

Brighton and Sussex University Hospitals NHS Trust

Royal Sussex County Hospital










Quality Report

Eastern Road
Brighton
East Sussex
BN2 5BE
Tel: 01273 696955
Website: www.bsuh.nhs.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Sussex County Hospital (RSCH) in Brighton forms part of Brighton and Sussex University Hospitals Trust. RSCH is a centre for emergency and tertiary care. The Brighton campus includes the Royal Alexandra Children's Hospital (The Alex) and the Sussex Eye Hospital.

The hospital provides services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex, and more specialised and tertiary services for patients across Sussex and the south east of England.

The Trust has over two sites, the other being the Princess Royal in Haywards Heath, 1,165 Beds; 962 General and acute, 74 Maternity, and 43 Critical care. It employs 7,195.92 (WTE) Staff; 1,050.59 of these are Medical (WTE), 2,302.52 Nursing (WTE), 3,842.81 other.

It has revenue of £529,598m, with a full cost of £574,417m and a Surplus (deficit) of £44,819k

Between 2015-2016 the Trust had 118,233 inpatient admissions; 640,474 Outpatient attendances, and 156,414 A&E attendances.

This hospital was inspected due our concerns about the Trusts ability to provide safe, effective, responsive and well led care. We inspected this hospital on 4-8 April 2016 and returned for an announced inspection on 16 April 2016.

Our key findings were as follows:

Safe

- Incident reporting was understood by staff but there was a variation in the departments on completion rates and a lack of learning and analysis.
- The trust have reported seven never events (5 of which were at RSCH) between Jan' 15 to Jan' 16, all seven were attributed to surgery and four of which were related to wrong site surgery incidents.
- Not all areas of the hospital met cleaning standards and the fabric of the buildings in some areas was poor, and posed a risk to patients, particularly with regard to fire safety.
- We had particular concerns that the risk of fire was not being managed appropriately. We found that the Barry and Jubilee buildings were particular fire safety risks as they were not constructed to modern safety standards and had been altered and redesigned many times during their long history. They were overpopulated, overcrowded and cluttered with narrow corridors and inaccessible fire exits. We found flammable oxygen cylinders were stored in the fire exit corridors. We found that fire doors with damaged intumescent strips which would not provide half an hour fire barrier in the event of horizontal evacuation.
- Patients in the cohort area of the emergency department were not assessed appropriately; there was a lack of clinical oversight of these patients and a lack of ownership by the Trust board to resolve the issues.
- There were no systems in place for the management of overcrowding in the 'cohort' area. Staff were not able to provide satisfactory details of "full capacity" protocols or triggers used to highlight demand exceeding resources to unacceptable levels of patients in the area.
- The recovery area at RSCH in the operating theatres was being used for emergency medical patients due to having to reduce the pressure on an overcrowded ED and to help meet the emergency departments targets such as 12 hour waits. Some patients were transferred from the HDU to allow admission to that area and some patients were remaining in recovery when there was no post-operative bed available. Some patients at were kept in the recovery area for anything between four hours and up to three days

Summary of findings

- Staffing levels across the hospital were on the whole not enough to provide safe care for example the mixed ICU and cardiac ICU frequently breached the minimum staff to patient ratios set by the Intensive Care Society and the Royal College of Nursing.
- In some areas the trust had systematically failed to respond to staff concerns about this and mitigating strategies had failed.
- Medicines management in the hospital was generally good, with the exception of Critical Care and out patients, where it was inadequate.
- We saw that records were well managed and kept appropriately, apart from OPD where we observed records lying in unlocked areas that the public could access.
- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the intranet and staff were able to access this quickly. However, safeguarding training for all staff groups was vastly lower than the Trusts target.
- Staff compliance in mandatory training, statutory training and appraisals fell well below the trust target of 95% for statutory training and 100% for mandatory training, for both nurses and doctors across every department in the hospital.
- The trust had a Duty of Candour (DOC) policy, DOC template letters and patient information leaflets regarding DOC, and we saw evidence of these. The trust kept appropriate records of incidents that had triggered a DOC response, which included a DOC compliance monitoring database and we saw evidence of these. Most staff we spoke with understood their responsibilities around DOC.

Effective

- Staff generally followed established patient pathways and national guidance for care and treatment. Although we saw some examples of where some aspects of patient pathway delivery could be improved.
- National clinical audits were completed. Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) scores. Reviews of mortality and morbidity took place at local, speciality and directorate level although a consistent framework of these meetings across all specialities was not in place. The trust's ratio for HSMR was better than the national average of 80%.
- Staff knew how to access and used trust protocols and guidance on pain management, which was in line with national guidelines.
- Patient's nutritional needs were met although patients in the cohort area and recovery did not always have easy access to food and water. In critical care there was no dedicated dietician.
- Appraisal arrangements were in place, but compliance was low across the hospital. Trust wide only 68% of staff had received an annual appraisal. Accountability for these lapses was unclear.
- Some services were not yet offering a full seven-day service. For example in medicine constraints with capacity and staffing had yet to be addressed. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.
- There were innovative and pioneering approaches to care with evidence-based techniques and technologies used to support the delivery of high quality care and improve patient outcomes in children and young peoples services

Caring

- Staff were caring and compassionate to patients' needs, and patients and relatives told us they received a good care and they felt well looked after by staff.

Summary of findings

- Children and young people at the end of their lives received care from staff who consistently went out of their way to ensure that both patients and families were emotionally supported and their needs met.
- Privacy, dignity and confidentiality was compromised in a number of areas at RSCH, particularly in the cohort area, out patients department and on the medical wards in the Barry building.
- The percentage who would recommend the trust (Family and Friends Test) was lower than the England average for the whole time period until the most recent data for Dec '15, where it is currently above the England average.
- Patients reported they were involved in decisions about their treatment and care. This was reflected in the care records we reviewed.
- We saw no comfort rounds taking place whilst we were in the ED department. This meant patients who were waiting to be treated may not have been offered a drink nor have their pressure areas checked.

Responsive

- The admitted referral to treatment time (RTT) was consistently below the national standard of 90% for most specialties. The trust had failed to meet cancer waiting and treatment times.
- The length of stay for non-elective surgery was worse than the national average of for trauma and orthopaedics, colo-rectal surgery and urology
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently higher than the England average.
- According to data provided by the trust, between January 2015 and December 2015 3,926 people waited between 4 to 12 hours (and 71 people over 12 hours) from the time of “decision to admit” to hospital admission. Since the inspection an additional 12 patients have been reported as waiting over 12 hours.
- Interpreters were available for those patients whose first language was not English. This was arranged either face to face or through a telephone interpreter. Staff told us that under no circumstances would a family member be able to act as an interpreter where a clinical decision needed to be made or consent needed to be given.
- We saw examples of wards including the dementia care ward that operated the butterfly scheme. The butterfly scheme is a UK wide hospital scheme for people who live with dementia. We also saw that they had a dignity champion. This is someone who works to put dignity and respect at the heart of care services.

Well Led

- There was a clear disconnect between the Trust board and staff working in clinical areas, with very little insight by the board into the key safety and risk issues of the trust, and little appetite to resolve them.
- The trust had a complex vision and strategy which staff did not feel engaged with. There was a lack of cohesive strategy for the services either within their separate directorates or within the trust as a whole. Whilst there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership in bringing the many directorates together.
- The trust had a complex vision and strategy which staff did not feel engaged with. There was a lack of cohesive strategy for the services either within their separate directorates or within the trust as a whole. Whilst there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership in bringing the many directorates together.
- The culture at RSCH was one where poor performance in some areas was tolerated and 50% of staff said in the staff survey they not reported the last time they were bullied or harassed.
- There was a problem with stability of leadership within the trust. There were several long term vacancies of key staff such as matrons and clinical leads. During the inspection we noted a number of senior management staff had taken leave for the period of the inspection.

Summary of findings

- BME staff felt there was a culture of fear of doing the wrong thing so nothing was done. They told us this was divisive and did not lead to a healthy work place where everyone was treated equally.
- Ward managers and senior staff reported that they received little support from the trust's HR department in managing difficult consultants or with staff disciplinary and capability issues. They told us that HR advised staff to put in a grievance as a first step in resolving any issue.
- The relocation of neurosurgery intensive care from Hurstwood Park to Brighton in June 2015 had been inadequately managed and lacked evidence of robust staff consultation. This had led to a culture in which nurses did not feel valued and there was significant and sustained evidence of non-functioning governance frameworks.
- The executive team failed on multiple occasions to provide resources or support to clinical staff in critical care to improve safety and working conditions and there was no acknowledgement from this team that they understood the problems staff identified.

We saw several areas of outstanding practice including:

- The play centre in The Alex children's hospital had an under the sea themed room with treasure chests full of toys and a bubble tank. There was also an interactive floor where fish swam around your feet and changed direction according to your footsteps.
- The virtual fracture clinic had won an NHS award for innovation. It enabled patients with straightforward breaks in their bones to receive advice from a specialist physiotherapist by telephone. It reduced the number of hospital attendances and patients could start their treatment at home.
- We found that an outstanding service was being delivered by dedicated staff on the Stroke Unit (Donald Hall and Solomon wards). The service was being delivered in a very challenging ward environment in the Barry building. Staff spoke with passion and enthusiasm about the service they delivered and were focused on improving the care for stroke patients. The results of audits confirmed that stroke care at the hospital had improved over the past year.
- The children's ED was innovative and well led, ensuring that children were seen promptly and given effective care. Careful attention had been paid to the needs of children attending with significant efforts taken to reassure them and provide the best possible age appropriate care.

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

Importantly:

- The trust must ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times.
- The trust must ensure that all staff have attended mandatory training and that all staff have an annual appraisal.
- The trust must ensure that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.
- The trust must undertake an urgent review of staff skill mix in the mixed/neuro ICU unit and this must include an analysis of competencies against patient acuity.
- The trust must establish clear working guidelines and protocols, fully risk assessed, that identify why it is appropriate and safe for general ICU nurses to care for neurosurgery ICU patients. This should include input from neurosurgery specialists.
- The trust must take steps to ensure the 18 week Referral to Treatment Time is addressed so patients are treated in a timely manner and their outcomes are improved. The trust must also monitor the turnaround time for biopsies for suspected cancer of all tumour sites.

Summary of findings

- The trust must ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines and intravenous fluids. Additionally the trust must ensure patient group directives are reviewed regularly and up to date.
- The trust must implement urgent plans to stop patients, other than by exception being cared for in the cohort area in ED.
- The trust must adhere to the 4 hour standard for decision to admit patients from ED, ie patients should not wait longer than 4 hours for a bed.
- The trust must ensure that there are clear procedures, followed in practice, monitored and reviewed to ensure that all areas where patients receive care and treatment are safe, well-maintained and suitable for the activity being carried out. In particular the risks of caring for patients in the Barry and Jubilee buildings should be closely monitored to ensure patient, staff and visitor safety.
- The trust must ensure that patient's dignity, respect and confidentiality are maintained at all times in all areas and wards.
- The trust must stop the transfer of patients into the recovery area from ED /HDU to ensure patients are managed in a safe and effective manner and ensure senior leaders take the responsibility for supporting junior staff in making decisions about admissions, and address the bullying tactics of some senior staff.
- The trust must review the results of the most recent infection control audit undertaken in outpatients and produce action plans to monitor the improvements required.
- The trust must ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates.
- The trust must urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board.
- The trust must undertake a review of the HR functions in the organisations, including but not exclusively recruitment processes and grievance management.
- The trust must develop and implement a people strategy that leads to cultural change. This must address the current persistence of bullying and harassment, inequality of opportunity afforded all staff, but notably those who have protected characteristics, and the acceptance of poor behaviour whilst also providing the board clear oversight of delivery.
- Review fire plans and risk assessments ensuring that patients, staff and visitors to the hospital can be evacuated safely in the event of a fire. This plan should include the robust management of safety equipment and access such as fire doors, patient evacuation equipment and provide clear escape routes for people with limited mobility.

In addition the trust should:

- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.
- Review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- Consider improving the environment for children in the Outpatients department as it is not consistently child-friendly.
- Ensure security of hospital prescription forms is in line with NHS Protect guidance.

Summary of findings

- Ensure that there are systems in place to ensure learning from incidents, safeguarding and complaints across the directorates.
- Ensure all staff are included in communications relating to the outcomes of incident investigations.
- Implement a sepsis audit programme.
- Provide mandatory training for portering staff for the transfer of the deceased to the mortuary as per national guidelines.
- Ensure there is a robust cleaning schedule and procedure with regular audits for the mortuary as per national specifications for cleanliness and environmental standards.
- Review aspects of end of life care including, having a non-executive director for the service, a defined regular audit programme, providing a seven day service from the palliative care team as per national guidelines and recording evidence of discussion of patient's spiritual needs.
- The trust should ensure all DNACPR, ceilings of care and Mental Capacity assessments are completed and documented appropriately as per guidelines.
- The trust should implement a formal feedback process to capture bereaved relatives views of delivery of care.

