual. We were told that winter pressures the previous year had led to a full team of junior doctors being allocated to manage the outliers. The average number of outliers in general medicine at Epsom between January and June 2015 was 139. In cardiology the average was five, rheumatology three and geriatric medicine eight. A medical handover was held each morning to identify where patients had been assigned. Consultants in the medical directorate were allocated wards where they wouldcover medical outliers.

### Competent staff

- Staff said they received regular appraisals and had access to training (including bank staff). Data provided by the trust however showed that over the course of the last financial year the rate ofappraisals in the medicine directorate was just 67%.Low performing wards included Chuter Ede, the diabetic unitand Gloucester.
- Staff new to the hospital told us they receive a good induction. This included bank and agency staff. The hospital had prepared an induction leaflet for these staff which outlined shift times, gave useful phone numbers and set out hospital specific care requirements relating to infection control and pressure area care.
- Some staff felt overseas nurse recruitment was detrimental in terms of skill mix because most new recruits were immediate post-graduates, they had not had direct work experience and in some cases needed to improve their level of English. We saw the trust had taken steps to address the latter issue by providing the overseas nurses with regular English lessons.
- We spoke with a number of newly recruited overseas nurses. We found their English comprehension and verbal skills varied, and they unanimously welcomed the provision of English lessons. All were positive about their recruitment and experience to date, and felt well supported by the hospital.
- Agency staff told us that their competencies were regularly checked; they were given clearly defined duties and were encouraged to attend ward based study sessions.
- We saw that the respiratory ward was in the process of rolling out competency training for all staff in, for example, inhalers, chest drains, suction and oxygen prescribing. Training modules were designed by respiratory nurse specialists.
- We observed a consultant on a ward round on the stroke ward teaching on the job, and providing good explanations to a junior doctor and nurse.
- Ward matrons told us they had team and individual goals for staff. New staff were provided with a mentor. We met with a mentor and their mentee. Both were positive about the experience and the learning opportunities.

### Multidisciplinary working

- Within the medical directorate we identified a strong commitment to multidisciplinary working. Staff commented on good access to a full range of allied health professionals and team members described effective collaborative working practices.
- We saw two multidisciplinary team (MDT) meetings in progress. Both were led by a doctor, with input from a range of staff including therapists, nurses, discharge coordinators and representatives from local social services departments. They were effective, thorough and demonstrated staff had a clear understanding of their patient's needs.
- Ward teams told us they had access to mental health services from a mental health trust. Psychiatric assessments were carried out as a result of referrals. Similar positive comments were made with regard to the specialist palliative care team.
- We noted one patient required 1:1 nursing care. This was discussed in the MDT meeting and post the meeting the matron has already commenced the process to obtain a specialist nurse.
- The hospital had an Older Persons Assessment and Liaison team (OPAL). We met with enthusiastic members of the team who demonstrated an in-depth knowledge of the needs of elderly patients. They were proactive in taking steps to ensure patients were placed on the correct ward, underwent a dementia assessment and had an appropriate level of support upon discharge.
- We observed an occupational therapist provide a rehabilitation session. They were calm, kind, caring and took their time in delivering an effective session.

### Seven-day services

- Managers described their approach to seven-day services as "a work in progress".
- New medical admissions were seen every day on one of the post-take ward rounds.

# Medical care (including older people's care)

- A consultant did not routinely see and review patients at weekends in all specialties. For example, there was a cardiology consultant ward round every day, but no routine elderly care ward round at weekends.
- Access to therapy and social care services was available seven days a week. However, the service at weekends was limited and focused on assessments that enabled patients to be discharged. Specialist areas such as the respiratory ward had seven day a week access to therapists.
- Endoscopy services were delivered as part of the South West London upper GI bleed rota which was led by a specialty registrar and available 24/7. However, this was not compliant with NICE guidance which says it should be consultant led.

### Access to information

- We saw that information that was needed to deliver effective care and treatment was available to staff in an accessible way. Staff told us this included care and risk assessments, care plans, case notes and test results.
- Ongoing care was shared appropriately, in a timely way and in line with relevant protocols when people moved between teams and services at times such as referral, discharge, transfer and transition.
- Staff felt working across organisation was a challenge. They found separate records between disciplines frustrating.

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

- Staff told us training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was available, but it was not mandatory.
- Staff we spoke with were able to talk about their responsibilities under the MCA. They could name the DoLS lead and gave examples of how they used their expertise. A number of nursing staff commented however that they believed the use of a DoLS application was the only way to obtain additional staff.
- Nursing staff were aware that best interests meetings may be required establish a patients' capacity and determine their best interests in line with the Department of Health code of practice for implementing the MCA.However they believed this was very much the responsibility of the medical team.
- Staff understood the concept of deprivation of liberty and could give examples of where the safeguards had been applied or considered.
- Patients told us that staff told them about their treatment, explained what they were going to do and asked for consent.

## Are medical care services caring?

Good

Patients and relatives spoke of care being delivered with kindness and of privacy and dignity being upheld. Patients and their relatives told us they felt supported emotionally by hospital staff. Almost all of them told us that they felt involved in their care and received adequate information about their care and treatment.One patient and their relative complained that they had not been informed of the possible side effects of a diagnostic procedure.

Friends and Family results were overwhelmingly positive however the response rate was notably low.

### Compassionate care

- The majority of patients we spoke with told us staff treated them with respect and they were kind and caring. One patient told us the 'care could not be improved'. Another told us 'the staff cannot do enough [for me]'. One described their nurse as a 'credit to their profession'.
- Not all feedback received prior to the inspection was positive. Criticism was made of staffing levels; lack of assistance at meal times; patients being left to soil beds creating an infection control risk; poor/no monitoring of IV fluids and broken equipment, including pressure relieving mattresses. Two relatives commented that the privacy and dignity of patients was not maintained. These comments were not confined to one ward but related to Alexandra, Croft, Chuter Ede and Buckley wards.
- We observed that patients were treated with kindness and respect, and there was a culture of caring. Patients' privacy and dignity were maintained; for instance, we saw that care interventions were carried out behind closed doors or curtains, and staff asked permission before they entered.
- We observed patients had their call bells to hand and with one exception they told us that these were usually answered quickly.

# Medical care (including older people's care)

- Some patients said it could be noisy when lots of visitors were allowed at same time, however, we did not find evidence of this when we visited.
- One patient said their notes were not referred to on admission and errors were made but these had since been rectified.
- Patients appreciated the newspaper round provided by the Friends of the hospital.
- Patients were given a 'message in a bottle' (a bottle into which they could place emergency contact details and relevant medical information) and the small posters they could display at home to alert emergency responders of the location of the bottle. Where appropriate patients were also given a 'keep warm pack' containing a blanket; soup; socks, a hand warmer and a flask.
- We noted on all the wards we visited that the Friends and Family Test response rates were exceptionally low, albeit the responses themselves were overwhelmingly positive. In June 2015 92% recommended the medicine directorate, whilst 4% did not. The response rate was only 14.1%. The average response rate at Epsom hospital was 29%. The best average response rate at Epsom came from the CCU, with the worst from Chuter Ede. Staff were unable to explain why the response rates were so low, and were not sure of ways to improve this. The senior management team acknowledge that this was an issue trust-wide and was something they were trying to address.
- We carried out a Short Observational Framework (SOFI)for Inspection which is an observational tool used to help collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems) onBuckley and Alexandra wardsat Epsom hospital. On both wards we observed most staff introduce themselves to patients and explain what they were doing. We saw one pharmacist spend some time reviewing a patient's notes at the patient's bedside but they did not introduce themselves or speak to the patient at any point. We saw nursing staff maintained patients' privacy and dignity by drawing bedside curtains when they needed to carry out any personal care. We saw staff attend to initial patient calls for assistance promptly, although in one case there was a subsequent delay of over 10 minutes for a commode to be brought. This was due, however, to the nurse being called away to another patient.
- Data gathered throughpatient-led assessments of the care environment (PLACE) in 2015 showed over 97% of patients positively rated the wards for cleanliness; and over 79% for privacy.
- The trust was rated in the middle 60% for 17 indicators and within the bottom 20% for 20 of the indicators in the Cancer Patient Experience Survey 2013/14).

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

- With one exception during the inspection, patients told us they were given information which allowed them to make informed decisions. One patient and their relative complained to us they had not been made aware of possible side effects following a diagnostic test. Feedback given to the Commission prior to the inspection included four relatives who said they were not kept informed or involved in their family member's care.
- Patient said doctors had time for them. One told us they saw a consultant daily during the week, and junior doctors at weekends.
- Several patients told us they were made to feel safe

### Emotional support

- We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care, and that these staff offered appropriate support to patients and their families in relation to their psychological needs.
- We saw that staff took a holistic approach to their patients and in MDT meetings considered both their physical and psychological needs, seeking referral to the mental health team where appropriate.
- Chaplaincy services were available, within an hour in the case of an emergency. The chaplaincy team was made up of ordained Christian clergy and a team of chaplaincy volunteers who visited thewards weekly. Chaplains had a list of leaders of local churches and faith communities if a patient wanted their own faith leader.

## Are medical care services responsive?

Good

We found that the medical directorate responded to the needs of local people in a number of ways. For example

clinical nurse specialists had developed training programmes for staff, and take home diagnostic kits for patients. Dementia care was a priority, and ably supported by the OPAL team. However we found that cross site working was disjointed, with specialist teams working to different practice models.

In all but neurology and dermatology, the medical directorate achieved the 18 week referral to treatment thresholds. The average length of stay at Epsom hospital was slightly longer for non-elective care than the England average.

The medicate directorate was slow to respond to complaints and hadachieved just 8% response rate within designated timescales. We saw how one ward had taken steps to reduce the number of complaints it received, and had successfully reduced the number by 95%.

### Service planning and delivery to meet the needs of local people

- We saw nursing staff advocate for a patient with learning disabilities who required a residential placement. They rejected the first available placement and pushed for one that more closely met the patient's needs. We also observed staff liaising with another hospital so that they could place a patient at Epsom in the same residential home as their partner, who was a patient in that other hospital.
- We saw that the trust was promoting supported discharge arrangements for stroke patients so they could continue their rehabilitation at home.
- We saw that cross-site working was in some areas dysfunctional, and did not best meet the needs of the local people.For example, both Epsom and St Helier hospitals had a specialist diabetes team, and there was an additional diabetes team at the renal unit. There was no inter-site working to share best practice, and each site used a different practice model. The trust acknowledged this and had recently appointed a band eight nurse whose remit was to work across sites.
- The trust was also in the process of aligning service managers to specialities that were provided at both sites to enable cross site interaction to take place.
- We did not find there was a capacity issue which necessitated patients being transferred between hospital sitesbut there was often a lack of medical beds which led to patients being placed as outliers on inappropriate wards.
- We saw the respiratory clinical nurse specialists had designed a newCOPD (chronic obstructive airways disease)diagnostic kit for patients to take home, with the aim of reducing re-admissions.
- A screening proforma had been introduced for staff to refer to when issuing a death certificate and the information gathered would be used to identify any clinical concerns/incidents within the patient's time in hospital. Learning from this was escalated and fed into trust wide audits.

### Access and flow

- The average length of patient stay across the trust was similar to the England average but at Epsom it was longer for elective cardiology and nephrology and slightly longer across all non-elective care.
- Across the trust the18 week Referral to Treatment threshold was achieved for each pathway with the exception of neurology and dermatology.
- There was a clear admission pathway in the medical admission unit. All required diagnostic tests were carried out there, and patients allocated to a specialist consultant. A daily board meeting was attended by the consultant on duty, the nurse in charge, social services, therapists, the OPAL team and the bed manager. Psychiatric liaison was available as were clinical nurse specialists such as the tissue viability nurse.
- Medical handover arrangements ensured that medical patients in non-medical beds were reviewed in a timely way.
- The trust's bed occupancy had been in line with the national average since January 2015.
- Trust wide, within the medical directorate, 99.5% of patients were seen within six weeks for diagnostic tests.
- The medical directorate was meeting most of the national standards for cancer waiting times. Ninety five percent of appropriate two week wait cancer patients were seen within that timeframe(national standard 93%) and 97.8% were treated within 31 days of a decision to treat (national standard 96%).The trust fell below the national standard for the two month wait from urgent GP referral to treatment achieving 76.8% compared to the national standard of 85%.

- Data provided by the trust showed that in July 2015, 97 patients at Epsom had been moved between wards after 10pm. This was a reduction on the 132 who were moved after 10pm the previous month.
- Between August 2014 and July 2015 at Epsom hospital, 18% of patients were moved between wards once; 6% were moved twice, 2% were moved three times and 1% were moved four or more times during their admission. Seventy three percent were not moved at all. This worse than the previous 12 months when 76% were not moved at all.
- Staff commented that up to a quarter of beds on some wards were blocked due to delayed discharge. This was most commonly due to a lack of nursing/residential placements.

### Meeting people's individual needs

- Within the medical directorate, 94.4% of staff had attended equality and diversity training. This was just below the trust threshold of 95%.
- We saw that patients with sensory impairments were often identified through the use of a discrete magnetic sign to ensure staff could manage their communication. We saw that signs on elderly care wards had recently been replaced with dementia friendly signage.
- People with dementia were usually, though not always, identified by a discrete 'forget me not' sign so all staff would be aware of their special needs. We saw that 'This is me' documents produced by the Alzheimer's Society were used to ensure staff had access to a patient's biographical data to inform the patient's care plan.
- One ward had a designated 'dementia corner', which was equipped with a table and chairs and two reminiscent cases. Staff told us that its use was limited because there were often insufficient staff numbers to allow them to sit with the patients and make use of the equipment. It was also situated in a busy corridor making it less than ideal for staff to engage with patients. Other wards had been supplied with memory boxes by the OPAL team.
- We saw that bathrooms and lavatories were suitable for those with limited mobility. Supplies of mobility aids and lifting equipment such as hoists to enable staff to care for patients were adequate.
- Staff told us that interpreting services could be accessed;however, professional interpreters were not used as staff relied on colleagues who spoke another language.
- Staff told us they were able to undergo training in dementia care, and spoke highly of the support the OPALs team gave in this regard.
- We noted the stroke ward had own physiotherapist and speech and language therapists. The respiratory ward had full 7/7 physiotherapy cover. We saw patients and relatives could access a wide range of information provided by the British Lung foundation.
- Some of the wards we visited were mixed gender. Whilst we did not observe any breaches of guidance on mixed-sex accommodation in some cases male patients had a long walk to the designated male toilets.

### Learning from complaints and concerns

- We reviewed the concerns that had been expressed by people who had contacted us prior to this inspection. Most concerns related to low staffing levels but also included concerns relating to a lack of discharge planning, poor communication, poor palliative care, failure to assess the mental capacity and decision making ability of patients (where relatives felt this was indicated), unavailable, broken and faulty equipment, a lack of consultant visits, general poor nursing care and unhygienic wards.
- We talked with one manager whose ward had historically received a notable number of complaints regarding poor care in general. To address this the manager had introduced a number of new measures including protected meal times and the 'perfect handover (a tool to ensure handovers are consistent, relevant and appropriate). They had also introduced team meetings to discuss values, provided dementia care training for staff and created a 'pledge tree' upon which all staff had placed a leaf stating how they intended to improve patient care. The manager has also invited unhappy relatives to come and talk to the staff team. Since July 2014 the number of complaints made about the ward had dropped by 95%.

# Medical care (including older people's care)

## Are medical care services well-led?

Good

Governance arrangements in the medical directorate wereadequate, and performance was monitored and managed. Outcomes of data collection and audits were shared with staff, and we saw ward based staff took pride in good outcomes.

There was a positive culture within the hospital. Staff commented on very good multidisciplinary teamwork; collaborative care and line management support.

Patients, relatives and family were able to feedback through the FFT but the uptake was low. The Trust had introduced the 'Patient First' programme to improve communication and liaison with relatives and carers at ward level. Some wards introduced their own initiatives to seek feedback.

Staff felt able to raise concerns and give feedback. Most of their concerns related to low staffing levels which led to an increased workload and deterioration in the level of care they could provide. They felt this was most notable on the care of the elderly wards.

There were a number of innovative projects at the hospital, including the newly openedClinical Assessment DecisionUnit; the dementia corner; the breakfast club on the stroke ward; the OPAL team and the expansion of the cardiac catheter laboratory.

### Vision and strategy for this service

- The trust had a five year clinical strategy, which included a SWOT analysis (a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project) and identified the medicine directorate strengths and weaknesses. Identified strengths included achieving dementia care targets; its 18 week referral to treatment performance and its Stroke performance. Identified weaknesses included the lack of a cardiac catheter laboratory (resolved as a new laboratory opened not long after this inspection); not having an out of hours endoscopy service; below target statutory and mandatory training levels and an insufficient number of junior medical staff.
- Staff were aware of the trust's vision and values. We found that ward areas had developed their own strategies for implementing the trust's vision. Staff spoke passionately about these visions and told us how they tried to make them part of their work.
- We noted that staff were engaged with the broader issues of the trust. For instance, they were aware of the lessons learned from a Never Event at another site and which had relevance across services.

### Governance, risk management and quality measurement

- We found governance systems were in place. The medicine directorate's governance and risk committee met monthly. The July 2015 meeting had as agenda items reviews of complaints, infection control and staff training. Attendees at the meetings included the clinical director, matrons and head of nursing.
- We saw dashboards were maintained and provided a range of key management and quality metrics that could be benchmarked against agreed performance targets. For example, the rate of mandatory staff training in the medical directorate.
- Performance information was displayed in ward areas in the form of 'How we are doing' displays accessible to staff, patients and their families. Some ward managers displayed additional performance data. Staff we spoke with were aware of this data and took an interest in their team's performance.
- We saw that some areas, such as infection control, were assigned incidence thresholds. When these thresholds were reached, the ward entered a period of 'special measures' and enhanced monitoring of key metrics relating to the issue.
- The medical directorate maintained a risk register. The version we saw was not specific to individual issues but general concerns. However, following the factual accuracy check by the trust, we were told that this may have been because the spreadsheet cannot display all fields and therefore a judgement had to be made as to what to display.
- A quarterly Medicine Directorate quality report was produced. The August 2015 report reviewed, for example, incidents by specialities (with the emergency department being the highest at Epsom); near misses –the most prevalent at Epsom related to staffing levels; and the top five worse wards for patient falls. At Epsom hospital these were Alexandra, Chuter Ede and Croft.

- The trust had identified quality meetings needed to be more frequent and it had appointed additional clinical managers.

### Leadership of service

- Senior management discussed with us where they were felt they were not as effective as they could be and outlined what they were doing to address this. For example they acknowledged that there was no cross site working in the diabetic specialism and had recently recruited a Band 8 nurse to work across both sites.
- Ward based staff confirmed that the matrons were highly visible but that they would not recognise the directorate's managers and board members and did not think that middle and senior managers visited ward areas. We noted however that the newly appointed chief nurse was taking steps to address this. For example the senior nurses' uniform colour had been changed to red so that staff could easily identify them.
- Staff told us they felt supported by matrons. They described them as having an open door policy and easily approachable.
- The majority of junior doctors reported they were supported by senior staff.

### Culture within the service

- We observed that staff spoke positively about their work, colleagues and the trust. Each person appreciated the contribution they made to the care of patients.
- We found that staff showed a keen interest in their work and that of others, and demonstrated a commitment to improving services.
- The average staff sickness rate within the medicine directorate was 8% amongst clinical staff and 5% amongst nursing staff. The trust's average sickness rate was 6%.
- We found good morale amongst staff. Some had worked at the trust for a considerable length of time but did not feel that this inhibited either their motivation or vision.

### Public engagement

- Patients, relatives and friends were able to comment and feedback on the care and service being provided through the Family and Friends test (FFT). The low response rates suggested that publicising the test was not seen as a priority for staff.
- The Directorate had introduced Patient First training to try to improve ward based communication and had developed a message book for ward teams to capture any issues or concerns raised by relatives or carers for patients. The concerns were then discussed at the daily board rounds and the relative or carer contacted with an explanation and to resolve concerns.
- The patient advice and liaison service (PALS) had received 413 enquiries relating to the medical directorate for the first quarter of 2015, an increase on the previous quarter. The majority of enquiries were attributed to care and treatment enquiries; requests for information and advice and communication and information.
- Individual wards devised their own ways to engage with relatives. One ward invited dissatisfied relatives to a ward meeting so that they could discuss with staff their concerns in a constructive environment.
- We carried out a public engagement exercise at the hospital prior to the inspection. We received a number of positive comments about the level of care and the food. Concerns were expressed regarding staffing levels; the quality of cleaning on some wards; being moved wards late at night with no warning and poor pain relief.

### Staff engagement

- Staff told us they felt able to raise concerns, and the hospital promoted an open environment.
- Staff talked of feeling valued, good team work, effective multidisciplinary cooperation and positive leadership. They felt the availability of supervision and appraisals met their needs however some commented on the difficulty attending training days because of staffing shortages.
- We saw some wards had implemented 'Safety Huddles' to handover important patient information to all staff on the ward. However some staff commented on the inconsistency in getting feedback on incidents.
- Staff felt there was good communication and their direct managers listened however there was also concern that issues which affected patient care - namely increased acuity and staffing shortages, were not being addressed.
- Prior to the inspection we carried out a number of focus groups with staff of all grades. Positive comments were made about ward managers; the speed faulty equipment was repaired/replaced; the new 'safety huddles'; collaborative working; student, trainee paramedics and agency/bank staff being made to feel welcome and part of the team and funding to enable them to attend courses to maintain their professional

development. Negative feedback predominantly related to staffing issues – high use of agency staff, student nurses being asked to undertake health care assistant duties and a general shortage of staff. Some staff reported that due to the heavy workload back injuries were not uncommon.

- The NHS staff survey carried out in 2014 indicated that the trust performed in line with other trusts in all but three areas. The areas where the trust performed worse were the percentage of staff receiving well-structured appraisals; the percentage of staff working extra hours and the number of staff who believed the trust provided equal opportunities for career progression.

### Innovation, improvement and sustainability

- The stroke ward held a number of initiatives such as the 'breakfast club' designed to improve patient mobility and encourage patient interaction.
- The OPAL team had clearly had a positive impact in increasing the quality care of the elderly, particularly those living with dementia. They had provided innovative dementia care on the wards, and developed a close working relationship with the Alzheimer's Society. Some wards had been supplied with 'dementia suitcases' containing items of bygone eras. Over the year to date, the trust had carried out dementia screening on 96% of (appropriate) patients.
- A Clinical Assessment Decision Unit (CADU) opened the week before this inspection took place. It was designed to assess patients referred by their GP with the aim of avoiding where at all possible a hospital admission.
- The Cardiac Catheter laboratory service was expanding and due to takeits first coronary angiography patients at the end of November 2015.
- Electronic patient monitoring was being introduced to assist staff to recognise and promptly respond to deteriorating patients.
- Ward managers discussed with us the areas they wanted to improve and the aims they had set for the next quarter.
- The discharge lounge provided a 'Winter Warmer' pack and 'Message in a Bottle' - initiatives designed to provide care and support for elderly patients who live alone.

# Surgery

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

## Information about the service

Epsom General Hospital provides a range of day case, elective and emergency surgical services to a mostly local population of patients from south west London and north east Surrey, including Epsom, Merton and Sutton. 13,100 surgical procedures were carried out in 2014. Epsom General Hospital is used mostly for day case and elective surgery, with 83% day case procedures, 16% elective procedures and 1% non-elective procedures in 2014.

There are eight operating theatres at Epsom General Hospital covering general surgery, orthopaedics, cardiovascular and urology. They operate Monday to Friday 8:30am-5:30pm, with additional availability for elective lists at weekends. The post-operative recovery facility has five bays. There are approximately 37 inpatient surgical beds in the designated surgical wards.

Surgical activity at Epsom General Hospital is managed by one directorate within the trust. This inspection focused on the services provided by the Surgery, Critical Care and Anaesthetics directorate. The Regional Services directorate within the trust was responsible for managing the South West London Elective Orthopaedic Centre and renal services, which are covered in separate sections of this report.

During our inspection, we visited Swift and Northey wards, the surgical admissions area, day surgery unit, main operating theatres and the recovery area. We spoke with 18 patients and their family members. We observed care and treatment and looked at care records. We also spoke with more than 40 staff members, including allied healthcare professionals, nurses, doctors in training, consultants, ward managers and senior staff. In addition, we reviewed national data and performance information about the trust.

# Surgery

## Summary of findings

We found that the surgery service at Epsom General Hospital was effective and caring. However, improvements were needed to ensure that the service was safe, well-led and responsive to patients' needs. Appropriate procedures and staffing were in place to prevent harm, wards and theatres were clean, and there were few serious incidents. There were low surgical site infection rates across surgical specialties. The surgery service used the safer surgery checklist but it was not fully meeting the necessary guidelines. The management of patient records also required improvement.

Patient outcomes were good across surgical specialties and the trust performed well in national surgical audits. There were good training and development opportunities and staff felt that the trust was investing in them. Staff across the surgery service were friendly, caring and professional and patients told us that care by nurses on the wards was excellent. Feedback was consistently very good across surgery wards.

The hospital had very good day surgery rates. However, theatre usage was sub-optimal. We observed good flow of patients though theatres, recovery and onto the wards, but the initial stages of the elective pathway experience during admission did not provide a dignified or person centred approach.

The staff we met were all highly motivated and well informed about how their respective areas were performing. Staff were very loyal to the hospital and felt very much part of a team. Many staff had worked at the hospital for a long time. There was limited evidence of a clearly defined vision for the service. There were good governance structures and reporting mechanisms in place, however we found a lack of responsiveness to some known challenges and concerns.

## Are surgery services safe?

**Requires improvement**

Safety within the surgery service at Epsom General Hospital required improvement. The surgery service used the five steps to safer surgerychecklist but we found it was poorly implemented. Team briefings and sign outs were perfunctory and debriefings were not fully embedded. Engagement in this area needed to be improved. Our review of patient records found poor care planning in nursing notes. We also found that not all patients were assessed for venous thrombo-embolism. Controlled drugs were managed appropriately and there were good safety procedures in place, but local anaesthetics were not stored separately from other drugs. Duty of candour was not well embedded in the wards with patchy knowledge amongst nurses.

Staffing levels in wards and theatres were good with low use of bank and agency staff, but staffing on wards was not based on degree of acuteness. The surgery service performed well on safety thermometer indicators. There was good completion of mandatory staff training at above 93% for surgery wards and theatres. The areas we visited were visibly clean and tidy and hygiene procedures were followed appropriately. Staff knew how to report concerns and most staff felt that they received good and timely feedback about reported incidents. There were low surgical site infection rates across surgical specialties.

### Incidents

- The surgery service at Epsom General Hospital reported zero never events between August 2014 and October 2015. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented.
- Three serious incidents (SIs) requiring investigation took place in the surgery service at Epsom General Hospital between August 2014 and July 2015, of which two were grade 3 pressure ulcers and one concerned the death of patient following an elective procedure in the urology department.
- The trust used an online incident reporting system. All surgery staff had individual user login details to access

this system. Doctors and nurses told us they felt able and comfortable to submit incidents to the system. Ward and theatre managers used dashboards to review the incidents reported in their respective areas of responsibility.

- In the trust's incident reporting log for surgery we found general themes of patient falls, pressure ulcers, nursing staffing and equipment. The trust reported more no/low or moderate harm incidents compared to other similar size trusts.
- Falls were within the top three of reported incidents within the surgery service, and were particularly prevalent in Swift ward. There was a trust wide action plan in response to this, with a dedicated falls team set up to support teams across the hospital. A specialist falls nurse worked with the surgery wards to address falls, which included Cannard assessments, development of care plans, and a falls awareness week in March 2015. The latter was to promote and reinforce the trust's new policy on falls support and changes to the trust's Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) process. Doctors in training received training in falls support during their induction. The falls nurse also provided information to patients on optimising their stay and preventing falls. As part of this initiative, band 6 nurses were also given further training to support patients, and sensor mats were used to monitor falls from beds. Senior nurses within the surgery service reported that the interventions were working well and the number of falls had started to reduce in Swift ward.
- Learning from incidents was shared effectively. We saw that learning was disseminated in staff memos and nurses told us it was discussed at handover and weekly ward and theatre meetings. The surgery quality manager and head of nursing shared findings and learning from serious incidents with matrons each week, but we were told that less severe incidents were discussed on a more ad hoc basis.
- We found evidence of effective learning from a grade 3 pressure ulcer incident on Northey ward in February 2015. We reviewed evidence of the process used for reporting and investigating this incident. The incident was reported to the online reporting system and the trust's tissue viability team was contacted. A root cause analysis investigation was conducted and the conclusions of this investigation were fed back to staff during handovers. Learning from the incident was documented in a file on wards for staff to read through. Tissue viability training followed the incident and a new handover system of 'safety huddles'. Matrons told us that safety huddles were held on wards three times each day. These meetings were used to discussing patient risks such as falls and pressure ulcers. The surgery service did not experience any grade 3 pressure ulcer since introducing the huddles system.
- In response to serious incidents there were formal meetings such as the directorate meetings, clinical governance and sisters' meetings. Matrons reported that these channels were effective and robust and ensured all staff were aware of learning. Nurses told us that matrons go round each ward to meet with staff to make sure that learning from incidents was embedded.
- Consultant surgeons told us that all reported serious incidents were followed up with action plans and a completion date for their implementation. Actions taken after serious incidents were reviewed through the trust's audit process. Clinical staff were allocated protected time for audit and learning as a clinical team.
- Learning from incidents was shared across clinical directorates within the hospital. For example, the surgery staff we spoke with were aware of the misplaced nasogastric tube which occurred in a medical ward elsewhere in the hospital. The trust medical director sent an email to all staff summarising the lessons learnt from the nasogastric tube incident and the surgery quality manager followed this with a memo to all surgery staff with information on what happened which were printed and made available on the wards. Nurses and doctors told us about policy changes, leaflets and training which occurred as a result of this incident. The anaesthetists we spoke to in theatres were aware of the never event nasogastric tube but one told us that it was not necessary to check for this in theatres as they did not feed patients in theatres.
- Learning from incidents across directorates was supported by the trust's quality managers. There was one quality manager for each clinical directorate and all were collocated in the same office, which facilitated sharing of information from each directorate. The surgery quality manager told us that there was good understanding each team's incidents. The quality managers shared reports and held weekly meetings to discuss incidents from across the trust.
- Anaesthetists told us about a serious critical incident in theatres which occurred when a patient developed

severe laryngospasm after a procedure when an ODP was not present. The patient required re-intubation. Lessons were learned from this incident and a new policy was introduced in theatres to ensure that ODPs remained in the department until all patients were fully awake following their procedure. Training in airway emergencies was also introduced for staff in the recovery area. The nurses we spoke with in recovery told us that they would value further training in the hospital's new simulation suite to help them identify and support deteriorating patients.

- The Deputy Chief Nurse in the hospital reviewed all root cause analyses of serious incidents and never events. Action plans were then developed and matrons were responsible for ensuring that these actions were implemented. The surgery Quality Manager monitored progress and reported these as part of the service's quality metrics.
- Staff in theatres were acutely aware of their own safety culture and all were able to describe learning from local incidents. However, some staff were not aware of the retained swab never event which occurred at Epsom General Hospital's sister site: St Helier, which highlighted that learning may not have been shared effectively across sites.
- The surgery service held weekly morbidity and mortality meetings where difficult surgical cases were discussed by consultants and doctors in training. All deaths were discussed at the morbidity and mortality meetings. Consultant surgeons reported a close knit group which fostered open and constructive dialogue in these meetings.

### Duty of Candour

- We found a good level of understanding of Duty of Candour responsibilities amongst senior nursing staff. More junior staff did not have a good understanding of the term Duty of Candour, but were able to describe how they would address a concern with a patient should something go wrong. A surgery matron was an allocated Duty of Candour lead and we were provided with examples of how Duty of Candour would be applied in different situations. We were told of one case where a matron telephoned a family member of a patient who had died while in hospital. The matron recognised the need for honesty and clarity, but also the pastoral and emotional support aspect of difficult conversations. Consultants understood Duty of Candour and felt supported in this. There was good awareness of the principles of Duty of Candour in theatres, for examples openness and apologising to patients when mistakes happen.

### Safety thermometer

- The trust participated in the NHS Safety Thermometer scheme, which was used to collect local data on specific measures relating to patient harm and 'harm free' care. The measures were the prevalence of pressure ulcers grade 2, 3 and 4, falls with harm, and new catheter acquired urinary tract infection.Data were collected on a single day each month to indicate performance in key safety areas. This data were collected electronically and a report was produced for each clinical area within the hospital.
- Safety Thermometer performance data were clearly displayed in an easy to read format on patient information boards in each of the surgical wards of the hospital.
- The patient information boards highlighted that Swift and Northey wards reported 100% 'harm free' care in October 2015, the month preceding our inspection. There was one grade 2 pressure ulcer.
- The trust's safety thermometer performance for surgery was comparable to another trust of its size. The trust had seen an increase in the frequency of falls peaking in July 2015 to 10 per 100 patients surveyed, prior to this the rate had remained low since September 2014. Catheter acquired urinary tract infections had fluctuated in frequency but apart from a peak of three per 100 patients in March 2015 there had only been one or two per month. For pressure ulcers there had been a peak of nearly one per 100 patients in April 2015, otherwise the rate had remained low.
- We saw five monthly patient falls reports recording the falls occurring in each surgical ward across the trust including information on time and type of fall, fall repeaters and a statement that indicated where staffing was an issue. There was no analysis or evidence provided of how staffing might be an issue in relation to the falls recorded.
- Senior service leaders told us that that safety thermometer performance data were corroborated with data from audits, online reporting, and feedback from

ward managers and the tissue viability team. There was no formalised threshold for the surgery directorate on the expected and reasonable percentage of harm each month.
- Matrons conducted audits of tissue viability on wards each week.

### Cleanliness, infection control and hygiene

- We found the surgery wards and operating theatres in Epsom General Hospital to be visibly clean and tidy during our inspection. All bays, side rooms, toilets and shower facilities in wards were seen to be clean. In theatres, the store rooms, anaesthetic rooms and operating theatres were clean, neatly organised and equipment was clean and available in marked trolleys. Cleaning of theatres was done daily by theatre staff and between cases. We observed good wiping down and decontamination between patients in theatres and hand washing by doctors and nurses was witnessed. Domestic staff were in attendance to clean floors and walls at the end of a list. Disposable curtains were used in the recovery area.
- Documentation provided by the trust showed that surgical areas had quarterly infection control audits. We reviewed two audit reports completed in April/May and August/September 2015. These audited performance against 14 cleaning standards including the management of Methicillin-Resistant Staphylococcus Aureus (MRSA), the management of patients with diarrhoea, equipment cleanliness and documentation, care of peripheral cannula, care of urinary catheters, patient and staff hand hygiene. Actions were indicated and monitored, for example by assessing staff hand hygiene technique using an ultra violet hand inspection tool. Each component within the infection control quarterly audit was used to calculate an overall compliance score. Wards were put into 'special measures' if they fell below the minimal complaint target which or <75%, or if they had a trust apportioned MRSA bacteraemia or C. difficile infection. The most recent audit report highlighted that Swift ward achieved 84%, Northey ward achieved 89% and theatres and recovery achieved 95% compliance.
- We reviewed safety performance indicator scorecards for the April 2015 to July 2015 reporting period and found no reported MRSA or MSSA cases in surgery wards during that time. There were no cases of patients with C. Diff in surgery wards since 2012.
- Cleaning rotas and daily schedules for domestic staff were displayed in the wards outside each bay and side room. We saw that these were updated, signed and complete. A domestic manager monitored cleaning. Domestic staff worked on a day time rota on one ward only, with on call cleaning staff at night. All of the nurses we spoke with told us that cleaning staff were responsive and available. We spoke with domestic staff on wards who told us that they felt very much part of the ward team.
- The matrons did 'walk rounds' of surgery wards twice per week in Epsom General Hospital to check cleanliness and compliance with hygiene processes.
- Hand wash basins and alcohol hand sanitising gel were available at both ward and theatre entrances. Alcohol sanitising gel was also available at the entrance to individual side bays in wards.
- Infection control signage was clearly visible on posters in the corridors of wards and theatres.
- The sluice rooms on each ward were seen to be clean, tidy and well organised.
- We observed surgeons, anaesthetists and nurses washing hands between patients on wards and in theatres.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and most staff were witnessed using PPE appropriately. Staff in theatres wore PPE and used disposable gloves when treating patients. We witnessed theatre staff and anaesthetic practitioners don gloves prior to cannulation and intubation and removed after each procedure. However, we observed many medical staff wearing PPE incorrectly, for example blue gowns over scrubs were not wrapped around and tied, therefore defeating the purpose of protective clothing over the scrubs to prevent contamination. We also witnessed a number of theatre staff wearing protective clothing such as blue gowns and caps outside of the theatre environment. This meant there was a risk of cross contamination between the operating theatres and public areas, which presented a potential risk to patient safety and infection control.
- Operating theatres were clean, however some rooms and equipment looked very old. We saw a plastic cover missing from an operating light in theatre one with cracked and loose plastic casing and an uncovered joint which was not cleanable and therefore an infection risk.

Theatre staff told us this was first reported two years ago but a business case for a new light was rejected. Staff told us that they were encouraged to not show CQC inspectors around this theatre.

- Syringes and other disposable single use medical equipment was discarded appropriately in sharps bins which were labelled and dated. All of the sharps bins we saw were within date and none were overfilled. Laryngoscope blades were single use and handles had single use sheathes.
- Enhanced recovery bowel patients were kept in individual side rooms for infection prevention and control purposes and to prevent cross-contamination.
- There was an on-site surgical instrument sterilisation service for theatre equipment. Equipment was cleaned and decontaminated in well organised and well equipped rooms. Sterilisation processes were tracked and logged and equipment such as flexible endoscopes were stored in filtered and locked cabinets ready to be supplied to various departments within the hospital.
- The trust's Infection Prevention and Control Team undertook surgical site infection surveillance of selected procedures, which was coordinated by the Centre for Infections at Public Health England. The trust were contributing data, for the period January to March 2015 for repair of neck of femur and the trust was performing slightly better than the national average.

### Environment and equipment

- The equipment within surgery was mainly managed by the trust's Electrical and Biomedical Engineering department (EBME). Some specialist equipment, such as anaesthetics and theatre equipment was monitored by the theatre matron. We saw a manual system for checking equipment in place in theatres. Environment checks in theatres were undertaken on a weekly basis by the theatre matron with the subcontractor supervisor.
- The trust's Medical Devices Committee had identified a number of weaknesses in providing assurances that medical devices were maintained to the required standards. An action plan had been commenced in September 2015 to have department equipment coordinators in each department to review asset registers, categorise equipment into high, medium or low risk and to establish where devices not maintained by the EBME. This meant that the trust could not be assured that all medical equipment was maintained to the required standards and was safe to use.
- In theatres, equipment was neatly organised, clean and available in marked trollies. Drawers were labelled for ease of use.
- The general state of the fabric of theatres was reasonable, but there was noticeable disrepair in the changing room walls and some old equipment.
- The Day Surgery Unit had 15 potential operating trolleys available to use, but theatre staff told us that some of the trolleys were 20 years old and there was no planned replacement programme for these or other theatre equipment across the surgery service.
- Surgeons told us that old equipment was impacting on their ability to treat patients effectively. For example, orthopaedic surgeons were able to perform five arthroscopy procedures per session but they had only enough equipment to do four procedures because the fifth set was decommissioned. Surgeons had submitted business cases and other attempts at funding, but were unsuccessful and some operating lists were running at a loss because of it.
- Capital bids were done once a year and when needed to replace or purchase new equipment. Senior leaders within the surgery service told us that the directorate lost out in capital bids for new funding of equipment and high risk equipment needs were identified on directorate risk register. Senior staff were required to complete risk assessments for new equipment to evaluate need and the trust's director of estates and deputy director of finance make the final decision.
- A number of theatre staff told us about repeated requests for equipment to be fixed or replaced, such as the swinging operating light in theatre one, but after two years of requests it was still a risk to patient safety. Senior staff recognised this as a priority and had put in some emergency capital bids for new equipment.
- The general manager for surgery recognised that the directorate was trying to be more proactive and plan and audit equipment needs and replacement. Equipment had been neglected but action was being taken, for example new contracts with suppliers to get updated equipment.
- Each theatre had forced air warming blankets and fluid warming systems to keep patients warm during and after surgery.

- Equipment was available for cardiac output monitoring to facilitate fluid management intra-operatively for enhanced recovery.
- We saw that bedrails were used and we were provided with a bed rails assessment and policy on their use.
- We saw resuscitation equipment available in all clinical areas with security tabs present and intact on each. Systems were in place to check resuscitation equipment. We saw that checklists were completed daily and in full and audit and policy documents were present, signed and up to date. All necessary trolley equipment was present and sealed as appropriate. There were daily logs for equipment in each bay, such as wall suction and emergency bells.
- Annual maintenance and revalidation checks of the operating theatres' ventilation were carried out. We saw evidence of the latest report dated September 2015, which provided sufficient evidence to assure that a safe, clean, compliant environment for surgical procedures was provided.
- We checked anaesthetic machine log books in theatres, which must be checked routinely by ODPs and anaesthetists. Full monitoring to AAGBI standards was available on all anaesthetic machines in theatres. However we found some partially completed log book records and observed several gaps on previous dates. This was found across main theatres and the day surgery unit.

## Medicines

- Medicines were stored safely and appropriately on surgery wards and theatres at Epsom General Hospital, including items which needed to be stored in refrigerated conditions. All of the drugs we reviewed were stored securely and were within date. Each ward and theatre had a locked cupboard for controlled drugs with the keys kept by the responsible member of staff.
- Drug fridge temperatures were monitored and recorded appropriately in line with national guidance. We checked a sample of fridge temperatures and these were within the acceptable range. Drug fridge logbooks were correctly filled in with no gaps, except for one fridge in the Day Surgery Unit theatre where the logbook had not been completed since 10 October 2015. We informed the theatre manager of this.
- In theatres we saw that anaesthesia drugs were stored in a locked fridge and only removed prior to a patient's induction. Drugs were signed for by the anaesthetist as they were released by the ODP. However, we found local anaesthetic drugs were stored with anaesthetic drugs in the same cupboard, which contravened current good practice guidelines. We also did not see different coloured syringes for use with local anaesthetic, which meant there was a potential risk of staff drawing up the wrong drugs.
- Pre-operative assessment clinics were used to identify patients with existing medications and to develop bridging plans while they were in hospital.
- All the surgical wards had pharmacist input into the reconciliation of patients' medicines and the clinical screening of prescriptions. Pharmacists were involved in discharge planning. On discharge patients were advised by nurses on the use of their medicines. The pharmacy team attached a checklist to all medicines to take out (TTOs) to help with this, which was signed and added to the patient notes.
- A pharmacist attended each of the surgery clinical areas on a weekly basis to check drugs and fridges. Nurses told us that pharmacists interact with staff and explain things such as changes to drug storage legislation.
- The trust used red bands to signify patients with allergies, which were recorded in patient notes.
- We saw medicines were given to patients by nursing staff in accordance with the prescription and that safety checks were carried out during the administration process. Patients had paper medication administration records as electronic prescribing was being introduced across the trust. Medication prescriptions we saw were written clearly with the patient's allergy status. Nurses wore a red apron which identified them as administering medication during the medicines round and for them not to be distracted. Staff had access to up to date guidance on medicines and could access advice from a pharmacist.
- Medicines policies and resources were available on the trust intranet. Medicines management was included within trust induction for nursing staff. Each nurse was also given a 'Clinical Competency Workbook' that they had to complete to record their progress. Nurses told us they found this useful.

## Records

- Most patient care was recorded in paper records. Electronic record systems were used for storing and viewing x-ray and scan images.

- On the wards, patient records were stored in locked record trolleys securely attached to the wall in close proximity and within sight of administrative staff and the nurses' station.
- We reviewed a sample of patient records on Swift and Northey wards. Our overall observation was that care plans were very brief with limited description of care needs. Care plans were not patient centred nor sufficiently detailed. In the nursing records we reviewed, folders were not ordered in a logical way or divided into sections for risk assessment, care plan, additional instructions and discharge planning. This was recognised by nursing staff as an area for improvement.
- In some records, nursing evaluation was recorded within medical notes so it was not clear if a structured assessment of need was followed and evaluated in a logical way utilising a nursing model of care.
- Fluid balance charts were recorded in patient notes and updated at points throughout each day.
- Falls assessments were completed and recorded, but we found some associated care plans were incomplete.
- We spoke with patients about their pre-operative assessments and information they had received, this correlated with information recorded in the medical notes. The pre-operative assessment included written consent, medical history relevant to the procedure, a record of being given printed information about the procedure, and if any additional needs had been identified. The notes were legible and the pre-assessment section was easily identifiable. Documentation for those having day case or short stay surgery followed the guidelines from the Association of Anaesthetists.
- Patients with known co-morbidities received a pre-operative anaesthetist check and a 'red sheet' was put in their notes to record their post-care needs, such as a high dependency bed.
- Whiteboards were used in each of the surgery wards with information on each of the patients in the ward. Staff names on duty clearly documented, with their allocated patients.
- In theatres we reviewed contents of the daily patients folder. We were told that staff prepare notes the night before patient arrives and complete a comprehensive theatre checklist. The forms we saw were completed but provided no detail as to what pertained to each individual patient. On questioning the circulating staff nurse, we were told that the detail was noted on the operating list but this was not included in the file and would therefore be significant obstacle to anyone auditing the process.
- Documentation in the main theatre and day surgery unit recovery areas was completed well. Appropriate observations were recorded and fully completed.

### Safeguarding

- The staff we spoke to were able to explain their understanding of safeguarding and the principles of safeguarding for children and adults. They were clear about the trust's safeguarding escalation process.
- All clinical staff were required to complete level one adult safeguarding training on an annual basis. Senior nursing staff such as ward managers were required to complete level two training, which was a one day training course. Level three training was over three days for senior staff who may instigate and carry out safeguarding investigations and proceedings. The trust's target was 95% compliance, data was only available trust wide for non-medical staff working in surgical wards and theatres and indicated that 86% of staff had completed this training. Medical staff compliance for safeguarding adults training was 70%.
- Staff were required to complete safeguarding children training, the level required depending on their role and contact with children. Some nurses in theatres working with children felt they should be doing level three safeguarding children training (levels one to three depending on contact and work with children). The intercollegiate document on roles and competencies for health care staff in safeguarding children published by the Royal College of Paediatrics and Child Health does not include this staff group as requiring level three training. The trust's safeguarding children training target for compliance was 95%. Data provided for the three levels of safeguarding training for non-medical staff working in surgical wards and theatres across the trust showed an average of 87% compliance for level one, 80% for level two of 81%, and 95% for level three. Medical staff compliance for safeguarding children was 63%.