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Inadequate



Why have we given this rating?

Overall we found ED inadequate

- The ED did not adequately protect patients from avoidable harm.
- Whilst the trust had undertaken initiatives to resolve capacity issues frequently affecting their ability to move patients through the emergency care pathway, the ED was still not consistently meeting national targets. Patients therefore experienced delays, some of which were significant. One cause of this was a lack of available hospital beds due to “exit block” of patients deemed medically fit for discharge awaiting appropriate placement in the community or support packages for home care.
- There was insufficient flow through the department, which meant it was not able to meet capacity demands.
- The ED environment did not meet the needs of patients.
- Levels of mandatory training and appraisals fell well below the trust targets.
- There was a lack of assessment of patient’s conditions before they were placed in the ‘cohort’ area.
- There was a lack of clinical ownership of patients in the ‘cohort’ area.
- Patients were not protected from harm in the ‘cohort’ area and their respect and dignity was compromised whilst in this area.
- There was a lack of nursing and medical leadership to support the department.
- Staff morale was low which may be hindering recovery and performance.

Medical care (including older people’s care)

Requires improvement



We found medicine to require improvement because:

The wards in the older buildings were extremely difficult environments for staff to provide safe and effective care. Some of the most challenging and vulnerable patients were being cared for in premises that were no longer fit for purpose.

Summary of findings

Although the trust had a strategy for managing this was not carried out in practice. Risk assessments were poorly completed or out of date and did not provide assurance that risks to patients, staff and visitors were identified and managed appropriately. Although the trust had plans to replace the older buildings, the project was planned to take a minimum of nine years.

Substantial numbers of overseas nurses have recently been recruited. This had raised additional staffing concerns with their mentoring and support whilst adjusting to nursing in England. The majority of medical wards reported there continued to be severe staffing problems. We had concerns that due to staff shortages, nurses without appropriate skills and competencies with poor language and communication skills were left in charge of wards at night.

Patients were not always protected from avoidable harm because there was not a system to ensure trust wide learning from incidents or take action where poor infection control practices were identified.

The different medical directorates operated in isolation with little cross directorate learning or sharing of information.

The management of incident reporting was variable across the directorates with limited feedback or learning identified. This issue was raised at the previous inspection. Whilst staff knew how to report incidents and told us that reporting was encouraged, we found no changes or evidence of learning as a result of reported incidents.

Although medicines were usually supplied, stored and disposed of securely and appropriately on the cardiology wards, Albion and Lewes, the clean utility contained various pieces of equipment and the drug cabinet was unlocked and had no means of being locked. We found intravenous fluids stored on open shelves

However:

We saw that patients' care needs were assessed, planned and delivered in a way that protected their rights. Medical care was evidence based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The

Summary of findings

care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. Patient outcomes were monitored and reviewed through formal national and local audits.

The patients we spoke with during the inspection told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. During our inspection we observed patients being treated with kindness, respect, professionalism and courtesy. This positive feedback was reflected in the Family and Friends feedback and patient survey results.

Risk assessments and care plans were in place and were completed appropriately, with appropriate action taken when a change in the patient's condition was detected.

The hospital measured and monitored incidents or avoidable patient harm through the National Safety Thermometer scheme. The information gathered was used to inform priorities and develop strategies for reducing harm.

Staff training was prioritised which ensured staff had the skills and knowledge to provide safe care and treatment for patients. Staff were aware of safeguarding principles and able to follow the correct procedures.

Surgery

Requires improvement



Overall we rated the service as requiring improvement.

The service had experienced seven never events over a seven month period in 2015, five of these took place at the RSCH and involved three wrong side nerve blocks, one wrong tooth extraction and one wrong route of medication. These had been rigorously analysed and changes had been made in order to ensure they were not repeated.

The services, wards and departments were clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of a patient was clearly documented. There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts. Generally this was well managed but patients' needs were not always met.

Summary of findings

Treatment and care were provided in accordance with the National Institute of Health and Care Excellence (NICE) evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. There were examples of effective multidisciplinary working. The service was not always responsive to people's needs and may not be able to make reasonable adjustments to enable patients to receive care or treatment that is appropriate to their needs. Patients were being kept in the recovery area of operating theatres for significant periods of time due to the trust attempting to reduce its target of moving a patient within 12 hours out of the emergency department (ED), lack of beds on the high dependency unit (HDU) and lack of beds in other areas of the trust.

Some patients could be kept in the recovery area for over four hours and up to three days with some patients being discharged home directly from the recovery area. This meant patients did not have their privacy when they needed it and did not have free access to washing and toilet facilities, could not move freely around the recovery area and could not see their relatives whilst in this area.

Not all staff had received annual appraisals and very few staff had the opportunity to complete statutory and mandatory training provided by the trust. Staff in the recovery area did not have the skills to look after emergency medical patients who were transferred to the recovery area directly from the (ED) or (HDU).

Other development and clinical training was accessible and there was evidence of staff being supported and developed in order to improve outcomes for patients.

Performance against national audits such as patients with a fractured neck of femur (broken hip) audit showed evidence of good outcomes for patients but adherence with the national emergency laparotomy audit (NELA) 2014 standards were poor with 14 of the 32 standards not being met. However the service had put systems in place which was starting to show significant improvements in outcomes for this group of patients.

Summary of findings

The service worked well with its seven clinical commissioning groups (CCGs). The service was also not meeting its referral to treatment targets of being seen by the service within 18 weeks, the only specialty to meet this target was cardiology surgery. Some patients waiting for a follow up appointment did not always get one in a timely manner. The service did not fully understand why these patients appointments had been missed and had started work to identify them and review their treatment. The service had experienced a reconfiguration of its services and had started to get its governance systems in place but this was in its early stages and needed further embedding. Additional reconfiguration was being planned to further focus elective and non-elective activity onto specific sites. Leadership at a local level was good and staff told us about being supported and enjoyed being part of a team. There was evidence of innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.

Critical care

Inadequate



Overall we rated critical care as inadequate. This reflects consistently poor staffing levels of nurses that breached national critical care guidance and resulted in unsafe levels of care. Mandatory training did not meet minimum trust standards and due to sickness absence and the volume of new nurses, the nurse practice educator team were able to provide only limited support to staff. Incident reporting was sporadic and poorly investigated and there was limited evidence senior staff used investigations to improve practice. There was inconsistent input from a multidisciplinary team of specialists due to short staffing, including amongst pharmacy, occupational therapy and dietetics. The standard of medicine management was variable and 37% of incidents on the general ICU and mixed ICU were medication errors. Critical care services did not fully meet the National Institute for Health and Care Excellence guidance on the rehabilitation of patients. The mixed ICU was also not fully compliant with national best practice on the care of patients with a

Summary of findings

head injury. There was a significant gap in the ability of the service to provide specialist care and treatment to neurosurgical ICU patients because of a lack of available staff and the lack of clinical governance oversight.

There was a demonstrable focus on providing individualised care based on feedback from patients and their relatives. Additional support for critical care patients was provided by a follow-up nurse and a critical care outreach team, who also provided a cross-department education programme.

There was room for improvement in infection control practices and hand hygiene audit results were particularly poor.

Governance and risk management were not fit for purpose and the lack of a relationship between the clinical leadership team and the trust executive team meant a culture of disrespect and bullying had emerged, in which some nurses felt devalued. Clinical leads did not demonstrate an understanding of this, which was reflected in consistently high rates of sickness absence and staff turnover.

Maternity and gynaecology

Requires improvement



Midwives reported on staff shortages and some staff expressed their concern about the potential risks to women and their babies. They told us staff routinely covered vacant shifts, could not always take breaks during 12-hour shifts and provided the scrub practitioner role in theatre. The service identified risks from the shortage of medical staff, the high use of locum cover and the failure to achieve waiting time targets in gynaecology.

The lack of a second theatre had been identified as a risk. There was no reliable plan to resolve this issue. There was no plan or timetable in place for the development of midwife-led unit. The main theatre had problems with its ventilation and was an infection control risk.

Staff did not meet the trust target for mandatory training.

However, the service had some of the best rates across England, for home birth and for breast feeding. In addition, the trust had appointed three new consultants and they were making a positive contribution to the service. Patient records were

Summary of findings

up-to-date and accurate and the areas we visited were clean. The service had responded to the local demand for variety of menus and alternative treatments in the form of aroma therapy. The service had introduced an advanced recovery programme in gynaecology. They ran one-stop clinics for women and their babies who were vulnerable as a result of their circumstances. The service had a committed team of midwives and nurses and an active Maternity Services Liaison Committee with participation from local parents and their families.

We held a focus group at the Royal Sussex County where 20 staff attended. In addition we spoke with a further 40 staff from all areas of gynaecology and maternity. We spoke with the leadership team, specialist midwives and managers working at ward level. We spoke with ten patients from gynaecology and maternity. We also looked in detail at 10 sets of patient records.

Services for children and young people

Outstanding



We rated the children and young people's services as outstanding.

The service had a clear and robust process which ensured that incidents were reported and investigated and that lessons learned were shared with all staff to reduce the risk of recurrence. All ward areas were visibly clean and all exceeded the required standard in regular hygiene checks. Staff had a clear understanding of their safeguarding role and responsibilities and there was an excellent system to provide high quality child protection medicals when needed. Patient risks were appropriately identified and promptly acted upon with clear systems to manage a deteriorating patient.

There were innovative and pioneering approaches to care with evidence-based techniques and technologies used to support the delivery of high quality care and improve patient outcomes. Patient outcomes were consistently better than the national benchmark, including patients with asthma, diabetes, referral to treatment times and readmission rates. Staff adopted a holistic approach to assessing, planning and delivering care and treatment to children and young people who used the service.

Summary of findings

Staff at all levels were strongly motivated to provide reassuring and compassionate care to both patients and their families, including siblings, and demonstrated a passionate commitment to this. Staff used highly innovative ways to ensure that the views of children were heard and made use of this to develop the service in ways which improved their experience. Parents were unanimous in their praise of the service and reported that staff went “the extra mile” to support them as well as their child. Parents were considered to be active partners in their child’s care, and staff took great care to ensure that individual needs of both patient and families were met.

We rated the responsiveness of the service to the needs of patients and their families as good. The service was tailored to meet the needs of individual people and was delivered in a way to ensure flexibility, choice and continuity of care. Services were flexible, provided choice and ensured continuity of care. Integrated person-centred pathways were developed with other providers that ensured the holistic needs of children and young people were met through shared working and information sharing.

We rated leadership as good. There was clear evidence of dynamic and innovative leadership within the nursing teams. We saw numerous examples of innovative developments to improve the patient experience and patient care. However, the vision and strategy of the service was not well communicated within the hospital and there was some evidence of teams working in silos. Links with the trust were limited with no non-executive director lead on the Board and no formal mechanism for ensuring that the voice of children was represented at board level.

End of life care

Good



Overall we rated the end of life care service at the Royal Sussex County Hospital good for safe, caring, responsive and well-led and requires improvement for effective.

The duty of the inspection was to determine if the hospital had policies, guidelines and training in place to ensure that all staff delivered suitable care and treatment for a patient in the last year of their life. The hospital provided end of life care training at

Summary of findings

induction for staff and an ongoing education programme which was attended by staff. A current end of life care policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained. The specialist palliative care team were a dedicated team who worked with ward staff and other departments in the hospital to provide holistic care for patients with palliative and end of life care needs in line with national guidance.

The Royal Sussex County Hospital and its staff recognised that provision of high quality, compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team, end of life care guidelines and an education programme. The palliative care team was highly thought of throughout the hospital and provided support to clinical staff. The team worked closely with the end of life care facilitator to provide education to nurses and health care assistants. Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals.

The majority of end of life care was provided by clinical staff on the wards. The palliative care service worked as an advisory service seeing patients with specialist palliative care needs, including those at the end of life.

Staff at the hospital provided focused care for dying and deceased patients and their relatives. Most of the clinical areas in the hospital had an end of life care link person. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.

Staff in the mortuary, bereavement office, PALS and chaplaincy supported the palliative care teams and ward staff to provide dignified and compassionate care to end of life care patients and their relatives. Medical records and care plans were completed and contained individualised end of life care plans. Most contained discussions with families and recorded cultural assessments. The DNACPR forms were all completed as per national guidance.

Summary of findings

There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. These referrals were seen and acted upon promptly. The trust had an advance care plan which supported a patient to develop their wishes and preferences. The plan could be located in the patient's health record on admission and was accessible to the out of hour's community service. The trust had a Rapid Discharge Pathway (RDP) and the documentation for this process was available on the end of life care intranet site which staff could access. The discharge team worked closely with the specialist palliative care team and coordinated the discharge of end of life care patients across the trust. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.

The trust had a multi professional end of life steering group that oversaw the improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also meeting the National Institute of Health and Care Excellence's (NICE) end of life guidance. The end of life care service had board representation and was well led locally. This had resulted in a well led trust wide service that had a clear vision and strategy to provide a streamlined service for end of life care patients.

However:

We found there was not a specific cleaning schedule and procedure for cleaning of the mortuary as per national guidelines.

Portering staff did not receive a specific training programme with appropriate updates for transfer of the deceased to the mortuary, as per national guidelines.

The trust was not meeting the requirements of three key performance indicators of the National Care of the Dying Audit 2014. In their response to the audit in the End of Life Audit- Dying in Hospital 2016 the trust was worse than the national average for two areas.

There were inconsistencies in the documentation in the recording of spiritual assessments, Mental Capacity Act assessments and recording of ceilings

Summary of findings

of care (best practice to guide staff, who do not know the patient, to know the patients previously expressed wishes and/or limitations to their treatment) for patients with a DNACPR. Patients did not have access to a specialist palliative support, for care in the last days of life in all cases, as they did not have a service seven days a week.

Outpatients and diagnostic imaging

Inadequate



Overall we found the outpatient and diagnostic imaging departments to be inadequate. We identified areas of significant concern with regard to infection control. The outpatient areas did not consistently comply with hospital building notes in relation to infection control. Compliance with infection control training was poor. The most recent infection control audit score for the outpatient department was below the target score. There appeared to be no action plan following it. Not all clinic rooms had cleaning checklists. Not all staff were confident to report incidents, incidents were not always discussed at staff meetings and there appeared to be no learning from incidents. Compliance with mandatory training was poor. We identified concerns about the storage and security of hospital prescription forms. Resuscitation trollies were not tamper proof and, although drugs were kept in sealed boxes, they were not stored securely. Confidential medical information was not always stored securely and around 4,500 medical records had gone missing each month. The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. We saw that staff on the whole had a good awareness of National Institute for health and Clinical Excellence (NICE), although some staff in outpatients were unaware what a NICE guideline was. We saw competency documents, which indicated staff were competent to perform their roles.

Summary of findings

Patients were not always treated with dignity and respect. We saw staff did not always consider the privacy of patients. Staff did not always introduce themselves to their patients. We witnessed breaches of confidentiality in patient waiting areas. The trust had failed to meet the England standard for referral to treatment (RTT) times since September 2014. The trust had failed to meet cancer waiting and treatment times.

The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.

Call centre data indicated almost half of all calls had been being abandoned and unanswered. Of all appointments cancelled by the hospital, 60% were cancelled with less than six weeks' notice. There was no monitoring of overrunning clinics by managers. Staff recorded clinic delays on an ad hoc basis.

There was no formal strategy or vision in place in the outpatient department. Not all staff felt they could approach their managers for support. Senior managers and the executive team were not always visible to staff in the department.

The trust had won an NHS innovation award for the implementation of a virtual fracture clinic which cut the number of times patients had to go to the hospital.

Royal Sussex County 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;

Detailed findings

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Background to Royal Sussex County Hospital

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital with two sites the Royal Sussex County Hospital in Brighton (centre for emergency and tertiary care) and the Princess Royal Hospital in Haywards Heath (centre for elective surgery). The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital.

Providing services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.

Out of 326 authorities, Brighton & Hove is ranked 102nd most deprived authority in England in 2015. This means they are among the third (31%) most deprived authorities in England

The health of people in Brighton and Hove is varied compared with the England average. Deprivation is higher than average and about 17.7% (7,700) children live in poverty. 13.3% (294) of children are classified as obese, better than the average for England. The rate of alcohol

specific hospital stays among those under 18 was 63.1%, worse than the average for England. The rate of smoking related deaths in adults was worse than the average for England.

The health of people in Mid Sussex is generally better than the England average. Deprivation is lower than average, however about 7.7% (2,000) children live in poverty. Life expectancy for both men and women is higher than the England average. 11.6% (147) of children are classified as obese, better than the average for England.

The Trust has 1,165 Beds; 962 General and acute, 74 Maternity, and 43 Critical care. It employs 7,195.92 (WTE) Staff; 1,050.59 of these are Medical(WTE), 2,302.52 Nursing (WTE), 3,842.81 Other.

It has revenue of £520,761m; with a full cost of £521,218m and a Surplus (deficit) of £457k.

Between 2015-2016 the Trust had 118,233 inpatient admissions; 640,474 Outpatient attendances, and 156,414 A&E attendances.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper Consultant

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

Detailed findings

The team included CQC inspectors and a variety of specialists: including consultants in Surgery, Medicine,

Paediatrics, end of life care, senior nurses, a non-executive director, a director of nursing, allied health professionals and experts in facilities management, governance, pharmacy, and equality and diversity.

How we carried out this inspection

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch team.

We spoke with staff, patients and carers via email or telephone, who wished to share their experiences with us.

We carried out the announced inspection visit on 4-8 April 2016 and returned for an announced inspection on 16 April.

We held focus groups and drop-in sessions with a range of staff in the hospital including; nurses, junior doctors, consultants, midwives, student nurses, staff side representatives, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from the majority of ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about Royal Sussex County Hospital

Trust wide Safe:

- The trust have reported seven never events between Jan' 15 to Jan' 16, all seven were attributed to surgery and four of which were related to wrong site surgery incidents. All never events took place between June to December 2015. All reported within Surgery. Wrong site surgery accounts for the majority (4).
- 98% of NRLS incidents were rated as low or no harm.
- The trust reports lower incident numbers compared to the national average.
- There have been 54 serious incidents reported between Jan' 15 and Jan' 16.
- Safety thermometer Public Health observatory data for Dec' 14 to Dec' 15 reports low numbers of MRSA (2) compared to MSSA (21) and C.Diff (58).
- Between December 2014 to December 2015 there have been two MRSA cases.
- C. diff cases have peaked above the England average 7 out of 12 months.
- Safety thermometer data for Jan' 15 to Jan' 16 shows a decline in the number of Pressure ulcers and Falls and consistent C.UTIs reported across the time period. From

Apr' 14 to Jul' 15 ambulance median time to initial assessment was significantly higher than the England average however fell to below the England average from Aug' 15 to Oct' 15

- Medical skill mix is similar to the England average for all staffing groups.

Trust wide Effective:

- Unplanned re-attendances to A&E within seven days percentages were consistently higher than the England average throughout the period Sep' 13 to Oct' 15
- Unplanned re-attendances to A&E within seven days percentages were consistently higher than the England average throughout the period Sep' 13 to Oct' 15
- Trust scores in the CQC A&E survey 2014 were rated as "about the same as other trusts" for questions relating to the effective domain.
- Trust scores were within the upper England quartile for three of the measures in the 2013 RCEM Consultant Sign-off Audit

Detailed findings

- Scores for Royal Sussex County Hospital (RSCH) in the severe sepsis and septic shock 2013/14 audit were within the upper England quartile for two, in the lower quartile for four and between the upper and lower quartile for the remainder of the 12 measures audited
- RSCH scores in the assessing for Cognitive impairment in older people audit 2014/15 were within the upper and between the upper and lower England quartile for the five measures audited.
- Asthma in children's audit 2013/14 placed the Royal Alexandra Children's hospital in the upper England quartile for five, and in the lower quartile for two of the seven measures.
- Mental health in the ED 14/15 audit for RSCH scores were in the lower England quartile for four of the eight measures and between the upper and lower quartile for the remainder.
- No mortality indicators highlighted as a risk for this trust.
- There are no mortality outliers for this trust.
- Cancer patient experience survey, has eight measures in the bottom 20% comparable to other trusts, four measures were within the top 20% and the remaining were in the middle 60% comparable to other trusts.
- Paracetamol overdose audit 2013/14 scores at Royal Sussex County Hospital were in the upper England quartile for three of the four measures audited and between upper and lower quartile for the remaining one measure.

Trust wide Caring:

- The percentage who would recommend the trust (FFT) is lower than the England average for the whole time period until the most recent data for Dec '15, where it is currently above the England average.
 - CQC inpatient survey 2014, the trust scored about the same compared to other trusts for all measures.
 - Patient-led assessments of the Care Environment (PLACE) were found to be better in each audit from 2013 to 2015, however Privacy, dignity and wellbeing and Facilities have declined over the time period from previous scores.
- The standardised relative risk of re-admission for elective procedures at Princess Royal Hospital for elective procedures were 33% higher than the England average noticeably for General Medicine (across all sites) and Clinical Haematology.
 - Scores in the National Diabetes Inpatient Audit 2013 (NaDIA) at Royal Sussex County Hospital were worse than the England average for 17 of the 20 measures audited but better for the remaining three measures.
 - MINAP 2013/14 scores at Royal Sussex County and at Princess royal Hospitals were lower for two of the three measures compared to 2012/13 scores and lower than the England average for two of the three measures.
 - The standardised relative risk of re-admission at Royal Sussex County Hospital for both elective and non-elective procedures were mostly the same as the England average.
 - Trust scores in the Sentinel Stroke national Audit programme (SSNAP) for combined total key indicators (patient centred and team centred) at Princess Royal Hospital declined from C to D in the Jul' to Sep' 15 quarterly audit. Whereas the combined total key indicators improved from D to C at the Royal Sussex County Hospital in the same period.
 - In the 2012/13 Heart failure audit Royal Sussex County Hospitals scored below the England average for in hospital care measures and mostly the same for discharge care measures whereas Princess Royal Hospital score below for in hospital measures and better than the England average for two of the seven discharge care measures.
 - NaDIA 2013 scores for Princess Royal Hospital were better than the England average for seven of the 19 measures but worse for the remaining 12 measures.
 - The percentage of patients seen within four hours were consistently lower than the England average and lower than the 95% target throughout the period Sep' 13 to Dec' 15.
 - The total time spend in A&E was consistently longer than the England average throughout the period Sep' 13 to Oct' 15.
 - The percentage of patients waiting four to twelve hours from decision to admit to being admitted through the A&E were consistently worse than the England average for the period Jan' 15 to Dec' 15.
 - The percentage of patients leaving before being seen were worse than the England average for the majority of months between Sept' 13 – Nov' 15

Trust wide Responsive:

Detailed findings

- The trust were rated as “about the same as other trusts” for all the questions in the A&E survey 2014 pertaining to the responsive domain.
- Delayed transfer of care between Apr’ 13 and Aug’ 15 has the top three reasons as waiting for further non acute NHS care (46.6%) patient or family choice (20.7%) and awaiting care package in own home (12.3%).
- Bed occupancy is below the national average between Q1 14/15 to Q1 15/16 the most recent data up to Q3 15/16 has it above the England average.
- The number of complaints have varied between 1,338 to 1,126 over the five year financial period.
- Since 2012/13 there has been a slight decline in the number of complaints with the lowest number reported in 2013/14 (1,126).

Trust wide Well-Led:

- General Medical Council 2015 national training survey highlights the trust score about the same as other trusts for all but two measures where it scored worse for Induction and Feedback.
- In the NHS Staff survey 2015 the trust has improved its score across most measures, it scored better than other trusts in 16 measures compared to the 2014 survey, where the trust scored worse than other trusts for 20 measures and was found to be similar to other trusts for all other questions.

Our ratings for this hospital

Our ratings for this hospital are:




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

Detailed findings

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The Royal Sussex County Hospital (RSCH) provides accident and emergency services in the emergency department (ED), the Urgent Care Centre (UCC) and additionally at the Children’s ED department located at the Royal Alexandra Children’s Hospital, which is co-located at Brighton.

Paediatric patients with injuries due to trauma are assessed and treated in the main ED before being transferred to the Children’s hospital or discharged as appropriate. The paediatric ED team are called by pager to attend when a child is admitted to the main ED. There were 340 patients aged between 0-16 years old treated in ED at RSCH between April 2014 – December 2015. Further details about the paediatric emergency services are contained in the children’s and young person’s section of this report.

RSCH ED is located within the “acute floor” directorate, which includes UCC, acute medicine and critical care.

The department had a total number of 156,358 attendances between 2014 - 2015. This represents a significant increase compared to the previous two years when an average of 82,000 adults attended annually. Of attendances, 24.6% resulted in admission, which is worse than the England average of 22.2%.

Patients arriving at the ED by ambulance are taken into the department through a designated entranceway where they are assessed by a nurse in a two-bay

assessment area. The triage nurse prioritises patients for treatment depending on the severity of their needs and allocates them to the appropriate area of the ED for treatment.

Patients who self-present to the ED are booked in by a receptionist and directed to the UCC where they are assessed by a nurse and then allocated to the appropriate area within the department.

The ED comprises of a five-bay resuscitation area (Zone 1), 14 spaces and two side rooms for treating major cases (Zone 2a), a two-bay patient assessment triage area, a “cohort” area (corridor) and 12 further treatment bays and one side room (Zone 2b). In addition, there are two areas utilised as clinical assessment or holding units (a 6-bed unit named ‘short stay ward’ with one side room and a six -bed unit named ‘clinical decision unit’).

We reviewed data and a variety of information supplied to us prior to and during the inspection. We also received information from members of the public who contacted us to tell us about their experiences both before and during the inspection. In addition, we also reviewed performance data provided by the trust.

The CQC held 29 focus groups where staff could talk to inspectors and share their experiences of working at the hospital.