### Mandatory training

- Nurses, health care assistants (HCA) and ODPs told us that mandatory training was booked by the ward managers for the surgical wards and a sister in theatre. The trust's electronic programme showed which

mandatory training staff had completed and showed when training was next due. The system highlighted any breaches. Staff could access their learning record using this online system. The 'bank partners' were responsible for ensuring all non-permanent staff such as agency and bank nurses received their statutory and mandatory training before they commenced work.

- The target set by the trust for completion of mandatory training was 95%. Across the surgical wards and theatres in the trust this figure was not met consistently, with an average of 90% for nursing staff at the time of our inspection. Infection control and safeguarding training reported 100% completion across that directorate. The lowest figures were 59% for information governance and 74% for conflict resolution.
- Mandatory training rates for medical staff in surgery across the trust showed an average of 77% compliance, with the lowest rate being for equality and diversity training which was only 50%.
- Nurses told us that the trust had introduced a number of e-learning training modules which had made mandatory training more accessible. The modules were seen as suitably challenging and detailed with tests at the end.
- Mandatory training completion rates were included in quality data at monthly directorate governance meetings.
- There was a set programme of learning and development during staff induction. This included a one day corporate trust-wide induction, and a local induction on the wards and theatres. Mandatory e-learning during induction included equality and diversity and information governance. We saw an orientation programme for new staff which included an induction checklist and competencies to be achieved in line with the national Knowledge and Skills Framework (KSF).
- Local induction on wards included orientation, meeting team members and patients, review of codes of practice and completion of the trust's 'red competency book' which contained all aspects of basic nursing care. Newly qualified nurses were also assigned a mentor.
- Nurses, HCAs and ODPs reported sufficient time for completion of mandatory training such as manual handling training and safeguarding adults, as well as more developmental training such as suturing. However, we were told that staff often book training on the day instead of planning in advance. Occasionally they had to cancel training due to staffing shortages.
- Senior staff told us that the same agency and bank nurses were used where possible. Short- term locum/ bank staff were given brief induction information highlighting essential information and details about the trust from the 'bank partners'. Local induction checklists and staff handbooks were completed with the nurse in charge on their first day of work.
- Consultant and trainee anaesthetists told us that there was no formal induction process for agency anaesthetists. Locum doctors are were introduced to their duties and oriented by a middle grade doctor covering the other rota.

### Assessing and responding to patient risk

- We saw that staff in surgical wards recorded the observations of patient safety parameters such as heart rate, respirations, blood pressure, temperature and pain. These were hand written in the patient notes. Patients were assessed for actual and potential risks related to their health and well-being and we saw evidence of these in patient's bedside folders.
- Surgery wards recently introduced handheld devices and specialist software to record patient observations. The system automatically calculated an early warning score to identify if the patient was deteriorating. If so, the nurse was warned to increase the frequency of their monitoring of the patient and, in some cases, to alert a doctor or a rapid response team. However, not all staff had access to this system, such as bank staff and student nurses.
- Management of deteriorating patients was recorded on the trust risk register, although it was reported as a problem within medical specialties rather than surgery.
- Senior nurses told us that deteriorating patients were sometimes transferred to another hospital. In emergency situations nurses were expected to activate a 'peri-arrest emergency call'. We were told that patients are stabilised before a senior nurse decides whether the on call surgical team will attend the patient or if the patient should be transferred to St Helier hospital or to St George's Hospital for vascular patients. Matrons told us that 4-5 patients were transferred to St Helier hospital in the previous 6-12 months.

- Nursing staff told us they would call the doctor if they were concerned about a patient but some staff we asked where unsure about when to put out an emergency call. Senior leaders within the service also recognised that emergency pathways for different types of patients may not be clear to doctors in training.
- Advanced nurse practitioner support was provided at night if ward staff were concerned about deteriorating patients.
- The Clinical Director for surgery told us that critical care outreach was not available because ITU consultants felt it would be abused as an extra medical registrar. The trust planned to set up an acute response team with acute physicians instead of intensivists. At our unannounced inspection the hospital's sister site St Helier Hospital, we found an 'Interim Acute Response Team' standard operating procedure was introduced with a dedicated hospital team attending following identification of a clinical deterioration to provide immediate assessment and intervention and stabilise the patient to prevent further complications. There was a dedicated trust wide doctor for this with separate pager numbers for Epsom General Hospital and and St Helier Hospital.
- Our review of patient notes found that venous thrombo-embolism (VTE) assessments were not completed for all patients or consistently available in notes if they had been completed. Nurses reported this to us a problem and told us that VTE assessments were often not completed because doctors were so rushed and so they only completed a paper copy, which sometimes got lost or was not put in the notes folder. Some senior nurses were not aware of the organisational standard relating to VTE practice, reassessment and actions. Senior managers in the surgery service were conducting a review of the VTE process on wards.

### Use of the 'five steps to safer surgery' procedure

- The surgery service completed safety checks before, during and after surgery as required by the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organisation (WHO) surgical safety checklist. Each patient in theatre had a paper WHO surgical safety checklist that the theatre and anaesthetic staff used and completed. These were included in the patients' notes.
- We followed the patient pathway through a number of different surgical procedures in main theatres and the Day Surgery Unit. Most of the procedures we witnessed completed the checklist comprehensively. However, our observations and interviews with staff did not demonstrate that the ethos and importance of the safer surgery checklist was fully embedded. Its application was also inconsistent in some of the surgical procedures that we witnessed.
- A daily pre-briefing was held in theatres each day at 8:30am. The team briefings we saw were perfunctory.
- We witnessed anaesthetic practitioners lead the sign in procedure and complete sign-in of the patient in the presence of the anaesthetist.
- On transfer of the patient from the anaesthetic room to the operating theatre, we observed time outs which were led by consultant surgeons once the patient was safely transferred to operating table and secured. This was done in a satisfactory way. The 'time out' is a momentary pause before the procedure begins to confirm essential safety checks are undertaken and this involves the whole team. Although we witnessed time outs, an observational audit by the trust on one day in September 2015 highlighted that 'time out' was not happening in all cases and occurred in 85% of all cases. WHO guidance states that missing this stage could result in a procedure on the wrong patients or wrong site of the patient's body. Compliance was audited once per year with a plan to do observational audits and health record audits twice per year. The report of the trust's health records audit in May 2015, although only a small sample, showed 12% of surgery patients had a checked and completed WHO checklist in their records. WHO surgical safety checklist in endoscopy was implemented three weeks prior to our inspection so there was no audit to examine performance and compliance in this area.
- In main theatres we saw empowerment of scrub nurses, with scrub nurses asking surgeons to wait during the swab and instrument check. Scrub nurses spoke confidently and with authority. There was good communication during the swab and instrument count and usage of the swab board was seen which included patient details such as allergies, procedure details and required instrumentation. However, in one case we

observed a swab count but this was not recorded on the swab board. We spoke to the theatre sister after the case who told us that it was common practice not to do so for some procedures such as cystoscopies.
- Theatre staff used the theatre register effectively for instrument tracking and documentation. We saw staff setting and preparing instruments and all equipment was calibrated and in good order.
- Sign out was led by a consultant surgeon. In the cases we observed the sign out was completed in several interrupted steps or completed adequately but very quickly. In one case the surgeon was only available for swab and instrument count but the paperwork was still completed and signed.
- On transfer of patients into recovery following surgery we witnessed anaesthetists provide full handover to the recovery nurse.
- We did not witness debriefings at the end of a list and theatre staff told us that debriefings were not fully embedded as standard practice.

### Nursing staffing

- We found a stable cohort of nurses across surgery wards and theatres at Epsom General Hospital. However, the surgery risk register highlighted a shortage of nursing staff across surgical adult inpatient wards across the trust as a high risk that could lead to inadequate patient care. It was identified that this could happen as a result of work-related stress for staff and possible injury and high usage of bank and agency staff impacting on continuity of patient care. The controls reported by the trust included an overseas and local recruitment programme, flexing nurses between Northey and Swift wards and medical wards to cover rota gaps, nurse retention programmes, improved sickness return processes and increasing the supply of bank staff.
- In June 2015 the trust had recruited a new cohort of nurses from southern Europe. Ward managers told us that the new nurses had settled in well and had good English language skills. They felt that the new nurses were already making a difference and were performing well on the Friends and Family test scores.
- Staffing needs in theatres were calculated according to Association for Perioperative Practice guidance. Staffing in theatres was adequate and reviewed by the theatre matron on a daily basis to ensure there was sufficient cover for the operating theatres. The rostering in theatre was based on national guidelines with two scrub nurses, one operating department practitioner and one theatre health care assistant per theatre. We saw this in rosters produced and the operations we observed. Information from the trust for May to August 2015 inclusive showed between 23 and 35 shifts per month were covered by either bank or agency operating department practitioners.Information provided on staffing was trust wide for main theatre recovery. Between April 2014 and March 2015 29% of staff working there were bank nurses.
- Anaesthetics and recovery nursing staff rotated between main and Day Surgery Unit theatres.
- Senior theatre staff reported challenges in recruiting ODP staff and at the time of our inspection there were three vacant posts. The loss of eight ODP student placements from local universities had limited the trust's opportunity to proactively recruit, but no staff were able to explain the reason for removal of placements. The theatre matron reported that gaps were filled by staff doing overtime, additional working and agency staff.
- Shift patterns in wards and theatres were 7am-6pm or 9am-7pm, and 7pm-8am for night shifts on wards.
- There were on call staffing arrangements in theatres after 8am with two scrub nurses, one anaesthetic practitioner and one recovery nurse. In the Endoscopy unit there was one member of staff on call to attend and work with the theatre team. Radiography staff were also on call if needed.
- Documentation and interviews with staff highlighted adequate staffing in the Lithotripsy and Endoscopy units in the hospital, with full staffing establishment in both areas.
- The surgery wards did not use proactive acuity tools to determine or adjust staffing levels. Acuity was measured three times per year using the safe nursing care tool.
- There was low turnover of nursing staff and many of the nurses we spoke with had worked at the trust for many years. Senior leaders in the directorate identified no challenges with staff retention but considered the location of the hospital a risk factor in recruiting new nurses because increasing property prices were deterring many potential recruits from the area.
- Staffing figures were displayed on information boards in each ward, which demonstrated planned and actual numbers of registered nurses and health care assistants on duty.

- Sickness and absence rates for each clinical area were reported to ward and theatre matrons on a weekly basis. Ward managers reported good support from the trust's human resources department in bringing down long term and short term sickness level. They did not identify problems with long term sickness at Epsom General Hospital.
- Ward managers reviewed nursing rosters to identify the need for bank or agency shifts and requests were approved by the head of nursing. At times when shifts could not be filled, registered nurses on the wards were sometimes required to 'work down a grade' to cover gaps. Many agency nurses had worked at the hospital on a long term basis, up to six months.
- Daily morning meetings (safety huddles) were used in theatres to discuss the day's activity, issues from the previous day's performance and any possible future issues.
- Safety huddles were also conducted on wards at three points during the day during handover to review the status of each patient within the ward. This was followed by a detailed handover for each patient. We observed a safety huddle on Swift ward which was led by the ward manager. Nurses discussed new admissions to the ward, the progress of each patient, discharges, risks and any patients with specific needs, for example patients needing one to care, at risk of falls, or those under deprivation of liberty safeguards. The outcomes of the safety huddle were recorded on handwritten notes. The principles of structured communication tools such as Situation, Background, Action, Result (SBAR) were used in the huddle and we witnessed well-structured communication between nurses.

## Surgical staffing

- Surgical treatment at Epsom General Hospital was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the trust for many years. Consultants worked across both Epsom and St Helier hospitals.
- The trust had a comparable level of consultants and doctors in training to the England average. The general surgery rota was 1:9 for on calls. Information provided by the trust for locum use for April 2014 to March 2015 showed low levels of locum usage. Service managers told us that rota gaps were covered in-house where possible, but with some use of locum middle grade anaesthetic cover out of hours. We were told that consultants were sometimes required to 'act down' in times where the service has been unable to fill rota gaps.
- The London Quality Standards March 2015 identified that consultant work patterns met the demands for consultant delivered care, senior decision making and leadership across the extended working day, seven days per week.
- As a predominantly elective site, the hospital did not have resident consultants during out of hours, but arrangements were in place to ensure adequate consultant cover at night and on weekends. Out of hours clinical support was covered by a medical on call team, which was staffed by a higher tier doctor in training (ST3 or above) and an ST1-2 anaesthetist. There were active protocols for triage and consultant surgeons were on call and available remotely to address surgical complications. Telephone advice was available from consultants based in Epsom General Hospital's sister site: St Helier hospital.
- On call medical cover was provided by physicians for all specialties including surgery and orthopaedics. Critical care was covered by a consultant general anaesthetist and there was provision for patients to be ventilated by the critical care team for up to 48 hours.
- There were twice daily ward rounds undertaken by surgeons. From these the Foundation Year one trainee doctors told us they were responsible for producing individual patient plans and acting on them.
- The doctors in training we spoke with felt there were enough doctors to meet patient's medical needs. Nurses told us they felt well supported by the medical teams. When we visited the hospital we observed doctors reviewing patients and liaising with nurses.
- Doctors in training and staff grade doctors felt well supported by consultants and reported good access to supervision and advice. The trust had seen a reduction in the number of surgical training posts allocated by Health Education England. To fill gaps the trust was recruiting to middle grade staff posts. Consultants reported positive feedback from doctors in training and locum doctors.

## Major incident awareness and training

- There was a major incident plan due for review in October 2015 which set out key locations and reporting points in an emergency. There was also a business

continuity plan due for review in August 2015 for managing business disruptions. Most staff we spoke with were aware that there was a plan but not always certain of their role within it. Senior staff told us there was a need for more developed business contingency plans and to undertake major incident exercises.

- The surgery service leadership told us that a practice run of the major incident plan was overdue as they had not conducted a test for over two years. There was recognition that surgery staff would benefit from more exercises and more developed business continuity plans. Nurses in theatres were aware of major incident plans and had seen leaflets with instructions. This included action cards for different emergency situations.
- There was a protocol in place for managing inpatient emergency theatre bookings. The surgical day case unit was designated as the overflow area. Staff in theatres were aware of the theatre preparation for major incidents and how the protocol worked as per the trust leaflet. They were aware of different command levels.

## Are surgery services effective?

Good

Surgery services at Epsom General Hospital were effective. Patient outcomes were good across surgical specialties, but especially for colorectal patients and for those requiring a laparotomy. The trust performed well in national surgical audits, comparable with similar sized trusts in England. There was a good approach to pain relief. Patients told us that their pain relief needs were met quickly and appropriately.

Appraisal and mandatory training for medical and nursing staff had good completion rates in wards and theatres. There were good training and development opportunities and staff felt that the trust was investing in them. Doctors in training experienced good supervision and learning opportunities.

We found that consent for surgical procedures did not follow best practice. There were some problems with the transfer of patient information between hospital sites. Staff knowledge and practical application of mental capacity awareness was limited, particularly in theatres.

### Evidence-based care and treatment

- Staff accessed policies and corporate information on the trust's intranet. There were protocols, policies and guidance for clinical and other patient interventions and care on the intranet. A new trust intranet was launched in 2015 and it was available to all authorised staff. Some staff told us they had difficulty finding policies and protocols on it. Policies were saved as PDF documents so that content could only be amended or deleted by authorised staff. Printed copies of policy documents were also available in ward and theatre manager offices for staff to access as needed.
- We reviewed a sample of trust policies for surgery and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- The trust's audit team reviewed and disseminated new clinical guidelines, for examples those produced by national regulators such as NICE and professional bodies such as Royal Colleges. The trust's clinical quality team produced a regular report every 6-8 weeks listing all relevant NICE guidelines for surgery and this was reviewed in governance meetings.
- Surgical pathways were delivered in line with referenced national clinical guidance. Senior service leaders reviewed their service outcome data, such as Patient Reported Outcome Measures and National Joint Registry compliance.
- We reviewed documentation that showed theatres followed NICE guidelines on the prevention of surgical site infections.
- Local audit activity was mostly effective. The surgery service conducted standard weekly audits of tissue viability, pain management, cannulas and catheters, falls and hygiene. Weekly audit results were shared with surgery staff in weekly team meetings. Other internal audits included lithotripsy, delayed medication, laparoscopic gall bladder removal, and pancreatitis demographics. Regulatory compliance and clinical audit performance was presented at planned audit meetings which were attended by consultants, doctors in training and nurses.
- The trust had enrolled in Anaesthesia Clinical Services Accreditation scheme (ACSA) but had not yet completed the process. An inspection of the services was due in 2016.

- The endoscopy service at Epsom General Hospital was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy.
- The trust conformed with best practice guidance for separation of children and adults in recovery and emergency drug NPSA alerts.

### Pain relief

- There were effective processes in place to ensure that patients' pain relief needs were met. Pain was well managed in the surgery service.
- We witnessed nursing staff regularly asking patients whether their pain was being effectively managed and if they were comfortable. Patients told us that nurses were very responsive to pain relief needs.
- Consultants recorded post-operative pain relief requirement during pre-operative assessments.
- There was an acute pain service at the hospital which was staffed by one consultant anaesthetist and a pain nurse. This service advised nursing staff on pain relief, reviewed patients post-operatively and prescribed medication. Nurses told us that the service was very accessible.
- The pain team was available three days per week. The surgery service had direct access to the acute pain lead during these times and telephone contact at all other times.
- For those patients unable to take medication by mouth, pain relief also included patient controlled analgesia (PCA) and epidural infusion. Pain was assessed using the Bolton Pain Assessment Scale which included observing the patient and identifying any behaviour that indicated pain. This scale was included in the early warning scores assessment.
- The trust used a PCA observation chart for patients with nausea and vomiting.
- The pain team provided training to nurses on pain management and competency based training was available for ward staff on using PCAs and epidurals. The trust ran 11-12 study days on this per year.
- Many surgery patients at the hospital were in for laparoscopic procedures so nurses and physiotherapists would make sure that these patients were up and walking soon after their procedure to reduce the pain from gas dissipating.
- In the hospital lithotripsy service, patients were given pain management information sheets. Evaluation from patients highlighted that they found these guides useful.

### Nutrition and hydration

- There were protected meal times on surgical wards and we saw that these were respected by staff and visitors. This meant that 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.
- Patients were given drinks and snacks post operatively in the day surgery unit.
- The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. The accredited screening tool also screened patients at risk of obesity. Where patients were identified as at medium or high risk of malnutrition, food intake was to be recorded, and the patient was to be encouraged and given assistance with meals. The meal hostess was also alerted on the menu card. Patients identified as at risk of dehydration also had fluid balance charts to monitor fluid intake and output. We were told that a new fluid balance system was being introduced using the electronic hand held device.

### Patient outcomes

- The trust contributed to relevant national audits and performance in national and local audit was presented at regular planned audit team meetings.
- Hospital standardised mortality ratios (HSMR) were comparable to other similar sized trusts.
- The trust provided data submitted to the National Bowel Audit. The audit showed that the trust performed better or about the same as the England average in its treatment of patients. All patients were discussed at a multi-disciplinary team meeting, nearly all had a CT scan and 96% were seen by a specialist nurse.
- National data for December 2013 to November 2014 showed the relative risk of readmission to Epsom General Hospital following an operation was better than the England average for elective (planned) surgery. The relative risk of readmission for all elective surgery was better than expected with 88 (compared to the expected figure of 100) and 98 for emergency surgery. The trust's surgery performance scorecard for September 2015 showed an emergency readmission rate of 4% for the year to date, above its threshold of 3%.
- The length of stay (LOS) for surgical patients at Epsom General Hospital between January and December 2014 was below the England average (better than) for those who had elective surgery and slightly higher for those

who had emergency surgery (worse than). It is recognised that longer stays in hospital than necessary are inappropriate for the patient and are a barrier to other patients being admitted. Enhanced recovery programmes for colorectal, hysterectomy, nephrectomy and spinal surgery, along with enhanced recovery trained nurses on wards had reduced length of stay for these procedures. Day case procedures accounted for 83% of surgery procedures, with subsequent impact of reducing length of stay for these patients.

### Competent staff

- Surgery staff told us that there were extensive learning and development opportunities at Epsom General Hospital. This included access to formal learning such as degree level courses, simulation training, external clinical supervision and mentoring opportunities. There were also more informal learning opportunities such as ward based teaching. The matron of Swift and Northey wards provided bespoke ward-based training opportunities for nurses on wards, including caring for patients with dementia and medicines management.
- Training needs were identified during annual appraisals. Senior managers within the service highlighted that the trust's training provision had enabled them to retain a stable contingent of nurses. Junior nurses told us that the trust was supportive of learning and provided time and funding for them to participate in continued professional development. Nurses told us that they were encouraged to think about their career development.
- Information provided by the trust for the whole surgery directorate, showed that 100% of nursing staff in Swift and Northey wards had an appraisal between April 2014 and March 2015, against a figure of 82% across the directorate. 85% of doctors within the directorate had received their annual appraisal up to June 2015. Surgery matrons reported that completion of appraisals and objective setting required improvement, particularly for non-clinical staff, as this was bringing the overall completion rate down.
- Surgeons and anaesthetists in the hospital participated in the GMC revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice. At the time of our inspection the trust had not met its target for 95% of eligible doctors to complete revalidation. Some doctors at the hospital had deferred revalidation, for example those on long term leave.
- Doctors in training told us that they felt well supervised and supported by consultants. College Tutors for surgery and anaesthetics were on site and doctors in training reported good access. However, the General Medical Council (GMC) 2015 national training survey reported that the trust scored worse in indicators for induction and feedback than other trusts.
- The trust provided an induction handbook for nursing staff on surgical wards and staff told us that the induction they received adequately prepared them. There were several nurses from overseas who were in their initial year after qualifying and they told us they were well supported by colleagues on the ward. A senior member of staff confirmed that these newly qualified nurses were not on a preceptorship programme. Preceptorship is a recognised and recommended framework for supporting newly registered nurses.
- Surgery staff had good access to the hospital's simulation training centre. The centre provided a surgical first assessment course, laparoscopy training, paediatric and adult life support, and Care, Recognition and Initial Stabilisation in Simulation which was introduced in 2015 to improve recognition and management of care for deteriorating patients.
- Training on risk management, audit, incident investigation and root cause analysis was available to staff and facilitated by an external trainer.
- In 2015 the trust established a training budget to improve access to learning and development opportunities for staff grade doctors and to invest in this staff group. Training for administrative staff was also recognised as a priority area to ensure that they felt developed and part of the wider team. Coaching was provided to administrative staff, with plans to provide management and leadership training.

### Multidisciplinary working

- There was an effective multidisciplinary team (MDT) working environment within the surgery service at Epsom General Hospital. We found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards. Patient records demonstrated input from therapists including physiotherapy, dieticians, speech and language therapists, occupational therapists, pharmacists as well as the nursing and medical teams.

- There were dedicated orthopaedics physiotherapists, occupational therapists and enhanced recovery nurses who were attached to the surgery wards and present every weekday.
- Patients reported good levels of support from physiotherapists and told us that their input had helped with recovery after their procedure.
- A MDT meeting was held each morning attended by the nurse in charge, a physiotherapist, an occupational therapist (OT), the ward clerk and the discharge co-ordinator. They discussed individual patient needs and the appropriate patient pathway. There was a second MDT meeting twice per week with the orthogeriatrician, the nurse in charge, OT and dietician.
- There was a weekly MDT discharge planning meeting, which the full ward team attended to plan as discharge arrangements for patients arriving and leaving the ward in the following week.
- Surgeons reported good support from the hospital interventional radiology service, particularly for gastro-intestinal and vascular procedures, but they highlighted that the radiology service was "snowed under" with a very busy workload. We were told that members of the MDT would review surgical patients at various points in their pathway and expedite MRI or other scans where necessary.
- Senior nurses reported that there were not enough discharge coordinators to support the wards and the incumbent discharge staff were over stretched because of this.
- Allied health professionals told us in a staff focus group that staff across the trust "work well across the disciplines, one thing we do really well".
- There was a formal arrangement to access anaesthetic review of patients at pre-assessment. There was anaesthetic referral rate of 15-20%.
- Nursing staff described good working relationships with the ward team. Nurses were not always able to attend ward rounds but we observed doctors liaising with the ward manager on plans for ongoing medical care. All team members were aware of who had overall responsibility for each patient's care.

### Seven-day services

- Arrangements were in place to ensure adequate out of hours medical cover on Swift and Northey wards. Consultant surgeons were on call, rather than resident within the hospital.
- In theatres there was no anaesthetic cover overnight.
- Pharmacy and radiology were available on weekdays and then on call during nights and weekends.
- Physiotherapy provision for surgery patients was on week days only, with limited physiotherapy cover at the weekend for respiratory patients. Patients and their relatives reported that they would like physiotherapist support over the weekend.

### Access to information

- On surgical wards all authorised nursing staff and medical staff were able to access patient notes from a locked notes trolley to read and add relevant information. There were also risk assessments, and fluid charts in patient's bedside folders.
- Staff with access to computer workstations were able to access test results electronically. Access to patients' diagnostic and screening results was good.Portable computers and fixed computers were available on the surgical wards for staff to use.
- Permanent members of nursing staff had access to the trust's computer workstations and the electronic hand held device to access and record patients' observations. Nurses told us that agency staff did not have access to electronic information such as early warning scores, not the trust intranet to access policies and other documents. Minutes from senior nurses meetings had instructed that paper copies of policies were not to be used and they were to be accessed via the intranet.
- Medical staff had access to the trust's computer network but not the electronic recording of patient observations. This meant that these doctors were unable to directly access current patient observations or early warning scores unless a nurse was present.
- Patients told us they received copies of letters sent by their surgeon to their GPs. These letters included a summary of the operation.

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

- Patients told us staff explained treatment and care and sought consent before proceeding. All patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form. We saw evidence of consent forms with risks recorded by the doctor.
- We found evidence that consent for surgery processes did not follow best practice, with records highlighting that patient consent for surgery was in some cases

being taken on the day of the procedure. This meant that some patients did not have a 'cooling off period' in advance of their surgery, should they wish to reconsider their procedure. This approach is suboptimal, although it is widely recognised as a difficult problem to solve unless the patient is seen on a separate occasion.

- During our inspection we found a consent form dated 2002 being used that referred to outdated legislation. We brought this to the attention of the adult protection specialist nurse who gave us an updated consent form. We saw the policy with relevant legislation was available on the trust's intranet, we were told it had been uploaded one week before our inspection. The trust provided us with an electronic copy of the policy.
- There was discrete mandatory training for all staff in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). It was also included in the trust's corporate induction. Records showed that 87% of staff had received this training yet some staff, including doctors in training we spoke with were unaware of the term MCA or DoLS. Staff told us they knew who to contact for advice in cases where a patient may require safeguarding support.

## Are surgery services caring?

Good

Overall we found that staff across the surgery service were friendly, caring and professional. Patients told us that care by nurses on the wards was excellent. Some examples of above and beyond care were evident, particularly for elderly and dying patients.

Friends and Family Test results were consistently very good across surgery wards, but with a below average response rate. The trust had introduced a staff pledge scheme for staff to record their own individual pledges of improving care and these were used in annual appraisals and objective setting.

Some patients felt that levels of care and compassion fell during the night, which was seen as more task focused rather than caring. Some patients also felt that they were left for too long in the admissions waiting area and there was a lack of information about wait times.

### Compassionate care

- The majority of patients we spoke with were very happy with the care and treatment they had received while in hospital. Direct comments from patients, which were representative of this feedback included: "the staff are all lovely", "the doctor was charming and he reassured me that everything went well" and "nurses are very attentive". However, some patients highlighted concerns that there were inadequate night staff which meant they "work hard, but they are too busy to care". This was a common theme in the feedback we received.
- Friends and Family Test results were consistently very good across surgery areas, but with a relatively low response rate. Both Swift and Northey wards received 100% recommendations in September 2015, but from a 27% response rate. Main theatres received a 100% positive score with 68% response during the same period. Staff on Swift ward had used feedback from the Friends and Family Test to provide a space for patients to change in, which resulted in a side room being installed.
- The trust conducted follow up telephone surveys and ward managers told us that patients had provided some useful recommendations which they had implemented, such as ensuring that staff introduce themselves clearly. We saw staff do this during our inspection.
- We saw a number of thank you cards on the wards which included messages from patients and their relatives. Some of these mentioned the kind way in which nurses had cared for patients.
- We saw consultant anaesthetists and clinical fellows communicate with patients in a polite and friendly manner. They sought the patient's permission prior to all interventions and provided explanations while demonstrating a caring and professional manner. In the anaesthetic room checks were completed by the ODP and consent forms were seen and signed. We saw ODPs reassuring anxious patients and putting them at ease by holding their hand as they were anaesthetised.
- We witnessed consultant surgeons and operating theatre staff treating patients with dignity and respect during their procedures. Patients were covered by gowns so they were not exposed and when operation drapes were removed the sheet and gown were put in appropriate position to preserve the patient's dignity.
- In the recovery area patients' dignity was maintained with the use of bed clothes and staff used curtains when

checking catheter drainage. Staff in recovery were fully engaged in the patients' needs such as airway management. There was good emotional support both verbally and through physical contact.

- We saw examples of above and beyond care by the surgery nursing team. During our inspection there was a palliative care cancer patient with an immediately terminal diagnosis on Swift ward. The patient and family were very happy with the quality of care by staff on this ward and wanted to stay on the ward to receive their end of life care. Nurses on the ward recognised that the patient was not going to live until Christmas and individual nurses made a Christmas dinner with Christmas crackers and decorations for the patient and their family to celebrate their last Christmas together.The family was allowed to stay overnight to keep company for their relative. There was daily liaison with the hospital palliative care team who visited the patient daily.

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

- Patients we spoke with told us that their treatment had been explained to them fully and that consultants had explained things clearly and patiently and were able to address any anxieties or fears. For those having day surgery this had been during their outpatients appointment. Most patients and relatives told us they felt fully informed and involved with decisions when appropriate.
- Nurses understood the potential for patients and their relatives to be anxious and we witnessed a caring and reassuring approach towards patients in the admissions area in Swift ward. A member of staff from the ward accompanied the patient to theatre with the operating department assistant and remained with the patient until they went into the operating theatre. The member of staff reminded the patient of what was going to happen. Family members were able to remain in the dayroom to wait for their relative to return.
- There was service specific literature for patients and their relatives available at the entrance to surgery wards. This included information on enhanced recovery pathways for orthopaedics, gynaecology and urology procedures. Patient information boards were visible in each of the surgery wards, with information on hydration and nutrition, preventing pressure ulcers, cleanliness and hygiene.
- Paper Friends and Family Test forms were clearly available in the main corridor of the surgery wards and an information poster encouraged patients and their relatives to provide feedback.
- Some patients felt that they were left for too long in the admissions waiting area of Swift ward and there was a lack of information about wait times.

### Emotional support

- We were not made aware of any specific counselling or support services available to inpatients with regards to their clinical care. Nurses told us that if a patient required extra support they would get the senior nurse to talk to the patients.
- There was a chapel in the hospital described on the trust's website as 'places of quiet for prayer or reflection for people of any faith or none'.
- A consultant told us there were no rooms to break bad news and that it could be difficult to find a suitable place for this.

## Are surgery services responsive?

**Requires improvement**

Improvements were required to the responsiveness of the surgery service at Epsom General Hospital.

We observed good flow of patients though theatres, recovery and onto the wards. However, the initial stages of the elective pathway experience during admission did not provide a dignified or person centred care approach.

There were low cancellation rates and no breaches in 18 week RTT across surgical specialties. The hospital had very good day surgery rates, at 83% of all procedures. However, theatre usage was suboptimal as theatre sessions were frequently stood down because of ineffective scheduling and unfilled operating lists.

There were medical outlier patients on surgical wards, which created some challenges for bed management. However the care of medical patients was managed appropriately with good access to physicians. There was no out of hours resident surgical team at Epsom General Hospital so patients were transferred to St Helier Hospitalif there were problems.

# Surgery

## Service planning and delivery to meet the needs of local people

- The trust was working to meet the needs of local service users through consolidation of different surgical services at single sites within the trust. For example, in 2015 the trust consolidated ophthalmology and urology surgery services at Epsom General Hospital. Acute/emergency and planned/elective care were divided between Epsom and its sister hospital St Helier. Epsom was the elective site. Senior leaders in the service felt that this system enabled more effective management of clinical rosters and delivery of planned care only at Epsom General Hospital meant that surgeons were able to focus on routine operating lists.
- High risk surgery was not undertaken at Epsom and patients requiring non-routine surgery were referred to St Helier or other hospitals in the area. There were facilities for some vascular procedures at Epsom General Hospital, but emergency vascular surgery, venous access and amputation procedures were not available at this site.
- The trust had very good links with The Royal Marsden NHS Foundation Trust for prostate cancer procedures and a visiting surgeon from St George's hospital for invasive urology surgery.
- The service had identified unmet demand in oral surgery. This was highlighted as a risk as the trust had one oral surgeon only which limited capacity. The trust's plastic surgery service was also limited to one surgeon and one doctor in training which limited the trust's ability to expand this service.
- The clinical director for surgery explained that the trust's tertiary surgical services were held in high regard by local GPs. The service leadership team was interested to develop a regional centre for urology as GPs were referring patients from across the region.
- The trust worked closely with commissioners and other NHS trusts in South West London to plan and meet the needs of the local population. The hospital's lithotripsy service was a regional centre that provided services to patients from across south London and Surrey. The trust was also part of the South West London cancer network, with close contact with regional centres at other hospitals. Surgeons at Epsom General Hospital conducted joint replacement surgery in partnership with surgeons from three other local trusts at the South West London Elective Orthopaedic Centre (SWLEOC).
- The surgery service was seeking more engagement with its local clinical commissioning groups (CCGs). The CCGs had set certain challenges for the service, such as treating patients with chronic ear disease. The trust had introduced new pathways and was limiting procedures of limited clinical value as a result of these challenges.
- There were links with partners in the local health and social care economy in developing integrated working on areas such as timely patient discharge.

## Access and flow

- NHS England data (April 2013- May 2015) for the referral to treatment time (RTT) indicated that the trust had fallen below the standard and been variable against the national average since June 2014. The RTT had risen above the national average since April 2015 but was still below standard. By specialty, Trauma and Orthopaedics and Urology were not meeting the standards for RTT. The trust's performance scorecard for January to September 2015 demonstrated 87% compliance for the admitted pathways within 18 weeks, close to the trust's threshold of 90%. This increased to 90% for non-admitted pathways within 18 weeks, close to a threshold of 95%.
- The trust was not meeting its 85% threshold the cancer 62 day target - those patients being treated within 62 days of GP urgent suspected cancer referral. The trust's performance scorecard for January to September 2015 showed it was 63%. The percentage of patients waiting more than six weeks for diagnostic imaging was in line with the national average.
- There was a dedicated bed coordinator for surgery. The trust's bed occupancy rate for the last quarter of 2014/15 was 90%, comparable to the NHS average of 91%. Bed occupancy was reviewed daily at 7am and we were told by staff that surgical beds were in high demand. To avoid on the day cancellations, ward clerks telephoned patients the night before their procedure and alerted them to wait until phone call the next day before coming into hospital.
- Across the trust only one surgery patient was not treated within 28 days of their cancelled operation between April 2013 and April 2015 and the trust performed better than the England average for the percentage of operations cancelled. In the trust's scorecard for September 2015 it was meeting its threshold of 1% for cancelled operations for non-clinical reasons.

# Surgery

- National data on delayed transfer of care for April 2013 to May 2015 indicated that 25% of delays were a result of failure to complete an assessment (25% compared to a national average of 19%) and 24% were because of patient or family choice.
- Nurses told us that bed capacity challenges resulted in frequent movement of patients within and between wards. Nurses felt that patients were moved around a lot. There were infrequent transfers of patients from Epsom to St Helier hospital, with six in the previous year.
- During our inspection we found a high number of medical patients on the surgical wards. Surgical ward beds were not ring fenced and senior staff told us that the trust was focused on the four hour wait in the Emergency department. Consultant surgeons told us that on average the surgical wards had eight medical 'outliers' each day. A senior member of staff reported that surgery was "clinically led, but managerially facilitated bed management". Ward staff cared for patients who had undergone different types of surgery, in addition to medical 'outliers' for whom no bed was available on a medical ward. Ward staff told us they felt confident caring for outlier patients and that physicians were accessible and responsive, but that it was sometimes difficult to meet the needs of patients who required high levels of personal care.
- We followed the patient pathway for surgery patients when they arrived at the hospital. The surgical admissions area is located on Swift ward, and all patients and their relative sit in communal waiting room at the entrance to the ward. When ready for theatre, patients were called to a very small room for consent to be taken and to change into a gown. Patients were then required to walk to theatre through the main ward entrance and past the waiting patients. This approach did not promote privacy and dignity at a sensitive and stressful time for the patient. The waiting area was very near to ward kitchen and smells of hot food were apparent which could be frustrating for who are nil by mouth patients. Single sex toilet facilities were not available for this group of patients, which again did not promote privacy and dignity. There was no call bell in this area for patients to call a member of staff.
- The surgery service at Epsom General Hospital provided treatment to private patients and NHS patients. Swift ward was used predominantly for NHS patients and private patients were allocated to Northey ward, although NHS patients were also allocated to this ward. Some staff reported concerns about how private patients were managed in collaboration with an NHS list at Epsom General Hospital. A senior member of staff informed us that private patients were not booked onto NHS theatre lists within the trust, but there was a separate list and no waiting list for private patients. There were no clear guidelines or standard operating procedures for managing private patients in collaboration with an NHS list. In the Day Treatment Unit, staff told us that some consultants would operate on private patients at the start of an afternoon list instead of at the end of the list. The staff member told us this was a regular occurrence, but that they did not feel supported by senior staff to challenge this arrangement.
- The hospital had very good day surgery rates, at 83% of all procedures. Theatre utilisation at Epsom General Hospital was at 74% between April and July 2015. Staff recognised that theatre usage was suboptimal and explained that theatre sessions were frequently stood down because of ineffective scheduling and unfilled operating lists. Matrons and senior staff told us that scheduling problems were impacting on theatre usage as there were inadequate numbers of schedulers to cope with workload. Consultants and the theatres matron told us that capacity was available but it was not being utilised efficiently.
- A multidisciplinary theatre utilisation group was chaired by the theatre matron every two weeks. We reviewed the minutes of these meetings and found that they were very brief with no evidence of actions or updates, for example on improving scheduling.
- At the time of our inspection, the trust was working with an external management consultancy to assist with theatre improvements. However, theatres staff told us that the management consultancy added extra cases to lists with little consideration of their complexity.
- The hospital had installed three whiteboards to demonstrate list capacity and bookings. This information was available for the current week and the two following weeks. We saw evidence of under filled sessions and some vacant sessions on the scheduling boards in main theatres.
- We were alerted to administrative problems with patients' appointment letters, with systemic errors in letters which were outsourced to an external provider. Consultant surgeons highlighted problems of serious mistakes concerning patients' personal details, such as name and gender. We were provided with examples of

these letters and mistakes were evident over a period of time. We were told that this matter had been escalated many times but had not improved. Documentation provided by the trust explained that all letters for clinics were outsourced to UK-based typists working for an external provider. The external typists return the letters and highlight any queries for the doctors (patient names, drug names, unclear dictation) to check and action.

### Meeting people's individual needs

- There were language translation posters at the entrance to Swift and Northey wards explaining the translation services that were available for 11 different languages. Nurses told us that face to face interpreting and British Sign Language interpreters could be booked.
- There was adequate equipment for bariatric patients including bariatric trolleys and hoists. Extra time was allocated to bariatric procedures to allow for preparation and movement of bariatric patients. This support was planned in advance of the patients' arrival.
- Most of the patients we spoke to told us that surgery staff were respectful of their specific religious and cultural needs. However, one patient told us about an instance of religious dietary requirements not being respected by the hostess and felt that this was insensitive.
- Support for patients was limited mobility was provided as required and requested. Patients told us that nursing staff offered to help with personal care but respected their independence and dignity.
- The trust had developed accessible easy read information for patients with learning disabilities and this was complemented by a resource pack for ward staff. Learning disability patients and their carers were asked to complete a health care passport, which was kept at the end of the patient's bed and referred to by all staff providing care and treatment. Patients with learning disabilities were put first on the theatre list to avoid long wait times.
- Staff attended dementia awareness training. A symbol of a blue flower was used above ward beds to indicate a patient with dementia. Patients with dementia were usually placed in a bay near to the nurses' station, but this was not always possible.
- The wards were accessible for wheelchair users. One patient told us that they had to be hoisted from their wheelchair and felt that this caused a delay in getting a bed on admission. The patient had to wait for five hours in the waiting lounge before a suitable room was made available. The patient was kept informed while having to wait and felt it was positive that the ward tried to accommodate their needs.
- Most of the patients we spoke were very pleased with the availability, choice and quality of food during their stay. They reported adequate sized meal portions and regular refills of water, tea and coffee.
- The meal hostesses on the surgery wards told us that they generally have adequate supply to serve each patient their first choice of meal and those with specific dietary needs. Specific dietary needs, such as vegetarian, high calorie, or religious requirements were recorded daily by nurses for each patient so the cook could prepare in advance. The meal hostesses recognised of important role of food with medicine.
- One patient told us that catering staff had run out of hot food when they arrived on the ward in the evening after a procedure. The patient told us that the cook provided a banana, yoghurt and a plate of ham, which contravened the patients' religious beliefs. The patient felt that this was insensitive and should not have happened.

### Learning from complaints and concerns

- There was a dedicated team in the trust which managed complaints for all clinical directorates. The hospital provided a Patient Advice and Liaison Service (PALS) to deal with concerns and complaints. The PALS office was located on the ground floor next to the reception at the main entrance and open Monday to Friday 9:30am-4:30pm.
- A new trust complaints policy was introduced in July 2015, staff told us there was work to improve the quality and timeliness of responses to complaints at the trust. The policy set out the process and time lines for handling complaints. If an incident graded at moderate or above was identified with a complaint a duty of candour investigation was instigated and a duty of candour lead nominated.
- Between July and September 2015 there were 50 complaints for surgery. Senior staff within the surgery directorate reported a back log of complaints and told us that the trust had employed more staff to respond in

a more timely way. Management staff told us that the back log of complaints was also linked to consultant surgeons not responding to requests for input to complaints in a timely way.

- Complaints were discussed in departmental meetings, from minutes provided it was only in relation to administration. In the Surgery, Critical Care and Anaesthetic governance meeting from July 2015 complaints were discussed in terms of having a lot of overdue complaints and 'a lot of work required to get them in good shape'. From the August 2015 minutes complaints were discussed in terms of drafting letters and looking at how complaints were handled in other areas. There was no recorded discussion as to what the complaints were, how they were being addressed and if any actions had been taken to resolve them. The quality manager for the directorate told us they were not involved in the complaints process.
- Matrons told us that they shared learning from complaints with individual staff and groups of staff on wards and in theatres. Matrons had developed action plans and carried out root cause analyses to respond to complaints and prevent them from happening again.

## Are surgery services well-led?

**Requires improvement**

The staff we met were all highly motivated and well informed about how their respective areas were performing. Staff were very loyal to the hospital and felt very much part of a team. Many staff had worked at the hospital for a long time.

Nurses felt there was a flat hierarchy where they felt safe to share ideas and raise concerns. All of the staff we spoke with felt supported by their immediate line managers, but they did not know much about senior management of the service.

There was limited evidence of a clearly defined vision for the service. Some staff also felt that the senior team was not visible in theatres or on wards.

There were good governance structures and reporting mechanisms in place, however we found a lack of responsiveness to equipment and infrastructure problems in theatres and it was not clear if these risks were being addressed in a timely way.

### Vision and strategy for this service

- In the trust's presentation to the CQC the chief executive spoke of the trust aiming to give "great care to every patient, every day". For surgery the chief executive spoke of "needing to do better" in the following: theatre utilisation, improving the 18 week RTTs for trauma and orthopaedics and urology, and improving the cancer 62 day target (those patients being treated within 62 days of GP urgent suspected cancer referral).
- The trust had a five year plan launched in March 2015. Senior leaders within surgery told us that the executive team had re-established a vision for the trust with the five year plan and this was cascading down to operational staff. Some staff told us that they had received information about the trust's five year plan and strategy in their April 2015 payslips. Others had seen corporate documentation and information on the trust intranet. However, while most staff knew there was a strategy for the trust they were not able to articulate what that was.
- Surgery was part of the Surgery, Critical Care and Anaesthetics directorate. The Clinical Director had been in post for five years and spoke of a vision to develop planned care services but this had not been formalised or approved at board or directorate level.
- The Clinical Director presented a vision to develop Epsom General Hospital as a regional planned care surgery centre and to set up a regional urology centre like SWLEOC. This would require the creation of new operating theatres at Epsom General Hospital and to develop St Helier as the acute site. However this vision was not widely known amongst operational staff and was not documented.

### Governance, risk management and quality measurement

- We saw minutes from governance meetings, a quality report, directorate management meetings (DMT), sisters' meetings and exception reports on falls. The governance and DMT meetings were attended by the clinical director, the general manager, the interim head of nursing, service managers and matrons and the quality manager.

- Directorate management team meetings were held every Thursday for two hours. There were rotating themes each week, such as governance, finance and staffing. Governance was discussed on the third week of the month and was held across both sites by video conference. Quality Manager and service manager, matrons, heads of departments, CD attends. The agenda for the governance meeting included the monthly risk register, incidents and themes, complaints and FFT.
- The directorate's quality report was presented to the trust's clinical quality assurance group and then to the trust board through the Patient Safety and Quality Committee. One of the duties of this committee was to make recommendations and seek assurances as to the robustness of the controls in place with particular focus on the key challenges identified of strengthening staffing in key areas. The quality report for April to June 2015 highlighted incidents and staffing issues in surgical wards in May, June and July these were not reported on or actioned in minutes we saw for the Patient Safety and Quality Committee meeting in July 2015.There was a performance scorecard for surgery and scorecards for individual wards. The ward scorecards included staffing issues, complaints, falls, pressure ulcers, and infection control and gave RAG ratings.
- Clinical governance meetings were used to share new national guidance and audit results. We were told that minutes from the meetings were put on staff boards. Minutes and action points that we saw were inconsistently shared with ward staff and were focused on action points rather than evidence based information.
- Matrons held bi-weekly meetings with ward managers, and there were staff meetings in wards and theatres. Some wards held monthly meetings, others were more frequent. The outcomes of meetings were communicated on staff information boards.
- The quality manager shared governance meeting minutes with matrons so that the information was cascaded to sisters and staff in wards and theatres. However, the quality manager explained that it was difficult to be assured that more junior staff were fully briefed and aware of information that needed to be passed down the chain of command. The quality manager contacted ward managers to ensure that meeting minutes were shared. We were told that the quality manager had also visited wards and staff meetings to verbally communicate information.
- Matrons were required to produce exception reports for each of the clinical areas they covered, this included infection control, risk assessments, patient falls, pressure ulcers and other concerns. These reported were produced on a monthly basis. However we were informed that some matrons did not send these exception reports in advance of governance meetings and instead provided a verbal report.
- There was good reporting of the main risks in surgery. The highest rated risks related to equipment and estates such as old patient trolleys in theatres, and staffing – both medical and nursing. There were separate risk assessment for both of these concerns.
- There was a trust-wide policy with criteria for identifying and reporting risks. All reported risks were submitted to the quality manager, who then discussed the concerns with the individual who raised it. Reported risks were submitted to the monthly governance meeting to be approved for inclusion on the directorate risk register.
- The surgery quality manager felt that the trust valued quality improvement. The trust had introduced a centralised quality team and we were told that some staff took quite a bit of time to understand the role and need for the quality manager.
- Quality managers held audit days for staff to attend and share learning from incidents. They were well attended. A recent joint audit day focused on learning from incidents around cement reaction. A guide was produced for doctors and nurses following the audit day.