During our inspection, we reviewed notes and papers and spoke to over 40 members of staff. We visited all areas of ED and UCC and were able to observe care being delivered in each of the clinical settings.

Urgent and emergency services

Summary of findings

Overall, we found that services at Royal Sussex County Hospital were 'Inadequate'. This was because:

- The ED did not adequately protect patients from avoidable harm.
- Whilst the trust had undertaken initiatives to resolve capacity issues frequently affecting their ability to move patients through the emergency care pathway, the ED was still not consistently meeting national targets. Patients therefore experienced delays, some of which were significant. One cause of this was a lack of available hospital beds due to "exit block" of patients deemed medically fit for discharge awaiting appropriate placement in the community or support packages for home care.
- There was insufficient flow through the department, which meant it was not able to meet capacity demands.
- The ED environment did not meet the needs of patients.
- Levels of mandatory training and appraisals fell well below the trust targets.
- There was a lack of assessment of patient's conditions before they were placed in the 'cohort' area.
- There was a lack of clinical ownership of patients in the 'cohort' area.
- Patients were not protected from harm in the 'cohort' area and their respect and dignity was compromised whilst in this area.
- There was a lack of nursing and medical leadership to support the department.
- Staff morale was low which may be hindering recovery and performance.

Are urgent and emergency services safe?

Inadequate



We rated ED Inadequate for 'Safe' because:

- The environment within ED was not adequate to meet patient demand. There were frequent occasions during the inspection when the number of patients requiring treatment exceeded the number of cubicles available. This meant that patients spent long periods of time waiting in the 'cohort' area, a corridor immediately adjacent to the ambulance entrance and handover bay. We concluded that the systems in place to monitor these patients were unsafe; their privacy and dignity was not maintained and patients were not provided with adequate nutrition and hydration.
- There was a lack of medical leadership and ownership of the patients in the 'cohort' area which meant patients were put at risk because they were not adequately assessed or monitored. This meant opportunities to prevent or minimise harm could be missed.
- The 'cohort' area was previously identified as a risk during our comprehensive inspection in May 2014 and we issued a compliance action instructing the trust to ensure service users are protected against the risks associated with unsafe or unsuitable premises. We raised concerns again following a focussed inspection in June 2015; however the actions taken by the trust since our last inspections remain insufficient to mitigate the risk.
- Between 1st January 2016 – 31st March 2016, 6623 patients waited in the 'cohort' area and according to information provided by the trust, the most time a patient spent in the corridor was 12 hours 53 minutes.
- Overcrowding in the 'cohort' area of the ED meant the privacy and dignity needs of patients were not consistently met and in the interim, the use of the 'cohort' area has become more normalised practice.
- We found that the risk assessments used for placing people in the 'cohort' area were not sufficient and patients sometimes received nursing care – by a combination of ambulance paramedics and ED staff - without appropriate monitoring. The responsibility for

Urgent and emergency services

ongoing care seemed arbitrarily allocated and confusingly signposted, as described to us, by an informal system of either leaving or taking gloves off the bottom of the respective patient trolley.

- Staff told us that there was no limit set on the maximum number of people who could be cared for in the 'cohort' area. During our observations, we saw up to nine patients held or 'stacked' at one time. We were told at a focus group that this number could be up to 20 or more.
- Overall, we found that there was a lack of systems, processes and practices in place to keep patients safe within the 'cohort' area, there were no systems in place for the management of overcrowding in the 'cohort' area. Staff were not able to provide satisfactory details of "full capacity" protocols or triggers used to highlight demand exceeding resources to unacceptable levels.
- We found two cubicles within ED (zone 2b), which were not being used. When we asked, we were told this was due to a lack of nurse funding. However, we subsequently observed a nurse leader utilizing this space by preference.
- We saw also that the medical leadership was not clearly defined and there was a lack of clinical responsibility or senior assessment of the patients waiting in the 'cohort' area.
- Nursing leadership was poorly organised with no single individual providing strategic nursing direction.
- We saw up to three senior nurses coordinating on each shift; however their roles and responsibilities were not clearly defined. There was a lack of communication between the multidisciplinary team (MDT) which led to delays and confusion.
- Junior nursing staff lacked clear managerial supervision.
- The inspection team felt that the leaders working in ED were not acutely aware of all the patients present in the department and this affected patient safety.
- Staff told us that the trust's senior management lacked understanding of their challenges and trying to make changes was so difficult staff became despondent and often gave up.
- We were told there was no funding available to make improvements that may influence change and long-term outcomes, however there was planned building work scheduled to create additional cubicle space.
- We found staff morale to be extremely low. Staff reported feeling stressed and said they spent their time "firefighting" to the detriment of patient care. Some appeared despondent and seemed unable to lift themselves out of the situation they felt they were in.
- Staff told us that nurse staffing requirements had not been reviewed since the hospital became a trauma centre and were no longer in line with the department's needs.
- The monthly planned staff hours for registered nurses during the daytime was 218.5 hours, although during the month of March 2016 the monthly actual staff hours was below this figure nearly two-thirds (61%) of the time.
- Staff compliance in mandatory training, statutory training and appraisals fell well below the trust target of 95% for statutory training and 100% for mandatory training, for both nurses and doctors.
- The levels of documented safeguarding training among ED staff required improvement to protect patients from abuse.
- Staff told us that poor behaviour and work performance was tolerated and not challenged.
- The Hospital Rapid Discharge Team (HRDT) had an assessment area within ED that demonstrated good practice. The Discharge team provide support and advice to staff, patients and their families for the management of safe and timely discharge home or to further care settings. The department worked closely with other members of the multidisciplinary team and the assessment process commenced early in ED to minimise delays.
- Despite intense operational pressure staff generally had a caring and compassionate attitude towards patients.
- **Incidents**
- Some of the data supplied to us was trust wide and not split into sites. We were shown a summary of 20 serious incidents (dating from 2011 – 2016) and 478 safety incidents (2015 – 2016) where we were able to identify as from RSCH. Of the latter, 419 incidents (87%) resulted in no harm to the patient.
- Incident reports were analysed to identify trends. For example, all falls and pressure ulcers for patients in ED were recorded and analysed to increase staff awareness. Incidents relating to staffing, facilities and environment were the most commonly reported category of incident (107), accounting for 22% of the total.

Urgent and emergency services

- The incidents we reviewed revealed a number of patient safety concerns. For instance:
 - All cubicles in 2A and 2B full. Cubicles one and side room two had high acuity patients (measurement of the intensity of nursing care required by a patient) which should have been in the resuscitation department with only one nurse to monitor and care for them.
 - A patient in cubicle one had a seizure and suffered a cardiac arrest. The arrest trolley in cubicle one was not appropriately stocked and had no defibrillator pads or oxygen mask. The arrest trolley check list had been signed indicating it had been checked and was correct for that day.
 - A patient in cubicle two had a glyceryl trinitrate (GTN) infusion (a drug used to treat angina) which had not been checked at the start of the shift. The cannula was not working which meant the patient had not received any of this critical medication.
 - A patient with respiratory failure required bilevel positive airway pressure therapy (BIPAP - a machine to assist with breathing) and was in the side room, a side room is not considered a safe environment for a patient with this condition. The commencement of BIPAP was delayed as the nurse was transferring patients to the ward.
- These examples demonstrate that patients were not adequately protected from avoidable harm, due to inadequate flow through the department, and of these incidents 108 out of the 153 included concerns regarding capacity, full department, 'cohort' area and UCC.
- There was an incident where a patient who had suffered a cardiac arrest whilst in the 'cohort', area reported in February 2016. The nurse in the cohort area had escalated her concerns regarding the patient to the coordinator but there was no space available elsewhere for the patient. The patient then suffered a cardiac arrest and had to undergo cardiopulmonary resuscitation (CPR).
- We found there was a strong culture of incident reporting and staff told us they were encouraged to report incidents; however staff reporting incidents also reported not having enough time to report every patient safety incident that occurred within the 'cohort' area. Additionally staff told us they did not see any changes to practice as a result of reporting incidents.
- Of the 153 incidents reported in the 'cohort' area, 141 of these were graded as "No harm/Impact prevented" including the examples above. The investigation information stated that work streams are in progress to deal with the issues and therefore no learning or action to prevent repetition was required. This demonstrates that the severity grading of incident may not be robust, the seriousness of incidents not acknowledged and that opportunities for learning were missed.
- Other themes of incidents reported include; reference to lack of joined up working with other areas such as surgical assessment unit, many inappropriate treatments carried out in UCC, poor patient experience, lack of privacy and dignity and lack of patient trolleys.
- If an incident is assessed as a serious incident it is reported using StEIS (Strategic Executive Information System). Serious incidents can include but are not limited to patient safety incidents for example loss of confidential information. Any serious incident which meets the definition of a patient safety incident should be reported to both StEIS and (NRLS).
- There were five serious incidents reported between January 2015 – January 2016 in ED at RSCH there was no theme to these incidents. We were told that serious incidents were discussed at the ED safety and quality meeting. We looked at minutes from the meetings and confirmed this.
- The trust has implemented some innovative ways of sharing information from serious incidents including a 2-4 minute podcast made after every Serious Incident (SI) investigation. This is for staff to listen to or play at team meetings as the basis for discussion.
- There had been no reported never events in the previous 12 months. (Never Events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented, so any Never Event reported could indicate unsafe care.
- The trust produced a "patients 1st" safety bulletin which contained anonymised accounts of incidents, the lessons learned from each and remedial actions taken by the trust. This has been produced monthly since 2011 and we saw evidence of this. The bulletins are emailed to all trust staff on the 1st day of every month with a request to print off and share with any staff that do not regularly access emails.

Urgent and emergency services

- The Chief Executive published a weekly message which included a 'Spotlight on Safety' section where current safety issues are highlighted.
- In the 2014 staff survey 11% of staff felt they were not treated fairly when involved in an error compared to 5% in 2013, this suggested not all staff thought there was a fair transparent process when involved in incidents.
- Learning from incidents was discussed at the daily acute floor meetings as part of a safety briefing however, junior nursing staff were not able to attend these meeting.
- We reviewed minutes from monthly emergency department operational meetings and acute floor directorate safety and quality meeting, and noted that attendance at these meetings was not recorded.
- We saw that staff, patients and relatives were supported and informed of the outcome in accordance with the trust's Duty of Candour (DOC). 'The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust had a DOC policy, DOC template letters and patient information leaflets regarding DOC, and we saw evidence of these. The trust kept appropriate records of incidents that had triggered a DOC response which included a DOC compliance monitoring database, and the trust's patient safety form included prompts to ensure DOC conversations were undertaken when incidents were graded as moderate or above and we saw evidence of this.
- The trust provided DOC compliance data as of 1st April 2016 77% of patients had a DOC conversation within 10 days, 71% of patients received a DOC letter within 10 days and 51% of DOC reports were completed within 60 days.
- We found that staff were confident in describing the process to us. Whilst some staff did not always understand the terminology, the process they described in communicating with patients and their relatives reflected openness and transparency.
 - **Cleanliness, infection control and hygiene**
- There were infection prevention and control policies and procedures in place that were readily available to all staff on the trust's intranet.
- There were no methicillin resistant Staphylococcus aureus or C.difficile (forms of bacteria) acquisitions associated with the ED between April 2015 - October 2015.
- The cleaning of the department was undertaken by domestics employed by the trust, and we observed that the department appeared clean in most areas during our inspection and the staff we spoke with did not report any infection control issues. Staff told us that the domestic cover was poor, the workload was too much and the department was often dirty with overflowing bins and dirty toilets, however in last few weeks prior to the inspection the department has been thoroughly cleaned and painted.
- We observed that some parts of the department were in need of redecorating and updating particularly the floor covering throughout the department.
- There were designated staff with infection control responsibilities and side rooms were available for patients presenting with a possible cross-infection risk. We found that staff were generally aware of the principles of the prevention and control of infection (IPC.) However we observed equipment in the assessment area was not cleaned in between patients for example monitoring equipment.
- We saw that regular infection prevention and control audits took place in order to make sure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE.). For the month of January 2016, the hand hygiene score was 75%.
- Infection prevention and control was included in the trusts mandatory training programme, however only 35% of clinical staff and 50% of non-clinical staff had completed training.
- We noted that staff did not regularly use hand gel on entering clinical areas and between patients. Staff in the triage area changed their gloves between patients but did not wash their hands, despite hand washing sinks being readily available with sanitising hand gel. We saw multiple instances where the five moments for hand hygiene World Health Organisation (WHO) guidelines were not adhered to.
- We observed during the inspection that the CD register in the resuscitation department had blood on it, the blood testing machine in the resuscitation area and an infusion pump were splattered with blood and the 'bare below the elbows' policy was not consistently adhered

Urgent and emergency services

to, we observed staff wearing cardigans and fleece jackets which is against trust policy. There was no clinical room to prepare intravenous drugs and infusions. We saw this procedure being carried out on the majors' computer desk and at the staff station, which was a potential infection control risk

- Personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas but equipment was not marked with a sticker when it had been cleaned and was ready for use.
- The overcrowding and close proximity of trolleys in the cohort area constituted an infection control risk because they could be touching each other which increased the risk of skin to skin contact between patients in the cohort area.
- The trust had a waste management policy, which was monitored through regular environmental audits. We saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely. We noticed posters and information cards explaining waste segregation procedures and waste segregation instructions.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Domestic staff told us that the food waste disposal unit had been broken for the last eight months and they had to use the sluice in the short stay ward. We saw the broken waste disposal unit was not sealed off from use and was covered in food waste.
- The cleaning of the hospital was undertaken by trust staff. Cleaning equipment was colour-coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately.
- **Environment and equipment**
 - Zone 2a major treatment area had 14 cubicles and Zone 2b had 12 cubicles. The nursing station was central to the majors' area and had obstructed views of some of the cubicles. It was not possible to view the 'cohort' area, where many patients were cared for at times of high activity. We saw that there was a member of staff who was assigned to the patients in the 'cohort' area but they frequently had to return to the nursing station to complete tasks and collect equipment and medication this meant they could not observe their patients.
 - The trust's ambulance handover and cohort standard operating procedure stated, 'Four is the maximum number of patients that RSCH staff, without south east coast ambulance service (SECamb) support, will be responsible for in the cohort/assessment area.'
 - We observed hospital ambulance liaison officers (HALO's) working within the 'cohort' area, their role was to supervise and care for patients in the 'cohort' area, when patient numbers rose above four. We saw this happen on multiple occasions during the inspection. In order to identify which patients the HALO was responsible for a disposable glove was tied to the patient's trolley as a visual reminder.
 - We saw that there was a nurse allocated to the 'cohort' area, however we observed they were rarely in the area and the HALO supervised and cared for all the patients in this area.
 - Between 18th January 2016 and 24th January 420 patients were placed within the 'cohort' area the average time each patient spent in the 'cohort' area was 37.5 minutes.
 - We observed that there was no piped oxygen, suction within the 'cohort area' and there was insufficient monitoring equipment.
 - We observed that not all cubicles had a call button, which meant patients were unable to summons help if they needed assistance.
 - The inspection team noted signage within the department could be improved for example signs indicating where emergency equipment was located, for staff members not familiar with the department.
 - The x-ray department and computed tomography (CT) scanning facilities were adjacent to the A&E departments and were easily accessible.
 - We saw there were systems in place to monitor, check and maintain equipment. We saw records of the monthly equipment checks and servicing that took place. All the equipment we saw had been labelled to verify it had been electrically tested within the past year.
 - The medical equipment and devices management group had a meeting every three months and we have reviewed minutes of these meetings, and we saw evidence of a comprehensive equipment database and medical devices replacement programme.
 - Emergency resuscitation equipment was available in each area and had been routinely checked.

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- We observed that the urgent care centre (UCC) was not fit for purpose; it was cramped with not enough seats for the patients, there were door handles missing, holes in the walls and was generally unkempt.
- The waiting area within the UCC did not allow the triage nurse direct line of sight to patients who were waiting to be seen by a healthcare professional. Nursing staff we spoke to had raised this as a risk and, staff often had to leave the UCC to obtain equipment/ medication from other areas in the department which adversely affects the productivity within UCC.
- There is no procedure room in UCC for suturing wounds or minor procedures which added to the congestion for clinical space.
- There is no sluice within the UCC therefore staff must walk to the back of zone 2a to use facilities.
- The UCC is currently undergoing a development project aimed at improving the patient and staff experience.
- **Medicines**
 - We carried out medicine checks in ED at RSCH and found all stock drugs to be stored appropriately and in date. Medicines were stored in dedicated medicine fridges when applicable and records demonstrated that the temperature of refrigerators used were being kept and that medicines were being stored within recommended temperature limits.
 - We saw evidence that staff checked stock balances of controlled drugs (CDs) daily. CDs are medicines which are controlled under the misuse of drugs legislation. We reviewed the CD register and found 28 omissions including the dosage of the amount of the drug given was not recorded and missing witness signatures. Audits of medicines security (including controlled drugs) were undertaken, and between November 2015 – January 2016 there was 24 unaccounted for CD's.
 - Staff were unable to tell us what provision pharmacy provided to ED, however pharmacy services are available Monday to Friday 9am-5pm, with no out of hours service available.
 - We reviewed a sample of medication and administration (MAR) charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on charts and patients wore a red identity wrist band if they had an allergy.
 - Medication incidents are reported via the trust reporting systems, there was 63 medication errors in RSCH and PRH ED departments between October 2015 - January 2016, 37% of these were the wrong quantity of drug administered.
 - Prescribing guidelines are developed in line with best practice (national institute health and care excellence (NICE) and NHS Protect)
 - Patient group directions (PGD's) are written directions that allow the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition.
 - Staff were supplying or administering medicines via patient group directions. However these PGDs were all past their review dates and not all the copies used by staff had been authorised by the organisation.
 - Room temperatures were not monitored where medicines were stored and staff expressed concern at "how warm the rooms could get".
 - Emergency medicines including oxygen and equipment were available. Whilst these were checked daily they were not tamper evident therefore we were not assured that they were always available for use.
 - We found that medicine cupboards were orderly, neat and tidy
 - We saw that there was robust management controls for the security on CD cupboard keys and drug rooms could only be accessed with a swipe card.
 - We saw that the management of CDs was in accordance with the Misuse of Drugs Act (1971) Regulations (in England, Wales and Scotland) and statutory measures of the Health Act (2006) and associated Regulations.
- **Records**
 - The department used a mainly paper based system of recording care and treatment.
 - An electronic patient system ran alongside paper records and allowed staff to track patients' movement through the department and to highlight any delays.
 - We looked at 13 medical and nursing records and found they were not always complete with assessments missing such as tissue viability assessment, pain score assessment and falls risk assessment.
 - We reviewed the records of patients presenting with self-harm injuries and a known dementia patient these patients had not had a mental capacity assessment or mental health risk assessment completed.

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- Patients' records were not managed in accordance with the Data Protection Act 1998. Records in the 'cohort' area were not kept securely preventing the risk of unauthorised access to patient information.
- In addition there was a communication board within the staff base which was visible to the public, information displayed on this board included patient's name and diagnosis. This breaches the 1998 Data Protection Act.
- In general, medical records were accurate and fit for purpose and completed to a good standard.
- Between November 2015 – January 2016 there was 14 incidents of inadequate documentation when patients' records were audited by the trust.
- We saw some patients presenting to the ED followed standardised pathways, which was personalised through individual risk assessments and notes made in the care plans. For example patients attending with suspected sepsis (infection.)
- The care records included multidisciplinary input where required, for example, entries made by occupational therapists.
- **Safeguarding**
 - The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on its intranet. Staff demonstrated accessing this policy to the inspection team and found the policy easily and quickly.
 - Overcrowding in the 'cohort' area meant vulnerable patients could be at risk from harm from other patients in agitated or anxious states, particularly if under the influence of alcohol and or drugs.
 - We observed a female patient who was in an agitated state who repeatedly tried to abscond from the 'cohort' area; the HALO allocated to this area was left supervising this patient.
 - We observed a female patient who was crying and in obvious distress left in the 'cohort' area with six other patients.
 - We were not assured there was sufficient safeguarding arrangements in place to protect patients from harm in the 'cohort' area.
 - There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team the names and contact details were displayed in the department.
- There were systems in place to make safeguarding referrals if staff had concerns about a child or vulnerable adult.
- Safeguarding children training was included in the trust's statutory training programme, 57% of emergency nurse practitioners (ENP's) (who work cross site) had undertaken safeguarding children level three training and 42% of nursing staff had completed level three training. This was worse than trust target of 100%.
- Only 19% of medical staff (who work cross site) had completed safeguarding children training and only 18% of medical staff had completed safeguarding adults training. This was worse than the trust target of 100%
- Safeguarding Adults training is included in statutory training 50% of ENP's have completed this training and 81% of nursing staff have completed the training. This was worse than the trust target of 100%
- We consider the poor compliance with safeguarding training a significant risk, both children and adults may be at risk of harm due to inadequate knowledge and training of staff.
- We saw there were posters displayed in the department advising staff and the public of the steps to take if they felt a person in vulnerable circumstances was being abused, or at risk of abuse.
- **Mandatory training**
 - The ED department separated training into mandatory and statutory training. Staff told us mandatory and statutory training was a mixture of on-line training and face to face training.
 - Overall only 14% of medical staff had completed statutory training, this was worse than the trust target of 100% and 42% of nursing staff had completed statutory training, 39% ENP's had completed statutory training, this was worse than the trust target of 100%.
 - Of the remaining staff groups 47% of staff had completed mandatory training, this was worse than the trust target of 100%. Only 13% of medical staff had completed mandatory training, 53% of nursing staff, 37% of ENP's this was worse than the trust target of 95%.
 - Current health and safety law (RIDDOR 1995) places an obligation on employers to provide training in the use of infusion devices. Only 13.33% of staff had received infusion pump training this is worse than the trust target of 95%.
 - Information governance ensures the appropriate use and protection of patient information. All staff with access to NHS patient information are required to

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undertake appropriate information governance training. At the time of our inspection, 0% of reception staff had completed the training. This staff group had access to high amount of sensitive and confidential information that requires knowledge of information security management and NHS records management to ensure breaches do not occur.

- Information governance is part of the trusts statutory training, 43% of ENP's had completed the training, 49% of nurses had completed the training, 16% of doctors had completed the training and 0% of reception staff had completed the training. There was an overall trust completion rate of 31% this was worse than the trust target of 95%.
- Staff told us it was difficult to undertaken mandatory and statutory training as often they would book their training but it would be cancelled at short notice, as they were needed to work clinically.
- Mandatory and statutory training is essential in ensuring staff are up to date with skills and knowledge in order to provide the best, safest treatment and minimise risk to patients. Poor compliance with mandatory and statutory training within the ED is a concern; patients may be at risk of receiving care and treatment that is out of date and not best practice.
- **Assessing and responding to patient risk**
- Patients arriving by ambulance as a priority (blue light) or trauma call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
- Other patients arriving by ambulance were assessed by a nurse assigned to ambulance triage who took a 'handover' from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated.
- If a patient arrived on foot, they were registered by reception staff before being seen by a triage nurse.
- Triage was undertaken in accordance with the Manchester Triage System. This is a tool used widely in ED departments to detect those patients who require critical care or are ill on arriving at the ED. Triage nurses followed a pathway or algorithm and assigned a colour

coding to the patient following initial assessment. Red being the label assigned to those patients who needed to be seen immediately through to orange (very urgent), yellow (urgent), green (standard) and blue (non-urgent).

- The trust has an adult trauma call policy however it does not contain a date the policy was ratified.
- A trauma call notifies the trauma team that the arrival of a potentially major trauma case(s) is imminent or has arrived. It is activated by the emergency department and communicated by switchboard.
- When the department was full, patients were received onto trolleys and cared for in the 'cohort' area (essentially a corridor.)
- Arrangements for streaming patients to the relevant part of ED were not adequate.
- We asked the trust to provide a policy and inclusion criteria of patients that could be placed in the 'cohort' area, the trust has not provided us with this information.
- Staff told us that they would only place patients in the 'cohort' area if their clinical condition was such that they did not require close observation. However, during our inspection we found multiple examples where those in the 'cohort' area required closer observation.
- Patients were not receiving an adequate assessment of their condition on entering the department.
- Patients were assessed by a nurse in the triage area who could be a junior nurse. Nurses working in triage bay told us they had not completed a competency module prior to working in this area. We have been provided with a copy of core specialist competence emergency care in ED document; however we have not received records of staff that have completed this programme.
- Staff we spoke with expressed their concerns about maintaining clinical oversight of patients in the cohort area.
- Patients were placed in a 'cohort' area where they remained whilst awaiting assessment by a doctor.
- We witnessed patients in the 'cohort' area not receiving regular reassessment of their condition, which meant a patient could deteriorate and it would be undetected.
- Whilst waiting in the 'cohort' area none of the patients had access to a call bell, meaning they were unable to easily summon help when required.
- There was not a tool in place to support staff to identify which patients should be given priority for a cubicle. Patients waiting would be transferred to a cubicle in time order.