### Leadership of service

- The staff we spoke to in wards and theatres valued their line managers and felt supported by them. Staff surgeons and anaesthetists told us they worked well as a team and we observed in theatres that staff knew their job roles and helped to get ready and safeguard the patient in readiness for surgery, without direction.
- The Clinical Director, General Manager and Head Nurse for surgery told us that the surgery directorate was planning a new organisation structure to split responsibility for the service amongst four clinical directors instead of one. This was seen as an opportunity to develop the directorate culture and

share information more effectively. A transition period and training programme for the new clinical directors was planned and the incumbent clinical director would remain in post to be responsible for surgery only. The clinical director told us that the directorate was well integrated but recognised the potential risk of a shift towards more siloed working.

- The clinical director was line managed by the chief operating officer and was professionally accountable to the joint medical directors. The joint medical directors had clear accountability for different portfolios, with one leading on quality and governance and the other, job planning appraisal and contractual matters.
- Senior leaders within the service told us that they do 'walkabouts 'and drop in sessions along with the trust leadership. Matrons reported that he head of nursing was very visible, but several staff in theatres said they have not seen and would not know who the directorate leadership team were. A senior member of staff told us that the senior team could be seen as "a bit aloof" and they were trying to improve their visibility.
- Service managers for each of the services within the directorate reported directly to the general manager. We were told that the general manager post had previously experience a high degree of turnover because of the workload. The incumbent general manager had been in post for 20 months and reported that the directorate was looking into recruiting another general manager or deputy as the volume of work was not entirely manageable.
- There was an interim head of nursing during our inspection, with a permanent head of nursing appointed.
- Matrons reported that they value the peer support they receive from other matrons across the hospital.
- There were planned regular consultant meetings for each surgical specialty. These reported to the clinical leads meeting.
- Some nurses in the Day Surgery Unit felt that the directorate leadership did not deal with concerns in a timely manner. For example, in responding to capital bids for new operating theatre lights. They were disillusioned because they had been waiting for over 15 months for a decision to be made.

### Culture within the service

- We found, for the most part, a constructive and supportive organisational culture within the surgery directorate. Many individuals from different staff groups told us they had worked at the hospital for a long time and felt a strong link with the hospital. Staff appeared happy and confident and indicated that they received promotions in the department. The Clinical Director told us that the hospital benefited from having a very keen and engaged group of enthusiastic consultants and nurses.
- There had been a period of uncertainty over the future of the hospital and staff told us that it had been a challenge to recruit staff due to this. Recruitment overseas had been successful with over twenty staff recruited from Europe. Some staff highlighted that the stability and long service of many staff members resulted in limited promotion opportunities for others.
- Senior leaders within the service told us about a cohesive culture across sites, and that staff viewed the organisation as one trust and not as separate hospitals.
- Some staff reported that they would value more support from other staff within the directorate. For example, senior staff in theatres told us that they would welcome support from the directorate heads. Consultants felt that administrative staff and directorate heads needed to better understand the pressure on doctors such as bed closures, which impacted on their ability to treat patients.
- Support staff such as porters and health care assistants told us that the trust was a good place to work. They felt part of the team and empowered to speak with senior nurses and consultants and saw no barriers to communication. Ward nurses reported excellent team working at Epsom General Hospital and felt that all grades of staff work well as a team from consultant to porter. Many nurses reported excellent rapport with matrons and ward managers.
- The Swift ward won the trust's 'team of the year' award in 2014 for working as one team.
- Individuals across staff groups reported that the hospital promoted equal opportunities and that staff treat each other as equals and with respect in their roles. However, the NHS staff survey 2014 scored negatively for the percentage of staff believing that the trust provided equal opportunities for career progression or promotion and in the percentage of staff working extra hours.

- During our inspection we were told about a patient demonstrating racist behaviour towards nursing staff. The ward manager had spoken to the patient about their behaviour and explained that discriminatory behaviour would not be tolerated.

### Public and staff engagement

- The Lithotripsy unit conducted a dedicated survey for patients of its service. However, in other parts of the surgery directorate there was limited engagement with members of the public beyond use the Friends and Family Test.
- There were weekly meetings for all staff in wards, DSU and main theatres. Trust wide information was disseminated at these meetings.
- We were told of the Patient First Programme by staff in focus groups, they told us that a lot of good ideas had come from nursing teams. The trust planned for over half of its staff to have completed the patient first programme by March 2016. Patients and staff could put forward suggestions on how to improve the patient experience, people could sign up for a monthly newsletter and were encouraged to give feedback about the trust. One of the suggestions from this programme that we were told about was the introduction of lanyards with job titles for patients to be able to identify staff. During our inspection we saw very few staff wearing these lanyards. We were told that information about actions taken in response to feedback was communicated back to staff.
- Staff told us that if they had concerns about any aspect of work they would report it first to their line manager. The trust's 'raising concerns at work' policy issued in February 2015 set out that a member of staff should initially discuss the concern with their immediate manager, who would consider it fully and then seek appropriate professional advice.

### Innovation, improvement and sustainability

- Senior leaders within the directorate reported a stable financial position for surgery and that the annual budget was in check. At the time of our inspection the directorate had a £1.6m overspend and was slightly off income target. There was recognition that the directorate activity plan did not match their budget because they had stopped a lot of weekend operations, which had impacted on income. The directorate was re-introducing weekend operating lists to help reduce referral to treatment times and improve activity plans. The general manager planned to set up a monthly budget meeting with each ward manager to discuss finances each month.
- The trust had used management consultants to review the surgery service and introduce lean methodology in theatres to make them more efficient. Staff told us that this was starting to have an impact with increased throughput and busier wards.
- The British Society of Urology rated the trust's urology service as excellent. The urology unit conducted all investigations on the one site at Epsom General Hospital and they had invested in new equipment to improve the patient experience of lithotripsy and flexi-cystoscopies.
- The separation of acute and elective surgery between the two hospitals was seen positively by staff in the trust.
- The national audits such as the NELA and the hip fracture audit showed the trust was performing better than the England average.
- Staff told us there were good opportunities for development and progression through the hospital and we saw that staff received awards in acknowledgement for the work they do.

# Critical care

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

## Information about the service

The Critical Care Unit at Epsom General Hospital has seven beds, mainly used for Level 2 patients, with one of these beds allocated for Level 3 patients. The unit has the ability to open up one extra bed, although this is currently unfunded. Level 3 patients are stabilised and transferred to St Helier critical care unit, usually within 24 hours.

Approximately 800 patients were treated in the Critical Care Unit in the last year, with the majority of patients receiving post-operative care following elective surgery. A small number of medical patients were admitted to the unit, if their condition deteriorated on the ward.

We visited the Critical Care Unit over the course of one announced inspection day. During our inspection, we spoke with eight members of staff including doctors, nurses, allied health professionals and ancillary staff. We spoke with the divisional leadership team within critical care at the trust. We also spoke with four patients and two relatives. We checked six patient records and eight pieces of equipment.

## Summary of findings

We rated the critical care unit as 'requires improvement' overall. We found that although staff were reporting incidents, there was no system in place to ensure that all staff were learning from these incidents. We identified gaps in record keeping and safe storage of medicines. The unit was bright and airy but there were no individual rooms so patient with infections could not be isolated. The unit used a high number of agency nursing staff to meet staffing requirements. Staff reviewing patients on the unit did not always comply with infection control practices such as being bare below the elbow and hand washing. Patients had to be escorted off the unit to access toilet facilities.

There was a lack of agreed guidelines specific to the critical care unit and no system to ensure consistency of care, even though three different consultants cared for patients in one day. The unit had a larger number of delayed discharges compared to similar units. This led to mixed sex breaches, although the unit was currently not recording these breaches.

The strategy for the unit had not been agreed due to difficulties in reaching an agreement among the critical care workforce across the two sites and staff were not aware of the vision for the unit. Not all risk had been identified on the risk register and some risk had been on the register for some time and senior staff were still unclear on the timescale to address these risks.

# Critical care

The unit had good outcomes for patient when compared to similar units and staffing was in line with national guidelines. The unit had lower out of hours discharges compared to similar unit and staff in other areas did not report difficulties in accessing critical care. The unit managed booked beds for elective patients efficiently to ensure patients do not have their operation cancelled due to a lack of critical care beds. Staff, including agency, received a good induction and competency based assessment prior to caring for patients independently. Doctors in training received good teaching and support from consultants and patients and their relatives spoke highly of the staff and the care they received on the unit.

## Are critical care services safe?

**Requires improvement**

Safety on the critical care unit requires improvement. There were no isolation rooms on the unit, which meant patients who were subject to isolation precautions were cared for in an open bay. Signs to indicate infection presence were small and not clearly visible. We also observed some staff not being bare below the elbow when reviewing patients on the unit. The controlled drug cupboard was left open and unattended on the day of our inspection.

Staff knew how to report incidents and were encouraged to do so but there was no formal system in place to ensure learning from incidents was shared with all staff. Staffing on the unit was in line with national guidelines although agency nurses filled a high proportion of nursing shifts. Three different consultants cared for patients on the unit in one day and we observed some gaps in record keeping.

The unit was bright and clean and staff had access to most of the equipment they required to care for patients. The record for providing harm free care was good and staff on the critical care unit were mostly up to date with their mandatory training.

### Incidents

- The trust did not report any never events in critical care in the last year (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented). There were also no Serious Incidents (SI) reported for the Epsom Critical Care Unit.
- The Critical Care Unit reported incidents using an electronic system and all staff we spoke with during the inspection, including agency nurses, told us they knew how to report an incident and they received individual feedback from the matron or lead nurse. Incidents were discussed as part of the regular senior nurses' meetings but it was unclear how learning from these incidents was cascaded down to the rest of the nursing team. The Critical Care Unit did not hold regular staff meetings, although the nurse in charge discussed some incidents during nursing handovers. Some nurses told us they

received emails from the matron or lead nurse but often did not have time to read these. Nursing staff were unable to tell us of the last incident on the unit on which they had received feedback.

- The trust reported44other incidents for critical care at the Epsom site.The three main categories for the incidents reported were pressure ulcers, medical devices injuries, and medical equipment being faulty or unavailable. Senior staff acknowledged that there might be under-reporting of near misses and delayed discharges. Delayed discharges have been reported in other data but very few were reported as incidents. Staff felt delayed discharges were common and reporting did not result in any change.
- There were no specific meetings for critical care but critical care was included in the anaesthetic department monthly mortality and morbidity meetings.
- Senior staff we spoke with had a good understanding of the duty of candour requirements. However, more junior staff on the unit had limited knowledge on the duty of candour requirements and had not received training on this.

### Safety thermometer

- The Critical Care Unit participated in the NHS Safety Thermometer scheme used to collect local data on specific measures related to patient harm and 'harm-free' care. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected electronically and a report produced for each area.
- The information on harm free care was clearly displayed at the entrance of the unit along with the expected and actual staffing levels for that day. During our announced inspection, we observed the Critical Care Unit had the required number of nursing staff on duty.
- The Critical Care Unit reported pressure ulcers in May and June 2015 but reported harm free care in all other months for the period of November 2014 to October 2015. There were no falls, incidents of venous thrombo-embolism (VTE) or catheter urinary tract infections during that period.
- The records we reviewed showed that all patients had undergone a VTE assessment on admission or at their pre-assessment review for elective patients and were receiving the appropriate VTE preventative treatment
- Staff told us they had access to pressure-relieving equipment and were able to refer patients to the specialist tissue viability nurse. More specialist pressure relieving equipment for use in complex cases was loaned through an external company and staff reported the delivery of this equipment could sometimes take a few days. The lead nurse informed us she had recently put in a bid to purchase some more advanced pressure relieving equipment for the unit to ensure prompt availability but was awaiting to hear the outcome of this.

### Cleanliness, infection control and hygiene

- The units we visited were clean and all the patients we spoke with were satisfied with the cleanliness. Other areas within the Critical Care Unit, such as the relatives' waiting area and nursing stations, were clean and tidy. We observed bed space curtains were labelled with the date they were last changed.
- There were dedicated staff for cleaning the Critical Care Unit and they used nationally recognised colour-coded cleaning equipment to minimise cross infection. Cleaning staff understood cleaning frequency and standards and said they felt part of the ward team.
- We looked at the equipment used on the units, including commodes and bedpans, and found them to be clean. Labels indicated they had been cleaned and were ready for use. There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required.
- In the sluice area, we observed an overflowing clinical waste bin and bags of dirty laundry left on the floor. Staff told us the laundry was normally collected in the early morning but they were still awaiting collection on the day of our announced visit.
- The Infection Prevention and Control (IPC) audit for the last quarter showed that the Intensive Care Unit (ICU) had an overall compliance of 85% against the 10 elements being audited. Management of patients with diarrhoea scored 67% and staff undertaking hand hygiene scored 80%. Bedpan and commode cleanliness, cleaning records and catheter care all scored 100%.
- Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed one case of hospital-acquired Clostriduim difficile in the last six months and performance in this area was lower than comparable units. The unit had one case of unit acquired MRSA between January and June 2015.

- Alcohol hand gels were readily available at the entrances to the critical care unit and at each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit.
- Nursing staff on the unit adhered to infection control precautions throughout our inspection such as cleaning hands when entering and exiting the unit and bed spaces, and wearing personal protective equipment when caring for patients. However, we observed surgical teams reviewing patients on the unit were not bare below the elbow and did not decontaminate their hands after patient contact. Staff on the unit acknowledged this occurred regularly and they were not always able to challenge staff not complying with the Infection Prevention and Control (IPC) policy.
- Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns in relation to hospital-acquired infections, such as MRSA or C. difficile and performance in these areas was similar to comparable units.
- The Critical Care Unit had reported one case of acquired Clostridium difficile in the last year and we saw evidence of an investigation by the Infection Prevention and Control (IPC) team as well as more regular IPC audits on the unit.
- We observed staff using heated wet wipes rather than soap and water to wash patients. This was on the advice of the IPC team as the tap water had tested positive for pseudomonas bacteria previously. Although the water was regularly tested for pseudomonas, staff told us this would be ongoing due to the age of the building and pipework. The senior staff informed us that all staff were also expected to use alcohol gel after hand washing for the same reason.

## Environment and equipment

- The Critical Care Unit did not have an isolation room and this was a risk identified on the risk register. Patients subject to isolation precautions were cared for in an open bay. There were signs above the bed-space, displaying that there was a presence of infection but these signs were small and not obvious when first approaching the bed-space. The senior nurses told us of plans to put in an isolation pod but this could not go ahead due to the lack of air-conditioning on the unit.
- Staff told us the temperature was often quite high, especially in the summer months, and could be uncomfortable for staff and patients. During the months of July and August 2015, temperature charts recorded in degrees Celsius showed temperatures of 24 degrees at8am, 35 degrees at 4pm and 32 degrees at10pm. This was included as a high risk on the critical care risk register but there were no controls for this.
- The unit was divided into two sections and each section was staffed according to the acuity of the patients. Both sections were bright and airy and the space between the beds was adequate to allow all necessary equipment to be available.
- We saw resuscitation equipment readily available on the units, with security tabs present on each. Systems were in place to check equipment daily to ensure it was ready for use. We saw from records that staff complied with these systems. Difficult airway and emergency tracheostomy equipment was available on the unit.
- All the equipment we inspected had the necessary portable appliance testing and had been serviced in the last year.
- Staff told us they had access to all the equipment required and were able to loan other equipment from the medical library. The League of Friends had been proactive in raising funds to acquire new equipment for the unit. However, the risk register included a non-invasive ventilation system that was over 10 years old and a capital bid was in place to purchase a new one. The trust did not have a capital replacement programme in place.

## Medicines

- A controlled drug (CD) audit, carried out in May 2015, found that medications for specific patients were still present on the unit after the patient had been transferred. The audit also noted that entries in the CD book were not clear with crossing out or obliterations and errors in the CD book were not dated and signed by two members of staff. This was not in line with the trust policy. Another audit in October 2015 highlighted out-of-date stock and staff were still not following the right process when amending entries.
- During our announced inspection, we observed the CD cupboard had been left open and unattended. We immediately alerted the nurse in charge who obtained the key and locked the cupboard. All other medication cupboards were locked.
- There was a fridge temperature checking record, which showed inconsistencies and omissions in the recording of the fridge temperature on the Critical Care Unit. The

freezer temperature checking records also showed checks were not completed daily and we observed the temperature to be out of the normal ranges on two occasions. There was no documentation of action taken and staff on duty were unable to tell us what actions they would take in this instance.

- We reviewed four sets of medicine administration records and found all were completed accurately and according to national guidance, including stop dates for antimicrobial medication.
- A medicine administration test was part of the induction process for all new starters on critical care and staff were not allowed to administer medication until they have completed the test. All staff also needed to attend the Intravenous training course and agency staff were asked to provide evidence of their training.
- Senior staff told us the safe storage of medication and blood gas syringes could be compromised due to the increased temperature on the unit and this was included on the risk register.

### Records

- The Critical Care Unit used paper-based records. Each patient on the unit had a booklet containing the nursing risk assessments such as pressure ulcers and nutrition. The proforma used for nursing care plans was comprehensive but in the records we reviewed, these proformas were not completed fully. We observed the enhanced recovery pathway not completed at night in one record and wound assessment charts not filled in for a post-operative patient. The nursing documentation prompted staff to complete capacity assessment but this part of the document was not filled in all the records we reviewed.
- Staff told us the medical team carried out patient reviews three times a day but the evening ward round was not documented in all the records we looked at.
- The nursing staff also used a transfer/discharge summary with details of all important information to handover to the receiving ward staff. This was signed by the transferring and receiving nurse to maintain consistent communication when transferring patients out of the Critical Care Unit.
- All patient records were stored securely in locked cabinets.
- Agency nurses did not have access to the computer system to review results of tests and a patient we spoke with told us 'it is frustrating because I have to wait to hear the results of my test.'

### Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy. Nursing staff were able to give an example of the last safeguarding referral made on the unit and more junior staff reported they would seek advice from more senior staff if unsure. Staff told us they completed an incident report when they made a safeguarding referral and we saw evidence of this when reviewing the incidents data on the unit.
- 94% of medical staff and 100% of nursing staff had completed the safeguarding adult training. Safeguarding children Levels 1 and 2 had been completed by 81.9% of medical staff and 90% of nursing staff.

### Mandatory training

- Critical care nursing staff achieved the trust target of 90% for all mandatory training modules, except for VTE risk assessment where only 78.6% of staff had attended training. One hundred per cent of nursing staff had attended training for infection control, conflict resolution and equality and diversity.
- Medical staff achieved the target of 90% for conflict resolution, equality and diversity and infection control training and were close to achieving the target for other modules except for VTE risk assessment, where only 19.3% had attended training.
- Staff we spoke with told us they were up-to-date with their training and were booked onto training by the practice development nurse. They were also allocated time to complete e-learning.

### Assessing and responding to patient risk

- Ward-based staff used a clinical software system which allowed staff to use handheld devices to record inpatient observations (such as pulse, blood pressure and temperature) at the bedside. The system uses the data inputted to calculate an early warning score using the National Early Warning System (NEWS) as a measure

of risk for each patient. Staff would then escalate this to the medical team, in the event of any deterioration. Staff on the Critical Care Unit told us they did not use the NEWS.

- Patient admission to the Critical Care Unit was on a consultant-to-consultant basis. Staff in other areas of the trust did not report delays in accessing critical care, except on one occasion when a patient, with a tracheostomy, was readmitted soon after discharge.
- The critical care team did not, at the time of our inspection, undertake 24 and 48 hours review of patients discharged from the unit.
- There was no critical care outreach service at the time of our inspection but an Acute Response Team (ART) was set up following our visit. The ART members would be able to make direct referrals to critical care and the trust would be auditing the impact of this service.
- A consultant reviewed all patients admitted to the unit and those who required care above Level 2 were discussed with the consultant at St Helier. If transfer was deemed clinically appropriate, the patients would be stabilised and transfer would be arranged as soon as possible. However, the critical care draft strategy included poor adherence to transfer of Level 3 patients as a weakness for the service.
- The Hospital at Night Programme was developed from the Effective Hospital Care Steering Group. The programme was introduced in October 2014 to provide additional senior nursing leadership to the site at night and assist doctors in the management of deteriorating patients out-of-hours.
- A simulation suite opened early in 2015, and provides specific multi-disciplinary training for teams managing the acutely deteriorating patient.

## Nursing staffing

- The lead nurse and a matron, who both worked cross-site with St Helier Hospital, provided nursing leadership to the unit. The day-to-day running of the unit was the responsibility of the supernumerary shift leader.
- Nursing staff received an overview of all critical care patients from the shift coordinator at the start of their shift and then provided with a thorough bedside handover once they had been allocated a patient. Staffing levels were determined by the level of care the patients were receiving.
- The total Whole Time Equivalent (WTE) nursing establishment for the Critical Care Unit was 21 and the unit currently had four vacant posts.
- There was a high use of agency staff but the service was meeting the intensive care society standards of 1:1 care for Level 3 patients and 1:2 care for Level 2 patients. Staff reported agency usage of up to 50% on certain shifts and we observed this when looking at nursing rotas on the ward. Best practice guidance suggests no more than 20% agency staff usage per shift. The overall agency use for the Critical Care Unit for the period of April 2014 to March 2015 was 18% compared to the trust average of 14.3%. The highest agency usage of 37% was for the month of March 2015.
- Agency staff underwent a thorough induction to the unit. Senior nurses told us that they tried to use the same agency staff whenever possible to maintain the continuity of care and avoid repeated inductions to the unit, which can be time consuming for the shift leader.
- New nurses were initially supernumerary while becoming orientated to the department. They were allocated a mentor and received support from the Practice Development Nurse (PDN).

## Medical staffing

- A team of 10 anaesthetists provided consultant cover to the Critical Care Unit on a rota system. The lead anaesthetist has a special interest in intensive care medicine and worked closely with the intensive care consultants at the St Helier site. The lead anaesthetist did a ward round on the unit three times a week.
- Currently three consultants looked after patients in one day, each covering morning, afternoon and night. Staff told us this could affect continuity of care as decisions made in the morning could sometimes be changed in the afternoon. The service was recruiting additional anaesthetists and was planning to provide 24 hours cover during the week and 48 hours cover at weekend. The recruitment was currently ongoing, although a critical care qualification was not a requirement.
- The consultants on the unit were supported by a team of anaesthetic doctors in training. The junior doctors were not allocated to cover the critical care unit in blocks, which meant the cover could change from day to day. Nursing staff told us they were provided with a copy of the doctors' rota and were able to contact the doctors easily.

- The on-call anaesthetic team provided cover for the Critical Care Unit at night and there was always a doctor with advanced airway management skills on site, although they were not based solely on the unit.

### Major incident awareness and training

- All staff received fire safety training as part of their mandatory training programme; however, none of the staff we spoke with had practiced an evacuation procedure on the unit.
- There was an up-to-date major incident plan for the trust with a specific action card for the Critical Care Unit and staff we spoke with were aware of this.

## Are critical care services effective?

Good

Patient outcomes, such as mortality and unplanned re-admissions, were in line with or better than other similar units. Pain was regularly assessed and patients told us they received pain relief quickly when needed.

Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently Medical staff received regular training as well as support from consultants. There was good access to seven-day services and the unit had input from a multidisciplinary team, although access to occupational therapy was limited. There was also limited MDT input during ward rounds.

Records were mostly complete although we found some omissions such as nutritional assessments not being completed.

There was a lack of agreed critical care specific policies and procedures based upon current guidance although staff were able to access national guidelines. There was no system in place to ensure patients received consistent care by the different consultants covering the critical care unit.

### Evidence-based care and treatment

- There was a lack of agreed guidelines for the Critical Care Unit, based on National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations. Resources to help guide practice were available but many of these were not dated or version controlled, which meant staff might be using out-of-date information. The practice development team acknowledged the guidelines needed updating. The trust intranet contained the national and Royal Colleges guidelines as well as other trust-wide guidelines such as managing sepsis, which were relevant to patients on critical care. Staff we spoke with knew how to access this information.
- The unit followed the trust's Enhanced Recovery guidelines for all surgical patients and we saw evidence of these guidelines being followed in the records we reviewed.
- The lead consultant acknowledged there was no system in place to ensure patients received consistent care by the different consultants covering the Critical Care Unit.
- The unit was non-compliant with several standards when assessed against the critical care London Quality Standards. The senior management team were aware of this non-compliance but we were not told of plans to achieve compliance.
- The Critical Care Unit had achieved compliance of 99% with the central venous catheter care bundle for the period of January to July 2015. The unit scored 100% for the Ventilator Acquired Pneumonia (VAP) care bundle for the same period, except for the month of March, where compliance dropped to 87% due to the cuff pressure not being recorded for one patient.
- The Critical Care Unit contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.
- The nursing care plans were detailed and contained evidence-based risk assessment tools and checks for easy reference.
- All patients received daily physiotherapy as required by the National Institute for Health and Care Excellence (NICE) guidance and intensive care society standards. All patients were screened within 24 hours and their rehabilitation needs were identified at the time.

### Pain relief

- Consultants on critical care primarily managed pain relief. The specialist pain team also reviewed post-operative patients and staff spoke highly of their input.
- Staff used a standardised scoring tool to assess patients' pain. Patients told us they were regularly asked if they had pain and were given medicines quickly if requested.

- There were a number of patients on the unit with an epidural infusion (where pain medications is delivered through a small tube placed directly in the spine) to provide post-operative pain relief. Staff on the unit were had received training specific to epidurals and agency nurses who were not trained were clear they would request assistance from permanent staff when dealing with the epidurals.

### Nutrition and hydration

- The nursing staff used the Malnutrition Universal Screening Tool (MUST) assessed patients' nutrition and hydration needs. In most patient records, we observed the MUST assessment had not been completed and documented. Staff told us they did not complete the MUST for patients who were immediately post colorectal surgery and were unable to eat.
- Patient told us water was always available within reach and staff assisted with meals as required.
- Staff told us they had access to a dietician on referral. The dietician would then continue to review patients referred until they were transferred.
- On the day of our inspection, staff told us a patient was due to be fitted with a percutaneous endoscopic gastrostomy (where a feeding tube is inserted directly into the stomach) to ensure adequate nutrition.

### Patient outcomes

- The ICNARC Standardised Mortality Ratio shows a trend of good outcomes on critical care. The mortality ratio on the unit was better when adjusted for case-mix in comparison with data submitted by similar units. The rate of post critical care hospital deaths was better in comparison with other units.
- Unplanned re-admissions to critical care within 48 hours from unit discharge and after 48 hours were better when compared to similar units for the period of January to June 2015.
- The unit had a higher rate of non-clinical transfers out as all Level 3 patients were transferred to the St Helier site. Thirty-three patients were transferred from Epsom to St Helier Critical Care Unit since January 2015. The rate of non-clinical transfers out of the unit was low.
- Data we received from the trust showed Level 3 patients cared for at the Epsom site had a mortality rate of 35% compared to 20% at the St Helier site.
- Patients discharged 'out-of-hours' between 10pm and 7am are associated with worse outcomes and ICNARC data demonstrated a lower number of patients were discharged to the wards out of hours than in other similar units.
- The majority of patients returned to their pre-admission residence and previous level of independence on discharge from hospital.

### Competent staff

- The Critical Care Unit had two designated part-time practice development nurses, who made up less than one WTE nurse. The nurses were responsible for overseeing the professional development and learning of nurses working on the St Helier and Epsom site, as well as supporting student nurses on placement. A student nurse we spoke with felt she had received excellent support and information and we observed the feedback from the universities to be excellent.
- All new starters worked as supernumerary members of staff for a designated period. During this periodthey had to have specific competencies signed off by a senior nurse or practice development nurse before being able to care for critical care patients independently. Bedside training was available from the mentor or practice development nurse during that period.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post registration award in critical care nursing. On this Critical Care Unit 77.5% of nurses had completed this training.
- Nurses told us they mainly cared for Level 2 patients on the unit and felt they were losing some of their skills in caring for Level 3 patients. Staff did not rotate to the St Helier site to maintain these skills.
- Nurses told us they received training on new equipment introduced on the unit and were required to sign that they have read new policies and guidelines. However, we noticed only five staff had signed the Critical Care Fluid Challenge Guidelines, dated June 2015.
- Doctors received formal training with the anaesthetic team and bedside teaching, specific to critical care, during ward rounds.
- Senior staff told us the tool used for allocating nursing staff to shifts took into account which staff had additional intensive care qualifications, to ensure a suitable skill mix for each shift.

- Agency staff had a robust induction on the unit, which included a clear outline of their duties, equipment competency checks, and recording evidence of their IV training.
- Of nursing staff 91.7% had received an appraisal in the last year and all staff we spoke with told us they regularly received appraisals. Senior staff described a four-year development programme for band 6 nurses as part of their recruitment and retention plan.
- Physiotherapy staff told us they underwent a competency based training prior to working on critical care and being on call. All on call physiotherapist also had yearly training updates in caring for critically ill patients. We requested evidence of this competency training but did not receive it.

### Multidisciplinary working

- There was good external multidisciplinary working across critical care. Doctors we spoke with in other areas of the hospital reported good support from critical care when a patient required admission to the unit. The Critical Care Unit also worked closely with the unit at St Helier and all Level 3 patients were discussed and transfer arranged within 24 hours.
- The critical care consultants and their admitting medical or surgical consultants cared for patient on the unit jointly. We observed other teams reviewing patients on the unit during our inspection. The critical care team did not currently follow up patients following discharge from the unit.
- There was no multidisciplinary board round set up on the unit. The physiotherapist obtained a handover from the shift coordinator every morning. Staff told us MDT meetings were not routinely held although this might be considered for long term or complex patients.
- A team of physiotherapists and one therapy assistant provided cover to the Critical Care Unit and the surgical wards. Patients on the unit were prioritised and seen daily. However, the level of staffing meant that the physiotherapists relied on nursing staff to implement some of the rehabilitation plans.
- The AHPs services were provided by a neighbouring community trust. AHPs told us MDT working with the nursing staff was well established but remained to be embedded with the medical staff.
- The microbiology team and pharmacist join the critical care ward round once a week. The pharmacist visited the unit daily and the microbiologist was contactable over the phone on other days.

### Seven-day services

- The unit had a consultant present during the day and on call overnight, with a response time of 30 minutes. There were trainees available 24 hours a day, with advanced airway training.
- Portable X-ray was available on the unit and patients had to be accompanied to the radiology department for other scans. Medical staff told us there was no problem with accessing imaging services out-of-hours or at weekends.
- Emergency respiratory physiotherapy cover was available overnight and at weekends, on a bleep referral basis. A pharmacist was available to support critical care at weekend, although they also had responsibilities in other areas of the trust.

### Access to information

- When patients were admitted via A&E or the wards, a verbal handover was provided to the medical and nursing staff as well as written information in the patient records.
- On discharge from critical care, a comprehensive medical discharge summary was written and verbal handover to the receiving team was provided.
- Physiotherapists did not complete a written handover as they often continued to care for the patient when transferred to the ward. For patients they did not follow, a verbal handover was given to the ward physiotherapist.
- Staff obtained most of their in-house information via the intranet site, although some staff reported that only have two computer terminals made it harder to access the intranet during busy periods. There were some folders on the unit with trust policies, although some of these were not up-to-date. Staff referring to these folders would not be acting on up-to-date information.

### Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- All levels of staff were able to tell us how they would obtain consent and where consent could not be obtained, such as if the patient was unconscious. Staff told us care was provided in the patients' best interests.

# Critical care

- A patient mental capacity assessment was part of the nursing documentation and we saw these had not completed in the records we reviewed.
- Staff we spoke with were aware of when a Deprivation of Liberty Safeguard (DOLS) application was required and were able to give us an example of when an application was last completed.

## Are critical care services caring?

Good

The critical care unit provided a caring, kind, and compassionate service which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive. Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care. Staff provided emotional support and were also able to access the hospital multi-faith chaplaincy services, when required. However, patients and their relatives were not encouraged to provide feedback.

### Compassionate care

- Patients told us their privacy and dignity was maintained at all times and we observed staff pulling curtains around patient areas before completing care tasks.
- Staff ensured patient had their call bells within reach and those who were able to drink had water on their table.
- We observed several interactions between staff and patients, saw staff speaking to patients in a calm and reassuring manner, and listened to what patients had to say. One patient was feeling nauseous post-operatively and staff were attentive and immediately administered anti-sickness medications.
- All the patients, families, and friends we spoke with were happy with the care and treatment they received on the unit. Some patients called the staff "fantastic" and ''gentle and caring.'' Another family said they "could not have wished for anything better" and they would not change anything.
- The unit had not received any response for the Friends and Family test in the last six months and patients on the unit, who were due to be transferred on the day of our inspection, told us they had had not been asked to complete a patient survey.

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

- We saw surgical teams informing patients of how the surgery went and what the plan would be for that day. Patients were told of tests they were due to have and we saw a nurse explaining the need for the test to a patient, in a way they could understand.
- Patients and their relatives told us staff kept them informed as much as possible. One patient commented on how the physiotherapist had taken the time to explain the importance of getting out of bed and the transfer was done at a pace that the patient was comfortable with.
- The patients on the unit knew the name of their nurse and this was also written above each patient's bed.

### Emotional support

- Emotional support was available through the multi-faith spiritual service within the hospital 24 hours a day and representatives from various faiths could be accessed.
- Feedback from patients and relatives was positive and they told us staff had been reassuring and comforting. One relative told us how staff had been very accommodating about visiting hours and they were reassured and always given an update over the phone on the days they were unable to visit.
- We noticed one patient's bed-space had personal items such as cards and electronic equipment and staff ensured they could access these.

## Are critical care services responsive?

Requires improvement

Facilities for visitors were limited to a small waiting room with no drink making facilities or specified toilet and visitors were not able to stay overnight. There were no patient toilets on the unit and patients had to be accompanied off the unit to a dedicated toilet at the entrance of the adjacent ward. This meant that some

patients who were mobile were unable to access these facilities independently and had to wait for a nurse to be free.Nurses accompanying patient off the ward were then unable to supervise other patients in their care.

Elective patients requiring a critical care bed were identified pre-admission and the unit had an effective system in place to manage the booked beds, despite having a large number of delayed discharges. Delayed discharges meant the unit were encountering mix sex breaches regularly but this was not being recorded.Out of hours discharges were lower compared to similar units. Staff in other areas did not report difficulties in accessing critical care services.

Staff had access to communication aids and translators when needed, giving patient the opportunity to make decision about their care, and day to day tasks. Patient passports were used for patients with a learning disability and staff had access to the trust's safeguarding team and were aware of when a referral was required.

Visiting hours flexible and staff made an effort to accommodate requests from patient's relatives.

### Service planning and delivery to meet the needs of local people

- ICNARC data showed that the majority of admissions to the Critical Care Unit were planned admissions, although the unit also admitting some patients via the Emergency Department and the wards.
- Elective patients were identified by the nurse or anaesthetist at their pre-assessment checks and the decision to request a critical care bed was then taken. This allowed the unit to plan ahead in order to meet the needs of specific patients. Staff in theatres recovery told us they worked well with the Critical Care Unit and patients identified as requiring critical care input post-operatively did not experience any delay in accessing beds on the unit.
- The unit mainly cares for Level 2 patients, with data showing only 6.8% of bed days between January to July 2015 were occupied by Level 3 patients. The unit was proactive in stabilising all Level 3 patients and liaising with intensivists at the St Helier site to arrange transfer. All nursing staff had undertaken training for transfer skills and the nurse allocated to care for the Level 3 patients would assist with the transfer.
- The unit had established links with a local residential brain injury rehabilitation unit. Some young adults with permanent tracheostomies had been admitted to the unit on several occasions and staff on the Critical Care Unit had built a good rapport with staff at the rehabilitation unit to ensure effective communication and a smooth transfer of care.

### Meeting people's individual needs

- Toilet facilities for patients were located at the entrance of the neighbouring ward and patients had to be accompanied outside of the Critical Care Unit to use these facilities. Patients commented on this; 'it feels like you are going to another ward to use the bathroom.' Staff told us they had to be off the unit when accompanying patients to the bathroom, which meant they were unable to monitor the other Level 2 patient they were caring for during that time.
- A mixed sex breach occurs when Level one or Level zero patients are placed on an open ward area with a member of the opposite sex. Mixed sex breaches should occur infrequently on critical care units, as patients are stepped down to a ward once they reach level one dependency. The unit was currently not recording mixed sex breaches but due to the high number of delayed discharges from the unit, staff told us mixed sex breaches happened regularly.
- There was access to interpreting services; although staff felt that it took a long time to get an interpreter. Often they would use other members of staff in the trust to interpret, especially if they needed to communicate important information to the patients or relatives urgently.
- Staff were able to describe various formats of communicating with patients who could not speak, such as pen and paper, picture charts and using closed questions.
- A learning disability nurse was available on referral and those patients that had learning disabilities had the appropriate care and plans in place such as hospital passports as well as a review by the learning disability nurse, when appropriate.
- It was not clear how patients living with dementia were identified and we did not see evidence of specific documentation. We also noted there was no routine screening for delirium in place.

- There was a small relatives' room, which was clean and airy. Various information leaflets were available on the unit, although they were all in English but staff told us these could be provided in large print or in other languages if required.
- The unit operated a flexible visiting hours, with two visitors allowed at any one time but asked relatives to refrain from visiting before 11am and during the rest period of 12.30pm to 2.30pm. We spoke to relatives who told us they had always been able to visit at a time that suited them.
- There were no facilities for relatives to stay overnight and they were encouraged to return home but they were able to ring the unit for updates at any time the day. Staff told us they would direct relatives to local hotels if needed.

### Access and flow

- Staff told us there were difficulties discharging patients from the Critical Care Unit due to a lack of bed availability in the rest of the hospital. The critical care quality analysis data for January to July 2015 showed there had been 196 delayed discharges in that period. ICNARC data also showed a trend for the unit to be worse for delayed discharges compared to other units. This however did not lead to access delays for patients requiring a critical care bed as the unit managed their booked beds and would open up an eighth bed on the unit, when required. Staff were not aware of any actions being taken to address the high number of delayed discharges.
- There had only been one elective surgery cancelled due to the lack of a critical care bed in 2015. The anaesthetists reviewing patients in the pre-assessment clinic worked closely with surgeons to ensure patients requiring critical care beds post-operatively were scheduled to ensure availability of beds.
- ICNARC data showed the Critical Care Unit to be better in comparison with other similar unit for out-of-hours discharges. Staff told us they would only transfer a patient out-of-hours when they needed a bed in an emergency. Thirteen patients had been transferred out-of-hours between January 2015 and July 2015. There had been two non-clinical transfers out of the unit in 2015.
- The lead consultant told us access to the Critical Care Unit was on a consultant-to-consultant referral basis. They felt this was important to ensure that the consultant in charge of the patient care had been fully informed of the deterioration in the patient and had the opportunity to discuss ceiling of care. Staff we spoke with in other areas of the trust told us they were able to discuss patients with the critical care team and have not experienced delays in transferring patients to the unit.
- Bed occupancy figures ranged from 73% to 89% for the period of January to July 2015.

### Learning from complaints and concerns

- Relatives told us they were aware of how to make a complaint and could reference posters advertising PALS in the corridor. They felt they could also discuss any problems with staff on the unit.
- There had been no formal complaint made against critical care in the last year.

## Are critical care services well-led?

Requires improvement

We rated the 'well-led' element of the critical care unit as 'requires improvement.' There was no clear vision for the service and the strategy was still awaiting approval. The vision of the lead consultant was similar to the trust's five year plan but this was not in line with the draft strategy, which was mainly written by intensive care consultants at the St Helier site. Governance arrangements were in place, although staff felt critical care was overshadowed by the bigger services in the directorate. The unit maintained a risk register, but it did not reflect all the risks we identified during our inspections and some of the identified risks had been on the register for years.

Staff were recently engaged in discussions about the future of the service with an external advisor and but there was limited public engagement on the unit.

Staff we spoke with were not clear about the future of the service but were positive about the day to day leadership and culture on the unit. Staff felt part of a team and were able to participate in discussions about patient care.

### Vision and strategy for this service

- The critical care draft strategy was not aligned to the trust's five-year plan. The trust's five-year strategy for critical care services is the integrated approach for managing the most acutely unwell patients at the St

Helier site. This would allow for a single intensivist rota at the St Helier site with only an anaesthetic rota for the Epsom site. However, staff we spoke with and the critical care draft strategy stated the vision is still to provide critical care facilities through dedicated intensivists and the lack of intensivist review at the Epsom site was a concern. The plan, as per the draft strategy, is to employ two further intensivists to provide daytime input at the Epsom site.

- A critical care strategy was still in a draft format and was awaiting approval from the Trust Executive Committee. The directorate team for critical care told us that it had been difficult for the team to agree a strategy due to interpersonal challenges amongst the critical care workforce. Not all members of the critical care team shared the vision and strategy for the service and this had been acknowledged at the directorate and board level. An external advisor had been appointed to provide the critical care team with some assistance in agreeing a strategy and provide the board with a report highlighting the areas of concerns to be addressed.
- The strategy and vision for critical care services had also been discussed in regular trust meetings such as 'Safe and Effective Hospital Care Steering Group' and 'Managing Acutely Ill Patients in Hospital' since 2014, but the strategy was yet to agreed.
- Staff we spoke with were unclear on the future direction of the service, however all staff we spoke with said their vision was to provide high quality, safe, evidence-based, compassionate care to critically ill patients within the trust.

## Governance, risk management and quality measurement

- Most of the areas we identified as risks were on the risk register and appropriate control measures were in place considering some of the restrictions they had with the environment. However, some of these risks had been on the risk register for over two year and staff were still unsure of the actions being taken to address these. In addition, out-of-hours and delayed discharged, the lack of critical care specific recorded mortality and morbidity meetings and bathroom facilities being situated off the unit were not on the register, although senior managers were aware of these issues.
- The unit was engaged with governance activity within the hospital and had representation at a range of relevant meetings across the trust. This included the Safe and Effective Hospital Care programme (established in the trust to take forward recommendations from a variety of sources; Francis and Keogh reviews, London Quality Standards (LQS), NCEPOD and NICE guidelines) and the Managing Acutely ill patient Task group, which aimed to establish pathways to deliver quality safe and effective care to all acutely unwell patients admitted to the trust. However, the intensive care consultants at the St Helier site attended these meeting and it was unclear how this information was passed onto the lead consultant at Epsom General Hospital. The lead consultant used to attend the weekly consultant meeting at St Helier but was no longer doing so due to other commitments. The lead consultant at Epsom was not fully engaged in the overall governance of critical care across the two sites.
- There was a monthly risk and governance meeting where incidents, staffing and recruitment as well as any other performance issues were discussed for each of the surgical areas, critical care and theatres. The clinical director also provided feedback from the trust executive committee. We noted the lead consultant did not attend these meeting but the lead nurse or matron for critical care provided an update for the service. It was unclear how information and feedback from these governance meetings were sharedwith the rest of the staff and staff we spoke with told us they did not receive feedback from these meeting.
- A monthly quality scorecard was produced but critical care was reported in the surgical directorate and staff felt that issues in critical care were being overshadowed by the larger surgical services as the score cards did not provide a breakdown specific to critical care. It was therefore unclear how quality measurement for the critical care unit was being undertaken and understood at senior management level or how managers had full oversight of the concerns affecting front line staff and patient safety and experience.

## Leadership of service

- The lead anaesthetist together with the lead nurse and matron led the Critical Care Unit. The nursing leads also covered the St Helier site and staff we spoke with told us they were very approachable and supportive although they were not clear about the difference between these

roles. The nursing leads were also not always present on the unit, however the unit had three senior nurses, who each took a lead on certain aspect of the running of the unit such as rotas and staff training.

- Staff told us the lead consultant had a good understanding of the need of the service and worked closely with colleagues at the St Helier site. However, staff did not know the senior leadership team for the directorate and felt this was because they were based at the St Helier site.
- Staff told us the senior management team were not visible on the unit and they were not aware of any trust initiative to improve visibility of the executive team.

### Culture within the service

- Staff on the unit told us the culture was positive and some regular agency staff told us they felt part of the team. The medical and nursing staff spoke highly of each other and worked well together. All staff we spoke with were proud of their work.
- Staff told us that the culture was open, honest and the lead consultant encouraged discussions and welcomed ideas to improve patient care.
- The sickness and turnover rates for nursing staff on the unit were 6.7% and 5.1%, compared to the trust average of 5.7% and 13.7% respectively.

### Public engagement

- There was limited public engagement on the unit, as patients were not routinely asked for their feedback during their critical care stay. There was also no follow up visits or clinics for patients discharged from the unit, which limited further feedback from patients following transfer out of the Critical Care Unit.

### Staff engagement

- There had been recent meetings with an external advisor to facilitate the critical care workforce to work collaboratively and agree on a strategic plan for the service. This has been well received by some staff who felt it was important for everyone to be able to express their views. Staff told us they felt empowered to be engaged in planning the future direction of the unit. However, the report from the external advisor and the trust's response had not been shared with staff at the time of our inspection and so staff were unaware if these discussions would make a difference.
- Staff were aware of the trust five Year plan and the Chief Executive was well known but the executive team and senior staff not based on the unit were not very visible.

# Maternity and gynaecology

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

## Information about the service

Epsom women's services are open to the population of North Surrey. The services are commissioned by Surrey Downs. The maternity unit provides all services relating to pregnancy and inpatient and outpatient gynaecology. Some outpatients' clinics and procedures taken place at Leatherhead Hospital. Gynaecology patients for elective surgery use Swift ward. Private gynaecology patients stay in the Northey Suite, while private maternity patients stay in private rooms on the antenatal/postnatal ward.