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- This meant we could not be assured that those requiring the closest monitoring in a cubicle were receiving it.
- Staff told us that they employed nurses and HALO's to be responsible for patients in the 'cohort' area and they operated a ratio of five patients to one staff member. However there was no maximum number set for how many people could be cared for in the 'cohort' area.
- We saw numerous occasions when those being cared for in the 'cohort' area were given treatment such as intravenous fluids, oxygen, pain relief and had blood tests undertaken.
- We saw a patient who when they had been assessed in the 'cohort' area by a doctor needed to be immobilised as a result of a potential neck injury. The patient was being cared for on a trolley in the 'cohort' area and had no access to a call bell and was not being closely monitored by a member of staff.
- During an evening inspection on 6th April 2016, the inspection team felt that ED occupancy was not being monitored in real time in order to assess the level of risk to patients. During this evening inspection, there was nine patients 'stacked' in the 'cohort' area. The Royal College of Emergency Medicine states; 'crowding is dangerous and should not be accepted'.
- Despite our serious concerns raised in previous inspections regarding the use of the 'cohort' area there are still no systems in place to assess and monitor patients to protect them from harm. We reviewed incident forms relating to the 'cohort' area and we saw that staff had reported their concerns about the quality of care they were able to provide to patients in this 'cohort' area.
- The incident forms reviewed showed multiple examples of acutely unwell patients waiting inappropriately in the 'cohort' area. Examples included patients who had;
 - strokes on three occasions in September 2015
 - an acute subdural haematoma (blood clot in the brain) in May 2015
 - a seizure in April 2015
 - an airway obstruction (difficulty breathing) in October 2015 diminished levels of consciousness (in the area between 30 minutes and one hour) in September 2015.
 - abnormal blood results that indicated the patient was very unwell (in the area of over two hours) in July 2016
- We also found there was failure to escalate a patient with an abnormal arterial blood gas result reported in February 2016 and another patient in the 'cohort' area in August 2015 who was on intravenous fluids and was in the 'cohort' area so long the battery on the infusion pump ran out.
- Patients presenting with a mental health illness were not adequately risk assessed prior to being placed in the 'cohort' area, one patient in May 2015 tried to self-harm whilst in the 'cohort' area. One patient in September 2015 absconded from the hospital and was found collapsed and unresponsive on the road outside the hospital. Three other patients absconded from the department in August 2015, July 2015 and 10 May 2015, one patient was found safe and well the other two patients had no outcome recorded.
- The trust currently used a national early warning system (NEWS) tool. This scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support.
- When patients were undergoing assessment in the triage area a set of observations (vital signs for example blood pressure and pulse) were undertaken, the results of these observations were inputted into a computer system which generated a NEWS score.
- We reviewed three records of patients waiting in the 'cohort' area and none of the patients had undergone a further NEWS assessment.
- We noted that the NEWS assessment tool was on the reverse of the patient's observation chart, however it did not include what action or escalation should be undertaken if a patient triggered a NEWS score.
- Between January 2015 - December 2015 84.2% of patients had a NEWS score calculated with each set of observations.
- Patients in the department for more than 4 hours between January 2015 – December 2015 92.2% of patient's had a minimum of two observations undertaken, of these 84.1% of the last two sets of observations were calculated correctly.
- We saw the use of 'prompt cards' these were like a 'check list' of actions undertaken in medical emergencies or procedures. For example patient who presented with sepsis or a prolonged seizure, and to be used for example when sedation is used or a central

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venous cannula insertion (tube in the neck.) Prompt cards could be used by all members of the emergency team. If used correctly they improve patient safety and reduce human factor errors.

- Recognised tools were used for assessing and responding to patients risk such as the Malnutrition Universal Screening Tool (MUST) and the venous thromboembolism (VTE) assessment tool to identify those at risk from developing blood clots. The patient records we reviewed showed poor completion of these assessments.
- We saw risk assessments were not consistently undertaken where indicated for example moving and handling, skin integrity, nutritional needs, use of bed rails and VTE assessments.
- The department did undertake board rounds with consultants and nursing staff during handovers. This is a process which should improve communication among the multi-disciplinary team (MDT), enhance team working and provides a more coordinated approach to treatment of the patient and help in decision making. Board rounds also mean that patients were assessed by a consultant therefore if there had been any change in a patient's condition this would be highlighted. The process also gives an overview of the status of the department which can be responded to.
- **Nursing staffing**
 - ED had a turnover rate of 15% which was worse than the trust average of 12%; a vacancy rate of 5% which was better than the trust average of 9% and a sickness rate of 7% which was worse than the trust average.
 - There was one ENP that worked between 7:30am and 8pm, one ENP worked between 10:30am and 11pm and one ENP worked between 3pm and 11pm.
 - There were three emergency nurse practitioners (ENP's) rostered to work in UCC, however ENP service finished at 11:30pm daily and then is managed by the ED doctor.
 - There were 18 registered nurses and six health care assistants (HCA's) rostered on each long day shift. There were 17 registered nurses on each night shift and five health care assistants.
 - We saw that there was three supernumerary band 7 nurses on each shift their roles and responsibilities were not clearly defined.

- Staff told us that nurse staffing requirements had not been reviewed since the hospital became a trauma centre and were no longer in line with the department's needs.
- We asked the trust to provide us with the percentage of shifts that remained unfilled in order to understand if there were times when the department did not have the right number of staff, even with agency nurse support. This showed the monthly planned staff hours for registered nurses during the daytime was 218.5 hours, during the month of March 2016 the monthly actual staff hours was below this 61% of the time.
- We saw the use of four temporary staff daily was highlighted as a risk on the risk register; they are used to cover unfunded posts within the department.
- Staff told us that they were not able to provide the level of care that they should because of a lack of staff.
- Staff told us that understaffing would be reported on the trust's electronic incident reporting system. However despite completing incidents staff felt the matter had not been addressed by management.
- Between November 2014 – October 2015 there were 46 patient safety incident reports which related to lack of nursing staff; however staff told us that not all staff report such incidents
- Staff told us there was a high reliance on bank and agency staff leading to skills gaps in some cases. The average bank and agency use was 31% compared to the trust average of 21%. This indicates that the nurse staff establishment is incorrect if the vacancy rate is zero however, a high percentage of bank and agency staff were used.
- We saw evidence of an adequate induction process for agency staff.
- We found two cubicles within ED which were not being used. Staff told us this was due to a lack of nurse funding. However, we subsequently observed a nurse leader utilising this space by preference.
- The trust was taking positive action to recruit and retain staff. The recruitment strategy included investment in advertising, social media and recruitment agencies. The trust had recently undertaken a recruitment process in the Philippines.
- **Medical staffing**
 - Numbers of consultants and junior doctors were both similar to the England averages.

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- Emergency Medicine Consultants were on duty in the department 24 hours a day, seven days a week. The trust met The College of Emergency Medicine (CEM) recommendations.
- Medical staffing rotas were organised by the consultant group quarterly with the assistance of a rota coordinator and agreed with the clinical director.
- Junior medical staff told us they had received a full induction programme which was adequate prior to starting their work in the department.
- There were 15 full time consultants in post, consultants worked across both ED departments at RSCH and PRH. There was three full time consultant vacancies.
- There were 18.3 middle grade doctor positions and there was currently 18 in post.
- There were 15 trainee doctors employed; 11 junior doctors and six trainee GP's, in addition there were seven trust grade doctors (senior doctors employed by the trust and four education fellow doctors.
- There were two consultants working in the department between 8am – 3:30pm, two consultants between 3pm – 11:30pm and one consultant between 11pm and 8:30pm.
- There were four junior and middle grade doctors who worked between 8am and 6pm, five junior and middle grade doctors between 12pm and 11:15pm and six junior and middle grade doctors worked between 11pm and 08:15am.
- There was a GP rota which provided two GP's between 9am and 7pm daily to staff the urgent care area of the department.
- The average medical locum use for the acute floor is 2% this is compared to the trust average of 5%.
 - **Major incident awareness and training**
- The trust had an emergency preparedness, resilience and response policy which included business continuity management, which was issued in June 2015.
- This policy provides assurance that frameworks exist within the trust that support a high level of preparedness to any business-disrupting event or major incident, regardless of source.
- Staff told us that they did regularly take part in major incident training with other emergency services.
- Staff were made aware of the trust's major incident plan through electronic and paper means. The current policy was available on the trust's intranet.
- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items.
- We reviewed the equipment inside the storage area, it was well organised and items were in date. Staff told us that the equipment within this area was checked on a monthly basis, however we did not see evidence of this.
- Chemical, biological, radiological and nuclear defence training is mandatory based on information provided to us by the trust 49 % of staff had received this training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



We rated ED as Requires improvement for 'effective' because:

- Patient pathways and national guidance for care and treatment were generally followed. However, pain assessments were not always completed and band 5 nurses were not authorised to administer oral pain relief under the trust's Patient Group Directions (PGD). This meant delayed pain relief for patients on occasion.
- Some 62% of nursing staff had received an annual appraisal, but compliance with ongoing reviews was low and accountability for these lapses was unclear. We were not provided with evidence of compliance of medical staff who had received an appraisal.
- **Evidence-based care and treatment**
- Initial assessment of patients with different conditions were undertaken against standard checklists adapted from Royal College of Emergency Medicine (RCEM) guidelines. This included the care for patients with head injury, suspected stroke, chest and abdominal pain and sepsis. For each condition there was clear guidance of the time by which assessment should be made and under which criteria a senior doctor should be informed.
- We examined audit reports provided by the trust and saw that recommendations for improvement and re-audit had been identified and that audits were being carried out. Staff told us that audit reports were

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communicated via meetings, displays, board rounds, emails and staff team briefings. We also saw, in the single clerking audit, a good example of such reports being used to improve patient care and treatment.

- We reviewed a sample of 13 patient records of patients who had attended the ED. We found most patients had received care in line with national guidance.
- We saw some good examples of guidance having been followed. For example the 'Sepsis 6' pathway in a case with a patient who was septic (had an infection).
- Staff understood the National Institute for Health and Care Excellence (NICE) guidelines and stated these were referred to in discussions about care and treatment. We observed instances of this during treatment plan discussions and handovers.
- Staff told us they were able to assess relevant NICE guidelines on the trust's internet.

• **Pain relief**

- Patients told us that they had not received pain relief as required in the 'cohort' area. This was because the administration of pain relief was problematic due to overcrowding in the area.
- The ED used a scoring tool to assess patients' pain levels. Pain was scored from 0 – 10 with '0' representing no pain and a score of 10 extreme pain. We reviewed a sample of patient records and noted pain scores had not been consistently recorded. For example, out of the 10 records, six had no pain scores documented.
- Staff told us that band five nurses were not allowed to administer analgesia via a PGD due to a previous error. This meant a more senior nurse had to be called to approve pain relief, which may lead to delayed administration.
- We noted the absence of a nurse rounding system (NRS). One of the features of an NRS check (often performed hourly) is that patients have frequent pain monitoring.

• **Nutrition and hydration**

- Staff used the Malnutrition Universal Screening Tool (MUST) to assist in the assessment of patients' nutrition and hydration status.
- Nurses and support staff we spoke to understand the needs of patients they were caring for and the importance of ensuring they had adequate food and drink.

- There was very limited documentation about who had been offered food and drink and what their intake had been.
- The kitchen area for the acute floor was not fit for purpose. This was because it was small and outdated.
- There was a water dispenser in the UCC, the only refreshment machine was in reception and many people may not know that it was there, cannot get there, or risked losing their seat if they get up for a drink.
- Two elderly patients we spoke to reported missing meals for some hours. Neither could recall receiving explanations about food or fluids being restricted, nor did they have a condition that would normally prevent them from eating or drinking.

• **Patient outcomes**

- We saw that the department had Sepsis and deteriorating patient pathways in place that met the Royal College Emergency Medicine Standards in Emergency Departments (2014). The Royal College of Emergency Medicine established an audit standard for three patient groups (2013): Adults with non-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. The standards stated patients in these three groups should have either been reviewed by or discussed by a doctor of at least middle grade.
- The trust performed better than the England average overall. However, the average percentage of unplanned re-attendances to RSCH and PRH departments, within seven days, between September 2013 to October 2015 was 8.4% this was worse than the standard of 5% and worse than the National average of 7.2%.
- Paracetamol overdose audit 2013/14 scores at Royal Sussex County Hospital were in the upper England quartile for three of the four measures audited and between upper and lower quartile for the remaining one measure.
- Scores for RSCH in the severe sepsis and septic shock 2013/14 audit were within the upper England quartile for two, in the lower quartile for four and between the upper and lower quartile for the remainder of the 12 measures audited.
- RSCH scores in the assessing for cognitive impairment in older people audit 2014/15 were within the upper and between the upper and lower England quartile for the five measures audited.

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- Mental health in the ED 2014/15 audit for RSCH scores were in the lower England quartile for four of the eight measures and between the upper and lower quartile for the remainder.
- Clinical pathways had been developed for a number of conditions and they adhered to national guidance. They were available on the intranet which staff including agency and locum staff. In addition staff had access to the prompt cards which had established pathways for a number of clinical conditions for example asthma and prolonged fitting.
- The trust benchmarked their performance against national comparisons with other NHS trusts.
- Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) and CRAB (Copeland's Risk Adjusted Barometer) scores. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues.
- **Competent staff**
 - Advanced clinical and trauma training compliance was low. Out of 12 middle grade doctors in training one was out of date with advanced life support (ALS) training, three were out of date with advanced paediatric life support (APLS) and two were out of date with advanced trauma life support (ATLS).
 - Out of 15 consultants, no information was provided to us regarding the life support training compliance of five. Of the remainder, four were out of date with ATLS, three out of date with APLS and three out of date with ALS.
 - Only three nurses had in-date ATNC training. This compared poorly with the Adult Major Trauma Centre Measure (T14-2B-101).
 - The unit employed a band seven nurse educator to support the matron with clinical skills training, records and staff induction. We saw examples of the local induction process in place for agency staff and students. The induction consisted of a checklist used to ensure staff who had not worked in the ED previously were familiar with the environment and policies used by the trust. The practice educator kept a record of staff that had been inducted and we saw evidence of this. We spoke to two student nurses who confirmed they had received orientation and induction.
 - We reviewed nine appraisals chosen at random and found that although all had been completed in the last 12 months, the majority of six-monthly progress reviews had not been completed. Across all nursing staff groups the combined annual appraisal average was 62% which was worse the trust-wide target of 100%. We were unable to obtain information on medical staff appraisals.
- **Multidisciplinary working**
 - The staff we spoke with told us multidisciplinary relationships with other departments worked well for the majority of the time. Acute floor daily status meetings that included medical, surgical and imaging specialties demonstrated effective communication.
 - Overall, staff reported good multidisciplinary working with other services within the trust and with external organisations, such as local authorities and general practitioners. Other positive examples we observed were the interaction between the department and imaging staff.
 - There was a lack of communication between the immediate multidisciplinary team (MDT) which led to delays and confusion.
 - Patients who presented to ED with mental health needs were treated for their immediate clinical needs and the referred to the psychiatric liaison team for review. We spoke to members of the liaison team who told us they had a positive working relationship with the ED team. They said that delays occurred in care when there was a lack of available mental health beds in the region. This caused delays for patients with mental health patients and was consistent with the incident reports completed by staff.
 - The Hospital Rapid Discharge Team (HRDT) had an assessment area within ED that demonstrated good practice. The team provided support and advice to staff, patients and their families for the management of safe and timely discharge home or to further care settings. The department worked closely with other members of the multidisciplinary team and the assessment process commenced early in ED to minimise delays.
- **Seven-day services**
 - The emergency department is open seven days per week and twenty-four hours per day.
 - All pharmacy support services are available Monday to Friday 9am until 5pm.
 - The HRDT team do not work at weekends however a business case had been submitted to extend this service.

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• Access to information

- The hospital had an electronic system which recorded the results of patient investigations. Clinicians viewed the results from various locations and by remote access. The clinicians we spoke with told us the system worked well and gave them real time updates and information wherever they were.
- Laboratory and other medical investigation records could be accessed electronically, including past test results from previous visits. We were told that the availability of computer terminals was sufficient and software systems used by the trust were suitable for their needs.
- Information for GP's was sent electronically and patients were given a copy of their discharge summary.
- Staff told us most clinical information and guidance was available on the intranet. They also reported having access to information and guidance from specialist nurses, such as the diabetic, stoma and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.
- We saw that there was limited patient injury information leaflets available.

• Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that best interest decisions and deprivation of liberty (DoL) decisions were taken where indicated and these were formally documented.
- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Staff were aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were able to describe the arrangements that were in place should the legislation need to be applied
- Training on consent and the Mental Capacity Act 2005 was available, 53% of staff had completed the training.
- We were told that best interest decisions and deprivation of liberty (DoL) decisions were taken where indicated and these were formally documented but we did not see evidence of this.
- We did not identify any patients currently being treated under a DoL at the time of our inspection.

- Most of the nursing staff we spoke with had an understanding of the MCA and DoLS
- We reviewed the records of patients presenting with self-harm injuries and a patient living with dementia. The patients had not had a mental capacity assessment or mental health risk assessment completed.

Are urgent and emergency services caring?

Requires improvement 

We rated ED as Requires improvement for 'Caring' because:

- We spoke to 25 patients during the inspection.
 - We also invited patients who had received care from the hospital over the past few months to provide us with feedback prior to the inspection via our call centre.
 - Most of patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff were working very hard. However we also received negative feedback from patients who were dissatisfied with the care they had received.
 - Patient's privacy, dignity and confidentiality was not respected whilst in the 'cohort' area and their basic needs are not met, a large number of patients are cared for in the 'cohort' area.
 - We witnessed patients in the 'cohort' area not receiving the emotional support they required.
 - Patients cared for in the 'cohort' area did not know or did not understand what was going to happen to them during their care. Patients in the 'cohort' area did not know who to ask for help.
 - We observed in other areas that staff responded compassionately when patients required help and supported them to meet their basic personal needs when required. Patients' privacy, dignity and confidentiality was respected in other areas of the department.
 - The majority of patients felt involved in their care and participated in the decisions regarding their treatment, and staff were aware of the need for emotional support to help them cope with their treatment.
 - We observed patients being treated in a professional and considerate manner by staff.
- **Compassionate care**

Urgent and emergency services

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience.
- The percentage of friends and family that would recommend the service in the FFT between January 2015 – December 2015 has improved over the time period to above the England average since September 2015. In December 2015 91% of patients would strongly recommend or recommend the service.
- We saw that FFT information was not displayed on notice boards around departments, but was displayed in staff areas.
- The trust was rated as “about the same as other trusts” for all questions in the ED survey 2014.
- During our inspection, we saw staff talking with patients in a respectful and caring manner, taking time to explain options and interventions to patients.
- However we saw many examples of when privacy and dignity was not maintained in the ‘cohort’ area. For example we saw where staff conducted examinations of patients waiting in the ‘cohort’ area, in some cases this involved removing and lifting items of clothing. There was no visual screening used when this occurred.
- Staff told us that the two unused cubicles in bay 2a were meant to be used for examination of patients in the ‘cohort’ area however we did not see evidence of this. We saw multiple examples when patients were asked to confirm medical history and often with the doctor sitting on the end of the trolley.
- This meant privacy could not be maintained because other patients in the ‘cohort’ area could hear confidential information when patients gave their medical history.
- We saw a patient with a fractured ankle who was using a pain relieving gas arrive on a trolley, however because the ‘cohort’ area was already busy, a nurse wanted to re-direct the patient to the UCC. We witnessed the patient experiencing severe pain when trying to transfer to a wheelchair as patients on trolleys are not accepted in UCC. The patient was crying and obviously unable to transfer to a wheelchair, at this point a member of the inspection team voiced their concerns that this was subjecting the patient to unnecessary pain. The patient was then kept on the trolley in the ‘cohort’ area. We considered this interaction uncaring the action was taken because of the activity in the department and did not take into account the needs of the patient.
- We observed an elderly patient who was left on a urine saturated sheet on a trolley for over an hour in the ‘cohort’ area.
- We observed frail elderly vulnerable patients left in the ‘cohort’ area without call bells for extended periods of time and without any interaction with staff.
- Some of the patients we spoke to in the ‘cohort’ area felt they were “on a conveyer belt” waiting to be placed in a cubicle.
- We saw that there was constant moving of patients within the ‘cohort’ area and the inspection team felt this could disorientate and confuse patients.
- We observed patients in the ‘cohort’ area being transferred from the ambulance trolley to a hospital trolley without the use of privacy screens in full view of other patients. This compromised patients’ dignity and respect as they could potentially be exposed to other patients.
- We did not see interactions where staff apologised to those waiting in the ‘cohort’ area.
- Patients and relatives being cared for in cubicles were more positive about their experience.
- We heard staff make assumptions and judgements about patients depending on their presenting condition; this indicated that they did not deal for patients in a kind and caring manner.
- **Understanding and involvement of patients and those close to them**
- We spoke with patients at all stages of their journey through the department. They told us they felt involved in their care and in decision making about their treatment.
- Despite intense operational pressure staff generally had a caring and compassionate attitude towards patients.
- We spoke to some patients relatives who said they had been involved in their relatives care and had been given regular updates.
- The exception to this was a patient who had learning difficulties (LD) who was accompanied by a carer, we asked a nurse what support was available for the patient and would she contact the LD team. The nurse told us “it was not on her radar to contact the team and not something she had thought to do before”. The carer later told us that she had insisted that the nurse contact the LD team as the patient was well known to them, the LD team arrived in the department to provide support promptly.

Urgent and emergency services

- The patients we spoke with told us they were given adequate information about their condition and treatment plan.
- Patients in the 'cohort' area told us they felt forgotten about, additionally the space in the 'cohort' area is very limited and it was difficult for relatives to stay with patients.

• Emotional support

- There was not adequate arrangements in place to provide emotional support to patients and their families when needed.
- There was no bereavement room or viewing room in the department where relatives could spend time with a recently deceased loved one.
- We saw that behavioural assessments and assessments of individual psychological and emotional needs were not carried out prior to patients being placed in the 'cohort' area.
- Doctors and nurses were not able to provide adequate emotional support to patients in the 'cohort' area, we saw doctors sitting on the end of patients trolleys whilst taking their medical history.
- We witnessed patients undergoing potentially distressing procedures in the 'cohort' area, for example have blood tests undertaken without adequate emotional support.
- We saw posters giving details on a variety of support groups or services which could be accessed for example contact details of domestic violence support and mental health support groups.
- Staff confirmed they had access to the end of life team and previous referrals had been acted upon promptly
- There was a chaplaincy and bereavement service available seven days a week.

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

Inadequate



The ED was inadequate in its responsiveness to patients' needs, primarily through insufficient patient flow through the department.

Similarly to our last inspection in June 2015, issues around the department's inability to meet surges in demand; use of a 'cohort' area, escalation protocols, leadership and record keeping all caused concern. At the same time, we saw positive signs: a program of building works underway, new senior medical and nursing leaders and innovations such as single medical clerking.

The ED's capacity to cope with the number of people attending was still the highest risk on the departmental risk register and a persistent failure to achieve four-hour waiting time targets appears to have become normalised. Factors contributing to this remain unchanged and include lack of available inpatient beds, delays in the transfer of patients and an ongoing increase in the number and clinical acuity of patients accessing ED, all of which result in patients remaining in the department for longer. We learned that up to 40 patients a day were "blocking" beds in the hospital, despite being medically fit for discharge.

Many of these were longstanding issues brought to the trust's attention previously and while there had been some improvements, the trust needs to demonstrate sustained progress.

Service planning and delivery to meet the needs of local people

- One senior member of staff characterised the situation as "no real change" since our last visit. While we found evidence which supported this the inspection team also acknowledged that initiatives such as single clerking, better specialist cover and daily "acute floor" meetings began to show positive results.
- A program of works was about to be commenced that will increase the number of ambulance handover cubicles from one to five and almost double the number of consultation rooms in the walk-in Urgent Care Centre (UCC) where patients were seen by either emergency nurse practitioners or by a GP. The project is due to be completed by the end of May 2016 and we were told the UCC enhancement would be completed before the onset of winter.

Meeting people's individual needs

- Our observations of the 'cohort' area demonstrated shortfalls in dignity and privacy, with a mixture of genders all who had a variety of physical and emotional symptoms whilst in close proximity to each other.

Urgent and emergency services

- The facilities and premises used did not meet people's needs and were inappropriate for example the 'cohort' area and UCC.
- Services were not set up to support people with complex needs or people in vulnerable circumstances.
- The inspection team found patients in the lower acuity defined treatment bays (zone 2b or the "minors" area) with bedside call bells and glasses of water out of reach.
- We observed an occasion when a breastfeeding mother was moved from the 'cohort' area to a private area to enable her to feed her baby there was a delay in finding a suitable space meant she was prevented from breastfeeding for some 30 minutes.
- We were told that access to mental health services were good. We saw that staff could contact the mental health liaison team to provide input to any patients who required mental health assessments. However, we noted that patients at risk of self-harming were left in the 'cohort' area with minimal supervision. We observed the room used for mental health assessments was also used for daily meetings of the senior medical, nursing and operational staff. We were told that an alternative room was being identified.
- Staff told us that there was minimal support for patients who attended ED with learning difficulties and we witnessed this during our inspection.
- The trust policy stated that all patients aged over 75 had dementia screening undertaken, however we saw that this was inconsistent.
- There was no written information or any other material in the UCC, despite a TV screen being available to patients.
- We saw there was no information for patients about their status in terms of their assessment and care whilst waiting.
- We saw that there was no visible waiting times so patients did not know how long they might have to wait.
- The majority of patients that we spoke to told us that they didn't know what they were waiting for or where in the process they were.
- Patients had access to translation services via a telephone interpreter system. Staff reported that this system worked well whenever they were required to use it.
- Trust wide data provided to us demonstrated a monthly average of 550 ambulances experienced delays of 30 minutes or more and 87 waiting longer than 60 minutes, although this data had not been formally validated by the trust or ambulance service.
- The percentage of patients waiting four hours from "decision to admit" to being admitted through both RSCH and PRH was consistently worse than the England average for the period January 2015 - to December 2015.
- Reported 12-hour breaches had also reduced and the inspection team observed a refocussing on reporting and escalation, which was being promoted and supported by recently appointed senior medical and nursing staff. A feature of this was a new trigger set at 8 hours, when ED clinicians and managers are notified of patient delays. If the ED is unable to resolve the issue causing the delays, then further escalation takes place to senior management with regular updates. At 10 hours commissioning senior staff are informed, who escalated to NHS England. Subsequently, any 12-hour delays are subject to a root cause analysis and are reported to NHS England through established procedures. Since the inspection 12 patients have been reported as waiting over 12 hours.
- Between June 2015 and March 2016, 84 patients waited over 12 hours from the time of the "decision to admit" to the time of hospital admission at RSCH and PRH. The most amount of breaches at RSCH and PRH was in October 2015 (37) and the least amount was in September, November and December 2015 (2).
- The total time spent in RSCH and PRH departments was consistently longer than the national average for England throughout the period September 2013 - October 2015.
- After our last inspection in 2015, we reported that the trust invited the emergency care intensive support team (ECIST) to review emergency care pathways. We saw some improvement in the data since, with the percentage of people seen within four hours increasing from around 79% at the start of 2015 to a highest of 89% in November 2015.
- Between June 2015 and March 2016 the trust performance on the 90% standard of patients seen within four hours in ED was varied. The best performance (88.6%) was in November 2015 and the worst performance (80.9%) was in June 2015. The average performance for this time period was 83.99%

Access and flow

Urgent and emergency services

this is worse than the 90% standard and worse than the National average of 87%. There was an improvement in performance in November (88.6%) and December (88%) 2015 this was better than the National average.