The maternity unit is small in terms of births, with just over 2000 births a year. Community midwives provide antenatal care during pregnancy in GP surgeries and children's centres. Antenatal clinics for women with specific health conditions such as diabetes, mental health problems or obesity were run at the hospital run by a midwife and doctor.

An 'appointment only' early pregnancy assessment unit is open from 1.15pm to 3.30pm on weekdays. A maternity assessment unit (MATAU) runs, also by appointment, between 8am and 6pm, Monday to Friday. The consultant-led delivery suite has one obstetric theatre, two recovery beds and six delivery rooms, one with a birth pool. There is a midwife led birth centre, adjacent to the postnatal ward and maternal assessment unit. This has two birthing rooms and a postnatal room. The combined antenatal ward and postnatal ward, Simon Stewart, has 19 beds, including six single rooms. Two rooms are available for private patients.

Fertility clinics and fetal medicine clinics are run at the hospital.

Medical termination is offered at all gestations for significant fetal abnormality in keeping with the law for termination of pregnancy.

During our inspection, we visited all clinical areas, observed care and looked at patient records. We talked to over 30 staff including administrators, domestic staff, healthcare assistants, midwives, nurses, doctors in training and consultants. We spoke with 7 women and reviewed patient records as well as other documentation. We received comments from patients and families attending our listening events, from staff focus groups and from people who contacted us to tell us about their experiences. We reviewed national data and information provided by the trust.

# Maternity and gynaecology

## Summary of findings

We judged the maternity and gynaecology services as requiring improvement.

Systems and processes were in place for reporting and investigating incidents in maternity but dissemination of learning from incidents and complaints was inconsistent. In gynaecology incident reporting was very low. The service was slow to implement change. For example responding to failure to achieve its own or national performance targets in maternity services and despite restricting admissions of women in labour to lower risk women, some staff voiced safety concerns.

The trust mainly reported on and monitored maternity services based on merged data from both maternity units. Site specific maternity dashboards were produced but were not actively used and the dashboards we saw on display were trust wide, even though local dashboards were also available. This was unhelpful in terms of monitoring maternity performance at Epsom, which was smaller, less busy and served a different population and employed Epsom-based staff. Although we requested specific performance data for Epsom in addition to the data on the maternity dashboard, the trust was not able to provide this in many cases.

Most of the clinical guidelines had been reviewed recently in line with national guidance but not all staff were aware of key changes. There was limited evidence that national or local audits had an impact on practice.

Women and their partners were mainly positive about the care they received. They understood and felt involved in their care. Women received the emotional support they needed.There was a mainly positive response to the Friends and Family Test, with a reasonably high response rate among woman who stayed in the maternity wards of 33%. The response on outpatient services were much lower.

Midwives were aware of the characteristics of the local population and responsive to their needs. However, it was less clear whether the pattern of medically led antenatal clinics met the specific clinical needs of the local Epsom population. There was limited engagement with either staff or with the local community about the design of the service.

Management of the maternity service was weak and obstetricians were not sufficiently engaged in the maternity service. Midwives felt Epsom hospital was low on the trust priorities. Managers did not identify, analyse and manage all the risks of harm to women, such as items flagged red on the maternity dashboard for Epsom hospital. Staff provided little challenge to one another. The culture was hierarchical. Several staff said they had spoken up about concerns, but no action resulted. They felt the service was complacent.

Aside from the weaknesses in incident reporting, we had no concerns about gynaecology.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Requires improvement

The maternity unit was not busy on the three occasions we visited. The midwife to birth ratio was 1:31. Although this was higher than the London standard of one midwife to every 30 births, it appeared sufficient for the activity levels. The labour ward had a restricted intake, only admitting women in labour who were over 34 weeks into pregnancy because there was only a level 1 neonatal unit on site and a single obstetric theatre. They did not generally take women at high risk of complications because there was no Level 3 care at the hospital should a woman deteriorate.

The maternity unit had 98 hours a week consultant presence on the labour ward but this cover was very unevenly spread through the week. Furthermore, we were told that on call cover could be from an obstetrician only (not an obstetrician/gynaecologist) which was a risk if a woman suffered severe complications and, for example, needed a hysterectomy. Midwives were not able to provide one to one care in labour to all women as evidenced by data reported on the maternity dashboard..

Only elective gynaecology treatment was carried out at Epsom so women would be transferred to St Helier in an emergency.

There was an electronic system for reporting incidents, and most of the 591 incidents reported in the past year were clinical. Staff investigated serious incidents in a timely way, but action plans for some serious incidents did not always have action dates, and we saw that the service was slow to make some changes.

### Incidents

- Between April and August 2015 there had been two serious incidents(SI) requiring investigation, eight level 3 incidents in maternity and one SI in gynaecology. The Maternity Board reviewed maternity SIs rather than the Trust SI Panel. Investigation of incidents would involve a doctor from the trust's other maternity unit. Some SIs at Epsom indicated some concerning failures in screening resulting in serious outcomes for women and babies. Such incidents would appear to have merited external investigation, involving an expert from outside the trust, which did not take place. However, rates of missed screening abnormalities were in line with national rates.
- Junior doctors told us they did not usually get feedback from their supervisors after providing statements. Junior doctors were not involved investigating SIs, even though later in their careers then needed to be able to do this. Doctors in training said they only heard about incidents occurring at the Epsom site, which limited the chance for learning and improving.
- The themes of SIs in 2014/15 were similar to those in the previous year, particularly recognition of the deteriorating woman and escalation. This indicated further action was required to secure improvements in practice
- Midwives said they reported incidents on the electronic system. Some key issues reported were staff shortages, escalation, maternal re-admissions, and errors in investigations. Staff had reported 357 incidents the year to August 2015. Staff told us they did not always have feedback on incidents.
- There were local open invitation risk meetings weekly to engage staff at ward level. Unfortunately many midwives and doctors said they were rarely able to attend.
- Cases were reviewed monthly at a perinatal mortality meeting covering both maternity units. We reviewed meeting notes from June to October. Epsom did not have obstetric representation at every meeting and no trainee doctors attended. Managers did not assign follow up actions, with deadlines, to named individuals in these meetings, so it was unclear whether action was followed up. Most staff did not see the meeting notes, which limited scope for reducing risk in the service by helping staff learn and improve.
- Gynaecology patients were admitted to Swift ward, a women's surgical ward that had a 5-bedded bay and 17 single rooms. The two incidents reported in the past year both related blood clots. Two private gynaecology patients in Northey ward were also recorded as not having VTE assessments.
- The level of reporting in gynaecology was very low.There were no incidentsreported from the gynaecology service in Leatherhead, staffed by Epsom staff. This was surprising.

# Maternity and gynaecology

### Duty of candour

- The duty of candour requires staff to be open and honest with women and their families about the care and treatment they receive. Organisations have a duty to provide patients with information and support when a reportable incident has occurred or may have occurred. We saw a training presentation from September 2015 in folders on wards.
- Not all staff we spoke with were aware of the implications of the duty of candour. This was a concern because the duty had applied to NHS trusts since November 2014. In October 2015, the maternity department had produced a duty of candour sticker for a member of staff to add to a woman's notes when they raised an incident about care of a woman or baby which needed an apology to the woman and an explanation of the implications. It was not clear if this prompted any further action from staff.Staff were not able to give us an example of duty of candour in practice at Epsom.

### Maternity Safety thermometer

- The national maternity safety thermometer allows maternity teams to take a temperature check on harm in their unit. The trust aggregated this data across the two maternity units so it was not a useful tool for Epsom. However, the trust wide data over time was revealing in showing the variability of performance results in relation to the national mean, but most midwives and doctors were not aware of this tool.
- Both the maternity and gynaecology wards displayed the number of staff, planned and actual, on duty that day. There was no overview of the previous week or month, so trends were not evident to staff or patients. On our unannounced visits, there was a shortfall of staff in the birth centre and the combined antenatal and postnatal ward. Staff said they only reported staff shortage as an incident if the ward was busy and they could not provide proper care. All the wards displayed information about falls and infections.

### Cleanliness, infection control and hygiene

- The maternity wards were visibly clean during our inspection. Cleaning schedules were on display and cleaners understood cleaning frequency and standards. However records showed scores for infection prevention and control had been significantly lower at two audit points earlier in the year. We reviewed monthly cleaning audits where scores averaged 97%.
- We saw that the obstetric operating theatre had scored 100% for cleanliness in a cleaning audit. However, during our inspection the theatre was not as clean as expected. There were splatters of iodine and other sticky marks on the walls, which we could wipe off with clinical wipes. Although we were told the theatre had been deep cleaned three weeks before the inspection, this had clearly not involved cleaning the walls. The floor-covering joint alongside the scrub area was uneven and a potential trap for dirt. The door frames of the double doors were damaged and the paint had come off exposing , rough bare wood on the outside. There were sticky tape marks on the arm of the operating table.
- We observed most midwives and nurses washing their hands or using gel between attending to women. There was ready access to personal protective equipment and we saw this used.
- There had been no recent incidence of MRSA or Clostridium Difficile.
- Sharps bins were correctly assembled and dated, clean linen was stored correctly and equipment used by patients such as BP cuffs were clean in both maternity and gynaecology areas.

### Environment and equipment

- Ward midwives said there were shortages of dynamaps. Community midwives had no hand held IT equipment and had to come to the hospital to add information to computer records.
- Staff remarked on the slow IT infrastructure. Only one computer on the labour ward could be used to input data to the maternity computer system, so a manual register of births was maintained in a birth book. This duplicated data recording and had inbuilt potential for error.
- The scrub facilities for the obstetric operating theatre were in the theatre, which was not in line with current standards. Many items needed for surgery were stored within the theatre itself or piled within the small corridor space outside the changing rooms. There was no separate theatre storage area. The ventilation was basic and the ventilation grilles appeared to vent into the ward corridor.. The double doors opened into the corridor beside the reception area with no curtain to provide privacy when the door opened. The planned

twice-daily anaesthetic checks were not always logged and fridge temperatures were sometimes outside the maximum range but there was no record of action taken in response to raised fridge temperatures.
- Some staff told us the way women were positioned in the obstetric operating theatre was undignified. We were told it was standard practice for women to lie on the operating table with both their outstretched arms in splints, at right angles to their body. We were told this was done in order to enable clinical monitoring of the woman's condition. This is not common practice in other obstetric units, and did not appear to happen at St Helier hospital. It is a practice that would need to be justified by clear and urgent clinical need.
- Beside one bed in the two bed recovery room was an obsolete blood pressure monitor. This may have contained mercury and should have been removed.
- The small maternity assessment unit (MATAU) had three examination couches. It was staffed by one midwife. Midwives told us it was occasionally used as an overflow from the antenatal/postnatal ward. The consultant on the labour ward would be called to examine women in this area as needed. Some outpatient inductions took place here.
- The birth centre was bright, modern and well equipped with birthing pools, dimmable lighting, wall art, birthing balls and stools.
- The six delivery rooms were of varying quality. One, called "Rose" was formerly a theatre with laminar flow vents still in place. Some rooms, but not all had been refurbished and four had ensuite bathrooms. They were spacious enough for women to move around in labour.
- The labour ward had two types of buzzer: one for emergencies such as a Grade 1 caesarean or maternal collapse and the other for urgency, for example if a second midwife was needed. Some doctors were uncertain of significance of the different buzzers.
- Resuscitation equipment was checked daily and checks were recorded.
- The CTG equipment on labour ward was clean, checked and working, and there was evidence that PAT tests had been done. However staff commented that some of the equipment was old.

### Medicines

- A pharmacist visited the ward daily from Monday to Friday.
- Staff were aware of medicine management policies which were included in the trust induction for nursing staff. Medicines on wards were stored in locked cupboards. A spot check on the controlled drugs cupboard in the obstetric theatre showed that the logbook was correctly completed and the correct number of drugs were present.
- The unit had become latex free in June 2015 to avoid any risk to women who might be unaware of a latex allergy.
- A medicines management audit in September 2015 in maternity had shown some strengths at this unit in recording medical history , recording allergies, and VTE checks. There was room for improvement in areas such as legibility of prescriptions, documentation of drug discontinuation, and legibility of names on IV fluids. We heard that drug errors were continuing and would be made a disciplinary issue.
- Midwives did not always use trays to prepare drugs, in line with good practice.
- The trust did not have a ratified guideline covering the writing up and administration by midwives of a pre-set list of medications, in line with Nursing and Midwifery Council (NMC) standards for Midwives Exemptions. This was on the risk register. Since June 2015 midwives had started training in prescribing. Midwives would not be permitted to prescribe until all had received training

### Records

- All women attending antenatal clinics carried their own care notes and brought them when they came to hospital for the birth. Women's hospital records (pink notes) were not always easy to trace.
- We looked at two sets of notes in maternity. Plans of care were clear and entries were signed and dated.
- We reviewed two sets of gynaecology inpatient notes on Swift ward. We saw that pre- assessments had been completed and test results were recorded, a falls risk assessment and nutritional assessment tool was present. Some standard pages were colour coded so staff could find them easily. Entries were signed and dated. Discharge plans were clear and patients were given a number to call after discharge if they had concerns. Patients were given a patient experience form with an envelope to return.
- Patient records were stored securely.

# Maternity and gynaecology

## Safeguarding

- There were systems to identify and protect women and newborn babies. Midwives knew the name of the trust safeguarding lead from whom they could obtain advice and understood the reporting process. There was an interim midwife for safeguarding. Staff told us that mothers' social vulnerability, including risk of domestic violence was assessed as part of the booking process and extra information was sought from the GP if necessary. Safeguarding alerts were held on the maternity system. Mothers who missed antenatal appointments were followed up. They made regular referrals to the Multi Agency Safeguarding Hub (MASH).
- There was a clinic for women with mental health or substance misuse. Staff said this was one of the smaller clinics as there were few women in this category in the area. There was no specialist consultant for perinatal mental health at Epsom, nor a named perinatal psychiatrist.
- All permanent staff providing direct care to pregnant women should have face-to-face level 3 safeguarding training. Training in Women's and Children's Directorate on Safeguarding Children was 93% at November 2015. Training on safeguarding adults was 80%. The trust target was 90%. Midwives' Level 3 Child Protection Update was incorporated into mandatory training to ensure that it is accessed by all midwives. These were trust wide figures, not Epsom only. We requested a breakdown and it was not provided.

## Security in maternity wards

- Security in general was good. Entry to the wards was by buzzer. Staff at the nurses' station could see who was at the door before letting anyone through the door, and challenged visitors to find out who they were.
- One delivery room had a fire exit leading out to the lift lobby and staircase. On two occasions during our inspection this door was unlocked. On both occasions the door was re-locked and the alarm re-set after we drew attention to it.

## Mandatory training

- Core statutory and mandatory training in this trust included IPC, Resuscitation, Manual handling, equality and diversity, health and safety, child protection, safeguarding adults, fire prevention and conflict resolution. Includes fire, manual handling, mentoring and "skills and drills".
- The target set by the trust for mandatory training was 90%. The central record showed average performance in the Women's and Children's Directorate was 88% in maternity and 73% in gynaecology. VTE assessment training was the area of lowest compliance, 77% in maternity but only 34% in gynaecology. Data was reported by grade and staff group but not by site so it was not possible to identify whether there were training gaps at Epsom.
- Midwives had five mandatory training days a year. Staff could access online training from home. Staff were allocated to a pre-scheduled time shown on a timetable on a noticeboard.
- Annual CTG training was mandatory for midwives and doctors. Staff were required to retake CTG training if they scored below 80% in the competency paper. Training records showed bank staff were also trained. There was no consultant lead for CTG which was a concern given the acknowledged weaknesses in CTG interpretation.
- We noted a plan to roll out training to all staff on STAN (ST segment analysis) monitoring in 2016. STAN is a type of CTG that uses computer analysis of the baby's heart rate and heart muscle. It has the potential to reduce obstetric interventions in high-risk cases by providing more reassurance about the safety of the baby. Some midwives had undertaken training at a tertiary centre and would then train staff at Epsom. The decision to use this technology would still depend on reliable interpretation of CTGs. There was no central CTG monitoring or STAN hardware at Epsom.
- The practice development midwives kept local spreadsheets of midwives training and reported midwives were up to date with mandatory training.
- Training time was protected on the off duty rota and midwives said they were up to date with training.

## Assessing and responding to patient risk

- Women did not give birth at Epsom if they were less than 34 weeks gestation because there were no specialist neonatal services and no intensive care. We were concerned to note there were 71 unexpected admissions of term babies to neonatal care in the first six months of the year. This figure was higher than at the trust's larger maternity unit, which had a neonatal unit on site.
- Midwives and doctors confirmed that some high-risk women were booked for delivery at Epsom, particularly older women. We were told that in November 2015, a

woman with a very high-risk pregnancy was booked for an elective caesarean at Epsom. She subsequently had an emergency caesarean at Epsom, but also had a major post-partum haemorrhage necessitating transfer to the better-equipped St Helier Hospital. The trust had not been responsive to safety concerns raised by some staff.

- The policy for out of hours emergencies in gynaecology where women needed admission and observation was to transfer them to St Helier Hospital where there were emergency gynaecology beds.
- Staff said they had been trained in the use of obstetric early warning scoring (OEWS) to recognise women who were becoming more unwell. This had been response to incidents where staff had not recognised deterioration quickly enough. Charts that we looked at on the antenatal and postnatal ward were correctly completed.
- Some key policies designed to promote safety were not being followed in practice. The trust Induction of Labour policy said there should be strictly no more than three women induced on the same day, and that inductions at Epsom should only take place on Monday, Wednesday and Friday. A review of planned inductions during November showed planned inductions took place on most days which was not in line with the policy. There were five planned inductions on one day in November and four on two other days.
- There was one obstetric theatre. Planned caesareans were carried out on Tuesdays and Thursdays. We saw that audits for use of the Modified Maternity WHO checklist were routinely 100%. If a second theatre was needed, one of the main theatres could be used. These were not far away. We were told a second theatre was needed two or three times a year. We reviewed the escalation process for opening a second theatre. It would take an hour to make ready. As Epsom mainly carried out elective surgery, theatre staff needed to be called in from home if there was a night-time emergency. There was a rota for anaesthetists and ODPs.
- There were protocols to deal with obstetric emergencies. We were told the risk of misinterpretation of cardiotocography (CTG) had been reduced through training, although this remained on the risk register. Managers said not all midwives were confident in CTG interpretation. “Fresh eyes”, a structured review of electronic fatal monitoring by someone other than the midwife providing the care was not being recorded.
- Surgical or medical termination of pregnancy for significant fetal abnormality was offered for women up to 15 weeks gestation. Medical termination beyond 15 weeks would be undertaken at St Helier hospital in a delivery room.

### Midwifery staffing

- The midwifery establishment was shown on the maternity dashboard was 1:27. The actual ratio was 1:31 taking account of maternity leave and sickness. The vacancy rate was 13.8% and sickness levels were 5.5%. As these figures were not routinely monitored through the maternity dashboard the Directorate management and the Trust Board could be misled. Vacancies were filled by bank and agency staff. The Maternity Board had not discussed staffing at any of its recent meetings, Staff shortage was only added as a high risk on the risk register in October 2015, after new staff had been recruited.
- A core of long serving midwives, mainly band 7s did not work flexibly and some did not regularly cover night shifts. Labour ward co-ordinators at night were not always Band 7 as nationally recommended because that role needed a certain level of experience. Band 6 staff acting as coordinators had no additional training.
- Labour ward coordinators were not always supernumerary. The trust had its own definition of supernumerary: if the shift was without a supernumerary coordinator for more than two hours. The trust target was for 95% of coordinators to be supernumerary. The service’s definition of supernumerary was out of line with best practice which was proven to lead to improved outcomes and fewer interventions in labour, and therefore an important part of safe practice. An audit in August 2015 about the loss of supernumerary status attributed this to staff shortage, midwives acting as scrub nurses, many women requiring one to one care when the postnatal ward was busy, and a large volume of induction of labour. No action appeared to have been taken in response to these findings even though, at Epsom, the coordinator was less likely to be supernumerary than at St Helier.
- We reviewed records for one week at the end of October. There was one day when the coordinator was supernumerary, two days when they were not. The

remaining four days coordinators were supernumerary 50% of the time. On average during October the labour ward coordinator had been supernumerary for less than 50% of the time.

- A consultant midwife for normality, a lead midwife for inpatient services and a deputy community midwife lead, were based at Epsom. All other managers were based at St Helier maternity unit.
- The unit did not use the recommended NPSA intrapartum scorecard to record staffing, skill mix and activity. They recorded activity every six hours on a shift coordinator handover sheet. A recent audit had shown the handover sheet was not fully completed on 11 days in September and October. Uncompleted sheets meant there was no clear record of labour ward activity.
- A labour ward coordinator said staff did not always arrive promptly for handover.
- The midwives scrubbed for all emergency caesarean sections on the labour ward. A scrub nurse worked three days a week (elective surgery days) at both sites. When midwives had to scrub for emergency surgery there was a risk that only two midwives might be left working on the unit. Normal midwifery staffing on the labour ward was five but there were often shortfalls. This was not a safe level of staffing.
- Midwives told us it was very difficult to get agency or bank staff if needed when very busy, especially after 4pm. Bank staff usage for antenatal clinics was 28%, which was very high, between April 2014 and March 2015 and 12% on the maternity wards.
- There was a full time Supervisor of Midwives. Each supervisor had 15 midwives (trustwide figure) until July but the ratio had fallen in August to 1:17. This compared to the national standard of 1:15. The changed ratio was not shown on the dashboard, which reported a ratio of 1:14. We did not see a 1:14 ratio in any other documentation we received from the trust. This was one of a number of examples of inconsistent statistical information.
- The antenatal team were not meeting targets for screening compliance. We were told this was because some women did not book in time. However, 89% of women booked by 13 weeks on this site, which was almost the national target of 90% the reason for not meeting the target was unclear. It appeared that midwifery managers did not place high priority on screening.
- Community midwives worked in two teams, one covering Banstead and Cobham and the other Epsom and Ewell. They provided antenatal care in GP surgeries, children's centres and health centres. They also ran an 'appointment only' clinic in the hospital on a Saturday. The team was short staffed because of maternity leave and retirement.
- Community midwives were sometimes called in to the labour ward in times of peak activity. This happened 4-6 times a year on average.
- Maternity assistants were highly valued by the midwives at Epsom. They helped with breastfeeding and weighing babies.

### Obstetric staffing

- There were 26 obstetric and gynaecology staff at Epsom.
- The Royal College of Obstetricians and Gynaecologists recommends 98 hours a week of consultant cover for a labour ward with between 4000 and 5000 births. This unit had 98 hours cover for around 2000 births. Consultant resident on call cover was 3 nights a week (Monday to Wednesday). Normally a consultant was on site until 10pm. Out of hours and at weekends consultants were on call. Doctors said they did not often call consultants in, but did ring to seek advice. Consultants also covered gynaecology but only elective gynaecology took place at Epsom and emergency gynaecology was at St Helier. The same consultant covered both days of the weekend. The hospital did not record the hours of consultant anaesthetist cover on the dashboard.
- A consultant and midwife ran antenatal clinics for women with specific conditions that made their pregnancy higher risk. Consultants considered this a good model for junior doctors training, and believed women benefited from having a consultant interested in (although not necessarily expert in) each specific area of medicine. We were told the system would be audited early in 2016 but this was not recorded on the audit plan for 2016.
- There were two fetal medicine consultants. Doctors told us they were keen to develop fetal medicine research at this site.
- Trainee doctors reported good induction to the trust and to the obstetrics and gynaecology service. They said consultants were always available when needed.

# Maternity and gynaecology

- Locum use across both maternity units in obstetrics and gynaecology was 8%, below the trust average for locum use
- Many of the consultants had worked at the hospital a long time and their practices were not always contemporary.
- Midwives said the rota for on call obstetricians was on the noticeboard. They must live within 30 minutes travel time from the hospital when on call. Not all consultants were on the night on call rota. Some doctors worked only in obstetrics. We were told that three doctors who currently only practiced obstetrics, worked regularly out of hours without back up from an Epsom-based on-call gynaeocologist. However, a second consultant was available at St Helier. The presence of doctors who only worked in obstetrics presented a risk to women in the event of an emergency necessitating a gynaecological procedure such as hysterectomy or massive post partum haemorrhage. This was out of line with the satisfactory arrangements that units should establish in line with the RCOG's Safety Alert on Out-of-hours cover for consultants who do not perform major gynaecological surgery (2011).
- Handovers took place morning and evening. There was not always an anaesthetist present.

### Gynaecology staffing

- Most consultants, and all trainee doctors worked in both maternity and gynaecology. Trainees and clinical fellows only worked at Epsom.
- A new consultant appointment at Epsom would enable urogynaecology clinics to take place at this site.

### Major incident awareness and training

- The Staffing Levels and Escalation Plan' dated October 2015 provided no indication of the skill mix required to sustain the maternity service when there were capacity issues . Skill mix was not assessed as part of the labour ward shift coordinator's sheet. We observed that sometimes women or staff were moved between the two maternity units at times of peak activity.
- The birth centre had been closed on 24 December 2014.The birth centre was not open during part of our inspection but closure was only declared as an incident if a woman came in to use it. An incident report showed staff had tried to close the unit on 19 January 2015 when the labour ward was full. A woman in early labour had been transferred to St Helier Hospital.
- Staff said they would follow trust policy in the event of a major incident. They were aware there was a plan on the intranet. We did not see information on wards about major incident plans and staff did not know what their roles would be in an incident and had not been involved in incident rehearsal.

## Are maternity and gynaecology services effective?

Requires improvement

The maternity service requires improvement to be effective. Although we noted policies had very recently been updated in line with best practice standards, practice itself was not always contemporary nor evidence based. Many staff were not familiar with recent protocol changes so some policies were not being observed in practice

The service had a maternity dashboard to monitor its performance. This did not include some key indicators normally included. Few staff beyond managers were aware of the dashboard or overall performance at the unit. At governance meetings staff did not little challenge performance even though instrumental and caesarean rates were higher than national rates. This both increased the cost to the service and also the risks to women and babies. Although managers told us they recognised the unit was outside the expected range in some respects they did not have a strategic plan to tackle these issues.

Although we were toldstaff had been trained in the communication tool SBAR (Situation, Background, Assessment, and Recommendation) to report information to other professionals , we did not observe these being effectively used in handovers, and there was a risk some key information was being missed.

### Evidence-based care and treatment

- Most protocols and processes had been very recently updated using national guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists. The guidelines were up to date, clear, and available on intranet and had some multidisciplinary input in their development. However, a limited range of staff were involved in revising guidelines. Trainee doctors had only

been involved in 12 of the 115 revisions. Staff did not feel ownership of the changes or understand them and information about changes were inconsistently shared with staff.

- Antenatal care followed Quality Standards 22 about risk assessments, except Epsom did not collect data on numbers of women booking their first antenatal appointment by 10 weeks. Quality Standard 32 was followed in documented decisions about caesarean sections and Quality Standard 37 on postnatal care.
- The unit did not follow the guidelines in Safer Childbirth: minimum standards for the organisation and delivery of care in labour February 2015 and NICE guidance 'Safe midwifery staffing for maternity settings' February 2015. These recommended all women in established labour have one-to-one care". The trust's own target was for 95% of women to have one to one care. One to one care had been available to 91% of women on average since April 2015. However in August this had dropped to 87%. Managers were not able to explain why the trust did not aim to provide 100% of women with 1:1 care in labour.
- The maternity unit contributed to some national audits but the use of merged data in national returns limited its usefulness as poor performance at one unit could be evened out by better performance at the other unit.
- All relevant babies had temperature records taken which achieved the standard of the national neonatal audit programme. All parents of babies admitted to special care had a documented consultation within 24 hours of admission. All relevant babies were screened for retinopathy of prematurity
- The unit followed the National Screening Programme and details were documented in the care notes. All women were given the National Screening Programme booklet. Nuchal screening was done (scan & blood) and the risks were calculated and women advised of findings. Data submitted to the NHS Screening Programme was merged data for both units so the performance at Epsom could not be identified. The dashboard indicated the Epsom unit only scored 44% for thalassaemia and sickle cell testing against a target of over 75%.
- The Northgate failsafe system for six inherited diseases in babies was used. The dashboard did not record whether results were received within 17 days.
- Data was provided to UNICEF Baby Friendly Programme and to the Maternal, New born and Infant Clinical Outcomes Review Programme (MBRACE-UK).
- Few local audits were registered for maternity services and even those which maternity policy or guidelines deemed necessary to report to the Directorate Risk Group such as audits for induction for prolonged labour or previous caesarean section had not been registered or carried out.
- The unit had just begun to participate in the Perinatal Institute's Growth Assessment Programme (GAP) for reducing stillbirths through improved detection of fetal growth restriction. It was too early to see results.
- Women we spoke to at Epsom confirmed they had a named midwife throughout pregnancy who they were able to call for additional support if needed.
- In gynaecology we saw up to date protocols for early pregnancy loss, ectopic pregnancy, and hyperemesis, and manual vacuum aspiration, medical management of miscarriage and pregnancy of unknown location.
- Urogynaecology guidelines corresponded to NICE 2013 guidelines.
- We saw evidence of local clinical audits in gynaecology at Epsom. An April 2015 audit of the newly introduced procedure of Manual Vacuum Aspiration (MVA) for miscarriage as a day procedure as an alternative to surgery under a general anaesthetic recommended this should be adopted for suitable woman as it was less expensive and as reliable. An April 2015 re-audit of Pregnancy of Unknown Location had found management satisfactory at Epsom but recommended changes to make audit more reliable, to organise a cross site MDT meeting to discuss complex cases and consider electronic records to replace the handwritten book in the Early Pregnancy Unit. Staff were not able to tell us whether these changes had been implemented. However, it was unclear how the findings of audit were communicated to staff so as to impact on care.
- The Women's Health Clinical Audit meeting discussed audits every two months. The audits presented covered maternity and gynaecology at both sites. Some audits were only carried out on one site, which was a missed opportunity for comparison.

### Pain relief

- During labour, women should have a choice of pain relief methods appropriate to the type and care chosen. Women on the labour ward had a choice of epidural analgesia and other pain relief such as nitrous oxide (gas and air) and pethidine. We were told most women having pain relief chose epidurals. The maternity

dashboard did not show the epidural rate so we could not confirm the percentage. Records showed women who needed a caesarean section usually had spinal anaesthetics.

- A trust-wide audit from January to September 2015 showed 94% of woman as happy with pain relief in labour, 99% were happy with pain relief after surgery and 97%with pain relief after a caesarean section. We requested but did not receive Epsom specific data. Women we spoke with reported pain relief had been good. However, we noted from patient complaints during this same period that some patients had reported insufficient pain control and delays in receiving relief.
- On Swift ward patients told us nurses had asked them if their pain relief was adequate.

### Nutrition and hydration

- The unit had achieved the UNICEF Baby Friendly Initiative Level 3 accreditation for supporting new mothers with the feeding of new-borns (a worldwide initiative to encourage breast-feeding). The unit's breast-feeding initiation was 86% and dropped to 77% 10 days after delivery. This was significantly below the trust target and the UNICEF target of 90% and 100% for these two measures.
- The Swift ward used the Malnutrition Universal Screening Tool (MUST) for patients who were at risk of malnutrition. Patients at risk of dehydration also had fluid balance charts to monitor fluid intake and output.
- Mealtimes were protected. Most patients considered the food acceptable.

### Patient outcomes

- The unit had a maternity dashboard as recommended by the RCOG (Good Practice No 7). The dashboard did not contain data for all the standard maternity outcomes recommended in that document. For example, it did not display details of staff sickness rates, use of agency staff or the actual ratio of midwives to deliveries so the staffing levels to deliver a safe, high quality service were not clear. The trust wide dashboard was included in papers for the Maternity Board each month. There was a significant time lag in data presented to the Maternity Board: the trust wide dashboard for March was presented to the June meeting. The action plan section of the dashboard was not used to show how the unit would improve its performance in order to meet trust targets.
- Risk had not been highlighted in any of the maternity outlier indicators in CQC intelligence monitoring report because risks were obscured by reporting trust wide data. However, performance on some indicators was below national norms and the unit was not meeting the trust's own targets in a number of areas.
- Only 3% of women missed appointments but 19% of women changed their appointments. This appeared to indicate the appointment system was not flexible enough to meet women's needs. The trust target for client-changed appointments was 10% but clinic staff could not tell us of any action to reduce this.
- The percentage of women with spontaneous deliveries was average, at 59%, from April to September. 11% of all births took place in the birth centre, which was below the trust target of 20%. The birth centre was under-used. The home birth rate was also below target, at 1.6% of births since April 2015.
- The planned caesarean rate was 8.4%, which was below the England average and was a positive indicator. According to the dashboard, the overall caesarean rate had averaged 24% since April 2014, which was within the national range, although in one month this had risen to 30%.
- The trust provided trust wide data to RCOG for the second report on Patterns of Maternity Care in English NHS Hospitals for the previous a year. The commentary on the trust's results (trust-wide figures rather than figures from Epsom) specifically indicated that the trust as a whole were outliers for episiotomy procedures for vaginal delivery. Epsom were results were higher than St Helier, over 28%.The unit averaged 3.9% over the six months to September 2015 for severe post partum haemorrhage (PPH) (over 1500ml. 4% was the threshold for a red flag on the dashboard. We noted that in two months of 2015 PPH had been more than double the trust target of 3%. We did not see an audit or a formal action plan to reduce these serious events.
- National rates for maternal re-admission to hospital within 42 days of giving birth rates are 0.5 -2.4%. 23 women were re-admitted between April and August 2015, which was at the upper end of the range. Re-admission of babies born at term was 1.7%.
- Third or fourth degree tears were low: 3%.
- Most women were assessed for the risk of venous thromboembolism (VTE): 98%, although we noted two incidents where a woman needed VTE treatment and their initial assessment had been incorrect.

# Maternity and gynaecology

- Women were encouraged to have a normal birth for a second child after a caesarean birth first time, known as VBAC. Staff told us 80% of women were consenting to VBAC but the numbers were small and the programme was relatively new. In the previous year the trust performance on this indicator had been worse than the national average. Managers told us women's choice was respected. Some midwives told us there was too much pressure on women to agree to VBAC and first time caesareans should be the priority for reduction.
- An enhanced recovery programme for women having a planned caesarean section had been started in February 2015. This programme encouraged early mobilisation, eating and drinking and enabling women to go home the next day if she was ready. Numbers were low. Staff said there were not enough community midwives to offer the postnatal support needed.
- There had been three stillbirths in Epsom since April 2015. In England and Wales there were about 5 stillbirths per 1000 births. The Centre for Maternal and Child Enquiries (CMACE), showed the death rate of new-borns and the number of stillbirths in the trust were below average. Combined figures for both trust maternity units showed 3.2 deaths/1000 births. The average number of neonatal deaths (during the period from seven to 28 days after birth) was 0.8/1000 births trustwide (national figure 2.1/1000).
- The number of consultant hours on the delivery suite had risen from 60 to 98 from July 2015. Doctors said the unit planned to meet the 168 hours consultant obstetric presence on the labour ward in line with London standards by 2015/16. The London standards applied to all maternity units regardless of size. Doctors told us they expected the rates of failed instrumental delivery and caesarean section to decrease with better cover from senior staff but there was no plan to audit this in the announced audit plan for the year.

### Competent staff

- Data on appraisals showed 77% completion for nurses in gynaecology and 77% for midwives. Community midwives reported they had had appraisals. Some hospital-based midwives said they had not had appraisals.
- Induction for new permanent staff was a three week orientation programme and attendance at a monthly trust wide induction day. New midwives and nurses told us the trust induction was useful.
- Regular skills and drills took place using simulation to rehearse obstetric emergencies. Midwives, doctors and anaesthetists attended. There were some unannounced drills. Some midwives had not experienced unannounced drills.
- Some midwives were trained to undertake the newborn and infant physical examination (NIPE) where support was available from paediatricians when required.
- Midwives handovers were not used as an opportunity for training. On one day the labour ward handover last less than five minutes as there were only two women on the ward. The occasion could have been taken to consider topical issues in the department and help staff develop their skills.
- We were told about a proposal to rotate midwives through the birth centre to maintain competencies. The community midwives at Epsom said a few midwives already worked across inpatient and community and one worked in the birth centre. At the time of our inspection, manager's planned that rotation to be done by new, less experienced staff only, rather than including all staff in the rotation. This was not conducive to building an integrated midwifery service.
- Trainee doctors received a Weekly Educational Newsletter from a consultant with teaching activities for the week. The national training survey of the trust by the General Medical Council showed the unit scored less well than expected for the induction and feedback junior doctors received. Trainees working at Epsom were GP trainees.

### Multidisciplinary working

- Midwives and doctors had separate handovers on the wards. A midwife usually attended the medical handover. We observed a handover attended by five doctors (Consultant, Registrars, SHOs and an anaesthetist) and two midwifes (one band 7 lead and one student). There were only two women on labour ward. Notes were made on the handover sheet and two of the doctors signed the sheet at the end of the meeting.
- There was little contact between clinical staff at Epsom those working at the St Helier, other than a few senior staff who had cross-site roles.
- In gynaecology there was a weekly MDT for colposcopy. The trust was also a member of a regional network and a representative attended a monthly MDT with other local hospitals involving uro-gynaecologists, urologists,

clinical nurse specialists, physiotherapists , trainees and continence advisors. The combined services at St Helier and Epsom had contributed 37 cases to discussion March 2014 – April 2015. Staff considered there was very good multidisciplinary working and that the service was outward-looking.

- Women were given choices over the treatment for miscarriage: expectant management, surgical management or evacuation under general anaesthetic. For ectopic pregnancies, women also had choices of medical or surgical treatment, where appropriate.

### Seven-day services

- On Saturday and Sunday a consultant did a ward round on both the maternity wards and gynaecology patients on the women's surgical ward. Full time medical cover was a Registrar and SHO. The junior doctors said their cover was stretched thin at weekends.
- Ultrasound was only available during the week, although a mobile mini-scanner was available on the wards at weekends. The maternity assessment unit (MATAU) and the early pregnancy unit were not open at weekends.

### Access to information

- All guidelines and protocols were on the intranet which had recently been re-launched. Medical staff confirmed guidelines were easy to locate. We were not able to find aguideline for maternal collapse.
- Patient notes were mainly paper based, although there was an electronic management information system (PROTOS) that midwives completed after delivery. We witnessed a delay in finding the medical notes of an older mother at risk of complications after she had been admitted to the labour ward. At night midwives said it was often difficult to obtain notes.

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

- Consent was appropriately obtained and women were supported to make decisions about their care and treatment. We saw consent was recorded in women's notes in both gynaecology and maternity wards. There had been no audit of consent in maternity.
- Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was part of the trust induction programme.

## Are maternity and gynaecology services caring?

Good

We saw staff interacting with women and their partners in a respectful and compassionate way, however we noted from reviewing women's complaints about the labour ward that some women considered communication was poor and occasionally rude. Staff said they considered emotional support for women was good, particularly in times of bereavement. Women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women were involved in their birth plan and had care from the same midwife during pregnancy.

Women's responses to the Friends and Family test were mainly positive, 98% of women would recommend the inpatient service in September 2015. The results for antenatal care only based on 5 responses which was too small to be significant..

### Compassionate care

- In the CQC Maternity Service Survey 2015 showed results were broadly in line with other trusts, but the information was combined data for both sites.
- We observed doctors asking permission to open curtains, asking permission before bringing trainees into a bed area and good respect for patient privacy.
- Women we spoke with on the antenatal/postnatal ward described midwives and maternity assistants as kind and caring. One woman said there was a lack of staff presence on both the labour ward and the maternity ward but they responded if called.
- We saw staff were welcoming to patients in labour ward and the birth centre. Two mothers we spoke to on the antenatal/postnatal ward said their antenatal and inpatient experience was generally good and they had been able to consider birth options and pain relief. Neither woman had a named midwife, although one woman who had antenatal care from community midwives had seen the same midwife at most appointments. Another mother, with a medical condition whose antenatal clinics had been at the hospital, had seen a different doctor and midwife at every visit.

# Maternity and gynaecology

- One woman said she had 'nothing but praise' for the midwives, but found the medical staff less caring in their approach. Another said staff had been helpful postnatally in supporting her with breastfeeding and bathing her baby.
- On Swift ward one patient remarked on the 'outstanding care' from her consultant whom she had seen in outpatients and on the ward. She said all staff were caring, kind and willing to help and the ward was clean and tidy.

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

- Women we spoke with said they had been involved in decisions about their choice of birth location and the benefits and risks of each. They felt staff supported their decisions.
- We observed clear explanations and reassurance being given by a doctor while a woman was having an ultrasound examination.
- Doctors advised women of their options when fetal abnormality was identified. If they chose to have a termination later than 15 weeks the woman would be admitted to a normal delivery room at St Helier. Post mortems for miscarriage or stillbirth took place at another trust.

### Emotional support

- Managers had recently reviewed their processes for women who had lost a baby. A bereavement midwife was responsible for speaking with women who were bereaved during or after childbirth or had a late miscarriage or termination for medical reasons. There were sensitive mementos for parents and on-going postnatal support in some cases. Women were assessed for anxiety and depression and counselling services were available.
- Individual cremations were held with the parents invited, including for late terminations. Burials and blessing could be arranged through the chaplain who was available on call.
- Nurses told us they would help women cope emotionally with their care on the gynaecology ward. Feedback from gynaecology patients was generally positive.
- Staff said they had been trained to recognise when an individual woman might need extra support, for example women with a learning disability or a mental health condition

## Are maternity and gynaecology services responsive?

Good

There was a good flow through the service and women had no difficulty accessing appointments. Staff told us interpreters could be arranged if needed. Although women did not have a named midwife there was good continuity of care from midwives during the antenatal and postnatal period. Continuity of care in labour was not always achieved and consultant's working patterns meant some women might see several consultants during their labour.

There was no provision for partners to stay in the hospital after the birth.

### Meeting the needs of all women

- In July generic hospital antenatal clinics had been replaced by condition based clinics for women whose pregnancies might have complications. The nine clinics were each led by an obstetrician and midwife, and each focused on a broad set of conditions which could cause problems in pregnancy. A doctor told us Epsom clinics had on average 14 patients and took place weekly, except for theteenage pregnancy clinic for which there waslow demand. An objective of the new clinic system was to improve continuity of care, but two women we spoke with said they had attended more than one antenatal clinic since this change. Doctors said they planned to audit the new clinic system after 6 months, although medical staff had not registered this in the annual audit programme.
- A telephone interpreting service was available. The trust had recorded75 instances of interpreters used in maternity, but no analysis of languages used.We saw no leaflets on display in other languages.
- Epsom maintained high levels of continuity of care for women through its community midwives. A survey in March 2015 showed 97% of women had seen the same team of midwives and 91% were satisfied with their care. There was less continuity of medical care. There was no consultant of the week and consultant rotas were for four hours sessions, which meant that women might see several different doctors during their labour. We saw no plan to change this.

- Some women in the area chose to give birth in other local hospitals. Senior midwives were reviewing the results of an audit to see how they could market the maternity service better. There was a choice of home birth, birth in a midwife led unit adjacent to an obstetric unit and an obstetric unit, in line with NICE guidelines.
- The Maternity Liaison Service Committee (MLSC) was to be re-launched, as it had not been active in involving local mothers in service delivery. The hospital did not share its maternity dashboard with the MLSC or any other consumer groups.
- There was an 'appointment only' early pregnancy unit for women in the very early stages of pregnancy who had concerns about their pregnancy or were suffering extreme nausea (hyperemesis).
- There was a room on the labour ward, which wasused for women who had suffered bereavement. It was not a dedicated room and had a hospital delivery bed and other birthing equipment.
- The birth centre sometimes closed for lack of staff.
- One woman told us she had been admitted to the antenatal ward 'for monitoring' but not seen any staff or monitoring equipment from midnight to 7.30am
- One gynaecology patient in a side room was disappointed not to have access to television or radio.
- Staff had a space on the labour ward where they could take their breaks

### Access and flow

- Most women were referred to antenatal services by GPs but women could refer themselves to the hospital by printing out a form from the trust website. Women could not register for antenatal care online. After the booking appointment low risk women would be seen by community midwives in GP surgeries or children's centres. Women with conditions that made their pregnancy higher risk were referred to medically led hospital clinics.
- Women had an initial assessment at their first antenatal appointment (booking). This did not have to be at the hospital, but women came to the hospital for scans, or if they needed to attend medically led clinics. Hospital clinics mostly ran weekly. Performance data showed that at December 2015 89% were booked (attended their first appointment in their pregnancy) before 13 weeks gestation which was good because early booking is associated with early identification of risk. No data was reported on women accessing antenatal care at 10 weeks compared to those accessing it by 13 weeks
- Admission processes when women thought they were in labour were not ideal. There was no formal telephone maternity triage so a woman telephoned the labour ward for advice. Assuming a midwife was free they could give advice but there was no dedicated triage midwife contrary to NICE guideline CG190. This meant womenwere often admitted to a delivery room on the labour ward, even if they were not in labour. Between April and November 2015 220 women were admitted to the labour ward and not delivered during that admission. This was not best use of the beds in delivery rooms and would be alleviated by the development of triage.
- The labour ward was underused. The bed occupancy averaged 35% between April and November compared to 53% at St Helier.The antenatal/postnatal ward occupancy was only 39% which is lower than many maternity wards.
- The Maternity Assessment Unit (MATAU) did not provide a triage service.
- Partners were encouraged to visit but overnight facilities were only available in the event of a stillbirth, neonatal death or other special circumstance. There were no beds or recliners for partners.
- Some midwives thought women followed the staffing pathway rather than a midwife following the woman's journey
- A debriefing service at the hospital had recently started but we had no feedback from mothers at Epsom on this. We did not see this advertised,
- Private Obstetric Services were run as a consultant-led service by a medical consortium including consultants from Epsom, St George's and St Peter's hospitals, with support from NHS midwifery staff. Private caesarean sections took place on the same days as elective NHS caesareans and private women were first on the list and procedures took place in NHS time. There were two private postnatal rooms for these patients on the maternity ward. These rooms could be used by other women as amenity rooms if they were not being used, although at a higher cost than the NHS amenity rooms.
- Some midwives expressed concerns about the impact of consultants' private work. Although it was small scale,

medical staff were keen that it should grow. Midwives we spoke to were unaware the trust had any policy governing private medical work undertaken within NHS facilities.

- We were not given any data on the number of gynaecology procedures at Epsom. All surgery was planned. Emergency gynaecology was available only at the St Helier hospital. The unit was small and some were admitted as inpatients and some had day surgery. Some women had to be admitted as inpatients for gynaecology procedures and hyperemesis (severe nausea in pregnancy) in the absence of a 23 hour day unit. The longer term objective was to increase the number of day cases and reduce inpatients. Leatherhead Hospital was the hub for Epsom's ambulatory gynaecology service. It encompassed most gynaecological cancer screening and had recently expanded to offer consultant-led, one-stop ovarian ultrasound screening as well as colposcopy and minor procedures.
- There was a private patients' wing (15 beds) at Epsom: the Northey Suite. Some gynaecology patients had procedures in the hospital, using the same theatres as NHS patients, butaccommodated in this wing after treatment.
- The average completed RTT pathways between February and July were 94.2%.We were told some consultants insisted on doing procedures on certain patients and this was delaying treatment times because staff were not acting as a team and cross covering lists.
- An audit of breaches of the two week rule for possible cancer diagnosis had identified capacity as an issue. There had been 16 breaches in 2014-15.
- Clinic waiting times were not available for this site. The combined figures for both sites between November 2014 to April 2015 were that 83% were seen in under 30 mins, 14% within an hour
- When women were discharged from the Swift ward after a procedure, they took home medicines to prevent VTE. There was a dedicated phone line on the ward and staff made post discharge phone calls.

### Learning from complaints and concerns

- We learned a new complaints handling process had been introduced which would better enable the complaints team to monitor directorate's responses to complaints and speed up responses which records showed had been slow earlier in the year. They were also seeking to improve the quality of responses. Maternity complaints were 16% of trust complaints.
- Nine women had made formal complaints since April 2015. Trainee doctors and midwives said they did get feedback from women's' complaints or lessons learned. Poor communication and rudeness or dismissive attitudes were mentioned in complaints. Women we spoke with knew how to raise concerns. We were told the PALS office was often closed and staff were not always helpful.
- Complaints were discussed in terms of numbers and administration rather than analysing what complaints were and what could be learned from them.
- Gynaecology complaints were mainly about communication and waiting times. We saw some examples of complaints and considered the responses rather formulaic.

## Are maternity and gynaecology services well-led?

Inadequate

Clinical leadership of the maternity and gynaecology service was weak. Obstetricians and midwives appeared to operate separately without a shared vision of the direction of the service. Governance was not sufficiently focused on a high quality care experience for all women.

Although there were named consultants for the labour ward/risk and a clinical director worked on site, most obstetricians were not closely involved in governance and driving improvement, such as reducing rates of post-partum haemorrhage or instrumental births. We did not identify any forum that discussed Epsom specific maternity data even though separate maternity dashboards were available. The practice of merging data for both units obscured areas where outcomes at Epsom were better or worse than the sister unit at St Helier hospital. The use of data and audits in the day to day running of the service was poor, and hindered by so much reliance on merged data.

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Risks were identified in various different meetings and documents, but not pulled together in a coherent risk register with a focus on timely mitigation of risks. Midwifery staff shortages were not always escalated.

The culture was hierarchical and senior midwifery managers were not considered to be visible or supportive.

## Vision and strategy for this service

- There was no overriding shared vision for maternity at Epsom. A trust-wide five-year strategy agreed in September indicated the trust would continue to provide two maternity units, but did not include a vision for development. Consultants and midwives did not share the same objectives for the service. Providing a high quality, safe service to all women seemed less important to medical staff than the development of specialist services. Ambitions for general growth in the service did not fit with the small size of the unit and the static number of births.
- Midwives at Epsom were unaware of a strategy. They were conscious of constant political change and threats of closure because of the cost of running two separate units, but were not involved in plans for developing the maternity service.
- There was a potential barrier to Epsom working closely with St Helier, even though they were part of the same trust,because commissioners for Epsom hospital were Surrey Downs whereas Commissioners for St Helier were Sutton and Merton. The two areas had different demographics with different needs. Some staff referred to the trust as 'an arranged marriage'.
- Clinical staff did not draw on the views local women for the development of the service.
- The vision for gynaecology was clearer and focused on modernising provision by increasing day cases to 90% (from 70%) and outpatient procedures to reduce inpatient ward beds and to offer an improved patient experience by more community based clinics, and telemedicine. However this was limited by capacity at Epsom.

## Governance, risk management and quality measurement

- We reviewed minutes of governance meetings, a maternity monitoring short report, risk meetings and directorate management meetings. The Maternity Board, which met monthly reported to the Chief Nurse. The primary function of the Maternity Board was to monitor clinical performance of maternity services and focus on risk. Doctors from Epsom often did not attend at Maternity Board meetings and did not always submit a report. Clinical staff and managers did not recognise the importance of data quality. There was a limited clinical audit programme in maternity and little evidence of consideration of value for money of maternity services.
- Minutes of governance meetings indicated limited scrutiny and challenge, with minimal comparison with other maternity units or with national standards. Scrutiny from the patient safety and quality committee in July 2015 had asked some challenging questions and not had robust answers. There appeared to have been no revaluation of practice in response to the concerns raised by this committee.
- Management of risk was reactive rather than proactive. The process for identifying, recording and managing risks was not robust. There was no Epsom specific risk register, even though the risks were different on each site. The risk register (trust wide) contained few clinical risks and did not cross-reference to either the local maternity dashboard or the maternity safety thermometer. The risk register contained some very old risks and did not identify some of the risks we observed on inspection, and about which staff told us, for example the static number of births, the underused facilities, staff shortages and the risk of post-partum haemorrhage. These risks were all relevant to the Epsom site.
- The minutes of the monthly Risk management meetings were brief and did not set timelines for improvement or review progress since the previous meeting. Obstetric consultant attendance was sporadic. Mitigating actions were not always recorded.
- We were told the trust board received a maternity report, via the Patient Safety and Quality Committee, which identified the latest performance standards and key risks within the maternity service. However, we noted that when the Maternity Dashboard had been to the Trust Board the focus had been on the Friends and Family Test performance rather than on maternity performance indicators. We were not confident there was a system to assure the Trust Board about the quality of the service at Epsom hospital.
- The governance of the gynaecology division had a clear structures and shared the formal clinical governance framework with the general surgical Division. Clinical

governance meetings for gynaecology took place monthly. The Epsom and St Helier hospitals operated largely independently but there were plans to achieve cross-site harmonisation and expand the service. There were capacity issues at Epsom that were relieved by the provision of services at Leatherhead hospital. However, we saw little evidence of engagement in the changing local health economy.

- Information from clinical governance meetings was inconsistently shared with staff. There was little evidence on the wards of staff discussing revised clinical guidelines and implementing change at ward level.
- Some staff told us about problems with IT and other equipment which affected the speed and effectiveness of their work. IT improvements were included in the trust's five year plan.

### Leadership of service

- Some midwives mentioned limited clinical leadership despite the number of senior management posts. Most midwifery managers were based at St Helier where the head of midwifery was based. There were 6 other midwifery manager posts, two of which were vacant. Some of these, such as the lead midwife for clinical governance worked across the two maternity units. Staff said contact was mainly by email. They felt senior midwifery management was remote. Neither trainee doctors nor midwives were involved in the decision-making process and staff considered they were notified of decisions rather than being involved. Leadership did not encourage openness and some staff felt there was a blame culture. Many midwives had worked at Epsom for some time and newer staff felt they were set in their ways and not interested in continuous improvement.
- At ward level, leadership was not strong. A group of staff had worked together for many years and preferred to work with people they knew rather than be open to working anywhere in the maternity service. Longer serving staff did not work regular night shifts, or shifts on the labour ward and did not provide good role models to new staff.
- The community midwives were a cohesive team and considered they were valued and supported by management. However planned changes in the organisation of care were, at the time of our inspection, only intended to apply to less experienced staff which was potentially divisive.
- Gynaecology leadership was clear and staff understood the direction of travel. Nursing staff were very supportive of one another and had respect for their managers.
- The private obstetric service was small but staff were concerned that there had on occasion been prioritisation of private elective caesareans sections over NHS elective caesareans as these were done on the same day as NHS lists. We asked for information about the governance of private maternity services but did not receive this. The wards used the same staff. We heard that consultants could be 'pushy' to theatre staff about giving precedence to private patients.

### Culture within the service

- There were a number of differences in the culture, quality, and delivery of care provided at the two maternity units. Many consultants worked entirely on one site.Medical staff were not closely involved in the development trust's maternity service as a whole.
- Front line midwives at Epsom did not feel part of the wider trust, and felt their hospital was the 'poor relation' as new practice was tested there first. We did not detect a collective will for midwives and obstetricians to make any changes.
- Many midwifes had worked in the maternity unit for a long time and told us they liked the 'friendly, feel'. However, because so many staff had no experience of working in other trusts they did not recognise the aspects of the service that were not fully contemporary. The attitudes of some staff were parochial and inward looking. Some new midwives told us it was difficult to integrate because midwives worked in cliques and were not always welcoming to those from other backgrounds. Managers appeared unaware of or unable to challenge this.
- Communication was mainly paper based rather than face-to-face because the management were mainly based at St Helier. Staff reported receiving the risk newsletter, the weekly midwifery matters, and a monthly newsletter. Risk noticeboards on the wards displayed plenty of information but we had the impression that many staff did not read this.
- Community midwives felt pride in the service they provided to women.
- Staff told us that if they had concerns they could report these to their line manager, but some staff with experience of doing this said nothing changed as a

result. Midwives and some medical staff told us it was not always easy initiate conversations with managers. Challenge was not encouraged and safety concerns raised by staff were not taken seriously by managers..

- There were some tensions among medical staff about patient safety and other issues that had not been resolved by mediation.
- The deanery report had suggested trainee doctors would have wider experience if they worked across the two sites, but no changes had been made to facilitate this.

### Public and staff engagement

- Some staff told us they had taken part in the Patient First programme. We observed care within the maternity wards was women-centred. However, there was no evidence of staff or patient engagement in developing the service. External stakeholder engagement is now a fundamental requirement for trusts. Other than the friends and family test, we saw no other methods for seeking women's views. The Maternity Services Liaison Committee appeared to involve few local mothers. Several mothers we spoke to were unaware of the friends and family test.
- Staff did not actively seek women's views and experiences to improve the service.

# Services for children and young people

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

## Information about the service

The children's service at Epsom and St Helier University Hospitals NHS Trust is provided on two sites; St Helier Hospital in Carshalton, in the London Borough of Sutton and Epsom General Hospital in Surrey. This report is about the Epsom General Hospital service.

The Epsom children's service comprises Casey and Ebbisham wards, paediatric outpatient clinic, special care baby unit, X-ray and surgery for children. Casey Ward has 16 inpatient beds, six single rooms and three bays. Ebbisham day ward has 11 beds with four single rooms. Paediatric outpatient clinics are provided in a clinic shared with antenatal with other services including x-ray located close by.

Children are cared for on Ebbisham Ward prior to surgery and afterwards before going home. Children also attend Ebbisham Ward for assessment of a range of medical conditions. GPs can arrange medical tests and investigations on the assessment unit which opens from 7.30am until 5.30pm five days a week, Monday to Friday. Staff on Ebbisham Ward also care for children whilst they wait for a bed to be available on Casey Ward. An area is set aside in the hospital's main theatre suite for children recovering after surgery, before they are transferred to Ebbisham or Casey wards.

There is a special care baby unit (SCBU) with six cots providing care for babies born prematurely or who are unwell. The service works with the level 2 neonatal intensive care unit based at St Helier Hospital. Babies requiring more intensive care may be transferred from Epsom to the St Helier unit, which is located nine miles away.

Children are admitted to Casey Ward via the emergency department at Epsom General Hospital. The ward is a level 1 paediatric oncology shared care unit (POSCU) which means staff care for children with cancer. A children's play area is available for children and families to spend time away from the main ward area. The room is decorated by a local charity, and provides a pleasant area for children and families.

A team of paediatric community nurses are located on the hospital site and work closely with the ward team to support children when they are discharged and return home.

The in-patient service treated 1885 children in 2014-2015. 89% of admissions were emergencies, 10% were day cases and 1% were planned admissions.

During the inspection, we spoke with four parents and three children, 20 members of staff, including: nurses, student nurses, matrons, play specialists clinical nurse specialists, doctors, consultants and support staff. We observed care and treatment being provided.

# Services for children and young people

## Summary of findings

Throughout the inspection, managers and staff told us they had concerns about the number of staff available to care for children. We were told the trust had implemented the 'Safer Staffing' model for ensuring there were sufficient staff on duty to meet children's needs and the service met nationally recommended staffing ratios, but we found examples of staffing ratios falling below these levels. There was also a high use of locums to cover for medical staff who were off sick or on maternity leave. There was a system in place for reviewing staffing levels if the dependency levels of children increased, but it was not always possible to allocate additional staff.

Ward staff relied on information about safeguarding concerns being brought to their attention by emergency department (ED) staff if the child was admitted via ED, by checking manual records or by contacting social services. The information was not held on computer. There was a risk that the manual records were incomplete or could be lost and therefore there was a risk that staff may not always be able to identify and protect children at risk of abuse. It is important to note that these arrangements were the adopted standard practice of the local authority who were responsible for maintaining the child protection database and was consistent across a number of acute services in Surrey.

Staff accessed the service's clinical guidelines on the trust's intranet, but these were not always reviewed and updated as required.

Staff uncertainty about the future structure of the trust had contributed to difficulties recruiting and retaining staff resulting in staffing pressures on the ward. Developing a strategy for the service had also been problematic without clarity about the organisation's future. Managers had responded to the uncertainty by developing a five-year business and service strategy.

An executive director provided board level leadership for children's services. Paediatric services were part of the Women and Children's Directorate.The directorate management team have overall responsibility for governance within the directorate. The directorate team includes the head of nursing, clinical director and general manager.

# Services for children and young people

## Are services for children and young people safe?

Requires improvement

Throughout the inspection, managers and staff told us they had concerns about staffing levels. The trust had implemented the 'Safer Staffing' model for ensuring there were sufficient staff on duty and that service met nationally recommended staffing ratios but we found examples of staffing ratios, which fell, below these levels. There was a system in place for reviewing staffing levels if the dependency levels of children increased but it was not clear if additional staff were provided when dependency levels increased.

The trust had implemented the 'Safer Staffing' model for ensuring there were sufficient staff on duty and that service met nationally recommended staffing ratios but we found examples of staffing ratios which fell below these levels. We saw three incident reports over three months prior to the inspection which had been submitted when staffing fell below the levels planned. Both incident reports highlighted that children on the ward had complex needs, some requiring one to one nursing support.

Reports produced following the investigation of serious analysed what happened and identified actions required to reduce the risk of a similar event recurring. The records of discussion about incidents were not detailed. The discussion involved consultant medical staff and were not multidisciplinary. It was not clear who was responsible for following up the actions agreed.

Staff told us about the process for identifying safeguarding concerns. They told us the emergency department made the ward aware by highlighting any issues on the child's case notes. Staff on the wards were not able to access the child protection register electronically and relied on this information being available within the child's records or contacted the local authority's children's services department for information during the day and the duty social worker out of hours. The children's service risk register highlighted the risk that the trust was not meeting its requirements to safeguard children because of the difficulties identifying children at risk and clinicians accessing the information they needed to prepare child protection reports. It is important to note that the arrangements of not having access to a live electronic database were the adopted standard practice of the local authority who were responsible for maintaining the child protection database and was consistent across a number of acute services in Surrey.

There was an age-appropriate early-warning score in place and children had their observations monitored dependent on their condition. There were separate assessments for children under one year, children aged one to five years, five to twelve and twelve and over. Records showed these observations were being carried out. The ward manager told us they audited the assessments and checked staff's understanding of what they should do when a child's condition deteriorated. We spoke with two staff who were familiar with the process.

There were areas of good practice identified including the provision of a clear record in medical and nursing notes of the care provided. Patients' admission sheets had all been completed, checked and signed by medical staff.

### Incidents

- There had been no never events reported by the hospital between April 2014 and October 2015. There was one serious untoward incident reported in June 2015. A baby admitted to the special care baby unit via the emergency department was transferred to another specialist hospital but died. The trust had carried out an investigation.
- A quarterly report for the first three months of 2015-2016 across both sites showed the number of paediatric and neonatal incidents had increased from 101 in the previous three months to 129 across both sites. This represented an average increase of an average nine incidents per month from over the six month period. Of the 129 incidents, 99 resulted in no harm and 30 resulted in harm. This compared with 27 harm and 52 no harm incidents in the previous three months. It is commonly accepted that where staff report high numbers of incidents which resulted in no harm or near misses, it is probable that a positive incident reporting and learning culture exists within the department.
- Incident reports across both Epsom and St Helier Hospital showed the service had reported occasions where there were inadequate staffing levels. There were 10 incidents relating to inadequate staffing between April and June 2015.

- There were nine incidents reported in the three months between January and March 2015, eight incidents in the quarter September 2014 to December 2014 and seven in the 3 months prior to this. Staffing levels had also been included on the service's risk register.
- There were 16 reported incidents concerning health records and safeguarding. Some of these were interlinked and involved the wrong letters being filed in notes and difficulties obtaining timely access to records. The quality report noted that these problems were similar to the incidents reported in previous quarters.
- Staff reported incidents using the hospital's electronic reporting system. Staff told us they received feedback on the incidents they reported. The learning from these was discussed at ward and directorate team meetings.
- Incidents that caused harm were investigated under the trust's investigation process. The results of any investigation into an incident were discussed at the monthly directorate meetings and governance meetings and any actions agreed were monitored though Senior Nurse Committee and Paediatric Emergency Medicine Board (PEMB) and Paediatric Surgical Committee.
- A quality report for 2014 -2015 showed there were 239 level 1 incidents, the lowest level resulting in no harm; 127 level 2 incidents resulting in low levels of harm, 27 level 3 incidents causing moderate harm and two level 4 incidents causing severe harm.
- An analysis of incidents showed a consistent pattern. The majority of incidents related to medication incidents, health records, access to safeguarding information, care and treatment incidents and staffing levels.
- Incident reports showed the service had reported occasions where there were inadequate staffing levels. There were nine incidents reported in the three months between January and March 2015, eight incidents in the quarter September 2014 to December 2014 and seven in the three months prior to this. Staffing levels had also been included on the service's risk register.
- Triggers for reporting incidents by staff in the community, special care baby unit and the wards had been developed into guidance. The triggers were based on a nationally recognised tool, the Safer Care – Paediatric Trigger Tool 2010. These included clinical issues for example, in the community, all instances of pressure damage or tissue injury resulting from cannula insertion or any other skin breakdowns should be reported or problems accessing health records. Staff on the neonatal unit were expected to report any re-admissions or transfers out because of a lack of cots. Staff told us the list of triggers was helpful, but they also felt confident to use their professional judgement to report any concerns.
- Junior medical staff said they were aware of the process for reporting incidents and they were made aware of changes implemented following investigation.
- Staff were able to provide examples of changes in practice following the investigation of incidents. We saw an example of an incident which had been investigated using root cause analysis. This is a process used by hospitals to undertake a thorough investigation to identify ways of preventing a similar incident happening again. The report supported the need for two staff to be present for children with complex needs when carrying out nursing procedures and also the importance of obtaining an X-ray as soon as possible after the accidental removal of a central catheter.
- The trust's 2014-2015 quality report described the process for reviewing a child death or serious incident. A lead investigator reviewed the case notes and produced a report for discussion at mortality and morbidity meetings. Senior medical staff attended mortality and morbidity meetings which were held every three months.
- We saw examples of the reports which had been produced as a result of the investigations which contained a detailed analysis of the what happened and any action required to reduce the risk of a similar event recurring. We also saw the minutes of the meetings where the incidents were discussed, but these were not detailed. It was not clear if the reports had been discussed in depth or who was responsible for following up the actions agreed.

### Duty of Candour

- Staff told us they had received training on the NHS's Duty of Candour and understood the importance of being open and transparent about incidents and complaints and apologising to parents and carers when things went wrong. Records showed staff had discussed what they had learned from their Duty of Candour training at a ward meeting. From April 2015, all healthcare providers were required to ensure they were open about notifiable safety incidents, offer an apology

to patients and carers following a moderate a serious incident and support staff investigating the incident. Staff were recording and reporting incidents in line with the hospital's policy on duty of candour.

### Cleanliness, infection control and hygiene

- We saw Casey and Ebbisham ward areas were clean. There were dedicated domestic staff responsible for cleaning and quarterly monitoring checks were carried out. The ward manager or matron checked the quarterly audits to ensure they were happy with the standards achieved. The cleaning schedules were displayed on the ward.
- Clinical areas were clean and there were three monthly infection control audits. These audits reviewed infection control practice in 10 specific areas. Actions to improve compliance were highlighted to improve areas of poor practice. Wards failing to attain a compliant score of 75% and above were audited by the matron in charge until a score of 85% and above was attained. The 'cleanliness matters' board showed 98% compliance with cleanliness tasks in October 2015, compared to the hospital average of 94%. On the children's wards, there had been no C diff cases reported in three years. Families could see this information displayed.
- We observed staff used appropriate personal protective equipment (PPE) such as gloves and aprons and used hand gel when entering or leaving ward areas. The wards provided care for children requiring isolation. The procedures were clearly displayed, PPE available and staff ensured visitors followed procedures.
- Cleaning staff followed cleaning schedules which were checked by cleaning service managers. Ward based cleaning staff could call on a specialist team to provide a deep cleaning service. For example, if an isolation room needed to be cleaned after a patient with an infectious condition was discharged. The audit for the three months between June 2015 and September 2015 showed the ward had met 100% of the standards for equipment cleanliness and staff hand hygiene.

### Environment and equipment

- The trust had not completed an audit of accommodation against the Department of Health guidance for hospitals because the unit was built before 1994, when the Health Building Note (HBN) was published. The current buildings did not provide the space and flows as suggested within the HBN.
- A relative told us staff were not able to use the hoists on the ward to transfer their child. The equipment could not be used with children's harnesses which had been made to fit their personal needs. Staff we spoke with were aware of the issue. The trust told us children used the slings provided on the ward to be transferred.
- The risk register highlighted problems with the cots on Casey ward. There was a risk an infant might be harmed by opening the hinge on the end of the cot and catching their clothing on the hinge. The company who manufactured the cots had informed trusts about the risk. The risk had been assessed and notices informing parents not to allow their children to play with hinges and bedsides placed was included in the ward admission information for all parents to read. The risk had been revised from a moderate to a low risk as a result. We saw another risk relating to the cots. Staff reported that in the event of an emergency, they would have to re-position children requiring resuscitation sideways which could potentially delay resuscitation and added to the stress of the situation for parents. The trust told us this had never occurred or an incident form been completed, but has been highlighted as a potential risk on the register and for staff to be aware of it to ensure the most appropriate cots are used for sicker children
- Staff told us the cots were old and in a poor state of repair. The risks were escalated, managers were aware of the risks and told us they had plans to replace them.
- There were single rooms for patients who were infectious or whose immunity was supresed and needed to be in isolation. The operational policy for children and young people with cancer stated children requiring overnight admission should be admitted to a cubicle on Casey Ward. There were occasions when cubicles were not available resulting in children being transferred to other trusts.
- Staff also tried to ensure children aged 16 to 18 were also admitted to a cubicle. There were two isolation cubicles with en suites bathrooms and a further four isolation cubicles for which bathroom facilities can be isolated.
- There were facilities for parents to stay by the bedside of each child and a parent's room with kitchen area. Staff told us they were usually able to provide older children with a cubicle.
- The children's ward had a mixture of cots and beds. Due to the unpredictability of requirement for cots and beds,

the ward had more beds and cots than bed spaces. These were kept in the corridor leading to the assessment unit. There was no space in the hospitals main bed store. The risks of storing equipment on a main corridor had been highlighted including the potential breach of fire regulations. Managers were aware of the issue, but had not been able to resolve the problem. Parents were able to stay with their child on the ward sleeping in a reclining armchair or a folding bed, which could be folded and stored away in the morning. Children receiving surgery were operated on in the hospital's main operating theatres.

- Children recovered from surgery initially in the main adult recovery area. One of the bays was used for children and could be closed off from the rest of the recovery area with a cubicle curtain. The cubicle was decorated with posters to create a more child friendly environment. Managers told us the strategic plan for children's services included the development of dedicated children's theatres. Children were transferred after surgery to Ebbisham Ward before being discharged later in the day. Children who needed to stay longer were admitted to Casey Ward. Children whose condition deteriorated on the ward and were awaiting retrieval by the South Thames Retrieval Team (STRS), were cared for in the theatres adjacent to the ward.
- Staff stored emergency equipment on a trolley according to the size of the child and there were records of daily equipment checks. This meant staff could be confident that the correct equipment could be accessed in an emergency.

## Medicines

- A pharmacist with specialist knowledge about children provided advice and support to the ward. Staff told us they received a good pharmacy service.
- The trust reported that quality reports showed analysis of medication incidents which included issues with pharmacy dispensing, prescribing, administration and incorrect weight recording across site.
- A quality report produced in July 2015 for Children's Services across Queen Mary's Hospital and Epsom General Hospital for the period April 2015-June 2015 showed there were 10 medication incidents over that three month period. The number had fallen the previous nine months.
- Staff in both the paediatric and the neonatal unit had their medicines competencies tested every year. This involved checking their understanding of drug dosages, administration and knowledge.
- Guidelines were written in draft format but had not been formally approved or in use for the administration and safe handling of cytotoxic drugs for children with cancer treated on Casey Ward.
- Medical staff were not trained to provide intravenous chemotherapy infusions, but plans had been developed to provide the necessary training.
- We saw an example of good practice. The service had developed a protocol for the administration of gentamycin to help administer this antibiotic safely.
- We reviewed three prescription charts on the ward and found these reflected good practice. All three charts had been checked by a pharmacist. One prescription had not been signed by a doctor, but the pharmacist had checked with this with medical staff and recorded that there had been no delay in the child receiving their medicine. All the records had weights and allergies recorded. Medicines were stored appropriately on the ward. A pharmacist visited the ward every day to pick up drug orders, provide advice and check records and individual patient requirements.

## Records

- We reviewed medical and nursing notes and found these provided a clear record of the care provided. Records were comprehensive in terms of describing the child's needs and the care required.
- Records included assessments of the severity of the child's condition and pain assessments had been completed. However, we found the safeguarding section of one set of notes had not always been fully completed.
- There was a lack of clarity about plans to resuscitate one child if their condition deteriorated. The notes stated the child should not be resuscitated, but we did not see an advanced care plan describing why the child should not be resuscitated. We saw a record of a conversation with staff at a specialist centre specialising in the care of children with a neurodisability stating the child should not be resuscitated. Staff told us there was a document, but this was difficult to find. This meant there was a risk the wishes of the child and their family may not have been followed.
- Another set of records showed a child's needs were reviewed regularly by a multidisciplinary team. The third

set of notes showed the child was reviewed regularly by a multidisciplinary team of nurses, medical staff and therapists. Admission sheets were completed, checked and signed by medical staff. Records showed children were assessed when they first arrived on the ward and age appropriate pain assessments tools were used to record the level of pain a child was experiencing.

- We looked at three sets of surgical records. These were fully completed and signed and contained a surgical review. They all contained completed World Health Organisation (WHO) surgical checklists, which recorded safety checks prior to, during and after surgery.

### Safeguarding

- Staff told us the process for identifying safeguarding concerns. They said the emergency department made sure the ward were aware by highlighting any issues on the child's case notes. Staff on the wards were not able to access the child protection register electronically and relied on this information being available within the child's records or contacted the local authority's children's services department during the day and the duty social worker out-of-hours. Trust managers said the process was the same for all five hospitals in Surrey. During the day, a referral centre which was always manned was able to provide information about children on the child protection register. Out-of-hours calls were taken by the duty social worker. Managers told us the trust had raised concerns about local safeguarding processes with the local safeguarding board; the group who oversaw child protection systems.
- 83% of eligible staff had received level 3 training in safeguarding, 85% received level 2 training and 86% received level 1.The children's services risk register highlighted a risk that the trust was not meeting its requirements to safeguard children as a result of internal working processes. For example, difficulty in obtaining case notes and prevention of completion of reports by hospital staff and in the community. We also saw an incident report about a problem staff had accessing information on the trust's intranet including key contact telephone numbers and other information. The trust told us about additional action they had taken to ensure this problem did not reoccur.
- We also saw an incident report about a problem staff had accessing information on the trust's intranet including key contact telephone numbers and other information. As a result, staff were unable to access information around safeguarding policies. No harm was caused by the lack of access to the computer system, however staff were unclear where the information could be found in the event of the computer not being available. Staff told us the problem with the trust computer system had been resolved, but it had resulted in delays to treating and discharging children because of problems accessing the information they needed.
- Child protection supervisors were in place. However, they were currently only able to supervise 66% of staff who required child protection supervision due to capacity issues. Group supervisions were held where possible to enable as many staff as possible to attend. High risk areas were prioritised for example children's community nursing and the children's ward areas. Staff were encouraged to contact the hospital safeguarding team in between sessions. A training event was planned for later in the year for staff working with other agencies in Surrey.
- Staff were aware that the safeguarding nurse visited the ward every Wednesday to discuss any issues. Managers acknowledged that increasing safeguarding supervision was a key objective for the directorate. This was recorded as a high risk in the service's risk register. The community paediatric service tried to ensure case conferences received written reports if a paediatrician could not attend in person.
- There was a risk of harm if healthcare professionals were unaware of case conferences and unable to access the information they needed to provide reports for case conferences. Managers told us staff were encouraged to contact the safeguarding team in between supervision sessions and they had supervision within a group scenario to ensure regular contact. Supervision training was planned for later in the year for staff working with agencies in East Surrey, which will aim mitigate against this risk.
- An example of good practice in this area was the trust's participation in a review of the initial health assessment process for looked after children. Actions were agreed to address the issues which included improving referral documentation and reviewing of clinic times to offer appointments.
- Nurses who worked in outpatients said they had level 3 safeguarding training and all staff nurses and healthcare assistants were level 3 trained. They said staff had also received female genital mutilation (FGM) awareness training.

- Information about escalating and reporting safe guarding concerns was displayed throughout the unit. We spoke with junior medical staff who told us they had all received level 3 safeguarding training.

### Mandatory training

- Training records showed 92.3 % of staff were up to date with infection control training, 96% were up to date with manual handling training, 79% of staff had received their annual resuscitation training.
- Staff training records were held on the trust's computer based training system 'wired'. Staff could check what training they needed and the system sent them reminders when the training was due.
- 88% of staff were up to date with infection control training in July 2015 and 89.7% in risk and health and safety management. There were five areas where staff training levels did not meet the target set by the trust which were staff appraisals (73.4%), resuscitation (84.9%), manual handling (85%) and level 3 safeguarding (83%).
- Staff received resuscitation training annually as part of the trust's mandatory training programme.

### Assessing and responding to patient risk

- There was an age-appropriate early-warning score in place and children had their observations monitored dependent on their condition.
- Early warning scores were communicated to staff at shift handovers. Scores were reviewed when the child's observations were recorded. An age-specific escalation process was in place for children whose condition deteriorated. There were separate assessments for children under one year, children aged one to five years, five to twelve and twelve and over. Records showed these observations were being carried out. The ward manager told us they audited the assessments and checked staff's understanding of what they should do when a child's condition deteriorated. We spoke with two staff who were familiar with the process.
- Children could only be provided with high dependency care on Casey Ward for a short period of time until a suitable bed could be found and arrangements made to transfer the child safely. Staff were able to access assistance from an anaesthetist if they were particularly concerned about a child although not necessarily an anaesthetist who specialised in caring for children.
- Children whose condition deteriorated on the ward and were awaiting retrieval by the South Thames Retrieval Team (STRS) were cared for in the theatres adjacent to the children's ward.
- Specialist emergency staff, such as anaesthetists, stayed with children who were transferred until they were picked up by the transfer service. Staff were monitoring how many children were transferred. Guidelines had been developed and were used by staff for transferring and escorting children. Staff had developed a policy as a guide to transferring and escorting children.
- The risk register recorded concerns about unwell children requiring high dependency care as a high risk if they could not be transferred to a high dependency unit and had to remain in the emergency department until their condition stabilised. Epsom General Hospital. All acute paediatric admissions were seen by a middle grade specialty trainee doctor within four hours of admission. This meant children were seen by a doctor with between three and five years training in the specialty who was able to provide immediate care, but always had support from a more senior doctor. A discussion of all acute admissions occurred between the middle grade and paediatric consultant at least every 12 hours, either over the phone or in a face to face handover meeting. Critically unwell or deteriorating patients were discussed with the responsible paediatric consultant as soon as possible and reviewed by the paediatric consultant within 30 minutes. Staff were able to mobilise a paediatric resuscitation team within the hospital for children in an emergency.
- The service had a policy in place for responding to the level of nursing care a child required. This specified that children needing level 1 critical care should be nursed by a maximum of one nurse to two patients. Children requiring level 2 critical care will be nursed one to one. High Dependency Care (HDC) and some level 2 interventions could be delivered on Casey Ward. Beds could be designated for short term high dependency care in the close observation bay or cubicles. The children's community service provided care for children with acute and short-term conditions, long-term conditions, children with disabilities and complex conditions, including those requiring continuing care and neonates. They also supported children with life-limiting and life-threatening illness, including those requiring palliative and end of life care.

- We saw examples of an early warning assessment which had been completed and scored. Procedures were in place for transferring children to other hospitals if their condition deteriorated. The ward was not able to provide high dependency or paediatric intensive care. The hospital managed the child's care until the South Thames Retrieval Service (STRS) team were able to transfer the child to a specialist unit if they required intensive care. Staff had developed a policy as a guide to transferring and escorting children.

### Nursing staffing

- The children's in-patient ward had two paediatric trained nurses on duty at all times and all nurses were paediatric trained. Nurses caring for children were trained in acute assessment of the unwell child, pain management and communication, and had appropriate skills for resuscitation and safeguarding.
- Casey Ward had 7.2 staff vacancies. 6.4 qualified nurses and 0.78 healthcare assistants. There were 1.6 posts vacant on the special care baby unit.
- The number of posts at Epsom General Hospital fully met the staffing standards for the British Association of Paediatric Medicine
- The trust monitored the number of staff on duty against planned staffing levels. The monitoring reports showed staffing levels had improved during 2015.
- We noted that the number of posts funded in the ward budget was 21.0 WTE, but the directorate was only recruiting to 15 posts, in order that the directorate could cover the costs of temporary staff and achieve their savings targets. The matron told us they had been advertising two band 6 posts for several months and were experiencing difficulty recruiting to the posts. They said the hospital was outside zone 6 of the London transport system, which meant some potential applicants were put off because of the travel costs. They said they covered gaps in the rota with bank staff already employed by the trust, because they were more likely to understand the hospital's policies. They said there was usually a number of highly dependent children on the ward and it was difficult to provide the quality of care and continuity when they were reliant on bank staff. There were no vacancies in the outpatient clinics or on Ebbisham Ward.
- Nursing staff shifts rotated with staff working both nights and during the day. There were four trained staff on duty on Casey Ward and one healthcare assistant. There were three staff on duty at night. The ward used bank staff to cover staffing gaps in preference to agency staff. This meant gaps in the staffing rotas were covered by staff who were familiar with the hospital.
- Staff told us they were usually able to cover vacant shifts with bank staff.
- A practice development nurse had been appointed to work with student nurses. Children's nursing staff would soon be able to gain experience of working in other areas such as the emergency department and on the wards in both hospitals.
- Pharmacists with specialist knowledge about children ensured the ward maintained adequate supplies of the medicines checked records and provided advice to staff on the ward.
- Staff ratios followed national guidance and were set at one member of staff to four children. Night shift ratios were one member of staff to four or five children. Senior nurses said staffing levels could be increased if a child's condition deteriorated or if acutely ill children were admitted. The staffing levels and the needs of children were monitored twice a day. A paediatric trained matron assessed the staffing levels required and could authorise additional staff if needed. The matron assessed throughout the day and provided plans and support for overnight staffing. There was a clinical site team to provide support out of hours.
- A paediatric trained matron assessed the staffing levels required and could authorise additional staff if needed. The matron assessed throughout the day and provided plans and support for overnight staffing. There was a clinical site team to provide support out of hours.
- Staffing compliance was monitored weekly via the matron's reporting. The matron told us it was difficult to maintain adequate staffing levels to meet children's needs. The trust had implemented the Department of Health's guidance 'Safer Staffing' to monitor staffing levels.
- We observed a ward handover. Named nurses did not hand over their own patients. Information was passed to staff coming on duty on the child's diagnosis, test results, care plan, medication, fluids and nutrition and observations. Any known child protection concerns were discussed. Children awaiting planned admission or return from another unit, and using the assessment unit for patients who were waiting for beds, were discussed. The process for reporting any concerns about staffing levels was also discussed.

- The children's services risk register highlighted concerns about the size of the community nursing service to meet the needs of the population. The Royal College of Nursing recommends that for an average-sized district, with a child population of 50,000, a minimum of 20 whole time equivalent (WTE) community children's nurses are required to provide a holistic children's community service. There were six nurses in post with 1.4 vacancies. Staff told us they prioritised the children on their case load to ensure those with the greatest need received co-ordinated care. As a consequence, they were not always able to provide visits for more routine tests and procedures. They were able to arrange for children to visit Ebbisham day ward for tests. They said vacancies in community nursing led to delays in assessing and discharging children from the ward.

### Medical staffing

- A number of junior medical staff posts were vacant because the Deanery, the local education and training organisation who allocated doctors in training to hospitals, had not recruited to all the posts. This meant there were gaps in junior medical staff cover at Epsom General Hospital, and these were covered by locum medical staff. The trust was looking to appoint two doctors on fixed term contracts or on secondment until the next intake of trainees was available. The total number of medical staff posts met the Royal College of Paediatrics and Child Health (RCPCH) standards for general paediatrics and the British Association of Perinatal Medicine (BAPM) standards for neonates.
- Consultant medical staff reviewed children's care twice daily during the weekdays and once daily during ward round over weekends.
- Emergency admissions were seen and assessed by a consultant in the paediatric emergency department until 10pm. Children admitted after 10pm were seen on the consultant ward round the next day.
- There was one rota to cover paediatric emergencies, general paediatrics and neonates.
- Paediatric medical staffing was discussed at the woman and children's directorate meeting in July 2015. The clinical leads for St Helier and Epsom General Hospitals described the pressures in paediatric medical staffing at Epsom hospital which had a 1.3% shortfall in the medical rota (0.4WTE gap at Registrar level only). All other staff were in place and any locums booked were for acute illnesses or short term sanctioned absence.
- The option of a fellow post at middle grade to rotate between the two sites and support gaps was being explored. Locum medical staff were used to maintain services. Pressures on medical staffing were identified as a high risk on the directorate's risk register.
- We requested further information from the trust about paediatric medical staffing. The figures supplied by the trust showed they were advertising one specialty trainees post. There were fourteen medical staff posts being covered by locum posts as a result of vacancies or maternity leave including a consultant. An analysis of bank and agency staff showed that between April 2014 and June 2015, over 3000 hours of medical staff cover was filled by temporary medical staff.
- We saw the report of an external review of medical education in 2015. At a previous visit in February 2012, there were concerns regarding the medical staffing rota and trainee supervision. A more recent visit found training opportunities had improved but the teams required continuing support from the trust to continue to develop. A recent survey of junior medical staff satisfaction found by comparison they were less satisfied with the training they received for medical handover, clinical supervision and overall clinical experience.
- We observed the medical handover on the ward. The needs of each child, plans for their care and test results were all discussed. Safeguarding concerns, beds available and plans for discharge were reviewed. Children who were being admitted were also discussed. Staff attending the handover were provided with a written summary about the child which they sued to make notes about unit and found this was an effective process. Detailed printed information about each of the babies on the unit was used to inform the discussion about each baby.

### Major incident awareness and training

- Plans were in place for maintaining services in an emergency. Senior nursing staff told us they were confident the plan would enable them to continue to provide services.
- The trust contributed to resilience plans to ensure services responded to increased workload pressure during the winter period.

# Services for children and young people

## Are services for children and young people effective?

Requires improvement

Staff were able to access clinical guidelines on the trust's intranet, but these were not always reviewed and updated. The service contributed to national audits and undertook their own local audits. However, were not clear what the process was or who was responsible for ensuring guidelines were reviewed and approved. Some guidelines were out-of-date and had not been reviewed.

The trust aimed to achieve the London quality standards for children's services by April 2017. The service at St Helier hospital was reviewed in 2015 to assess which standards the trust met. The trust's executive team had committed to reviewing the services at Epsom General Hospital to assess the extent to which the standards were met.

### Evidence-based care and treatment

- The special care baby unit at Epsom General Hospital had achieved the World Health Organisation's baby friendly level 3 accreditation and were working alongside the maternity service and the neonatal service at St Helier Hospital towards achieving a Bliss award. These schemes provided a way for health services to improve and maintain the best standards of care for mothers and babies, for example by promoting breastfeeding and safe bottle feeding and to strengthen mother-baby and family relationships.
- Staff on the neonatal unit at Epsom General Hospital contributed data to the National Neonatal Audit Programme (NNAPA). The special care baby unit compared well with other units on two measures and worse for three. The two areas where the service performed well were the number of babies who were weighed within an hour of birth and the proportion of babies receiving their mother's milk when they were discharged from hospital. The areas where the service did not perform as well as other areas were the number of eligible mothers who received steroids ante-natally. The hospital score was 59% compared with the standard of 85%. The hospital also did not score as well as other services for an eye screening test for premature babies. The service scored 75% against a standard of 100%. The trust were aware of the need to address these and the directorate included plans for improving the number of babies screened. A documented consultation with a member of the neonatal team was the third area where the service performed less well at 97% compared with the standard of 100%. A congenital heart disease service had been developed as part of the cardiology service at Epsom General Hospital.
- Intravenous (IV) cannula audit results for July to October 2015 were displayed on Casey Ward. The audit results showed compliance with recording of checks ranging from 90% to 98%.
- Staff accessed clinical guidelines stored on the trust's intranet. We reviewed a sample of the guidelines and found the neonatal guidelines had been reviewed and were shared between the St Helier Hospital and Epsom General Hospital sites. This meant staff were using the same policies and procedures for any babies transferred from the level 1 service at Epsom to the level 2 site at St Helier,reducing the risk of staff using different processes.
- Some general paediatric guidelines had not been reviewed, for example the hypoglycaemia guidelines and prolonged rupture of membranes.
- The bronchiolitis guidelines referred to the National Institute for Health and Care Excellence (NICE) guidance and there were guidelines for example for diabetic ketoacidosis. The asthma guidelines we reviewed were different to the ones being used at St Helier Hospital and we did not find some guidelines. The guidelines did not include information about the process used to approve them. We were not clear what the process was or who was responsible for ensuring guidelines were reviewed and approved.
- Medical staff had undertaken an audit of autism in children and young people in July 2015. The audit reviewed the care provided for 56 children and reviewed 38 care records to assess the service's level of compliance with the quality standards. The audit found high levels of compliance with the diagnostic standards but only 9% of children were followed up within the six weeks.
- Local audits included; a review of outcomes of new imaging for children with developmental delay. A re-audit had been competed for assessment of paediatric echocardiography against national standards, an audit of guidance for inter-hospital transfers of children requiring emergency inpatient care under the paediatric medical team and IV antibiotics in neonates.

# Services for children and young people

- Epsom General Hospital provided care for children with cancer in partnership with two other hospitals, which provided specialist care for children with cancer. The service provided level one shared care services which meant children received a limited range of care agreed with the specialist centres. The trust had assessed the service against national cancer peer review measures. The key challenges the service identified were staffing time and qualifications, out of hours cover, nurse training, the need for environmental changes to ward areas and pharmacy support for chemotherapy. The consolidation of more intensive neonatal support at St Helier meant medical staff at Epsom General Hospital had one medical staff rota to cover the special care baby unit, the general paediatric service and children's emergency care in the evenings and overnight.

### Pain relief

- Children admitted to the ward received pain assessments. A review of four care records showed staff were assessing pain levels.
- Neonatal and paediatric specific pain assessment tools were being used. There was a policy for managing pain in children based on the Royal College of Nursing guidance on the "Recognition and assessment of acute pain in children". Pain scores used on the children's units included the visual analogue scale and FACES scale (Wong- Baker) for children to self-report their pain. FLACC is the tool of choice for children with cognitive impairment and complex needs and any child unable to self-report their pain score. We spoke with the parent of a small child who told us they were happy staff had assessed their child's pain and provided pain relief when they needed it.

### Nutrition and hydration

- Children nutritional needs were met. Parents said the children enjoyed the food and were able to have snacks if they were hungry.

### Patient outcomes

- The service contributed to several national audits which enabled outcomes to be compared with similar services elsewhere.
- The results of the asthma and epilepsy audits showed the number of emergency admissions for asthma and epilepsy were lower (better) than the England average.
- The paediatric diabetes audit showed that the number of patients with a HbA1c test result of less than 7.5% was the same as the national England average in 2013/14.
- Staff made improvements to the service as a result of the audits. For example, following review of the national diabetes audit results, an information leaflet and screening was provided to all patients at their first annual review and when the patient was 12 years old. Information on exercise was also added to the new diagnosis pack. Families were contacted annually and offered an appointment with a dietician.
- The special care baby unit submitted data to the national neonatal audit programme (NNAPA). This national audit supported improvements in neonatal services by providing comparative information about babies who were born too early, with a low birth weight or who have a medical condition requiring specialist treatment. This was a continuous audit which required staff to submit information weekly. Each new group of doctors were informed about the data to be collected.
- Epsom General Hospital performed worse than the England average on three out of five measures. 59% of mothers requiring antenatal steroids received them compared with the national standard of 85%. Babies with a gestational age of less than 32 weeks or birth weight of less than 150g should undergo retinopathy screening. 75% of eligible babies were screened compared with the national standard of 100%. 97% of parents had a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission compared with the national standard of 100%. The latest report published in 2015 used data collected in 2014 on nine key areas, for example temperature on admission, consultation with parents, recording blood stream and cerebrospinal fluid cultures, infections, neonatal unit transfers, retinopathy of prematurity (ROP) screening, mother's milk at discharge and clinical follow-up at two years of age. The trust was one of 174 units submitting data across England and Wales.

### Competent staff

- An appraisal is a formal assessment of a staff's performance in their role, usually measured over a year in their post. 94% of non-medical staff had received an appraisal. 85% of staff had objectives set for 2015-2016.

- Staff appraisals were linked to six C's Caring, compassion, candour, communication, courage, and competency.
- Staff told us clinical supervision was good and there was a good culture of incident reporting. Induction training was mostly accessed on line.
- Junior medical staff all had supervisors and met with them when they first joined and mid-year. They said the service had made improvements as a result of feedback received and felt overall their training was good.
- Consultants undertaking surgery on children were paediatric immediate life support trained and there was training for consultants on the on-call rota to ensure all consultants were trained by April 2015.
- Nursing staff we spoke with were not aware what the trust had developed to support them with re-validation, which begins in 2016. The director of nursing told us they were prepared to launch their re-validation programme and had not wanted to launch it too far ahead, because some staff would not have to go through the process until the following year.
- Specialist diabetes, oncology and epilepsy nurses supported the care of children on the ward and in the community when they returned home. The paediatric oncology nurse was working towards completing the Practical Paediatric Oncology Programme: Supportive Care module which was required to fulfil the lead oncology nurse role.
- Nine staff on the Epsom special care baby unit had undertaken a post-graduate course in neonatal intensive care, 75% of the total number of staff.

### Multidisciplinary working

- The hospital's cancer services team supported the children's multidisciplinary cancer team to review services and ensure they were safe, improve the patient and carer experience and, participate in local and children's cancer network audits. Multidisciplinary working also ensured care was provided within a multidisciplinary framework and there was good quality information for families.This was achieved by a multi disciplinary network for children with cancer through the shared care unit (POSCU) arrangements.
- The service had developed links with other hospitals for children who required other types of specialist treatment. The trust had identified the need to develop guidelines to improve transfer arrangements by establishing multidisciplinary teams in all specialties to ensure children's needs were fully reviewed and documented. The trust had also highlighted the need to create a comprehensive directory of email and phone contacts to facilitate patient care at consultant level.
- The trust's strategy for developing clinical services highlighted the need to improve the mental health services provided for children with a neurodisability.

### Seven-day services

- Diagnostics services were not available at weekends. Physiotherapy services were available between 9am and 5pm every day of the week, including weekends.
- Consultant ward rounds were held twice daily in the morning and early evening during the week and once a day at weekends. The trust had developed plans to extend the twice daily ward rounds to seven days a week.

### Consent

- A consent policy was in place which was based on the Department of Health's Reference Guide to consent for Examination or Treatment, 2nd Edition (Department of Health 2009). The policy dealt with issues relating to mental capacity, the treatment of young people aged 16-17, treatment of children under the age of 14 and Gillick competencies. Gillick competences are concerned with a young person's ability understand the potential risk and benefits to make a decision about treatment. There was also guidance for staff on post mortems for a baby or child. Staff were familiar with the requirements of the policy.
- Consent to treatment was audited quarterly as part of the trust's clinical audit programme. The audit reviewed which clinicians obtained consent and whether they had received the appropriate training prior to obtaining consent particularly when this task has been delegated. The audits were completed for the directorate governance group.

## Are services for children and young people caring?

Good

Parents spoke positively about the care families received and said nursing and medical staff were approachable and explained the care provided.

# Services for children and young people

Staff provided care which was compassionate and empathetic. Parents told us the care was good even though staff were busy.

The trust had participated in a patient experience survey which showed the service was better than average on six questions, similar to other trusts surveyed on 52 questions and compared less favourably on one question, The trust was one of 69 organisations which had commissioned the survey for their children's service.

## Compassionate care

- We observed staff at Epsom General Hospital provided compassionate care for children and families. Parents told us staff were kind and caring and provided reassurance to them
- Families were encouraged to give feedback on their experience of using the service, The results showed 73% of those who responded would recommend the service to friends and family but the response rates were low at 8%. The ward manager told us the response rate had dropped because the service was moving over to electronic feedback using a tablet but there had been problems with the technology and some of the responses were lost. We saw friends and family feedback forms were available throughout children's services. The manager thought the response rates were reasonable. Staff said some families used the services often and did not wish to complete the same feedback form more than once.
- The trust had participated in a patient experience survey. The report, published in March 2015, provided information about both paediatric services in the trust at Queen Mary Children's Hospital and Epsom General Hospital. The survey results were better than the average on six questions. 95% of parents felt they were treated with respect and dignity by staff compared to the average of 85 % for other trusts. 81% of respondents felt staff communicated with the child in a way they could understand compared with an average of 67% elsewhere. 92% of parents felt that staff were always friendly compared to an average of 82% and 91% of parents felt their child was always well looked after by staff compared to an average of 82% elsewhere.
- The responses for the trust were significantly worse on one question. 25% of children felt they were not fully told what would be done during their operation compared to an average of 9 % elsewhere.
- A recent children's young person's audit demonstrated parental and child satisfaction. The areas identified, which could be improved, were waiting times in the paediatric assessment unit.
- In 2014 the Care Quality Commission (CQC) carried out a national survey of children and young people's views about the care they received in hospital. This was the first time the survey was carried out. It represented the experience of nearly 19,000 children and young people who received inpatient or day case care in 137 acute NHS trusts. 165 children and young people at Epsom and St Helier University Hospitals NHS Trust responded to the survey. The results were combined for both hospitals in the trust.
- CQC sent questionnaires to children and young people aged 8-15 with extra questions for their parents or carers. 18,736 young people were eligible to participate in the survey. In total 6501 (27%) 8-15 year olds responded. Children and young people aged eight to 15 were asked if they felt safe on the hospital ward. The responses from both adults and children were similar to the average for other hospitals.
- Where a child was younger than eight, a questionnaire was sent directly to their parent or carer. The questionnaire asked parents and carers of children below the age of seven if they felt their child was safe on the hospital ward.

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

- We observed medical and nursing staff provide children and parents by explanations about the care being provided.
- Children were encouraged to comment on the care by filling in 'Tops and Pants' cards about the things they liked and disliked. The results of the children's feedback was on display on the ward for people to read.
- We observed medical and nursing staff provide children and parents by explanations about the care provided.

## Emotional support

- There was access to psychology to support children with long term conditions for example diabetes and cystic fibrosis.
- There was an annual assessment of emotional wellbeing for all young people with diabetes.

# Services for children and young people

- Children with cancer accessed psychological therapy through the pathway to the principle treatment service. They were also able to access a social worker who specialised in supporting children with cancer.

## Are services for children and young people responsive?

Requires improvement

The service had developed a strategy for developing services based on an assessment of the strengths and weaknesses of the current services, the extent to which services met national and local objectives and met the needs of the local population.

Staff were concerned about children who required high dependency care. They said the ward were unable to provide this and they were concerned about capacity elsewhere for transferring children. In response to the risk identified, managers told us they were in the process of developing a business case for the provision of high dependency care.

Staff told us it was difficult to obtain assistance from the children and adolescent mental health service (CAMHS) in Epsom and children were sometimes transferred to St Helier Hospital to access the CAMHS service there.

The ward provided folding beds and armchairs for parents and carers to stay with their child and a room was available for families to make hot drinks and to spend some time away from the bedside.

### Service planning and delivery to meet the needs of local people

- Staff were concerned about children who required high dependency care. They said the ward were unable to provide this and they were concerned about capacity elsewhere for transferring children. We saw the risk register highlighted this concern. The risk register highlighted that acutely unwell children requiring intermediate care high dependency were unable to be transferred to such a facility as a result of problems with capacity of high dependency beds within south west London. Children treated in the emergency department, remained there until their condition stabilised and it was safe to transfer or be admitted to the wards at Epsom or St Helier; In response to the risk identified, managers told us they were in the process of developing a business case for the provision of high dependency care.
- The service had developed a strategy for developing services based on an assessment of the strengths and weaknesses of the current services, the extent to which services met national and local objectives and the needs of the local population. The strategy identified the need to increase paediatric day surgery and more neonatal intensive care (NICU) level 2 care and for developing specialised services for children with attention deficit hyperactivity disorder (ADHD), autistic spectrum disorder (ASD) and cardiology. One of the highest priorities was development of high dependency facilities in response to the number of children with complex needs and to reduce the need to transfer children to other hospitals for high dependency care.
- A wide range of speciality clinics were provided to meet the needs of the population for children with asthma, hearing problems, autistic spectrum disorders and attention deficit hyperactivity disorder, community paediatrics, diabetes and endocrinology, epilepsy, haematology, oncology, gastroenterology, homecare team and paediatric surgery.
- Paediatric community nurses supported children with complex health problems to be cared for at home.
- The directorate recognised the need for a Child Development Centre (CDC) to develop a comprehensive assessment and treatment service for children with complex needs.
- The service had introduced paediatric assessment observation beds as part of a local resilience plan for responding to winter pressures.
- Epsom General Hospital provides shared care services for children up to the age of 18 with haematological or solid tumour cancers. Specialist care was coordinated by the Principal Treatment Centre (PTC) at other specialist hospitals. The PTC was responsible for finalising the diagnosis and determining the treatment plan. Treatment was then provided jointly by the PTC in partnership with the local service based at Epsom General Hospital.
- Pathways and communication protocols were in place to ensure children's care was co-ordinated. Epsom General Hospital provided inpatient supportive care including care of children with febrile neutropenia, a fever resulting from infection in a child with reduced

immunity. Children also attended outpatients for follow-up care and oral chemotherapy. The service did not provide all forms of chemotherapy, for example intravenous bolus chemotherapy, but plans were being developed for this.
- Other forms of chemotherapy were prescribed and dispensed from the PTC and administered by the community children's nurses employed by trust. Cytarabine for example, was administered in the child's home or on Casey Ward if the child was an inpatient.

### Access and flow

- Children were admitted for acute care from a specialist neurodisability service. These children often had complex needs. The pathways for caring for these children including their return to the specialist centre were not effectively planned and co-ordinated. The hospital did not have a children's social worker who could ensure the child's needs were being met.
- Children who were admitted from the emergency department could be accommodated on Ebbisham Ward if they had to wait for a bed to be available. Ebbisham Ward also undertook a range tests and investigations and GPs could book appointments on the ward.
- Epsom General Hospital provided care for babies in the special care baby unit. Babies who needed more specialised care and women who were identified as having foetuses likely to require level two neonatal care, were electively transferred for delivery at St Helier Hospital.
- Protocols were in place to stabilise and transfer other less stable neonates who unexpectedly required level 2 support.
- There were discharge planning meetings for children with complex needs in collaboration with community services.
- To ensure that children with cancer received co-ordinated care, the multidisciplinary team at Epsom had agreed guidelines for referrals, diagnosis and care planning.
- We reviewed the levels of care required by children over several months and found there were many occasions when children required high dependency care and transfer. Managers told us they were in the process of preparing a business case to develop high dependency care on the ward in response to the continuing need for this type of care.

### Meeting people's individual needs

- Children were admitted to one of the three bays on the ward according to their age and their condition. Staff tried to ensure boys and girls were cared for in separate areas. They told us they understood older children preferred single rooms or same sex accommodation and they were usually able to accommodate this, but it depended on the child's needs, for example if they required a lot of equipment or high levels of nursing support.
- Staff were able to offer accommodation in single rooms for young people over the age of 14.
- Casey Ward had separate cubicles for children who needed to be isolated during their stay because their condition was infectious or they were at risk of contracting an infection.
- When we visited the ward there were three children with complex needs who required high levels of nursing support. It was not clear if there were pathways in place to ensure children's care from a nearby specialist children's hospital was effectively planned and co-ordinated.
- There was no access to a children's social worker in the hospital. Staff said if they needed support from a social worker, they would have to approach the local authority.
- Staff requested school work from the child's school if they were in hospital for more than a few days. There was an area on the ward which could be used for school work. Teachers were not employed in the trust. Staff said the majority of children stayed for one or a few days and so only experienced a brief interruption to their education.
- Young people told us they would have liked to have WiFi access to use during their stay.
- We saw the children's menu. The menu provided appealing choices for children. Children who may have missed a meal could order a snack box or a hot meal. The menus were colour coded to identify meals which were milk free, easy to eat or energy dense. There were options to meet children's cultural or religious needs for example halal meat. Sandwiches could be ordered for the evening, although it was never a problem ringing for a sandwich box at night. We observed that the children did not have a dining room; meals were served in the bays. Ward staff said they would like a dining area.

- Parents often stayed with their child. Folding beds and reclining chairs were available for parents who stayed overnight. A room was available for parents who wished to make a drink.
- Children with cancer could access services at Epsom General Hospital 24 hours a day. Parents were advised to contact Casey Ward when their child was unwell. This could be facilitated by the children's community nursing team or the specialist cancer nurse. Normally the child was admitted directly from home to a cubicle on Casey Ward. If there was no cubicle available the child could be assessed and treated on Ebbisham Ward or in the emergency department, before being transferred to another shared care service where a cubicle was available or to the Principal Treatment Centre. If the child presented at St Helier Hospital, then child would be stabilised and then transferred to the most suitable service, usually Casey Ward.
- There were play specialists in all areas including outpatients and inpatients
- Child friendly information leaflets were available for head injury, bronchiolitis, epilepsy, asthma and diabetes.
- We spoke to three parents on the telephone who had recently used the service. One parent said their child had a complex genetic condition. They told us, "I cannot fault hospital staff, they are very responsive. When my baby was born, we ended up being treated at a specialist children's hospital. Both the hospital and community nurses are outstanding they give so much support. I would never manage without them; 10 out of 10 rating for the community nurses. Staff on Casey Ward are also brilliant so professional".

### Learning from complaints and concerns

- Directorate performance reports showed 50% of complaints were answered within target time. Staff sickness and an increase in the number of complex complaints had resulted in slower response times.
- We saw examples of action taken as a result of complaints. Additional training was delivered by the neonatal practice development nurse to improve communication skills. Guidelines were reviewed for monitoring of patients on oxygen. The department's transfer policy was updated. A 'Traffic Light' risk assessment system was in place to assess type of escort required.
- We spoke with two families who had made a complaint about the service. One family told us they had raised their concerns with the ward staff and felt staff had listened and responded. They were happy with how staff on the ward had responded.

## Are services for children and young people well-led?

Requires improvement

The trust had developed a strategy for clinical services, approved by the board in November 2014. The strategy outlined plans for paediatrics including the development of the Royal College of Paediatric and Child Health 'Facing the Future' model for acute paediatrics care.

A further business and service strategy had been developed in September 2015 which had not yet been considered by the trust's board.

Uncertainty about the future structure of the trust had contributed to difficulties recruiting and retaining staff resulting in staffing pressures on the ward. Developing a strategy for the service had also been problematic without clarity about the organisation's future. Managers had responded to the uncertainty by developing a five-year strategy.

165 children and parents had responded to a patient experience survey commissioned by the trust. The survey provided valuable feedback and comparisons about children's services on both the St Helier and Epsom sites. The service compared better on six questions, about the same on 52 and worse on one.

An executive director provided board level leadership for children's services. Paediatric services were part of the Women and Children's Directorate with clinical leadership from a consultant obstetrician and a consultant paediatrician.

### Vision and strategy for this service

- The trust had developed a clinical strategy which had been approved by the board in November 2014. The strategy outlined plans for paediatrics including developing the Royal College of Paediatric and Child Health 'Facing the Future' model of acute paediatrics care. The plans included increasing paediatric day

surgery and neonatal intensive care unit level 2 care, developing specialist services for example for children with attention deficit hyperactivity disorder (ADHD) autistic spectrum disorder, and cardiology. The development of high dependency facilities was also planned in recognition of the number of children with complex needs requiring higher levels of care and the risks associated with transferring children to other specialist units.

- A combined clinical and business strategy had been developed in October 2015 which was due to be considered by the trust board. A series of internal focus group meetings had reviewed services. Staff had been able to contribute to the development of the strategy, although there had not been any formal consultation meetings. Few staff were aware of the strategy or what it contained.

### Governance, risk management and quality measurement

- The paediatric emergency medicine board (PEMB) and the paediatric surgical committee (PSC) met quarterly to ensure clinical governance matters were addressed by considering audit results and benchmarking information.
- Directorate managers discussed governance issues at a monthly local governance meeting which reported into clinical quality and assurance committee, and paediatric emergency medicine board (PEMB), paediatric surgical committee and trust safeguarding committee. The groups discussed audit results, complaints, incident reports patients and carer's views and experiences.
- The directorate management team reviewed their risk register and to improve the process for capturing risks identified by staff and managers.
- The risk register recorded concerns about unwell children requiring high dependency care as a high risk; because if they could not be transferred to a high dependency unit, they had to remain in the emergency department until their condition stabilised. The risk register also highlighted concerns about the adequacy of ward staffing levels for looking after children who required high dependency care. To reduce the risk, there was a process in place for liaison and discussion with the regional paediatric and the subsequent transfer of children needing this facility.
- To reduce the risk, it was agreed children should be referred quickly for transfer and staffing increased with senior nurses and temporary staff to cover this work load. Senior staff were able to provide short term cover, but this was not sustainable for an extended period. An escalation process was agreed for senior nurses to manage the risk and adjust staffing accordingly.
- A quality scorecard provided directorate management teams and the board with information about staffing levels, training, patient safety issues such as incidents, clinical effectiveness for example compliance with clinical guidelines and patient experience feedback from the friends and family test.
- Records of the women and child health directorate performance meetings showed clinical quality, clinical governance, performance, workforce and strategy issues were discussed monthly by the service's leadership team.
- Women and Children's Directorate monthly business report monitored risk and recorded changes or updates to the risk register. Infection rates, incidents, staff sickness, performance against targets, use of bank and agency staff were reviewed.
- The service had produced an annual quality report in July 2015 for the year 2014-2015. This analysed the severity of incidents during the year. The main types of incidents were related to medicines, health records, safeguarding children, care and treatment, issues around lack of staffing and one issue around security.
- The most serious incidents were highlighted. These included a cardiac arrest during elective change of tracheostomy tube and a preventable hospital acquired pressure ulcer. The incidents had all been investigated and reports on the learning disseminated to staff. They were included in the quality report to help identify if there were any similarities or trends when compared to other years. A list of incidents which would trigger an incident report for community and hospital was included. There was an analysis of complaints and the actions taken by the service as a result.
- Risk meetings were also held monthly which reviewed incidents, audited compliance with the world health organisation surgical checklists, the results of other local and national audits, updates to the risk register, safeguarding issues, medical devices alerts and national patient safety alerts.

# Services for children and young people

### Leadership of service

- Children's services were managed as part of the Women and Children's Directorate. There were clinical and nursing leads for both sites who met regularly as part of the directorate management team. The directorate management team had overall responsibility for governance within the directorate. The directorate management team included the head of nursing, clinical director and general manager.
- An executive director had been identified to provide board level leadership for children's services. They said they recently agreed to take on the role, but it was not clear how this would fit together with their other responsibilities. There was no non executive lead at board level for the service. The director of nursing was responsible for safeguarding across the trust.
- Clinical leads were working closely to integrate working arrangements across the two trust sites, for example bringing guidelines together. They told us uncertainty about the future of the organisation had led to delays in addressing strategic objectives, but they were keen to develop more joint working between the sites. They had made a start, but acknowledged there was still considerable work to be done.

### Culture within the service

- Staff were proud to work in the service, but told us uncertainty about the future of the trust had contributed to difficulties recruiting and retaining staff. This in turn led to staffing pressures on the ward. Some staff felt managers were responding to these concerns, for example by developing a five year strategy setting out a future for the service which would consolidate and expand the role of the paediatric service for the local community.
- Staff felt positive about the future whilst recognising that problems with the buildings and split site working meant the creation of an integrated service across two sites was a sizeable challenge. Staff supported integration and told us they were developing closer working links and working flexibly across sites.

### Innovation, improvement and sustainability

- The trust actively participated in the South West London Provider Collaborative. This was a programme of work involving four south west London acute trusts, working together to develop sustainable, high quality clinical, financially viable services.
- There were plans to review the service against the London Quality Standards for children's services. There were 21 standards relating to a range of quality standards for example providing seven day services.
- The service was working with partners to develop the care for children with complex and acute needs to be nursed within the community;
- The service was developing a community neonatal team to support families once they left hospital. The service implemented a quality improvement in 2014-2015 for increasing number of premature babies having retinal screening for premature babies. The target was 90% for babies with a birth weight of less than 1501g or less than 32 weeks gestation. Retinopathy of prematurity (ROP) is one of the few causes of childhood visual disability which is largely preventable
- The service planned to improve the discharge for babies under 36 weeks gestation by providing more support in the community and increasing the capacity within the service for mothers who have booked to have their baby at the hospital and for babies who needed to be cared for by the neonatal service. The scheme was an NHS England initiative. The service was planning to submit information to the paediatric safety thermometer by establishing the process for data collection and agreeing targets for harm reduction with commissioners.

# End of life care

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

## Information about the service

The Epsom and St Helier University Hospitals Specialist Palliative Care Team (SPCT) provided patient-centred advisory service to any patient with progressive illness in need of specialist support across the two hospitals of the trust. The team consisted of three consultants, one middle grade doctor, two junior doctors, seven palliative care clinical nurse specialists and two social workers. Medical and nursing staff referred patients to SPCT for symptom management.

Specialist palliative care was provided as part of an integrated service across both St Helier Hospital and Epsom Hospital. The SPCT worked six days a week, 9am to 5pm Monday to Saturday, and the consultant was on call out of hours and at weekends. The trust had secured Macmillan funding to expand the number of clinical nurse specialists and were planning to start a seven-day service in January 2016. The SPCT worked closely with the chaplaincy team and they provided spiritual and religious support to patients and their families 24 hours a day.

During the inspection, we visited various wards that provided palliative and end of life care, including Alexander, Britten, Buckley, Chuter Ede (AMU), Croft, Gloucester and Swift wards and observed end of life care and treatment and reviewed 6 sets of medical/nursing records. We also visited the bereavement office, multi-faith centre and the mortuary. We spoke with two palliative care medical consultants, palliative care clinical nurse specialists, registered nurses, bereavement officers, porters, mortuary staff and the hospital chaplain in order to assess how end of life care was delivered. We also spoke with 12 patients and their relatives about their experience of end of life care at the hospital.

The SPCT was actively involved in ward based formal and informal staff education on EOLC. They had delivered educational courses and presented at medical and nursing team meetings and had designed an end of life care resource folder for ward based teams.

# End of life care

## Summary of findings

The Specialist Palliative Care (SPCT) team provided end of life care and support six days a week, with on call rota covering out-of-hours. There was visible clinical leadership resulting in a well-developed, motivated team.

The Director of Nursing had taken the executive lead role for end of life care, along with a Non-Executive Director (NED) to ensure issues and concerns were raised and highlighted at board level. Trust board received EOLC report outlining progress against key priorities within the EOLC strategy, including audit findings, themes from complaints and incidents, evidence of learning and compliance with end of life training requirements.

The SPCT provided a rapid response to referrals, assessed most patients within one working day, their services included symptom control, end of life care (EOLC), and support for patients and families, advised them on spiritual and religious needs and fast-track discharge for patients wanting to die at home.

Most of the nursing staff were complimentary about the support they received from the SPCT. Junior doctors particularly appreciated their support and advice, and said they could access the SPCT at any time during the day. They recognised that the SPCT worked hard to ensure that end of life care was well embedded in the trust.

Nursing staff knew how to make referrals to the SPCT and referred people appropriately. The SPCT assessed patients promptly to meet their care needs. The chaplaincy and bereavement service supported patients' and families' emotional and spiritual needs when people were at the end of life.

Referrals for patients who required support during end of life care were made electronically to the specialist palliative care team from clinicians throughout the trust. The specialist palliative care team had daily morning briefings to update on changes in patients' condition, assess new referrals and allocate work for the day.

The National Care of the Dying Audit 2013/2014 (NCDAH) demonstrated that the trust had not achieved three out of seven organisational key performance indicators. At the time of the inspection, the trust had not fully rolled out the replacement of the LCP, and this delay meant that staff were not fully supported to deliver best practice care to patients who were dying. The leadership failed to apply enough urgency to have an individual plan of care in place.

# End of life care

## Are end of life care services safe?

Good

There were governance systems in place that helped to ensure end of life care services were safe and met patients' needs. There was learning and analysis of incidents that could affect patients who receive end of life care. This information was used to improve the experience for patients as well as safety of the services they received.

The processes for incident reporting and investigation was robust, and staff were aware of their responsibilities to report incidents. Learning from incidents was shared with staff. The EOLC strategy board and clinical governance committee discussed learning from incidents at their meetings.

End of life anticipatory medication were prescribed and administered in line with national guidance. We saw that specialist palliative care nurses worked closely with medical staff to ensure appropriate prescribing for patients at the end of their life.

Staff were committed to providing person-centred services for patients who were receiving end of life care. There was effective multidisciplinary team working to achieve this for patients at the hospital and when they were discharged.

We saw that the staff provided care for people in a safe and suitable way. For example we saw staff followed infection control procedures when barrier nursing patients. We also saw safe procedures when they assisted people with impaired mobility.

### Incidents

- Staff we spoke with were clear about how to report an incident using the Datix electronic incident reporting system and were confident these would be investigated. We saw team meeting minutes, which showed a standing agenda item for the feedback of incidents to the wider team and lessons learned.
- There had been no Never Events in the specialist palliative care service (serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented). Nursing staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and near misses.
- SPCT members told us incidents were discussed at the weekly team meetings and action plans and learning arising from an incident were disseminated to ward based staff at handovers. The action plans were available to staff on the ward in incident report folders.
- We noted that managers and senior staff had a good understanding of Duty of Candour and had attended relevant training about their responsibilities in informing patients when an incident has occurred that could cause harm.

### Medicines

- The trust had its own medicine guidelines for prescribing medicines at the end of life, based on National Institute for Health and Care Excellence (NICE) guidance.
- Some of the clinical nurse specialists within the SPCT were nurse prescribers and supported junior medical staff in prescribing medicines at the end of life. We observed nurses working closely with medical staff on the wards to support the prescription of anticipatory medicines at the end of life (medication that patients may need to make them more comfortable). Junior doctors told us prescribing the appropriate end of life medicines was made easier because of the guidelines, alongside the fixed set of anticipatory medicines.
- Some nursing staff said they needed at times to prompt doctors to prescribe anticipatory medicines. However, most said that this was managed well to avoid delays for patients and ensure good symptom management.
- Appropriate syringe drivers were available to deliver sub-cutaneous medication. Staff said there was a pool of medical devices available and they could obtain a syringe driver within 20 minutes of it being prescribed. This included those who were being discharged home. We were told the keys to operate the syringe drivers were the same whether in the community or in hospital making administration of medicines more prompt and timely.
- Nursing staff told us there were adequate stocks of appropriate medicines for end of life care available including controlled drugs and these were stored and managed appropriately in line with national guidance and trust policy.

# End of life care

## Records

- Patients' healthcare records were stored in a secure trolley that promoted confidentiality and were kept at the nurse's station. Nursing observations records were stored at each individual patient's bed space.
- Deceased information recording systems were in place in the mortuary to ensure details were kept accurately. Deceased people with similar names were flagged up to avoid mix up.
- The bereavement office kept records of all hospital deaths and funerals that was organised by the hospital when there was no next of kin or no means for families to arrange a funeral.
- The SPCT were responsible for completing advanced care planning and we saw evidence of this in use in the hospital. However, some nurses on the ward were not aware of advanced care planning completed for their patients by the SPCT.
- We reviewed five sets of DNACPR forms and all of them were completed accurately with notes about the discussions with family. Patients' notes included records of discussions about DNACPR with patients and relatives. In all cases, we saw that the DNACPR decisions were dated and kept at the front of the patient's file.
- We reviewed the records of nine patients' who were reviewed by the palliative care team for symptom management or end of life care. The records were clear and legible. When required, end of life care plans were completed.

## Safeguarding

- The specialist palliative care team informed us that safeguarding training was mandatory. Records confirmed all the palliative care team staff had undertaken the safeguarding level two training.
- All staff throughout the hospital were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable adults and children from abuse.
- Nursing staff we spoke with had a sound understanding of their responsibility in relation to safeguarding adults. The trust had a dedicated Adult Safeguarding lead nurse.
- There were adult safeguarding policies and procedures in place. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.

## Mandatory training

- Newly recruited nursing staff received training on end of life care on induction, as a part of the mandatory training.
- The specialist palliative care team offered a rolling education programme on end of life care for all staff. We saw evidence of staff attendance at the training.
- Syringe driver training was not mandatory for ward staffbut new nursing staff were trained as part of their competencies for working with EOLC patients and were required to complete it. All staff we spoke with on the wards and within the specialist palliative care team told us they were trained, assessed, and were competent in syringe driver drug administration.
- We saw records that confirmed the specialist palliative care team were up to date with all the trust's required mandatory training. This included health and safety and infection control training.
- The specialist palliative care team told us they provided training on the trusts mandatory training days. They covered a scenario about end of life care and asked staff to reflect on what they would do in the situation presented.
- The palliative care team felt the staff on the wards needed more training on improving their communication skills, to increase their confidence in discussing end of life care with patients and relatives. We did find some evidence that patients did not have conversations about advance care planning. This meant there was a risk patients were not given the opportunity to have conversations with staff about their end of life wishes whilst they had the capacity to do so.

## Assessing and responding to patient risk

- The trust used an early warning score (NEWS) which highlighted if escalation of care was required, additionally, they used an electronic system for recording patient's clinical observations, called Vitalpac. Paper documentation was used for indwelling devices such as central lines and catheters.
- Ward staff told us the SPCT had a visible presence on the wards and changes to patient's conditions prompted a visit by the SPCT. We saw patients' daily notes by nursing, medical and therapy staff with updates on changes recorded clearly.

# End of life care

- The wards we visited used a recognised early warning tool to identify any patients who were deteriorating. The documentation told the staff what to do when the scores increased.
- EOLC support was available from the palliative care team and covered 24 hours a day, seven days a week.
- Nursing staff on the ward we visited told us they could always get advice from a palliative care doctor out of hours as there was an on call rota in place with details of who to contact.
- For patients where the progression of their illness was clear, the amount of medical intervention was reduced to a minimum. Care plans were based on ensuring the person remained as comfortable as possible, at all times. Proactive, anticipatory care plans were put in place to ensure non specialist staff were aware of the best way to manage symptoms patients were likely to present as part of the disease progression.

### Nursing staffing

- The hospital had 8 specialist palliative care nurses, equating to seven WTE nurses, they supported cancer and terminally ill patients in the hospital.
- Nursing staff we spoke with confirmed there were always sufficient staff nurses to ensure that people who were very close to the end of life would have a dedicated member of staff with them at all times. Ward staff routinely provided end of life care with specialist support from SPCT.
- The specialist palliative care team provided services from 9am to 5pm six days a week, with on call access for specialist support from a consultant 24 hours a day.
- We were told there that was no end of life care link nurses on individual wards.

### Medical staffing

- The SPCT (medical and nursing) worked across the two sites of the trust and covered each other for holidays and other absences.
- The SPCT had 2.9 whole time equivalent (WTE) consultants in post; two consultants covered St Helier hospital and the other covered Epsom General Hospital. Two of the consultants in palliative medicine hold joint posts with the local hospices and a consultant from a local hospice did a single session at the hospital. Middle grade doctors supported the consultants.
- Most of the consultants were working across hospitals, the community and the local hospices, allowing for improved continuity and management of patients.
- The Palliative Medicine Consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.

### Major incident awareness and training

- The mortuary had a business continuity and escalation plan available for staff for reference. Mortuary staff we spoke with were aware of this plan. The mortuary manager informed us about the surge and escalation plans contained in their business continuity plan. This meant that should there be a sudden surge in demand for refrigerated mortuary space; the trust had an agreement with local undertakers to provide additional facilities or to transfer deceased patients to other trust's locations.
- Each ward had a plan for evacuating patients safely in the event of a major incident. Staff told us that their procedures for major incidents such as fire had been tested to ensure that it was fit for purpose.

## Are end of life care services effective?

Good

The SPCT based its care on National Institute for Health and Care Excellence (NICE) quality standards relating to end of life care (EOLC) and provided evidence-based advice to other professionals as required. They followed best practice guidance and provided advice and support to staff on all wards. Nursing staff on the wards provided care with revised EOLC guidelines to assist them.

The trust was not fully compliant with the Key Performance Indicators (KPI's) of the National Care of the Dying Audit (NCDAH) for 2013 – 2014; they achieved four out of seven KPI's. The end of life care policies and procedures were in line with the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care for Adults.

There was monitoring of patient outcomes in relation to end of life care taking place across the trust. There were action plans developedto address the three not achieved areas of the National Care of the Dying Audit Hospitals (NCDAH) for 2013 -2014.

The specialist palliative care team was highly regarded by all of the staff we spoke with throughout the trust.

# End of life care

Clinicians and nursing staff told us the team responded promptly to referrals and were accessible and effective in supporting patients with end of life care needs. Trainees and new staff received EOLC training from the SPCT.

Following the national review of the Liverpool Care Pathway (LCP), the trust responded to the recommendations of the review by reviewing their care of the dying protocol and developed guidance folder for wards caring for end of life patients. The folder contained best practice guidance for the care of the dying, the process for creating an individualised care plan, contact details of the specialist palliative care staff, and anticipatory medicines guidelines. Nursing staff were asked to follow this guidance to provide care and treatment to all patients nearing the end of their life.

### Evidence-based care and treatment

- The trust had in place an end of life care policies and procedures, which was based on the Department of Health End of Life Strategy 2008, Quality Markers and Measures for End of Life Care, NICE Quality Standards for End of life Care for Adults, the Report of the Independent Review of Liverpool Care Pathway – "More Care Less Pathway" and finally the Report of the Leadership Alliance for End of Life Care.
- The trust participated in the NCDAH in 2013/2014. The report published in 2014 showed the trust had not achieved three out of seven of the organisational key performance targets. The trust's executive lead spoke of their future aspirations to address the outcomes. We saw evidence of the implementation of action plans for the three KPIs which were not achieved. Funding had been secured from Macmillan to support a seven-day face to face palliative care service and a dedicated non-executive board member had been appointed to the EOLC Strategy Board.
- The trust had taken action in response to the 2013 review of the Liverpool Care Pathway (LCP), removed it from use and developed the Priorities for Care of the Dying – Duties and Responsibilities of health and care staff. The palliative care specialist nurses told us it was a tool for staff to provide a holistic approach to care for patients in the last days and hours of their life.
- However, only one ward at the Hospital had piloted the tool in the last two months and not all nursing staff at the hospital were aware of this tool or the pilot. The SPCT hoped to roll out the tool after it had completed the pilot.
- Chaplaincy service at the hospital was particularly good at meeting the needs of people receiving EOLC. There was also good links to other religions, with a local Rabbi providing support to Jewish patients and a Muslim Chaplin providing support to Muslim patients. The newly developed Priorities for the Care of the Dying patients care plans included a section to demonstrate that people's spiritual needs had been assessed and chaplains wrote in the patients' records when they had visited the patients.
- Most patients referred to the SPCT also had a referral to other services including chaplaincy and discharge coordinators.
- The Care plans for end of life patients were based on the Five Priorities of Care (One Chance To Get It Right").
- We reviewed five DNACPR forms for end of life care patients across a number of wards throughout the hospital. We found all the forms were completed appropriately, and relatives' involvement was recorded.

### Pain relief

- Nursing staff told us patients commenced on the personalised care plan for the last days of life would have their pain assessed, along with other symptoms to promote effective management of patients pain.
- Appropriate medication was available for the ward staff to use and we saw that anticipatory medication prescribing was well managed and provided effective pain relief and symptom control for patients receiving end of life care. Providing effective pain relief for patients receiving end of life care was a critical part of the SPCT's role.
- Patients we saw appeared to be comfortable and pain-free. When we spoke with family members, they confirmed their relatives were pain-free.
- Some staff described how they would assess pain in patients who could not communicate such as; through observations of behaviour, facial expressions and movements.
- Doctors we spoke with confirmed they were aware of the pain management guidance available to them and were familiar with contacting the SPCT for advice.

### Nutrition and hydration

- Patients and relatives we spoke with were happy with the availability of food and drink at the hospital, and we

observed hot and cold drinks available throughout the day. Nursing staff were able to tell us how they addressed peoples' religious and cultural needs regarding dietary requirements.

- Nursing staff on the wards we visited told us patients receiving end of life care could eat and drink normally and would carry on doing so unless their condition changed.
- We reviewed five records of EOLC patients and observed that a food record and a dietary action plan were in place, which stated that the patients should be encouraged to eat and drink if able to do so and they must be supported by the nursing staff to do so. This showed that the hospital had systems in place to support patients' nutrition and hydration needs.
- The trust scored 54% in the 2013/2014 NCDAH review of the patient's nutritional requirements, which was better than the England average of 41%. With the hydration requirements, the trust scored 64%, which was better than the England average of 50%. The trust was not able to provide us with location specific data for this audit despite out request.

### Patient outcomes

- The trust had systems which ensured there was timely identification of people needing EOLC on admission or who moved from active treatment to palliative or end of life care whilst an inpatient at the hospital. Patients in the last hours and days of life were referred to the SPCT. Their care needs were assessed and staff used the end of life guidance and protocols developed by the SPCT to ensure they received effective care.
- The trust supported patients to achieve their preferred place of death, either through fast track discharge home, hospice or nursing home, or by ensuring that high quality end of life care was provided for patients who wished to die at the hospital.
- The SPCT told us the team saw patients nearing the end of life referred to them by their medical or the nursing team. We noted that the SPCT reviewed referrals within hours of the receipt of the referral, and team members visited the patient and provided support to patient their families and ward staff caring for the patient.
- In the NCDAH of 2013/2014, the trust scored 64% for reviewing interventions during a patient's dying phase, which was better than the England average of 56%. They scored 86% for reviewing the number of assessments undertaken in the patient's last 24 hours of life, which was better than the England average of 82%. The trust was not able to provide us with a location specific data for this audit.
- The SPCT received 1,203 referrals from April 2014 – March 2015. The patient referrals included 58% who had a cancer and 42% who had other terminal illnesses.

### Competent staff

- The palliative care specialist nurses and doctors provided formal and informal EOLC training to junior doctors and nursing staff.
- Most of the nurses we spoke with demonstrated a good knowledge of planning care for EOLC patients and were clear about when to seek input from the specialist palliative care team.
- Nursing staff told us they were given the opportunity to attend end of life care training and some had received an update on the priorities of care.
- Mortuary staff trained porters on how to handle bodies with dignity and care. There were procedures and protocols within the mortuary area for safe back care.
- The SPCT provided us with their training programme for end of life care. We were told the training was often not well attended as nurses found it difficult to be released form the wards to attend training sessions. Some nursing staff told us there were limited opportunities to attend some of the EOLC training due to staffing shortages across the trust. The team also supported staff informally whilst on the wards.
- The SPCT maintained records of staff who had attended end of life care training. For example, we saw that 503 clinical staff across the trust had attended EOLC training.
- The mortuary technicians we spoke with were able to explain their role and responsibilities. They told us they had attended mandatory training. They had also attended other specific training that supported them in their role such as advanced communication with bereaved relatives.
- One of the key components of the SPCT teaching programme was educating nursing and medical staff on the fast track discharge process. Whilst the SPCT were instrumental in supporting the fast track process, the ward clinical teams were responsible for the discharges.
- The portering team told us that they had received training in moving and handling and in moving the deceased patients to the mortuary. The training

included out of hours access to the mortuary. The porters we spoke with were able to describe the process of moving bodies to the mortuary in a knowledgeable manner and were able to demonstrate how they treated deceased with dignity and respect.

### Multidisciplinary working

- Members of the SPCT participated in multidisciplinary team (MDT) meetings, they worked with other specialists to provide good quality end of life care across clinical specialities. A weekly specialist SPCT MDT meeting was held at the hospital. Members of the MDT included consultants, CNS, social worker, end of life care administrative staff, and a Chaplin.
- Discussion at the MDT included all new patients referred to the SPCT, patients who had died or been discharged from the service, patients of particular concern where a team member sought support and advice from the team.
- The SPCT met on a weekly basis at a multidisciplinary team (MDT) meeting to discuss all incidents, referrals, changes in patients' condition, discharges and deaths of patients under their care. We attended one of the meetings and were shown minutes of previous meetings and other governance meetings; they included feedback from clinical incidents in hospital and the community.
- The SPCT worked closely with other speciality including acute oncology team, community and hospice teams in order to give support with complex symptom management at the end of life. The palliative care medical consultant worked sessions at the local hospice providing streamlined care across hospital and the community.
- The MDT worked well together to ensure patients' care and treatment was planned and co-ordinated. We noted that patients had good holistic assessment and there was evidence of emotional support and anticipatory prescribing to support patients.
- The bereavement officers reported good working relationships with the wards, CNS, chaplaincy and mortuary staff. They also had easy access to the coroner's and mortuary staff. The bereavement office received a daily list of patients who had died in the hospital the previous day. Deceased patients' medical notes were delivered to the Bereavement Office and checks would be made with the ward doctors to find out whether any case needed to be referred to the coroner's office. The bereavement office arranged death certificate and cremation authorisations for relatives.
- The chaplaincy team told us they worked together with the SPCT in the development of the end of life care plan.
- The 2014 NCDAH, the trust achieved 73% for multi-disciplinary recognition that a patient was dying compared to the England average of 61%. The trust was not able to provide us with a location specific data for this audit.
- Consultants from the SPCT worked across the community and at the local hospices, which improved safety and continuity of patients care in the community.

### Seven-day services

- The palliative care specialists were available at the hospital during working hours from Monday to Saturday. The trust operates a 9am to 5pm visiting CNS service 6 days a week Monday to Saturday and 9am to 5pm Monday to Friday for medical work, administrative support and social work service. No seven-day face-to-face specialist care and support was available from the SPCT.
- The trust was working towards a 7 day 9am to 5pm CNS visiting service from January 2016 and had already secured a funding from the Macmillan Cancer services. Medical Consultant was on call for advice and attended the hospital when required.
- The SPCT told us, nurses and doctors needing support on Sundays to care for end of life patients had to manage with telephone support only. Ward staff who spoke with us told us this was satisfactory, as they had not experienced any other kind of weekend cover.

### Access to information

- We were given a copy of the bereavement pack, which were given to relatives when they collected the death certificate and other belongings from the hospital. The pack had useful information about what procedures to follow and gave some bereavement advice.
- The SPCT, that chaplaincy team, medical and nursing team had access to patients' records. We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant care plans to meet their individual needs.
- We viewed records that included detailed information about the management and control of symptoms, interventions and discussions with the patient and their

relatives. We also saw that when patients were seen by the specialist palliative care team, information and advice was clearly recorded so that nursing staff could easily access the guidance given and plan patients care accordingly.

- All the nursing staff had access to the care of the dying policy and procedures including the resource folder in the ward, these gave them guidance on all aspects of the EOLC.
- The SPCT kept all their records of their contact with EOLC patients in the patients' medical records in the ward along with any assessments they had completed, for ease of access for the ward teams.

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

- Nursing staff had undertaken Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS) training, and they understood and described to us what mental capacity assessment meant.
- We observed that medical and nursing staff, prior to any intervention with patients, asked for their consent where the patient was able to communicate or from the patient's relatives if the patients were unable to communicate.
- The SPCT members demonstrated an awareness of the issues around mental capacity and best interest decision making, and all the SPCT members had attended MCA and DoLS training.
- We examined five DNACPR records and all them had a mental capacity assessment form completed appropriately.
- We observed some patients receiving end of life care had been identified as not for resuscitation and had DNACPR form completed and kept in their medical notes so that staff were aware of not to initiate CPR in the event of a cardiac or respiratory arrest.

## Are end of life care services caring?

Good

Staff at Epsom General Hospital provided dignified and compassionate EOLC to patients. We saw that staff were committed to providing good patient care that focussed on meeting patient's' holistic needs. There was good recognition of the importance of family and friends during the last days and hours of life.

Nursing staff were caring, compassionate, and treated patients with dignity and respect. Patients felt well cared for by the nursing staff and the SPCT. Patients we spoke with and those close to them were encouraged to be involved in their care. They felt they were treated as equal partners, listened to, and were involved in decision making at all levels. Relatives we spoke with told us that staff were caring.

During the inspection, we saw staff treated patients in a way that showed them respect and that curtains were drawn to protect patient's dignity when personal care were being delivered. Nursing staff and the SPCT gave patients and relatives sufficient information to understand their treatment choices.

We found the care and support given to relatives after the death of their family member by the mortuary staff, chaplaincy team and the bereavement officer to be good. Feedback from patients and relatives was entirely positive about the care they had received.

The chaplaincy team supported ward staff and other professionals delivering end of life care. The chaplain attended the SPCT MDT meetings and was part of the team that developed the end of life strategy of the trust.

### Compassionate care

- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly and patients told us they were looked after well.
- Where possible, staff cared for patients at the end of life in a side room to ensure that their dignity was maintained.
- The bereavement office staff told us they contacted each bereaved family and met them when they collected the cause of death certificate and their loved ones belongings from the office.
- We spoke with a relative of a patient who was receiving end of life care and they told us they were very impressed by the level of care their relative had received. They told us nurses were very caring and understanding and provided them with all what they need in the ward.

# End of life care

- We visited the mortuary and spoke with the mortuary staff, who were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death.
- We were told how respectful hospital porters were when caring for the deceased before they were transferred to the mortuary. Hospital staff treated the deceased with dignity and respect, and saw that mortuary staff referred to the deceased in a respectful manner.

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

- The specialist palliative care nurses were actively involved with the patient, providing support and keeping families informed about the patient's condition, prognosis and progress.
- We saw that visiting hours were relaxed for family and friends when patients were at the end of life and this allowed the relatives to visit at any time. We noted that relatives were able to stay with patients at the end of their life if they wished.
- Patients we spoke with told us that they felt involved in their care. Relatives we spoke with told us they had been involved in decision making as necessary.
- We saw evidence that the SPCT had discussions with patients and relatives about where they wanted to receive care at the end of life. The SPCT told us they thought staff on the general wards needed more training in communication skills to provide them with the confidence in having discussions with patients about end of life issues.
- We reviewed five care records of patients receiving EOLC and saw documentation written by ward staff and the SPCT, which detailed discussions with the patients and their relatives. The recordings showed detailed information and discussions about medication, prognosis and family concerns.

### Emotional support

- The SPCT, the chaplaincy and bereavement officers were available to provide support for families and carers during the day, including out of hours. The team provided a dedicated service, which supported people through the end of life process.
- We observed that most patients who were actively dying had family members with them, so they could support their relatives and start the grieving process.
- We saw that visiting times were flexible for family and friends when patients were at the end of life and we saw that relatives were able to stay with patients at the end of life if they wished.
- The bereavement office supported relatives/friends after the patient's death by explaining all the legal processes, and what to expect after someone has died. The bereavement officers told us they always supported families or friends wishing to see the deceased by accompanying them to the chapel of rest.
- There was a chapel and multi-faith room available for patients, staff and visitors. The chaplaincy services within the trust were geared towards providing emotional support to patients and their relatives irrespective of their individual faith or if they did not follow a faith.
- Throughout our inspection, we saw that staff were responsive to the emotional needs of patients and their relatives. Nursing staff told us about examples where staff had considered the needs of relatives and waived visiting hours to ensure that relatives can visit as and when necessary.
- We observed staff providing emotional support to relatives of a palliative patient on one of the days of our announced inspection. Doctors spoke to the relative in a separate quiet room and answered their questions. However, the palliative care team was not contacted and were therefore unable to offer additional specialist support to the patient and the family members.

## Are end of life care services responsive?

Good

The trust had an EOLC Strategy Board, which met quarterly to discuss service planning and delivery, audits and action plans and training needs for staff involved in EOLC. There were weekly EOLC MDT meetings to discuss end of life care issues and the opportunity to update staff on new initiatives, training and share information around end of life care in the ward area. The trust had EOLC guidance for handling complaints, which included reviewing complaints and concerns from relatives about end of life care.

Fast track discharge protocols and processes were in place, and were effective in getting people to their preferred place

of care prior to their death. The hospital engaged and worked with local commissioners of services, the local authority and other providers to coordinate care and facilitates access to appropriate services.

The DNACPR records we reviewed at had documented that appropriate discussions had taken place with relatives regarding the decision.

Relatives were able to stay with the patient in a side room should they request to do so. The bereavement and mortuary services took into account people's religious customs and beliefs, and were flexible around people's needs such as releasing the body and providing death certificates within 24-hours.

The trust had a multi-faith room where all faiths were welcome. There were also a number of chaplains from different denominations.

### Service planning and delivery to meet the needs of local people

- The trust held a quarterly EOLC Strategy Board meeting to discuss service planning and delivery, audits and action plans and training needs for staff involved in EOLC and share information about end of life care at the hospital.
- There were weekly EOLC MDT meetings to discuss end of life care issues and the opportunity to update staff on new initiatives, training and share information around end of life care in the ward area.
- The SPCT provided a fast-track discharge for patients who wished to die at home, in a hospice or nursing home. Staff told us they facilitated and supported patients who wished to die in their place of choice.
- Relatives and friends could arrange an appointment to view their family member's body. This was usually organised through the bereavement office or with the ward staff during out of hours. The ward staff and the porters accompanied them to the chapel of rest for the viewing.
- The bereavement office managed funerals for people without a next of kin. They planned and organised a dignified funeral for the deceased.
- The SPCT received referrals from many specialities within the hospital, with the medical division being the largest user. The hospital did not record the number of patients dying in their preferred location. Staff said one of the reasons for this was that sometimes patients were not fully aware of their prognosis so staff did not want to ask. Clinical leadership confirmed this was an area of improvement for the trust and they were currently auditing that.
- The bereavement office had procedures in place to ensure timely issue of death and cremation certificates. However, they said the only complaints they ever received were about delays due to waiting for medical staff to complete the certificates when they were busy on the wards and unable to come down to the mortuary. These were fed back to the hospital to try to improve the process.

### Meeting people's individual needs

- We observed the SPCT supporting patients who had complex needs and they utilised appropriate members of the SPCT to access specialist input for patients including social workers and chaplain.
- The bereavement and mortuary services took into account people's religious beliefs and customs, and were flexible around people's wishes such as releasing the body within 24-hours of death. Death certificate could be issued within 24-hours if everything was in order.
- The trust had a protocol with the coroners to ensure bodies were released to family members promptly to comply with religious and cultural obligations.
- There was a range of viewing rooms and a chapel of rest to enable relatives to spend time with their deceased loved one.
- There was a separate bereavement office; however, there were no private room available for staff to take a distressed relative collecting personal belongings and paperwork. The bereavement office staff dealt with bereaved family at their office.
- The trust did not achieve NCDAH 2013-2014 on access to specialist support for care in the last hours or days of life. This was because they did not provide face-to-face specialist palliative care services from 9am to 5pm seven days a week, despite the national recommendation that this should be provided. However, there was a six days a week CNS service and 24 hour access to on-call advice from the consultant, with a planned increase to 7 day CNS service from January 2016.The trust was not able to provide us with a location specific data for NCDAH 2013-2014 audit despite our request for such data to be submitted.

- The SPCT supported teams to communicate clearly with the patients, their family and primary care providers. The SPCT also supported trust discharge co-ordinators in the completion of fast track documentation and liaised with the required primary care service through their close links with the community palliative care services and the hospices.
- Staff had access to a language line for interpretation services. Interpreters were available when needed. There were information packs from the bereavement office on what to do after a death; however, the packs only contained information in English and were not available in any alternative languages or formats. Staff said they might ask the interpreters to translate information if needed.
- A family who were visiting an EOLC patient told us they felt staff responded well to individual needs and they were overall satisfied with the care their loved one had received. The patient's wishes and preferred place of care were met.

### Access and flow

- The SPCT received referrals from any hospital team and from community teams. They accepted referrals for any adult patient who needed specialist palliative care input. They also provided telephone support and signposting for teams who only required advice. Referrals were picked up throughout the day by the SPCT.
- We spoke with the SPCT and they told us of their commitment to ensure patients' symptoms could be stabilised and patients could be discharged quickly to ensure they were able to end their life in a place they had identified in their advanced care plan.
- We saw fast track discharge planning which supported the fast track discharge of patients who wanted to end their lives in their own home or other place of their choice.
- Fast track discharge protocols and processes were in place, and were seen to be effective in getting people to their preferred place of care prior to their death.
- The SPCT received referrals daily from the hospital staff. Urgent referrals were responded to within few hours of the referral been received by the team from Monday to Friday. Others patients were responded to within 24 hours. Most of the referrals came from the clinical staff. When we spoke to staff about the circumstances under which they would make referrals, they described symptom controls and pain relief and terminal patients who had deteriorating condition. The trust had audited their July 2015 data, which showed 91% of patients were seen within 24 hours of referral and had commenced an audit of six months Trust-wide data to provide further assurance.
- The SPCT developed a Fast Track (FT) discharge flow chart for wards; this enabled the ward staff understood and implemented the timely discharge of patients to their preferred place of death. The FT was aimed to achieve discharge of patients within 48 hours and commenced with the early identification of appropriate patients. The SPCT supported the medical teams in the FT process.
- The trust had increased the SPCT Palliative Medicine Consultant and Clinical Nurse Specialist workforce following a successful service improvement project on the Acute Medical Unit (AMU), which enabled timely turnaround of FT discharges from AMU and Emergency Department to the patients chosen place of death.
- The SPCT supported teams to communicate clearly with the patients, their family and primary care providers and supported Trust Discharge Co-ordinators in the completion of FT documentation. The SPCT also liaised with the required primary care service through their close links with the community palliative care service.
- Educating nursing and medical staff on the FT discharge process is a key component of the SPCT teaching programme. Whilst the SPCT is instrumental in supporting the FT process, ward staff were the key drivers in the implementation of the FT discharges.
- Fast Track discharge numbers are rapidly increasing: 237 FT discharges were initiated in 2014/15 as compared to 76 documented in 2012/13 and 160 patients were successfully discharged to their preferred place of death in June 2014/2015.

### Learning from complaints and concerns

- The trust had EOLC guidance for handling complaints, which included reviewing complaints and concerns from relatives about end of life care.
- The staff were able to give us examples of how complaints and concerns had been acted upon on the wards that we visited, however there were no complaints in relation to EOLC patients.
- Patient Advice and Liaison Services team (PALS) told us they had not received any complaints specifically about patients receiving EOLC from June 2014 – June 2015.

# End of life care

- Nursing staff directed families and relatives to the PALS office for support to make a complaint or to request a meeting with the senior medical officer if they had concerns. PALS staff directed families and relatives to the medical team if they were not satisfied with the care or did not understand their relative's cause of death.
- Nursing staff were aware of the complaints procedure and who to report concerns to, and information about how to make a complaint was displayed on the wards we visited. There had been no recent complaints to the outpatients department but we saw that complaints received in other areas were shared with staff and any change in practice was recognised.

## Are end of life care services well-led?

Good

There was a clear strategy for End of Life Care and the management team understood the vision of achieving good end of life care. There was evidence of Board involvement in the EOLC strategy. We saw evidence of good leadership at board level and we saw a good approach to investing in services when a need and business case had been identified.

The SPCT had reported an increase demand on its services, and one extra CNS had been recently employed to provide support for Sunday services, which would allow the service to provide seven day services.

The EOLC clinical governance arrangements were well managed. The service was responding to local demand in a prompt and timely manner. Staff were noted to be clear about their commitment to providing care that ensured patients ended their life in a dignified and respectful manner in their chosen place of death. Care was guided by a SPCT who were supportive and provided good leadership to the rest of the hospital.

The SPCT had a key role in supporting the medical teams in this process. The trust had increased their SPCT Palliative Medicine Consultant and Clinical Nurse Specialist workforce following a successful Business Case to the trust and application for funding from Macmillan Cancer Support.

We found the leadership model of SPCT encouraged cooperative and supportive relationships among staff and a caring approach towards patients nearing the end of their life. We noted an open and positive culture within the service. Nursing staff reported they felt they could raise concerns and they were confident anything they raised would be dealt with appropriately. The SPCT strived for continuous improvement in the EOLC services offered and how it managed end of life patient care.

### Vision and strategy for this service

- The trust had a clear vision and strategy for end of life care services and had applied resources appropriately to develop end of life care services as a priority, including the appointment of a non-executive director to lead on the EOLC strategy. The NED lead for end of life care worked closely with the senior management of EOLC and the SPCT. The EOLC strategy was monitored through the End of Life Strategy Board. We spoke with staff who told us that they were aware of the EOLC strategy and their role on how this would improve the end of life experience for patients and their relatives.
- Staff were able to articulate the five priorities for the care of the dying person "One Chance to Get It Right" and the five key points for the End of Life Care.
- The trust had developed a care of the dying protocols, policy and procedure, which provided the staff with a plan relating to the care of the dying patients. Some of the nursing staff we spoke with, who were delivering end of life care, knew about the five priorities of the care of the dying patient and were able to describe the trust's vision around EOLC.

### Governance, risk management and quality measurement

- An independent review of the Liverpool Care Pathway (LCP) in July 2013 recommended the phasing out of the LCP over the following six – twelve months and then the implementation of individual plans of care. At the time of the inspection, the trust had not fully rolled out the replacement of the LCP, and this delay meant that staff were not fully supported to deliver best practice care to patients who were dying. The leadership failed to apply enough urgency to have an individual plan of care in place.
- Clinical governance committee meetings were held monthly within the service and all staff were encouraged to attend including junior staff and administrative staff. Complaints, incidents, audits and quality improvement projects were discussed at these

meetings. Minutes of the meetings we reviewed confirmed that incidents, complaints and audits were discussed with action points allocated to individual members of the committee.

- The end of life strategy board complied with the audit standards of the trust. Audits were a key part of the delivery and monitoring of good end of life care for the trust. There were a number of audits led by the SPCT for example, audit of the fast track discharge process, and survey of hospice to hospital transfer, national end of life care audit, bereavement survey and survey of patient satisfaction with palliative care service/team. The End of Life strategy board ensured audits were monitored to ensure that appropriate actions were taken to address and implement audit findings.
- The National Care of the Dying Audit 2013/2014 (NCDAH) demonstrated that the trust had not achieved three out of seven organisational key performance indicators, and the action plan drawn by the trust was not detailed enough with clear progress record to address the gaps identified by the audit. However, at the time of the inspection, the trust had implemented all three organisational KPIs that had not been achieved on 2013/2014 NCDAH and the EOLC risk register did not identify the gaps in the NCDAH as organisational risks. The trust was unable to provide us with location specific data for this audit.

### Leadership of service

- There was committed leadership of the SPCT, led by the senior consultant, non-executive director and the chief nurse.
- The leadership of the EOLC had defined responsibilities (audit lead, research lead, lead consultant for EOLC and lead nurse with service improvement role).
- There was a clear line of reporting to the trust's chief executive and board members so issues could be dealt with effectively.
- The SPCT demonstrated effective leadership and the leaders understood the challenges to provide good quality palliative and EOLC services across the CCG areas they were operating.
- The SPCT were encouraged to take up learning and development opportunities to expand their knowledge and skills to improve and enhance the service provided to patients.
- All the staff we spoke with felt their line managers and senior managers were accessible and supportive. They were also able to name members of the SPCT and gave examples of their involvement in end of life care for patients during their last days and hours of life. Ward nurses were very positive about the support and guidance provided by the SPCT.

### Culture within the service

- The SPCT were passionate about providing good quality care to patients at the end of their lives. The support and advice offered to ward staff was responsive and supported effective pain control, symptom management, and good communication with families.
- There was evidence that the culture of EOLC was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of patients at the end of life.
- Nursing staff we spoke with demonstrated a commitment to the delivery of good quality end of life care, they felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- The SPCT reported positive working relationships across all the hospital disciplines. There was a culture of sharing knowledge and expertise demonstrated through formal training and informal teaching opportunities provided to ward nurses.

### Public and staff engagement

- The trust had not achieved the organisational KPI for The National Care of the Dying Audit (NCDAH) for the process of obtaining formal feedback regarding bereaved relatives/friends views of care delivery. The trust submitted one page action plan to address the findings of the audit, this showed the trust had implemented a formal bereavement survey in November 2014.
- Training and education programmes delivered by the SPCT were designed to bring about skills and confidence in the delivery of good quality end of life care. We saw the training program, which encompassed all the EOLC priorities. Staff confirmed that the EOLC training met their learning needs.
- Regular meetings of the End of Life Strategy Board and Clinical Governance Committee were held to discuss how the service operated and to highlight any areas for potential improvement. Staff said they were encouraged to play an active part in these meetings.

# End of life care

### Innovation, improvement and sustainability

- The SPCT were slow in implementing the replacement of the LCP, however there were plans to implement the individualised care of the dying patients, but that was not going to be in place fully until the piloting phase had been completed.

# Outpatients and diagnostic imaging

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

## Information about the service

Outpatient services at Epsom General Hospital are located in several locations across the hospital, including the main corridor area on the ground floor. There were a total of 302,458 outpatient appointments at this site between January 2014 and December 2014 for first and follow up appointments.

The trust runs a wide range of specialties and medical conditions clinics including cardiology, neurology, ophthalmic, gastroenterology, diabetes, renal, respiratory and care of the elderly. There were surgical clinics for ear, nose and throat, colorectal, vascular, orthopaedics and trauma including pre-operative assessment clinics. During our inspection we visited the outpatient's service for several clinics including ophthalmology, acupuncture, gastroenterology and cardiology.

Phlebotomy and pharmacy services were also provided within the outpatient department areas. The radiology department supported the outpatient clinics as well as inpatients, emergency and GP referrals. They provided imaging for the diagnosis and interventional treatment of a number of conditions.

The hospital radiology services were provided for outpatient, inpatient and emergency referrals. Epsom hospital had four X-ray rooms used for general and interventional work, five ultrasound rooms and one computed tomography (CT) room. The magnetic resonance imaging (MRI) service was provided by an external company. The diagnostic imaging department provided all types of imaging which included plain film, fluoroscopy, interventional, ultrasound, nuclear medicine, CT and MRI.

The pathology department at Epsom Hospital provide a wide range of tests including blood sciences and blood transfusion. Histopathology services are mainly centralised on the Epsom hospital site.

During our inspection we spoke with 10 patients along with some of their relatives. We also spoke with 14 members of staff including reception and booking staff, nurses of all grades, radiographers, health care assistants, doctors, consultants and managerial staff. We observed care, received comments from our listening and staff focus group events and from patients and the public directly. We also reviewed the systems and management of the departments including the quality and performance information.

# Outpatients and diagnostic imaging

## Summary of findings

Overall, we found that outpatients and diagnostic imaging were good. The service was rated as good for safety, caring, responsive and well-led. The effective domain was inspected but not rated.

Patients, visitors and staff were kept safe as systems were in place to monitor risk. Staff were encouraged to report incidents and we saw evidence of learning being shared with the staff to improve services. There was a robust process in place to report ionising radiation medical exposure (IR(ME)R) incidents and the correct procedures were followed. The pathology department had a comprehensive quality management system in place with compliance targets set at higher than the national average to improve safety and quality. There was evidence of quality improvement in place following the restructure of pathology services. The focus on low radiation doses in radiology was excellent.

The environments we inspected were visibly clean and staff followed infection control procedures. Records were almost always available for clinics and if not, a temporary file was made using available electronic records of the patient. Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.

Nurse staffing levels were appropriate and there were few vacancies. The diagnostic imaging vacancies were higher, particularly ultra sonographers. There was an ongoing recruitment and retention plan in place.

There was evidence of service planning to meet patient need such as the contract for MRI services. National waiting times were met for outpatient appointments and access to diagnostic imaging although the wait for MRI services had increased. A higher percentage of patients were seen within two weeks for all cancers than the national average, but the cancer waiting times for people waiting less than 31 days from diagnosis to first definitive treatment and the proportion of people waiting less than 62 days from urgent GP referral to first definitive treatment were both below the national average.

Staff had good access to evidence based protocols and pathways. There was limited audit of patient waiting times for clinics, but patients received good communication and support during their time in the outpatients and diagnostics departments. Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005.

We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care. There was good support for patients with a learning disability or living with dementia. The outpatients department at Epsom hospital had good information display boards available for staff and patients to access.

Staff were aware of the complaints policy and told us how most complaints and concerns were resolved locally. The service had no open complaints at the time of the inspection.

The outpatients and diagnostic imaging departments had a local strategy plan in place to improve services and the estates facilities. From December 2015, the current outpatient services that are in Clinical Services Directorate, will move to a new Outpatients and Medical Records Division. Staff expressed some concern over these changes.

Governance processes were embedded across outpatients and diagnostics. The directorate was commended on its risk register in a recent review of risk registers in the trust. Senior managers told us the newly appointed Quality Manager had made significant improvements in making sure priorities, challenges and risks were well understood. Good progress was evident for improving services for patients.

We found good evidence of strong, local leadership and a positive culture of support, teamwork and innovation.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good

We rated this service as good overall for safety. There were examples of excellent practice in diagnostic imaging as regards to radiation dose levels.

Incidents were reported and investigated appropriately and learning was shared. Patients were informed about incidents and were provided with copies of the reports and given an opportunity to discuss in more detail. Some areas did not have the adequate space or capacity to deal with the demand on the service. We saw this particularly due to some of the outpatient clinic seating being based in the main hospital corridor.

Cleaning and routine checks on equipment were in place and complete. The environment was very clean despite the age of the building. We saw staff adhering to infection control procedures. The diagnostic imaging department had robust policies and procedures in place based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The IR(ME)R regulations are to protect patients, staff and the public. The department had good support networks in place for expert advice and were consistently demonstrating lower doses of radiation than the national average.

There were sufficient staff in outpatients to manage the service but vacancies in diagnostic imaging meant the ultrasound service in particular was under strain to manage the workload and were using agency staff. Staff were well supported for training but mandatory training levels were not meeting trust compliance levels overall. Staff had a good understanding of safeguarding procedures and what procedure they needed to follow in order to raise a concern.

All of the records were available for the outpatient clinics we inspected. Patient protocols were in place in radiology.

### Incidents

- Incidents were reported and managed appropriately and actions and learning was disseminated to staff. Staff we spoke to demonstrated a good understanding of the incident management process which was accessed via the hospital intranet.
- No 'never events' had been recorded by outpatient and diagnostic imaging services. NHS England define never events as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.'
- Outpatient and diagnostic imaging services at Epsom hospital reported a total of five serious incidents from September 2014 to August 2015. We saw that incidents had been investigated and root cause analysis had been completed to identify any causes for the incidents. Patients and their families had been involved and informed, as had any relevant stakeholders and commissioning groups.
- The majority of incidents reported were of low or no harm.
- Senior managers told us they encouraged a culture of open incident reporting and staff confirmed this. Staff told us they received the feedback and lessons learnt via staff meetings and the Trust wide 'Risky Business' bulletin
- We looked at the minutes for the Clinical Services Directorate Clinical Governance meeting covering May, June and July 2015. Reports on incidents were broken down by level of severity and trends were discussed.
- Diagnostic imaging staff gave an example of how practice was changed in the patient identification process following a trend in incident reporting. The results were analysed and improvements made. We observed the new process in action and senior staff confirmed there were no more incidents reported for this issue. All staff we spoke with in the diagnostic imaging department understood their responsibilities to raise concerns and to record safety incidents, including near–misses. All staff felt confident to discuss any issues regarding safety with their line manager.
- We saw the hospital Duty of Candour Policy and templates for duty of candour letters. Staff we spoke to told us about their understanding of the duty of candour and their obligations. They were confident systems were in place to ensure patients were fully informed of the circumstances which led to any incident resulting in moderate harm.
- The hospital had processes in place to report any radiation incidents to the Care Quality Commission (CQC) under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

# Outpatients and diagnostic imaging

## Cleanliness, infection control and hygiene

- On visual inspection all areas we visited in Epsom hospital outpatients and diagnostics appeared clean and tidy, including the toilets and changing rooms. Records of daily cleaning were visible and complete in all the areas we visited, including one for the children's toys.
- We observed staff using good infection control practices. Posters prompting hand hygiene were clearly displayed.
- We saw that all staff were 'bare below the elbows' in clinical areas. This reduced the risk of infections to staff and patients and was in line with good practice.
- All sinks were hand wash stations and fully compliant with HBN 0009 Infection Control in the Built Environment (March 2013), which is department of health best practice guidance.
- All soft furnishings were wipeable and in good condition. The vinyl floor in the majority of departments was in good condition. The flooring on the Bradbury unit had gaps between the floor and the wall and did not comply with HBN 0010 part A.
- There were adequate supplies of personal protective equipment (PPE) including glove and apron dispensers throughout the outpatient areas.
- We observed good hand hygiene practices and good use of hand sanitiser gel. Gel was available although we did not observe it being used.
- The hospital reported that 86.96% of staff had attended infection prevention and control training against a target of 95% in the year to date.
- Infection control policies were available on the intranet and staff were able to show them to us easily.
- The outpatients department had infection prevention and control link nurses in place that attended infection control meetings and then reported back to the rest of the team.
- We observed good waste streaming with the use of hazardous waste bins and recycling bins. However, we found some hazardous chemicals in a sluice room on the Bradbury unit which had not been removed. We asked the manager to arrange proper collection and disposal.
- There were clear notices around the hospital detailing hand hygiene and infection control measures for patients and visitors.
- Hand hygiene audits were carried out monthly using the World Health Organisation (WHO) 'Five Moments' audit tool based on WHO guidelines for hand hygiene. Overall the audit demonstrated 93% compliance.
- The staff in the diagnostics imaging and pathology departments understood their responsibilities in relation to infection control and hygiene. We observed good hand washing by radiography staff after a CT examination was completed and before the next patient entered the room.

## Environment and equipment

- The department's risk register included replacing ageing imaging equipment. The manager was aware of the limitations and put measures in place to ensure the equipment was used appropriately.
- One ultrasound room was in urgent need of redecoration.
- There was resuscitation equipment available across outpatients and diagnostics. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis.
- Two bariatric chairs were available in outpatients and the majority of staff were aware of their use.
- The hospital medical physics department check all outpatient equipment on an annual basis. The department holds ISOBS 9001, which is a Quality Management certification. A decision is made as to whether the equipment will be serviced in-house or outsourced to a private company. All Portable Appliance Testing (PAT) testing of outpatient equipment was in date.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation. There was a large range of protective equipment available.
- Some patient waiting areas in outpatients were small and cramped. Some clinic patients were waiting in the corridor.

## Medicines

- The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation
- We did not observe any medications left out in unsecured areas.

- Fridge temperatures were checked and recorded daily.
- Prescription pads were stored securely in locked cupboards and drawers. We saw good systems in place throughout outpatients including signed and dated log books.
- A patient told us they had received appropriate information about their recent changes in medication.

## Records

- We observed that medical records in use in the outpatient department were stored securely in a separate, locked room. Some patient information was also stored electronically such as referral letters, clinic appointments, blood and x-ray results.
- We were told that missing records was improving but when a record was missing, there was a system in place to set up a temporary record using the electronic patient information. The temporary files were clearly marked so that they could be reconciled with the permanent record when located.
- All the notes were available for the clinics we inspected.
- We looked at the audit of records pulled for appointments. This demonstrated an improvement from 97% being available in August 2014 to 99% in August 2015.
- To support the tracking of patient files the Trust has moved towards a technology system of Radio Frequency Identification (RFID) tagging. We were told this was an efficient and effective system and notes could be easily located across the hospital.
- The staff we spoke to had a good understanding of patient confidentiality and data protection and had attended information governance training. The compliance for information governance training was just short of the 95% target at 91.3%. We saw staff placing medical records face down when placed outside the clinic rooms.
- The diagnostic imaging department had a central electronic patient records system to record comprehensive details of each patient's imaging history. Any paper records such as MRI safety checklists were scanned into the system. We were told all CT requests were reviewed by the radiologist or lead superintendent.
- Staff in the diagnostic imaging department were able to show us how the radiation doses were recorded on the system for each procedure.
- A service level agreement has been set up with each of the Point of Delivery Units (PODs) to improve the medical records service. Health record engagement forums were held across the Trust to listen to the problems the staff had with records and to make improvements. These have included the creation of dedicated email accounts to improve communications.

## Safeguarding

- The outpatients department reported a compliance level of 100% in November 2015 for adult safeguarding training against a target of 95%. Compliance for children's level 2 was 95.45 % against the trust target of 95%.
- We saw policies were in place and in date for both safeguarding children and adults.
- The staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed and were able to show us the electronic policies and procedures.
- A link nurse was in place to attend the trust safeguarding meetings and report back to the outpatient's team. We saw the link nurse name was displayed in the staff office.
- The staff in diagnostic imaging told us all patients referred from the memory clinics were escorted to the department, including out of hours.

## Mandatory training

- Mandatory training included infection control, health and safety, fire safety, conflict resolution and safeguarding.
- Staff told us they were not achieving mandatory training targets but that this was due to insufficient access to computers in the workplace.
- Mandatory training included e-learning and face to face meetings. Staff told us the quality of the training was good.
- The trust target for all mandatory training was 95%. Targets were on the whole being met in outpatients for the majority of subjects.
- The staff in the diagnostic imaging department found it hard to access the training due to service pressures. The senior staff told us a plan was in place to achieve targets by the end of 2015.

# Outpatients and diagnostic imaging

### Assessing and responding to patient risk

- The hospital had a medical physics expert commissioned from a neighbouring hospital, available and contactable for consultation to give advice on radiation protection for medical exposures in radiological procedures. This was in line with IR(ME)R guidance.
- The diagnostic imaging department had named Radiation Protection Supervisors (RPS) to give advice when needed to ensure patient safety and minimise radiation risk. They were adequately trained and had all attended annual refresher training.
- Quality assurance tests on the x-ray equipment were done every morning prior to the service starting. We saw the results documented in each room. Any trends or increases in exposure were reported to the RPS and investigated immediately.
- The RPS's worked closely with the expert advisor to optimise the radiation doses. This meant the lowest possible dose is given to patients whilst maintaining good diagnostic quality.
- Dose reference levels were evident for all x ray rooms.
- An adapted version of the world health organisation (WHO) checklist was used for all interventional procedures. We saw copies of these scanned into the patient electronic record.
- A radiation safety policy was in place which included the Ionising Radiation Medical Exposure Regulations (IRMER) procedures. There was also a protocol for the management of contamination, monitoring and spillage of radioactive material and a procedure for the disposal of radioactive waste.
- We looked at the minutes from the Radiation Protection Committee held in August 2015. A recent incident in CT was discussed and we saw changes had been made to the request form to prevent the error from occurring again.
- We saw local rules were in place and available for all staff to follow in the imaging areas we visited. There were also clearly visible on the mobile imaging equipment.
- Staff in the diagnostic imaging department had been trained to support patients with needs such as swallowing difficulties.
- Resuscitation trolleys were available across the outpatient areas.

### Nursing/ radiology and pathology staffing

- There were dedicated nursing and health care assistant staff across the outpatients department. All staff rotated across the specialties allowing for cross cover for holiday and sickness.
- Bank staff were used to fill gaps in outpatient staffing. Induction was thorough.
- Agency staff were used in the ultrasound service. We saw they were given a local induction pack before starting with the service.
- We saw evidence of planned staff for clinics to meet consultant and patient need.
- There were 22.89 vacancies across all staff groups in the diagnostic imaging department against a full time establishment of 158.95.
- Bank and agency staff were used in the diagnostic imaging department but most of these staff had a long term relationship with the hospital.
- There was a shortage of sonographers across the ultrasound service. The service had been successful in training 'in-house' and employing these staff after training had finished. It was unfortunately only possible to train one sonographer per year.
- Diagnostic imaging services did not rotate staff. One staff member felt this should be looked at in the future to improve the staff experience.
- A new post in histopathology had been advertised and shortlisted. The interviews were due to take place shortly.

### Medical staffing

- Across the outpatient service medical staffing was adequate although there were some vacancies due to retirement. There were enough consultants to see the booked patients although the longest waits were in trauma and orthopaedics.
- Consultant appointment times were aligned to clinic times.
- Two new consultant posts have been funded for radiology services and are due in post by March 2016. Replacement radiologist posts have been filled. There is currently a 0.4 whole time equivalent vacancy in medical staffing for the department.

### Major incident awareness and training

- Emergency evacuation plans were clearly visible on the walls of all the departments we visited.

# Outpatients and diagnostic imaging

- The trust had a major incident plan in place and there was evidence of business continuity plans for both outpatients and diagnostic imaging.
- Staff understood what actions to take in response to a major incident and we looked at the departmental major incident box. This contained action cards to outline all the necessary roles. Staff told us the outpatients department would operate as an area for receiving relatives in the face of a major incident.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal. Appraisal rates were far below the trust target but we reviewed the plan for delivery of appraisals by December 2015.

We saw that staff worked collaboratively to meet patients' needs in a timely manner.

### Evidence-based care and treatment

- Staff had access to evidence based protocols and pathways based on NICE and Royal College guidelines.
- Relevant clinical guidelines, technology appraisals, interventional procedures, quality standards and diagnostic guidelines that are published by NICE are noted in the directorate performance report.
- We saw that clinics were in line with best practice and NICE guidelines in relation to appropriate referral, availability of information and completion of checklists.
- National Royal College of Nursing guidelines are used regarding the self-administration of anti-rheumatic drugs.
- Examination audits had been completed to comply with IR(ME)R safety policy. The 2014 annual RPA's report showed compliance with radiation regulations.
- Diagnostic reference levels (DRL) were monitored and audits of the levels completed. Where levels were raised the equipment was checked in line with the manufacturer's recommendations. The staff in the department had regular contact with the radiation protection advisor.
- All IR(ME)R protocols were updated and accessible for the staff to view on the electronic system.
- The outpatients and diagnostics department were currently involved with the national bowel, lung, head and neck and oesophago-gastric cancer audits. We looked at the audit plan for 2015/2016.
- We also looked at some pathology audits including the audit of inappropriate virology test requests in May 2015. Changes had been made to practice, improving the requesting of appropriate tests.
- We also looked at the diagnostic imaging local audit plan and looked at the audit meeting minutes from both radiology and pathology.
- In the imaging department we observed the World Health Organisation (WHO) checklist for interventions was routinely completed.
- The reporting radiographers produced reject analysis reports to look at trends in image quality and radiographer technique.
- We reviewed a number of radiographic images and noted the positional markers were present and in the correct place.
- The acupuncture clinic were trialling the NICE guidelines for low back pain, offering a maximum of 10 sessions over a period of up to 12 weeks.

### Pain relief

- We observed that FP10 prescription pads were available in clinics and we saw that prescriptions for pain relief were recorded in patients' notes.
- Pain relief(analgesia) and local anaesthetics were available for patients who needed this during procedures.

### Patient outcomes

- Follow up to new rate was slightly above the England average.
- The hospital has only recently started collecting data to show the percentage of patients waiting over 30 minutes to see a clinician. The OPD management team are currently working on methods to collect and report

this information robustly on an on-going basis to identify any areas where clinic waiting times are consistently long and enable action plans can be drawn up to address this.
- We saw wait times of thirty minutes for two afternoon clinics. The patients were not informed of this wait when booking in at reception.
- The DNA rate was consistently lower than the national average from Jan to Dec 2014
- The outpatient clinics work closely with the two week rule co-ordinator for patients with suspected cancer to ensure appointments are offered in a timely manner and to follow up any missed appointments.

### Competent staff

- An induction plan was in place for all new staff to gain competencies for their job role. Continual professional development was promoted in the departments.
- Staff were encouraged to widen their understanding of different aspects of the service with a rotational shift pattern in outpatients.
- Diagnostic imaging staff told us they were able to identify specific learning through the appraisal process and were encouraged to develop their professional practice.
- Completion of mandatory training levels was generally good for all the topics.
- The appraisal rate was 36.36% at the time of the inspection. The senior sister in outpatients showed us that these staff were currently due and their appraisals were booked for November and December. This meant the yearly target was not being achieved due to a delay in booking the appraisal dates.
- Specialist nurses worked within the outpatients department providing nurse-led clinics alongside medical colleagues.
- The imaging department were seen to have effective clinical supervision and mentoring systems in place for staff and they were proud to tell us they regularly developed their own staff. We saw imaging had competency frameworks for equipment use and nominated key trainers for each item of equipment.

### Multidisciplinary working

- At the time of the inspection the outpatient department did not hold pre clinic briefings, however they were planning to introduce these.
- Written referrals were arranged when care was to be continued at another hospital. Letters were sent to GPs regarding their patients and a summary of consultations, treatments and investigations from the outpatient clinics.
- The imaging department worked closely with an extended scope physiotherapist in ultrasound, offering musculo-skeletal scans.

### Seven-day services

- The outpatients department was open Monday to Friday 8am to 5.30pm, with occasional 'waiting list reduction' clinics being held on Saturday mornings.
- The radiography department were available seven days a week. The CT service were open Monday to Friday from 7.30am -5pm with extended hours until 8pm three evenings per week.
- Radiologists were on site until 8pm each weekday evening and 9am-12 noon on Saturdays and Sundays, with the on call provided by an external provider.
- Pathology laboratory was available out of hours on an on call basis. Blood sciences were available 7 days, 24 hours a day. Microbiology service was available Monday to Friday 9.00am to 17.00pm and out of hours had an on call service.

### Access to information

- Staff told us and we saw that they had access to trust policies and procedures on the intranet.
- X ray and diagnostic imaging results were available electronically which made them promptly and readily accessible to staff.
- Electronic access to pathology, microbiology and radiology results were available.
- Explanatory leaflets were available to assist staff to explain procedures and investigations to patients.
- Information boards were displayed around the outpatient area to give specific information to patients and staff. These were changed monthly and covered topics such as the use of inhalers and the use of ear drops. A general information board displayed information related to specific awareness weeks such as mental health and men's health. A wide range of leaflets relating to the subject were available for staff and patients to take home.

# Outpatients and diagnostic imaging

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

- The staff demonstrated confidence and competence in seeking verbal and written consent from patients. Verbal consent was observed in the x-ray room and the gynaecology outpatient clinic.
- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS). Staff reported they had received training.
- Staff knew the procedures to follow to gain consent and understanding from patients, including involving other professionals. Carers were encouraged to escort their relative to appointments to offer support.
- We saw examples of accurately completed consent forms.

## Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good. Throughout the inspection we witnessed good care being given. Patients were kept informed at all times and emotional support was given.

There is a strong person-centred culture across both outpatients and diagnostic imaging teams and this came across clearly from all the staff we spoke with.

We observed and patients told us that the staff were friendly and approachable. All patients we spoke with gave examples of good care. Several patients described the care as 'excellent.'

We observed the staff supporting patients that required any assistance. There were quiet rooms available for any patients who were to be given bad news including space in the Macmillan Butterfly Centre.

Staff demonstrated a good understanding of the privacy and dignity needs of their patients. We observed staff being respectful at all times.

### Compassionate care

- We observed excellent interactions between nurses, radiographers, medical staff, healthcare assistants and administration staff and their patients. It was clear that the departments put the patients first and senior managers confirmed this was their ethos.
- We spoke with 10 patients and carers across the departments. There were no negative aspects of care highlighted to us. We were told that the staff were very compassionate.
- One patient told us they were treated as if 'only patient in the whole world.' This patient had attended for an outpatient's appointment and an x-ray.
- We were told that chaperones were available for all patients and we saw signs displayed in the waiting areas. We observed one consultant asking for a chaperone to be made available for their next appointment.
- We observed patients being greeted in a friendly manner. Staff gave patients time to ask questions and address any concerns. The reception staff in the diagnostic imaging department were particularly helpful to a patient who had several questions about their examination.

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

- We saw that the outpatient department kept a wide choice of patient information leaflets which meant that patients were supported to make informed choices about their care
- All the patients we spoke with felt well informed about their care including any investigations that were planned. One patient showed us their information leaflet about attending for a CT scan and said they found it helpful.
- Another patient attending for the acupuncture clinic also told us the information leaflet was helpful, explained the procedure and outlined what to expect during and after treatment.

### Emotional support

- Patients told us staff were caring and professional. We observed staff to act in a professional way, offering discreet assistance where necessary.
- There was a bereavement and chaplaincy service in place. The outpatient staff we spoke with said they would refer patients to this service if required..

# Outpatients and diagnostic imaging

- Staff told us a quiet room would be made available for breaking bad news. This was often scheduled in advance by discussing the potential patient needs with the consultant prior to the start of the clinic.
- The Cancer Information and Support centre offered complimentary therapy and counselling sessions. In 2014, the centre offered 482 complimentary therapy sessions and 154 counselling sessions.
- A nurse specialist told us they use the counselling room on a regular basis to speak with patients and offer support.
- The centre was also staff by a large team of volunteers, supported by the centre manager. Staff told us the centre was 'invaluable' and 'an excellent resource.'

## Are outpatient and diagnostic imaging services responsive?

Good

People were able to access services for assessment, diagnosis or treatment when they needed to and were often given a choice of locations. The trust was meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways. Cancer waiting times were variable across the targets although waiting times for all urgent referrals were within two weeks.

The diagnostic waiting times were below the England average meaning patients were receiving a timely appointment. 'Did Not Attend' rates were lower than the England average but the clinic cancellation rate was slightly above at 11% compared to the national average of 7%. Most of the cancellations gave over six weeks' notice. The primary reasons given for clinic cancellations were annual leave, study leave or sickness

There was good support for patients with a learning disability and the departments worked closely with the community learning disability lead. Staff were also aware of patients with dementia. There was access to interpreters for patients whose first language might not be English.

The service closely monitored any complaints and no recent complaints were left open which meant they had all been satisfactorily resolved.

### Service planning and delivery to meet the needs of local people

- Waiting times were displayed on white boards in all the waiting areas for patients. We saw waiting times being updated during the running of the clinic and patients were informed by the receptionist.
- Signage to outpatients and diagnostic imaging services was clearly displayed at the main reception and in the corridors.
- The capital replacement and refurbishment programme was planned and senior staff told us how the services were to be reconfigured to meet patient need. The suitability and condition of the ultrasound rooms was a particular concern.
- Voice recognition reporting in diagnostic imaging was in place and used effectively.
- 98% of GP plain x-rays were reported in less than 7 days. The target of less than 48 hours for reporting of A&E plain films was under target in August 2015 at 46%. The department leads told us that the recruitment of new radiologists would help improve this target by January 2016.
- The majority of in patients' x-ray results were returned to the ward within 24 hours. Staff told us it was getting increasingly difficult to respond to the number of inpatient ultrasound requests required.
- Radiographers had been trained and were competent in some aspects of radiology reporting.
- The histopathology laboratory offered same day reporting for specimens received by 1pm.
- Outpatient appointments were offered at the various trust locations to give patients a choice of location and wait time.

### Access and flow

- Hospital Episode Statistics for January 2014 - December 2014 showed that 302,458 outpatient appointments were made at Epsom Hospital.
- Out of the total appointments made at the hospital, 7% had been cancelled by the hospital and 6% by the patients.
- The referral to treatment rate for non-admitted pathways between April 2013 and July 2015 ranged between 97% and 93%. The percentage has been below both the standard and the national average of 95% since June 2015.

# Outpatients and diagnostic imaging

- Referral to treatment rates for incomplete pathways was above both the standard and the England average of 92% from April 2013 to July 2015.
- The percentage of people seen by a specialist within two weeks for all cancers was above 96% which was above the England average from quarter one 2013/14 to quarter four 2014/15.
- The percentage of people waiting less than 31 days from diagnosis to first definitive cancer treatment was below the England average from quarter two of 2014/15. The target was met before that time.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive cancer treatment was below the England average from quarter three of 2013/14 and quarter four 2014/15.
- In November 2014, the Trust requested the support from the NHS Intensive Support Team (NHS IST) to review systems and processes. The NHS IST visited in November 2014, for two days, and gave initial feedback to the Trust in early December. An action plan is now in progress. Improvements have been made by utilising a patient tracking list specifically for cancer patients.
- The percentage of people waiting over six weeks between July 2013 and August 2014 was below the England average. From November 2014 onwards the percentage of people waiting over six weeks rose 1% to 7% in February 2015.
- The directorate team acknowledged there were often long waits for clinics. We were told a new directorate specifically for outpatients and medical records would be formed in December 2015. The team were keen to implement new ways of working to bring the waits down.
- An analysis of radiology services undertaken by London Cancer Alliance (LCA) in December 2014 showed that ESTH is the most productive CT service within the LCA, with 30,000 CT scans from the trust's two CT machines – 15,000 scans per machine. This compared with an LCA average of 9,700 per machine. To cope with existing demand and in order to reduce the wait for a CT scan, the trust has procured a mobile machine to operate on three days per month between March 2015 and March 2016.
- Bi-weekly performance meetings were held to monitor the backlogs of appointments. Waiting list initiatives had demonstrated effectiveness against waiting times.
- Waiting times for diagnostic imaging were monitored and recorded. The percentage of patients waiting more than 6 weeks for a diagnostic test ranged from 0.2 – 0.5% from January 2015 to June 2015. This was significantly lower than the England average.
- Requests for laboratory diagnostic tests were sent electronically from the wards and GP surgeries.
- 95% of results were available electronically within one hour for routine tests.
- The histopathology department offered a same day reporting system for any specimens received by 1pm. Histopathologists were available every afternoon to report renal tests.

### Meeting people's individual needs

- We saw that patient's relatives were welcomed into the consultation rooms if the patient was happy for them to be present.
- Staff told us interpreting services could be booked for patients attending outpatient appointments if the original referral letter stated an interpreter would be required. We saw posters clearly displaying information about accessing translation services.
- The staff we spoke with demonstrated a good understanding of the needs of patients with dementia and learning disabilities. We were assured the patient who may be distressed or confused would be treated appropriately.
- Patients we spoke with were very positive about the outpatient and diagnostic imaging services and told us they received good treatment and were happy to attend these departments.
- The outpatient staff liaised closely with patient transport services to ensure this ran smoothly. A monthly transport user group was attended by the outpatient sister, bookings staff and transport managers to ensure the service ran smoothly for patients.

### Learning from complaints and concerns

- The outpatient's senior staff told us the main reason for complaints in the department was waiting times. There was a system in its infancy in place for monitoring patient waiting times.
- Complaints were handled in line with the trust policy. Complaints were reviewed and discussed at the monthly Clinical Services Directorate Governance Meeting. There were no complaints received in July 2015.

# Outpatients and diagnostic imaging

- In diagnostic imaging, managers told us the complaints about the service tended to be a small part of a larger complaint such as the long waits in clinic prior to attending for an x-ray.

## Are outpatient and diagnostic imaging services well-led?

Good

The outpatient and diagnostic imaging department was well-led. Staff and managers had a vision for the future of the department and were aware of the risks and challenges they faced. This included the move to a new outpatients and medical records directorate by December 2015. Staff felt supported and were able to develop and progress within the organisation. Staff talked about an open culture and were able to raise concerns and put forward ideas for improvement of services.

Staff stated the senior managers were visible and approachable. The staff we spoke with said the chief executive was making a difference and provided clear leadership.

Staff we spoke with was aware of the trust vision. They were proud to work at the hospital and felt valued.

### Vision and strategy for this service

- All the staff we spoke with were fully aware of the trusts vision and values. We were told they felt listened to. Some pathology staff felt more work needed to be done to further progress some of the good quality improvements that had been started.
- We looked at the five year vision strategy for the outpatients and diagnostics departments. This included further quality improvements in pathology, more automation in pharmacy services, improving cancer pathways, providing a modern radiology 7 day service, consolidation of outpatient areas and improved IT systems. Staff were aware of the strategy and were supportive. There was some anxiety raised about the move to a new directorate. We spoke with the senior team about this and they gave reassurance that the process was being well managed, with staff central to the discussions.
- All the staff spoke with pride about their services. Where it was obvious that changes needed to be made to the existing environment, staff worked around the issues to provide the best solutions possible. For example, the ultrasound room had been redecorated to provide as pleasant an environment as possible, despite its' structural limitations.

### Governance, risk management and quality measurement

- Governance arrangements were in place. Staff were aware of these and participated in them such as undertaking risk assessments, audits and attendance at meetings.
- A new quality manager for clinical services was in post. They produced monthly quality reports looking at trends in incidents and any associated risks. Senior staff told us this post and the quality of the report produced had made a real difference to reviewing risks and completing necessary actions.
- Staff were given feedback about incidents and lessons learned comments, compliments and complaints. We also saw trust and departmental newsletters sharing information.
- We saw the departments had updated risk registers in place and the ones that had been identified in our discussions were reflected on these registers. These included radiology equipment and the unsatisfactory condition of the ultrasound room.
- Vacancies for staff were all currently advertised. The reduced staffing impacted on the quality of the service received, for example increased waiting times in outpatients.
- Audit systems were in place to measure the quality and accuracy of work carried out within the departments. This included audit half days for staff to attend.
- Good governance processes were in place for radiation safety monitoring.
- Dose reference levels were below the national levels and ageing equipment was monitored to still comply with these low levels of radiation doses.
- There were clear lines of accountability across the departments and we found the outpatients and diagnostic imaging staff worked well as a team.

### Leadership of service

- We found competent staff managing each of the clinical areas we visited. Staff told us they had confidence in their leadership. They made comment that the new chief executive was a good appointment for the trust and they felt optimistic for the future.

# Outpatients and diagnostic imaging

- The outpatient senior team told us they had requested an external review to look at the cancer pathways. We saw the report and the progress being made to implement the recommendations.
- The radiology service was well-led by a team of competent radiologists and radiographers.
- Pathology services had been reconfigured in the last two years and improvements were being made, such as locating all the operating procedures onto one system for all staff to access. The senior lead told us recruitment and retention had improved.

### Culture within the service

- We heard of a friendly, open culture within the outpatients and imaging departments. It was evident that quality and patient experience was seen as a priority for the services and was everyone's responsibility.
- Good working relationships and support networks had been built with the local hospitals and with external services such as radiation protection.
- The majority of staff described a positive working environment. Many of the staff had worked at the hospital for many years.
- Staff felt there was an open culture and they could raise concerns and be listened to.
- Pathology had undergone a reorganisation that had improved the service. However, there was feedback from senior staff that there was still a reluctance to change.
- We noted a culture of adaptable working. Staff would routinely rotate across different areas to develop new skills and be flexible in their approach.
- Staff in the diagnostic imaging department felt valued by their managers and enjoyed working as a diverse, multi-cultural team.
- There was evidence of a strong education culture for medical staff in training. There were named educational supervisors in place who held regular supervision sessions with staff.
- We spoke with a volunteer helper within the outpatients department who had worked at the hospital for over twenty years. The consultant referred to them as 'a pillar.' It was clear they were very much part of the team.

### Public engagement

- The departments actively sought feedback from patients.
- They took part in the friends and family test across the various units.

### Staff engagement

- Staff told us and we saw the weekly bulletin end from the chief executive. Staff told us it was informative and contained the right level of humour to make it engaging.
- A new weekly directorate newsletter was now sent following the appointment of the general manger.
- Staff had all received the new hospital 5 year strategy outlining the plans for the future. Staff told us this was reassuring to know that plans were more stable for the immediate future.

### Innovation, improvement and sustainability

- Advanced practice was evident in the radiology department with reporting radiographers. It was felt more advanced practice could be taken forward at Epsom hospital.
- The hospital offered an appointment reminder service where patients were reminded of their outpatient appointment by a free text message.
- The senior sister told us of improvements being made to the running of clinics. The nurses were allocated a specialty every six months and were set targets to achieve. We saw one of the current targets was to set up an evidence based folder for each clinic, containing relevant patient information including websites. allocation
- We visited the cardiology investigations unit. The department was well-led and staff told us they had great support from their managers and the cardiologists who were always looking to improve the service.
- The radiology department had an excellent approach to reducing radiation doses.

# Elective orthopaedic centre

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

## Information about the service

The South west London Elective Orthopaedic Centre (SWLEOC), based at Epsom General Hospital is a partnership commissioned by four South West London acute hospital Trusts and provides routine and complex elective and non-urgent emergency orthopaedic surgery services to patients aged over 18. SWLEOC performs around 5,200 procedures a year with some patients referred from around the UK and internationally. Sub-specialties include a young adult hip service, soft tissue, spine, foot and ankle procedures. The service generates 10.5% of the trusts annual income and therefore we inspected the SWLEOC separately from all other surgical services. Surgeons in the main surgery team at St Helier performed hip fracture operations, and we reported on these in surgery core service report.

Patients were referred to the service by either their GP or the consultant orthopaedic surgeon at one of the four base hospital Trusts.

There are two 27-bedded inpatient wards, five theatres, a 17 bedded post anaesthetic care unit (PACU), which includes a day case unit and an outpatients department. Derby Ward had 27 in-patient beds including three side rooms. Oaks ward has 27 in-patient beds including four side rooms. Both wards and provide post-operative care for those patients who require primary or revision joint replacements, pelvic surgery and spinal disorders surgery. They also provide post-operative care for those patients who require foot, ankle, lower limb, arthroscopic knee, hand, shoulder and upper limb specialised services.

We visited all wards, operating theatres and the adult preoperative assessment unit; a stand-alone anaesthetic led, multidisciplinary service that ensures patients are fit for anaesthesia and ready for admission for a surgical procedures.

We spoke with 13 patients and relatives of people using the service and observed interaction between patients and nursing staff. We spoke with 32 members of staff, including from nurses of all grades, domestic staff, anaesthetists and consultant surgeons. We looked at the medical and care records of 10 patients, observed staff handovers between the multidisciplinary team and reviewed data held at ward level.

# Elective orthopaedic centre

## Summary of findings

We rated this service outstanding as there was an open and transparent safety culture in practice and patient outcomes were amongst the best in the country. When things went wrong, there was thorough analysis and investigation owned by staff and changes were made in a timely way. The approach to staffing and skill mix across all staff groups meant that highly skilled staff always cared for patients.

Patient outcomes and patient satisfaction consistently exceeded national averages. Innovative practice in recording outcomes was the basis for national guidelines. The lead surgeon used patient outcomes to validate and proactively change each consultant's performance. The service was proactively met the needs of the population it served, coordinating with referring hospitals, external and community providers to ensure the surgical pathway was appropriate.

Staff understood the ethos of the service values, and unequivocal in praising the support received from leadership team and there were measurably high levels of staff satisfaction. Patients who used the service were actively involved in the way the service operated.

## Are elective orthopaedic centre services safe?

Good

There was a genuinely open culture in which all safety concerned were highly valued and integral to learning and improvement. The staffing and skill mix models, across all groups,was planned and implemented to meet patient needs at all times. Consultant surgeons tookthe lead and were present for every patient's operation. Highly skilled advanced nursepractitioners cared for patient's on ward areas, and intensivists provided cover twenty fourseven to support patient's with higher care needs. There was a proactive approach to managing the risk from infections, demonstrated by the very low rate of surgical site infections.

### Incidents

- There was an open and transparent safety culture. The service investigated concerns with staff and managers responded sensitively to those who raised concerns. The service encouraged to staff to raise incident reports when they witnessed care that had the potential to, or did, cause harm.
- The service made improvements to strengthen the safety culture in response to concerns. In response to specific concerns raised by a whistle blower regarding a slow response or lack of action when incidents were reported here were specific learning sessions held including leaflets to promote to staff when and how they could raise concerns and identifying who they could access for confidential support and statement writing.
- Data submitted by the service showed that over 700 incidents were reported between 1st September 2014 to 31st August 2015. Investigations showed these incidents caused no harm or very low levels of harm. 10 incidents had potential to cause moderate harm, and six of these were patient falls. Root cause analysis investigations were undertaken at the appropriate level as identified by the trusts incident reporting and investigation and senior nursing staff implemented a falls programme. Training was provided to staff which identified learning that could be implemented to prevent falls as a result investigations. We also observed patients who were at risk of falls wearing falls wristbands, which were congruent with their care plans.

- No Never Events (largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) or serious incidents were reported within the last five years.
- Staff we spoke with were confident to both explain and demonstrate the reporting mechanisms for any adverse event, near miss or accident using the trust wide electronic recording system. We saw that such events were reported as part of routine practice.
- We saw the learning from incidents folder and quarterly management team meeting minutes on the ward. Nursing and anaesthetic staff told us these were regularly reviewed, with feedback provided during team meetings and at lunchtime learning sessions.
- Staff discussed root cause analysis investigations monthly clinical governance meetings, health, safety and quality meetings and the trust serious incident panel.
- Morbidity and mortality reviews were held as a standing on the clinical governance meeting, and involved the multidisciplinary team involved in the care of the affected patient's. There was detailed information, which demonstrated a full review process for orthopaedic mortalities, including areas for improvement.
- The service provided duty of candour training to all staff in 2015, which covered the requirements of the legal principles, and the necessary steps staff needed to take when an incident potentially caused harm.

### Safety thermometer

- The SWLEOC participated in the monitoring of patient care in line with the NHS Safety Thermometer. Senior staff collected on a single day each month to indicate performance in key safety areas in respect of staffing levels, patient falls, and catheter-acquired infections, urinary tract infections, as well as the incidence of pressure sores.
- Daily results of the indicators used in the safety thermometer were displayed on notice boards in both Oak and Derby ward. Both areas showed the service maintained staffing levels and skill mix at the planned, safe, ratio of three nurses and one health care assistant, no infections or hospital acquired pressure ulcers each day on the week of our inspection.
- The rate of screening for patients at risk of venous thromboembolism (VTE) exceeded the trusts baseline; 100% of patients were screened pre-operatively. Patients assessed to be at risk of VTE were offered VTE prophylaxis in accordance with NICE guidance. Furthermore, technology and equipment was used to enhance the delivery of effective care and treatment. For example, staff used foot pressure pads to prevent thrombosis when post-surgery situations caused immobility. Following surgery, the service supported people to be mobile through minimal and discreet use of drips and catheters.
- No mixed sex breaches had been reported by the service in 2015.

### Cleanliness, infection control and hygiene

- We observed that the ward and theatre environments were visibly clean and maintained. Patients told us they were satisfied with the standards of cleanliness and one told us "it is exceptionally clean here, throughout the building."
- Mostly we observed infection control practice that was in line with the trust policy, including staff who were bare below the elbows and sufficient sinks and alcohol gel dispensers. We witnessed two members of staff who were in scrubs and theatres gowns outside of the sterile environment.
- Equipment used for patient care such as commodes were checked and found to be clean and ready for use. Cleaning of items used by patients was carried out in accordance with the trust's decontamination guidelines. Staff confirmed some items of patient use equipment were single patient use, which minimised potential for cross contamination.
- The service rigorously managed patients at risk of infection. Patients were barrier nursed and isolated in single rooms if identified as being at risk of a potential infection, which included patients who had diarrhoea awaiting a confirmation of their infection status. Isolation signage was in use.
- The Department of Health (2010) requires NHS Trusts to screen all relevant patients at risk to monitor screening compliance for MRSA. Compliance rates in the SWLEOC for screening elective admissions were better than the trust's benchmark of 95% in 2015. We saw evidence of screening for infections, including MRSA, in the nursing records we reviewed.

- Cleaning audits were carried out by the infection control team and fed back to ward staff on Derby and Oaks monthly. The SWLEOC reported hand hygiene results were routinely above 90%.
- The rate of surgical site infections stated to be lower than national average for all procedures and a zero rate for hip surgery and at 0.4% for knee surgery. There was an infection control nurse with a specialism in surgical site infections with a sole focus on managing the surgical site infection practice. This member of staff undertook a daily ward round to review patients at risk. Furthermore, a lead surgeon with a specialist interest in surgical site infections took a proactive role in monitoring infection control practice.
- Staff referred patients with allergies or concerning wounds to microbiology for specialist to decide on best course of antibiotics.
- Antibiotic prescribing stewardship, to prevent unnecessary use of antibiotics, was in place and staff told us this had a marked improvement on the rate of surgical site infections.

### Environment and equipment

- Senior staff in the service recognised much of the SWLEOC facility & equipment was over 10 years old and areas, including theatres, needed updating and refitting. Managers had escalated this via the SWLEOC risk register though the trust deemed it was not a sufficiently high priority for the trust, as the SWLEOC complex is more modern than the rest of the site at Epsom General Hospital.
- Resuscitation and emergency intubation equipment was available in the outpatients department, theatres and ward areas, and staff were aware of how to locate this equipment in the event of an emergency. Staff checked equipment regularly and the records reviewed did not have any gaps, which showed a consistent and regular approach to safety checks.
- Staff working in the operating theatre department reported having sufficient theatre instrumentation, including prosthesis and implants, to enable them to undertake their operating list.
- Theatre staff understood their responsibilities for preparing and handling surgical instrumentation at all stages of the operative procedure.
- There were arrangements in place for processing instrumentation, though these not always followed through in practice. The service management team recognised this as a risk and identified that not all instrumentation was ready for use in the terms of the contract with the central sterile services provider. The SWLEOC director raised these concerns with the contractor monthly.
- Staff monitored theatre ventilation and there was a mechanism for alerting theatre staff when ventilation had failed.

### Medicines

- Ward staff had access to regular pharmacy advice and medicines management input from three pharmacists who covered the service. The pharmacists visited the wards daily, checked prescription records/drug charts, and raised any queries with respective prescribers. They also undertook checks on antibiotic prescribing and compliance with agreed protocols. Staff told us the systems for medicines management meant there drug errors were rare.
- Three trained nurse prescribers on the inpatient wards who were responsible for prescribing and reviewing patient medication, with support from daily consultant ward rounds.
- Medicines were stored appropriately and systems were in place for the different types of medicines, including items, which required refrigeration. We saw temperature checks had been carried out on these fridges, thus ensuring correct, safe storage. Suitable disposal arrangements were in place for expired or no longer required medicines.
- Systems for the management of controlled drugs (CD) were in place. Records for the ordering, receipt and regular checks were contemporaneous and administration records included the name of the patient, date and time of administration, dose and signatures of staff who gave the drug and the witness to this. Patient medication records corresponded with CD doses administered. Each ward maintained separate CD registers. Staff followed processes regarding disposal of unused or expired CD's.
- Medicines charts checked as part of the patient records review indicated a thorough process around prescribing and administration, with allergies recorded and discrepancies noted, such as reasons for not giving medications for example patient refusal

- Wards had a supply of stock medicines which could only be administered in accordance with a written prescription. Wards also had a supply of over-labelled packs of medicine which may be supplied to a patient to facilitate discharge.
- Staff told us about the arrangements for obtaining medicines patients needed to take home, often called TTO's. Prescribers and the on-site pharmacy provided patients with medication for day cases and inpatient stays.
- Antibiotic prescribing standards prescribing was regularly audited and showed a high level of compliance with national best practice.

### Records

- Record keeping systems, processes and practices were in place and records were written and managed in a way that kept people safe.
- Due the nature of the way a large number of patients were referred to the service, their medical records remained property of their base hospital and were only available in their entirety in paper form. Therefore, staff in the SWLEOC outpatients department requested the referring hospital to photocopy the entire patient record to arrive on the day of patient's admission. Staff told us that if the notes provided by the base hospital were insufficient, this would be reported as an incident as the lack of information could compromise the safety of the care provided to the patient. They confirmed, and incident reports showed, that this rarely occurred.
- Pre-operative safety systems, processes and practices were in place to protect people prior to surgery and staff monitored and improved them regularly. The preoperative team maintained patient records throughout the pathway. For example risk assessments and pre-operative assessments were embedded in to the patient pathway and audited to ensure compliance.
- On admission, all patients were risk assessed to prevent harm, for example moving and handling needs, the risk of developing pressure ulcers and prevention of falls.
- We saw evidence that when a patient's circumstances had altered, staff amended details, for example during the recovery stage post-surgery if a patient deteriorated.

### Safeguarding

- Staff had access to guidance and information within the trusts safeguarding policy as well as having links to the local authority safeguarding team. The SWLEOC displayed details of the Trust's safeguarding leads on Oaks and Derby ward. Nursing staff could describe the actions they would take if they were concerned about a person. Staff told us they had made no safeguarding referrals in the last 4 months.
- Not all staff had attended safeguarding training. Staff training in relation to safeguarding vulnerable adults and safeguarding children was provided to all staff. We saw from training figures there was 80% compliance within the SWLEOC for level one training, which included non-clinical staff who provide face to face contact with people, such as domestic staff and receptionists. Compliance was approximately 60% for level two training, which applied to nursing staff. This compared with the trust's expected compliance rate of 95%. Managers did not have plans to increase uptake of safeguarding training.
- Surgeons received safeguarding training as part of their induction at their base hospitals.

### Mandatory training

- Mandatory training for staff working in the unit included topics such as basic life support, safeguarding, manual handling, hand hygiene, blood borne virus, and anaphylaxis training. Training was delivered either as electronic learning, face to face or work based training.
- Training uptake was mostly in line with the trust's expectation of compliance across the topic areas, location and staffing groups, though some areas were not compliant. For instance, key areas such as safeguarding and health and safety, fell well below the trust target of 95%. Conversely, equality and diversity, infection control and manual handling training all had excess of 95% compliance.
- Records showed all nursing staff were trained in advanced life support.

### Assessing and responding to patient risk

- There was a robust pre-admission pathway and pre-assessment process in place, which identified patient's who might be at risk of deterioration before, during or after their surgical procedure. This included screening for early signs of dementia, patient's who had allergies as well as those who were not fit for surgery.
- Patients receiving post-surgical care were nursed in accordance with the National Institute for Health and Care Excellence (NICE) guidance; "Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital."

- The SWLEOC launched comfort care rounds in June 2015, and nursing staff reviewed vital signs on an hourly basis.
- In our review of 10 patient records, we saw that staff appropriately used a national early warning score system, NEWS, to identify and respond to the deteriorating patient. This involved assessing the condition of patients, such as their heart rate, respirations and level of consciousness.
- The PACU incorporated care for high risk patients, with consultant availability twenty four hours a day, seven days a week, to support a deteriorating patient.
- The ward areas were staffed by advanced nurse practitioners and an intensivist was rostered throughout the day and night each day to provide medical input or emergency support for a deteriorating patient. A named surgeon was responsible for patients during the day.
- Staff told us that it was very unusual for a patient to be taken back to theatre post operatively.

### Five Steps to Safer Surgery

- The theatre staff completed safety checks before, during and after surgery as required by the 'five steps to safer surgery' procedures – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist. They also demonstrated an understanding of the procedures. Results were reported to the theatre matron's monthly meeting and concerns identified with teams not completing the surgical safety checklist would be escalated to a senior clinician. We were also told that staff could tell the theatres matron if they were concerned about failure to complete the surgical safety checklist.
- The safer surgery checklist was used in practice. Clinical staff were seen to be following the five steps to safer surgery, which included; pre-brief before commencing operating lists, sign-in of the patient, time out, sign out and de-brief.
- Compliance with this process was checked and we saw that the results of the monthly safer surgery checklist audit, where a sample of 10 or more checklists were reviewed, was routinely over 90%.

### Nursing staffing

- The service monitored staffing levels and skill mix continuously and levels were reported daily for the staff ratios on each shift.
- There were approximately 70 whole time equivalent (WTE) nurses employed within the service. On the ward areas there were 40.1 planned WTE nurse staff against 42.9 in post.
- Staffing levels of both qualified nurses and healthcare workers for each part of the 24-hour period were displayed in all areas of the service, and rotas showed the service maintained these levels.
- The expected staffing ratio on the post anaesthetic care unit (PACU) 1 nurse to three patients, with a supernumerary senior nurse in charge. The service used agency staff infrequently. On PACU with only one member of agency staff filling a shift within the last year. Instead there were regular bank nursing staff to support the service when shortfalls were identified in staffing levels. A process was in place to check the suitability of bank staff prior to arranging their work placement.
- Staffing arrangements in operating theatres were stable. Two registered nurses and one health care assistant staffed each theatre. Seven substantive, full time theatres nursing staff left in 2014. Managers cancelled lists and some theatres had to closed to ensure safe staffing levels. Since then there has been significant recruitment into these posts. There have been 21 new theatre staff recruited in 2015. General staffing facilitated theatre lists between the hours of 8am and 1pm followed by a break and then 2pm to 7pm. Bank and agency staff were used in theatre as required. Turnover rates in theatres were at 14% and there was a vacancy rate of 13 trained nurses and four untrained staff. Vacancies were attributed to various factors, such as national shortage of anaesthetic support staff and higher pay rates being offered by other providers. There were incentives in place for filling vacant positions and retaining new recruits including increasing bank staff pay rates, a 'golden hello' payment for new permanent staff and retention packages.
- Day staff in theatres told us they had to work late often due to general theatres overrunning.
- The service planned staffing levels for the ward areas to cover both Derby and Oaks ward.
- Handovers took the form of twice daily safety huddles (a meeting of all those involved in providing care to plan the day, identify and mitigate risks including patient's at risk of falling, pressure ulcers and at risk of deteriorating) between changes in shifts.

# Elective orthopaedic centre

### Surgical and medical staffing

- There were sufficient numbers of surgeons employed to ensure safety.
- There were 36 substantive consultant surgeons from the four commissioning trusts in South West London, employed on a substantive basis to work within the service. Six research fellows assisted in theatres.
- The staffing model in the service meant that most of the consultant surgeons and referring trusts employed junior doctors, who were not based permanently within the service. Instead, surgeons were employed by one of the four partnership hospitals and contracted to work on set days within the SWLEOC. The service recognised that whilst this sometimes posed issues with stability and meeting 18 week targets, the safety of patient's was paramount and maintained.
- Information provided by the trust showed a high locum usage which stood 54.6%, though the service told us this was strictly administrative and the rate reflected how the substantive cohort of surgeons were paid.
- Junior doctors followed their consultants from their base trust to gain experience of working in the SWLEOC. Junior surgeons were based only in theatres, and did not cover the ward areas. Those we spoke with told us this model of working did not impact negatively on their training or the care they provided. There were no foundation year trainees in the centre. They, and other staff, commented that this did not impact on continuity of care as the wards were run by advanced nurse practitioners and consultants were present for every procedure undertaken.
- Most staff paid as locums due to the risk share agreement though are substantive in the service. There was very low use of locum surgeons.
- There were six consultant anaesthetists, some of whom were specialist intensivists, who covered the unit twenty four hours a day, seven days a week.
- Senior daily ward rounds were provided by an intensivist which we observed.

### Major incident awareness and training

- The major incident policy and procedures highlighted that service had an appropriate major incident and business continuity plan in place.
- The staff we spoke with could tell us their role in managing a major incident and expressed confidence in doing so, for example in case of fire and evacuation procedures.

## Are elective orthopaedic centre services effective?

**Outstanding** ☆

Outcomes for patients with both routine and complex orthopaedic problems were consistently excellent and based on national guidelines and in some areas, innovative practice in recording outcomes was the basis for national guidelines. Enhanced recoveryprogrammes were in place for those patients identified as suitable candidates, having hipand knee joint replacement surgery. The lead surgeon used patient outcomes to validateand proactively change each consultant's performance. A multidisciplinary approach to carewas evident throughout all care pathways. The systems that managed information about people who used services supported staff to deliver effective care and treatment the majority of the time.

### Evidence-based care and treatment

- Services were planned and delivered in line with, and in some cases set the standards for, national evidence-based and best practice guidance.
- The service model encouraged surgeons to undertake high volumes of specific elective orthopaedic procedures, which is recognised by professional bodies including the British Orthopaedic Association and the Royal College of Surgeons, as best practice. All surgeons in the service undertook at least 20 specific orthopaedic cases per year.
- The service monitored long term outcomes of patients who underwent surgery. The research team have a nationally pioneering system in place to test new implants. They were able to agree a partnership with commercial companies and provide information of the performance of the implants in the long term or Orthopaedic Data Evaluation Panel to follow up hips and knees, and testing of implants used, for up to 10 years post operatively. The service had agreed to roll out the findings of this pioneering work nationally in 2016.
- The service ensured that professional guidance was followed in respect of recording and management of medical device implants including submitting data to the National Joint Registry (NJR). The service was compliant with this measure.

# Elective orthopaedic centre

- During the pre-operative assessment, patients were encouraged to consider healthy eating, exercise and the reduction or cessation of smoking and alcohol whilst awaiting surgery. Access to dietician was through a referral process similar to that of the cessation of smoking service.
- In the Patient Reported Outcome Measures (PROM's), a higher proportion of patients undergoing hip and knee replacements reported an improvement in their condition compared to the average.
- The service undertook regularly audits to benchmark the standards of care provide, for example, against the standards set by the Specialist Orthopaedic Alliance, where it was identified as a high performing service.
- The service was highlighted as one of four best practice units in the country in the 2015 publication 'Getting It Right First Time' by the British Orthopaedic Alliance.
- NCEPOD recommendations of reviewing peri-operative care of surgical patients and the NHS Institute for Innovation and Improvement with the enhanced recovery programme for elective hip and knee anaesthetic guidelines.
- We saw evidence that staff adhered to local policies and procedures for example the management of blood transfusions.

## Pain relief

- Anticipatory analgesia was individually prescribed prior to a patient undergoing treatment or surgery. Short and long acting analgesia were prescribed to give the patient maximum comfort levels.
- We saw information leaflets for patients were available, for example 'pain relief following day surgery for adults'.
- Advanced nurse practitioners on the wards were supported by consultant anaesthetists/intensivists to manage pain.
- A pain awareness week was planned across the trust for after the CQC inspection. We were told that these were attended by ward staff.
- A new pathway for patients with musculoskeletal conditions was in place, known as CATS (Community Assessment, Treatment & Signposting), for patients in the community who had a chronic pain condition.

## Nutrition and hydration

- Meal times on all wards were designated 'protected time' whereby no visitors attended or ward rounds took place.
- People's nutrition and hydration needs were assessed on admission and we saw that these were monitored through the in-patient stay.
- Following surgery people were given appropriate anti-emetics for the effective management of nausea and vomiting.
- Patients told us the food was of good quality with choice. Each patient we spoke with told us they enjoyed the meals and thought the portion sizes were generous.
- We saw that food and fluid charts were appropriately completed for patients identified as 'at risk' of dehydration or malnutrition.

## Patient outcomes

- The unit performs over 5,200 orthopaedic procedures each year and the hospital has become one of the leading referral centres for the treatment of routine and complex joint replacements.
- Average length of stay between 3.3 and 3.8 days in preceding year. This was longer than the England average for elective cases. A reducing length of stay working group had been established as the unit wanted to make further improvements, and reviewed the patient pathways to make improvements. For example, in relation to prescribing and administering injections for those at risk of blood clots, and making better use of the day case beds for follow ups.
- Standardised relative risk of readmission was lower than the England average and for the specialist orthopaedic trusts for both elective and non-elective trauma and orthopaedics.
- There was a considerably lower than average complication rate reported, at less than 1% in 2015 and a longstanding system in place for the purpose for following up complications.
- Readmission rate in 2015 were on average reported at a rate of 0.4% against a target of less than 1%. Fewer than five patients were readmitted as an emergency within 28 days of their initial discharge.
- Enhanced recovery programmes were in place for hip and knee joint replacement surgery for those patients identified as suitable candidates. The programme is shown to produce fitter patients, fewer postoperative complications, accelerate the recovery from surgery and improve the quality of the patient experience.

# Elective orthopaedic centre

- All patients were proactively called by a senior nurse four days post discharge to review their progress. There as a telephone line operated by experienced nursing staff twenty four hours a day for patient queries.
- Returns to theatre and from the ward to PACU were monitored by the electronic patient database, and were a rare occurrence.

### Competent staff

- We saw that staff had the right qualifications, skills and knowledge and they told us they were keen take on new responsibilities when necessary.
- Learning needs of staff were identified through annual appraisals. The service had achieved its compliance rate for the number of completed appraisals set by the trust as 90%.
- There were three practice educators in post who worked with nursing staff to develop education protocols and competencies.
- There were 36 consultant surgeons working in the service. Their appraisal and revalidation was managed by their base trusts. Records of these appraisals and revalidations were not requests by the service. Senior managers told us that all surgeons working within the service were successfully revalidated in 2014-15.
- Outcome data was routinely used to monitor competencies of surgeons. Surgeons received their outcomes in an annual report which is reviewed by the medical director and accountable officer. Robust data collected from PROMS and the theatre
- IT system was used in appraisal of consultants.
- Individual surgeons performance was reported on the NJR by consultant, and no junior doctor undertaking procedures without a consultant present. Data including volume and complications was reviewed during revalidation and shared across staff.
- This has led to some surgeons no longer being able to practice particular procedures to ensure patient safety.
- There was a Director of Education for the SWLEOC who offered training courses for the multidisciplinary team

### Multidisciplinary working

- Each patient's discharge plan was coordinated by the multidisciplinary team (MDT) involved in their care and the patient themselves.
- We observed a consultant led, MDT ward round take place and staff confirmed this occurred daily including weekends. Patient progress was reviewed by relevant MDT members based on individual needs and to prepare patient's for discharge.
- There was a MDT meeting in the anaesthetic room each morning to discuss cases on the list in theatres. Multidisciplinary meetings were held in theatre at lunchtime.
- Physiotherapy and occupational therapy services were provided by a local community trust during weekdays and on weekends and evenings.
- There was close MDT working with community teams for ongoing district nurse and/or therapy input.

### Seven-day services

- Surgery was consultant delivered six days a week with on call availability out of hours. Daily wards rounds took place with almost all patients seen at weekends.
- Pharmacy and imaging was available on site on an on-call basis with some availability during the daytime at weekends.
- Physiotherapy and occupational therapy services were provided 8.30am - 8pm between Monday to Friday, with a reduced weekend and bank holiday service provided 8.30am - 4.30pm.

### Access to information

- We saw that information that was needed to deliver effective care and treatment was available to staff in an accessible way. Staff told us this included care and risk assessments, care plans, case notes and test results.
- Ongoing care was shared appropriately, in a timely way and in line with relevant protocols when people moved between teams and services at times such as referral, discharge, transfer and transition.
- The systems that managed information about people who used services supported staff to deliver effective care and treatment the majority of the time. Coordination between electronic and paper based systems did not always work in partnership and this caused delays in staff having access to the necessary records.

# Elective orthopaedic centre

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

- Patients confirmed and we observed the consent process was undertaken in line with the trust policy. Patients who spoke with us recalled being given sufficient information to enable them to make informed decisions about their treatment and care.
- Within the pre-assessment unit we asked staff about patient consent for forthcoming surgery. Staff explained how patient consent was obtained by the consultant. They informed us also and provided examples of consent information given to patients. Evidence of patients having been given information prior to surgery was seen in records we reviewed. Signed consent forms were present in the records of patients who had undergone surgery. We saw medical and surgical staff providing information and securing consent from a patient who was going to theatre for surgery during our visit.
- In most cases patients gave written consent during the pre-admission process. This was checked and reviewed on admission. Some consultants preferred to gain the patients consent on admission.
- A person's mental capacity to consent to care or treatment was assessed and recorded in their notes on admission.
- Electronic consent forms were used effectively for blood transfusions.
- Nursing staff could also explain how they would effectively engage with patients who were assessed as not capable of giving consent.

## Are elective orthopaedic centre services caring?

Good

Feedback from patients and their relatives was consistently good. They told us they werefully informed of the surgical procedure, care pathway and length of stay prior to beingadmitted to the hospital. Most people we spoke with had attended on recommendation due to the reputation of the care and treatment.

We saw that patients with complex needs were well supported by knowledgeable staff who understood the importance of involving a relative or carer in all plans and discussions. We heard that patients felt they were well supported emotionally during the inpatient recovery stage and rehabilitation process.

### Compassionate care

- Patients reported consistently positive feedback and described being well cared for, consulted and informed about their treatment and care. Patients were very complimentary. They told us were referred from one of the satellite hospitals and because of the reputation of the service and the care they had been given they were happy to travel.
- We observed staff asking to enter side rooms and bathrooms when patients required assistance. Patients told us they felt well cared for and that staff had been kind, respectful and professional at all times.
- We observed staff to be professional in their manner whilst in the ward areas, protecting people's privacy and dignity in a discreet manner.
- Patient's we spoke with told us the service was "as good as or better than a private unit," that they felt informed as "everything was explained, it couldn't have been better" and spoke highly of rehabilitation, "I thought the recovery ward was exceptional. "
- The average Friends and Family Test (FFT) scores for in 2015 was above 70%, which were considerably better than the national level of 37%. FFT scores and response rates were consistently high for both wards. In July FFT 98% of patients stated that they would recommend the trust, better than the national rate of 95% of inpatients.
- The ratings provided by patients on the NHS choices website were consistently at five stars.

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

- We saw each patient had been provided with a bedside information booklet to help them understand aspects of their care.
- Patients felt confident that they had all the information they required and would receive clear answers if they had any queries about their care. One person told us a about a change to their medication regime which they could recall in detail.
- Patients told us they were phoned at least once before they attended for surgery and therefore felt confident to ask questions about their care.

# Elective orthopaedic centre

- Patient's spoke highly of the information received prior to surgery. They received specific details about the procedures they were scheduled to undergo in a DVD format, as part of the enhanced recovery programme used developed by the SWLEOC.
- The service held open days for prospective patients on a bi-monthly basis, lead by clinical staff to answer questions and resolve concerns which patients or their relatives may have.

### Emotional support

- We observed encouragement and reassurance being given to post-operative patients when mobilising.
- We saw advice and information leaflets available for patients and relatives to read about self-help, orthopaedic conditions and treatments and access to specialist services.
- We heard that the trust were able to refer patients to a psychiatric specialists when patients had mental health need requiring psychological support or treatment.

## Are elective orthopaedic centre services responsive?

Good

The service was proactively met the needs of the population it served, coordinating with referring hospitals, external and community providers to ensure the surgical pathway was appropriate. Delays and disruptions to care were clearly identified and people were keptinformed. There was transparency in dealing with complaints and concerns, which were responded to in a timely way.

### Service planning and delivery to meet the needs of local people

- The SWLEOC opened January 2004 initially to undertake elective hip and knee replacements for the South West London sector, in order to reduce waiting times and improve patient outcomes.
- The centre recognised the increasing need for joint replacement surgery to reflect the population where people were living longer in the four local authority areas it served.
- The service recognised an increase in referrals from people with dementia and both clinical and non-clinical staff had undergone training to enable them to support patients with dementia.

### Access and flow

- At the time of our inspection the average time that patients were waiting or procedures stood at 4 weeks. However, managers recognised the service was not meeting targets to ensure patients were seen and treated within the 18 week referral to treatment target in 2015. Senior staff described some difficulties in the management of outpatient referrals from base trusts which were often not referring appropriately with then 18 week pathway. SWLEOC surgeons were being referred patients more than 10 weeks into the pathway, with 60 patients a month referred at 17 weeks, and therefore some patient's were waiting longer.
- The SWLEOC director fed back these concerns to the partnership board for the four local trusts and had a clear understanding of the issues at the four sites, such as IT systems or delays in funding, and fedback through the governance structures.
- The incomplete pathway rate was 73.8% at the time of our inspection. The backlog of patients waiting at the time our inspection was 441 who had been waiting longer than 18 weeks with 8 people waiting more than 35 weeks. A review of the preadmission pathway and pre-assessment process, scheduling, impact of revisions, complex cases and shift patterns was undertaken in response. Plans were in place to clear the backlog by the end of November 2015 and measures were taken to increase activity such as the scheduling of weekend lists and all affected patients had been offered appointments.
- The service supplied the recorded monthly percentage for theatre utilisation. The average percentage over 2015 months was 92%. In April internal theatre throughput levels were below plan due to annual leave arrangements for surgeons that were agreed at their base trusts. Work to increase activity and strengthen annual leave arrangements since then meant that cases per session remained above the target.
- Bed occupancy rate between 56.2% and 76.6% in preceding year.
- There was a whiteboard at reception which enabled patient's to see real time information regarding their appointment setting and timeliness of the clinics.

# Elective orthopaedic centre

- Surgical lists commenced at 7am. People with vulnerable conditions were prioritised and were often seen first on the list and the service offered taggered arrivals to prevent patients waiting all day.
- Discharge arrangements were considered and acted upon from pre-assessment and thereafter throughout the patient journey, facilitated by nursing staff. We saw the multi-disciplinary team actively engaged in the discharge process, for example in ensuring patients could; mobilise safely, understood their post-operative exercises and had provision for aftercare when returning to the community or their own home and equipment was required. Discharge summaries were electronic and sent to GPs.
- There were very few hospital initiated cancellations. Pre-assessment process involves discussing patient's fitness for surgery numerous times prior to their attendance, including 48 hours before. Staff told us this helped to maintain a very low cancellation rate.
- Theatre scheduling took place four weeks in advance and were monitored weekly. Theatre lists were coordinated by a consultant anaesthetist and a theatre coordinator.
- Complex revision referrals were received swiftly from base trusts surgeons told us they were able to prioritise these patients.
- There were some delayed discharges though staff told us these were infrequent, and when they did occur the focus was on patient safety.
- The service recognised that a small proportion of patients stayed on the wards longer than average and were able to demonstrate in each case that this was due to lack of available support in the community. The longest stay in 2015 was 105 days, due to lack on ongoing support identified in the community. The SWLEOC director told us this was raised at the partnership board meetings.

### Meeting people's individual needs

- Interpreting services were available via telephone and could be booked quickly when appointments were arranged.
- We noted there was a wide range of information available to patients and visitors; however these were only available in English, though there was information visibly available in a range of other languages about access to interpreting services.
- The service encouraged the use of care 'passports' to ensure that staff had as much information and background about the individuals during their stay. Carers input and feedback was encouraged and used to improve services.
- The service encourages carers/family/ next of kin to stay with patients if necessary and were accommodated on the wards as well as on PACU.
- Patients at the end of life stage were provided with privacy and dignity and were allowed time with their families to the end.
- There were tea and coffee facilities in the discharge lounge. There were also facilities at the entrance where patients and their next of kin waited before they were taken upstairs.

### Learning from complaints and concerns

- In 2015 five complaints had been received to date, and all were responded to within the trust's expected time frame.
- Staff told us they attempted to resolve any issues immediately on the ward to avoid complaints occurring. Feedback from patient comments and complaints was used in weekly meetings.
- Notices displayed advertised the patient advice and liaison service (PALS) and the complaints service. They provided support to patients, carers and relatives, representing their views and resolving local difficulties on the spot by working in partnership with nursing staff.

## Are elective orthopaedic centre services well-led?

**Outstanding** ☆

The vision and strategy for the service was developed by staff in the service and well understood. The service worked systemically and closely with the four partner organisationsto ensure outcomes and performance were managed. Governance arrangements wererobust and proactive. Staff understood the ethos of the service values, and unequivocal inpraising the support received from leadership team and there were measurably high levelsof staff satisfaction. Patients who used the service

were actively involved in the way theservice operated. Innovation was evident and the service contributed to the national body of knowledge regarding best practice in orthopaedics.

### Vision and strategy for this service

- There was a unified and ambitious vision for orthopaedic services, which had been routinely shared with staff and stakeholders.
- The SWLEOC strategy document 'Vision for Growth' and the trust's integrated business plan for 2015 detailed clear plans for developing the service which included improve relationships within the orthopaedic service provided in Epsom hospital increasing capacity at the SWLEOC, to use increase use of day case theatres, to establish links with more local hospitals and plans to operate a franchise model.
- The service had put forward a business case in March 2015 to the board for a sixth theatre to grow the complex revision, spinal and hip and knee service and increasing catchment area of the local patient population. Senior managers described difficulties in the frequent change of board directors over the preceding decade which meant that plans for expansion were regularly halted.

### Governance, risk management and quality measurement

- The governance and risk management arrangements within the SWLEOC were well developed and mature, and we were assured that senior managers had full oversight of the concerns affecting front line staff and patient safety and experience. The clear and articulated governance structure, which staff we spoke with at more senior levels understood well, meant that concerns and risks that needed escalation and action were dealt with.
- The SWLEOC reported governance matters affecting all four trusts through served the host, Epsom and St Helier trust board
- There were a number of systems to capture and disseminate learning from incidents, complaints and audit to all staff, which factored in the complexities of the working arrangements of the surgeons. This took the form of the SWLEOC clinical governance monthly meeting bulletin which commenced in July 2015. Each bulleting contained concise examples of learning from incident, including early post-operative dislocation following three incidents and supportive of early relocation and surgery were suitable; unexpected post-operative confusion; VTE prophylaxis and antibiotic prescribing outside of protocol. There were also detailed updates on the requirements of duty of candour. Staff we spoke with were aware and more senior staff were able to recall details they had shared with their staff from each bulletin.
- We were assured that the arrangements were robust due to the formal structures in place and well attended meeting, evidenced by minutes.
- Managers were confident that most incidents were reported as the service and trust overall was a high reporting site for incidents.
- Clinical governance concerns and good practice were tracked through from senate meetings, monitored and reviewed by surgeons at clinical governance meetings and Medical Council meetings with senior orthopaedic surgeons and managers. High level concerns were escalated by exception to the clinical strategy group and partnership board.
- Risks were identified, escalated and the risk register was regularly reviewed with clear mitigation plans in plans in place. We noted four high level risks on the risk register in the October 2015 version. The issues we had identified in our inspection were reflected and had been mitigated, included the activity and referral to treatment time targets and plans to address them, staff raising concerns whereby and details of changes including an escalating concerns study day run by practice educators and a trust survey, cards given to staff with details of how to contact the head of quality, walk arounds by the senior nurse leaders and theatre nurse vacancies were also and how they had been addressed. A further risk regarding the impact of heavy lifting of prostheses and implants identified as a significant risk to staff and a mini fork lift truck was purchased for staff.

### Leadership of service

- Leaders within the SWLEOC and the partnership organisations had strong grip on the services provided. There were identifiable leads in all areas of the SWLEOC.
- Many front line staff we spoke with said they felt supported by their local leaders, including ward managers and matrons.

# Elective orthopaedic centre

- Senior nursing staff (band 6 and above) had enhanced nursing qualifications which enable the nurses to deal with the management of patient care on a higher level and this was indicated by the low readmission rate and low delayed discharge rate.
- Nurses told us of the support they received, and they felt concerns raised about staffing levels and the impact on patient care were always heeded.
- The team of doctors that had started this facility are still in place leading the service. Examples of the same members of staff working for five or more years together were described in theatre.
- There were no reports of bullying and harassment or discrimination experienced in the service from staff we spoke with.
- Staff we spoke with knew the leaders within the SWLEOC, and told us that the Chief Executive had been visible and supportive of the service within the last year. Staff were not aware of the changes to the executive team

### Culture within the service

- We saw a positive culture within the trust. Senior managers were in positive praise of the executive team. Many of the staff we spoke with told us how proud they were to work for the SWLEOC.
- Concerns were responded to swiftly and appropriately. A whistleblower raised concerns about staffing levels and senior nurse leadership. The whistleblower's concerns were investigated and they were protected and commended for raising concerns. In response staffing levels at night were reviewed and increased swiftly. Changes were made to the senior nursing staffing to reflect findings of the investigation.
- All staff were highly complimentary about the educational and clinical support they had received. Atmosphere and working relationships appeared cohesive and congruent with the service values.
- Some nursing staff told us they had worked in the service since it opened in 2004 and spoke highly of the positive culture demonstrated by the leadership team.

### Public engagement

- Patients were embedded into the running and governance structures of the service. A patient forum and a senate meeting every quarter with a patient representative.
- Patients' views of the entire pathway were sought through the patient panel and the NHS Friends and Family Test.
- The service held open days for prospective patients on a bi-monthly basis, led by clinical staff to answer questions and resolve concerns which patients or their relatives may have.

### Staff engagement

- Staff told us they were able to discuss suggestions to improve the service with their local leaders and line managers at the hospital but were engaged to influence senior managers over decisions affecting their work.
- The morale among theatre staff was recognised by senior managers as being lower than in the rest of the service due to the staffing shortages. However, staff we spoke with spoke positively of the working culture and were able to explain changes the managers had made to improve staff morale, including increasing recruitment and focusing on retention of staff.
- There was a positive working culture on the wards as evidenced on Oaks and PACU and the morale was high. Staff reported that senior leaders would be hands on when required and this made the teams more empowered.
- The senior managers held daily meeting on both wards and PACU which discussed the capacity for the week ahead and any action to be taken. There was value to any suggestions and decision made at the meeting and this was then cascaded to the rest of the staff.

### Innovation, improvement and sustainability

- We saw a strong culture of innovation. Staff were encouraged to bring opportunities to improve and felt engaged in the process of innovation to improve service.
- Options to expand the service across geographical boundaries were regularly discussed with the trust board.
- There was a good use of staff decision making to improve the patient's journey. The 24-hour helpline proved to be useful. We saw evidence of a patient encouraged to return to the ward to have post-operative after care when the service was unavailable at the GP.
- The service monitored long term outcomes of patients who underwent surgery. The research team have a nationally pioneering system in place to test new implants. They were able to agree a partnership with commercial companies and provide information of the performance of the implants in the long term or

# Elective orthopaedic centre

Orthopaedic Data Evaluation Panel to follow up hips and knees, and testing of implants used, for up to 10 years post operatively. The service had agreed to roll out the findings of this pioneering work nationally in 2016.

# Outstanding practice and areas for improvement

## Outstanding practice

- The leadership of the outpatients and diagnostic imaging teams was outstanding with staff inspired to provide an excellent service, with the patient at the centre.
- The diagnostic imaging department worked hard to reduce the patient radiation doses and had presented this work at national and international conferences.
- The safety and leadership of the SWLEOC, where outcomes for patients were consistently excellent and based on national guidelines.

## Areas for improvement

### Action the hospital MUST take to improve

- Ensure there are adequate numbers of nurses and midwives to deliver safe and quality care.
- Implement agreed guidelines specific to the critical care units.
- Ensure the management, governance and culture in the critical care units, supports the delivery of high quality care.
- Obtain feedback from patients/relatives in the critical care units, so as to improve the quality of the service.
- Identify, analyse and manage all risks of harm to women in maternity services
- Ensure identified risks in maternity services are always reflected on the risk register and timely action is taken to manage these risks.
- Improve the quality and accuracy of performance data and increase its use in identifying poor performance and areas for improvement.

### Action the hospital SHOULD take to improve

- Ensure cardiac monitors used in the majors area in ED and major incident equipment are fit and ready for use in the event of a major incident.
- Ensure the target for 85% compliance for mandatory training is met.
- Ensure staff always comply with infection control practices.
- Ensure child protection notifications from the trust are not up to date.
- Ensure staff appraisals are completed as required.
- Ensure all relevant staff are clear about how the Deprivation of Liberty Safeguards should be used.
- Ensure there are agreed guidelines specific to the critical care unit and that there are systems to ensure consistency of care.
- Improve the response times to complaints in the medical directorate.
- Ensure all women receive one to one care in labour.
- Improve the 31 day cancer waiting times for people waiting from diagnosis to first definitive treatment and the 62 day waiting time for people waiting from urgent GP referral to first definitive treatment.
- In critical care, ensure there is an agreed strategy for the unit that includes the critical care workforce across the two sites and that all risks are identified and on the risk register.
- In maternity, ensure monitoring data is separated by location.
- Improve and strengthen governance within the ED.
- Develop the leadership skills of labour ward coordinators to prepare them for this role and hold them accountable for their performance.
- Monitor action plans to ensure timely response to risk actions.
- Ensure the consultant hours in the emergency department meet the RCEM recommendation of 16 hours a day, seven days a week of clinical consultant working.
- Ensure that the paediatric emergency department complies with Royal College of Paediatric and Child Health staffing guidelines.
- Ensure all staff working with children are adequately trained to an agreed and measureable standard.

# Outstanding practice and areas for improvement

- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Increase the number of sonographers in radiology.
- Improve compliance with all stages of the World Health Organization (WHO) Surgical Safety Checklist across all surgery services.
- Ensure local anaesthesia drugs are stored separately from general anaesthesia drugs in all operating theatres.
- Take further steps to update and improve operating theatre infrastructure and equipment.
- Improve scheduling of surgical procedures to improve theatre utilisation and efficiency.
- Ensure all reported risks in surgery services are addressed in a timely way.
- There is access to seven day week working for radiology services.
- Staffing is improved in radiology for sonographers.
- Improve the response rate of patient feedback.
- Ask patients and relatives forfeedbackon critical care.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- There are appropriate processes and monitoring arrangements in place to improve the 32 and 61 day cancer targets in line with national targets.
- There is improved access for beds to clinical areas in diagnostic imaging.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided because;**<br>1. There were not agreed guidelines specific to the critical care units.<br>2. The management, governance and culture in the critical care units, did not support the delivery of high quality care.<br>3. Feedback from patients was not always obtained in the critical care units.<br>4. All risks of harm to women in maternity services were not always identified, analysed and managed.<br>5. Identified risks in maternity services were not always reflected on the risk register and action to manage risks was not timely.<br>**Regulation 17 (2) (a), (b), (e)** |