- The national average for percentage of patients that leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait) is between 2%-3% (September 2013 – November 2015). Trust wide data provided to us indicated that the trust consistently performed worse in this outcome apart from a three-month period during the winter of 2013.
- Between January 2015 and December 2015 3,926 people waited between 4 to 12 hours (and 71 people over 12 hours) from the time of “decision to admit” to hospital admission.
- Between January 2015 – December 2015 92.2% of patients had a full set of observations undertaken within 15 minutes of admission to the department
- A program of works was about to commence that aimed to increase the number of ambulance handover cubicles from one to five and almost double the number of consultation rooms in the walk-in Urgent Care Centre (UCC). The project was due to be completed by the end of May 2016 and we were told the UCC enhancement would be completed before the onset of winter.
- The single clerking model has been introduced it brings together all the specialty on-call doctors with ED doctors as one acute floor team, with the ultimate goal to ensure efficient excellent care is delivered every time. It ensured that patients are treated equally, regardless of the mode of presentation and get to a senior decision maker at the earliest opportunity. The data was still being collected at the time of our inspection but has showed an initial improvement in senior assessment.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. We were told that if a patient or relative wanted to make an informal complaint, then they would speak to the shift coordinator. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS), who would formally log their complaint and would attempt to resolve their issue within a set period.

- Complaints were monitored and discussed at departmental clinical governance meetings. There were mechanisms in place for shared learning from complaints through the staff meetings, trust briefings and safety briefings.
- According to information provided by the trust, 45 formal complaints were lodged between November 2014 – October 2015. This is slightly less than the 55 complaints made the year previously.
- The formal complaints related to triage, clinical care and diagnosis. Staff attitude was recorded against 26 complaints.
- Complaints were investigated by the matron or other senior staff within the department, such as the clinical lead, when the complaint related to a member of the medical team.
- By comparison, during the same period 78 ‘plaudits’ were logged for ED. This was consistent with the positive verbal feedback our inspectors obtained from patients and their families.
- The complaints process was outlined in information leaflets, which were available in ED and UCC.

Public website

- When we checked the trust website, we found the last performance figures for ED were published in 2012.

Are urgent and emergency services well-led?

Inadequate



We rated ED as Inadequate for ‘well-led’ because:

- Whilst the department had undertaken initiatives to try and resolve long standing capacity issues which frequently impacted on the ability to move patients through the emergency care pathway. National targets were still not consistently met; patients therefore experienced delays, and their safety, dignity and respect was compromised especially within the ‘cohort’ area.
- We saw that there had been little sustainable and meaningful improvement since our last inspection to ensure risks; issues and poor performance were dealt with appropriately or in a timely way. Staff told us that the risks and issues were not understood by leaders.

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- There was normalisation of poor standards, conduct and disjointed multi-professional working.
- Leaders were not always clear about their roles and their accountability for quality and safety and there was a lack of ownership and responsibility for the patients in the 'cohort' area.
- Since our previous inspection there was still a failure to listen to and act on concerns regarding the 'cohort' area.
- Senior medical leadership was visible in the department however it was not clear how they were providing overall support to the department.
- Strategic nursing leadership was absent however we saw signs of potential improvement with the recent appointment of a divisional nurse manager.
- Staff told us that there was managerial support up to the level of matron, but there was a lack of support beyond that point.
- Senior nurses felt unsupported in their role and felt they were left "to just get on with it."
- Some staff spoke enthusiastically about their department and were proud of their ED, however there was a significant number of staff who were unhappy in their jobs.
- **Vision and strategy for this service**
- The vision and values of the organisation were not well developed or understood by staff.
- We observed the trust's vision and values were not prominently displayed in the department.
- Staff told us they were aware of and supported the trust vision and values, however not all staff acted within them.
- The clinical director had developed a new strategy for the acute floor, this had been submitted to the executive committee but to date no feedback had been received.
- The department had developed a performance recovery plan for the ED with support from external experts.
- **Governance, risk management and quality measurement**
- There was a governance framework in place with responsibilities defined that monitored the outcome of audits, complaints, incidents however it was unclear how this fed into the wider governance structure within the trust.
- ED maintained its own risk register; however it was unclear how this fed into the directorate risk and trust register.
- We reviewed the risk register and saw the highest scored risk on the register was, the increase in admissions and delays in discharges which results in longer waiting times for patients and an increased risk to patients. We saw on the register this risk was supposed to be updated in February 2016.
- Clinicians and managers told us they could raise issues for discussion and resolution through a network of performance, clinical governance and safety meetings.
- There were monthly emergency department operational and safety quality meetings,
 - The objective of these meetings was to discuss operational, safety and quality issues relating to ED services. We reviewed the minutes from these meetings which had detailed action logs, however it did not contain a record of who had attended the meetings.
- Managers within the department met regularly to discuss the progress of ED and issues that affected the department.
- The department produced weekly operational dashboard data which was shared with staff and discussed at governance meetings.
- There was a weekly staff meeting which was chaired by the ED matron, we saw the minutes from these meetings and noted there were no action logs.
- The medication safety group monitored the governance and safety of medicines. The drugs and therapeutics committee in turn reports to the safety and quality board.
- **Leadership of service**
- The department is led by a consultant and divisional nurse manager.
- We observed the clinical management from the medical lead was developing and the staff we spoke with reported that they had good relationships with their immediate manager.
- Junior medical staff reported to the consultant or a senior registrar for advice and support, they told us this worked well.
- Nursing leadership in the department functioned on a day to day basis, but the strategic leadership of the nursing workforce was lacking, however we did see signs of improvement with the recent appointment of the divisional nurse manager.





Urgent and emergency services

- The inspection team felt the nursing leadership of the department was not strong enough to manage the challenges of the department.
- Staff told us they rarely received help from senior members of the trust.
- Staff told us the only time they saw senior managers in the department was when a patient was close to breaching the 12 hour target and then they would provide help to avoid the breach.
- Staff told us the trust's senior management lacked understanding of their challenges and trying to make changes was so difficult staff became despondent and often gave up.
- We saw that doctors did not take responsibility for updating the computer system when they had reviewed patients and this was the responsibility of the nursing staff.
- We saw a lack of clinical leaders and senior nursing staff encouraging supportive, co-operative relationships among staff and teams.
- Department leaders were not aware of all the patients present in the department and this affected patient safety. This was because there was a lack of communication between the team and a lack of assessments of the status of the patients in the department.
- Staff told us that poor behaviour and work performance was tolerated and not challenged.
- We saw that the shift leader at the end of each shift completed a shift handover sheet which was emailed to the band six and seven nurses, lead consultants, the matron and the directorate lead nurse. This included issues around staffing, the bed status, the amount of four and twelve hour breaches and any other issues. This as a good method of communication however staff told us that issues reported on this were rarely acted upon.
- **Culture within the service**
 - In the 2014 staff survey over 50% of staff said their last experience of harassment/bullying was not reported by themselves.
 - Some staff told us that they dreaded coming to work, and just concentrated on making it to the end of the shift. Several members of staff told us they were looking for alternative places to work.
 - In the 2014 staff survey 57% of staff felt there was enough staff in the organisation to do their job properly.
 - In the 2014 staff survey over 50% of staff said they put themselves under pressure to work, despite not feeling well enough.
 - We found staff morale to be extremely low. Staff reported feeling stressed and said they spent their time "firefighting" to the detriment of patient care. Some appeared despondent and seemed unable to lift themselves out of the situation they felt they were in.
 - Numerous members of staff told us that poor behaviour and poor performance of other staff members was tolerated and went unchallenged.
 - Staff lacked any responsibility for meeting targets as they felt it was an impossible task.
 - Poor performance with the four hour target had become normalised and staff told us "we don't even bother with that target anymore we focus on avoiding 12 hour breaches". This is corroborated by data supplied to us by the trust.
 - The use of the 'cohort' area had become normalised and we saw little effort to avoid placing patients in this area, with the exception of when one charge nurse was co-ordinating the department.
 - Staff told us how the culture was reactive rather than proactive and they were always crisis managing.
 - Staff told us that the department had been on under a lot of pressure for an extended period of time, and there had been little improvement since our last inspection.
 - Staff morale was low and the inspection team felt this maybe hindering performance and improvement within the department.
 - There was a general feeling that the staff were stuck in a rut and could not find a way out.
 - **Public engagement**
 - The hospital used various means of engaging with patients and their families. These included surveys, such as the 'Friends and Family Test' and ED surveys.
 - Patients and the public were given a wide range of information from the trust's website for example information regarding NHS choices and performance outcomes.
 - We read a trust publication called 'Best Of BSUH' which was a valuable and interesting publication, it highlighted areas of good practice in the trust.
 - The Family and Friends test results were not displayed in the department.
 - **Staff engagement**

Urgent and emergency services

- There were staff notice boards throughout the staff areas giving staff information about local and trust wide issues including training, development opportunities and team meeting minutes.
- There were weekly chief executive bulletins published on Fridays on the local internet.
- Staff told us that staff engagement between the executives and non-executives was non-existent.
- Staff told us that they weren't always engaged in changes within the hospital, an example of this was when staff parking arrangements were change without consultation and with only two weeks' notice.
- **Innovation, improvement and sustainability**
- The trust said they encouraged local initiatives to improve patient experience, care and treatment. However staff told us that there was a lack of investment in initiatives by the executive board and often staff gave up as so many obstacles were put in the way.
- We were told of plans regarding new ways of working which would improve the care patients receive and the flow within the department.
- An example of this is implementing a rapid assessment treatment (RAT) model, which involves the early assessment of 'majors' patients in ED, by a team led by a senior doctor, with the initiation of investigations and/or treatment.
- We learnt a new way of working had been implemented the 'single clerking' model. The single clerking model is a change in culture: it brings together all the specialty on-call doctors with ED doctors as one acute floor team, with the ultimate goal to deliver efficient and excellent care, every time. It ensures that patients are treated equally, regardless of the mode of presentation and get to a senior decision maker at the earliest opportunity.
- We were shown data which showed an improvement in time taken to decision to admit or discharge after the single clerking process had been implemented.
- We heard about a new model of care that had recently been introduced: right care, right time, right place, right team, every time, this is a patient flow improvement programme. We did not see evidence that this new model was embedded practice yet.
- The department is currently undergoing building works to improve facilities and improve flow.
- The hospital is undergoing a seven year redevelopment programme but the ED is not included in this.
- We were told there was no funding available to make improvements that may influence change and long-term outcomes, however there was planned building work scheduled to create additional cubicle space.

Medical care (including older people's care)

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

Information about the service

The Royal Sussex County Hospital is a location of Brighton and Sussex University Hospitals NHS Foundation Trust. This is a teaching hospital which provides general, specialist and tertiary services including cancer services, cardiac, renal services, general and specialist medical services.

The medical services within the trust are divided into six of the different directorates: the acute floor, abdominal surgery and medicine, cancer services, cardiovascular, neurosciences and stroke services and the specialty medicine directorates.

Between September 2014 and August 2015 there were 43,455 medical admissions. Of these the majority were emergency (47%) with 5% elective, 48% admitted as day cases, 25% were general medicine, 18% cardiology, 17% clinical haematology and 39% 'other' conditions.

During our inspection, we reviewed information from a wide range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, visited each of the general and specialist medical inpatient wards, the acute medical unit, the ambulatory care unit, the cancer care wards, the endoscopy suite and the discharge lounge. As part of the inspection we visited all 26 wards and units where medical care was being given and observed care being delivered by staff.

The CQC held 29 focus groups and additional drop-in sessions where staff could talk to inspectors and share their experiences of working at the hospital. We spoke

with over 45 members of staff working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, ward clerks, and housekeeping and domestic staff. We spoke with patients and their relatives. We reviewed 15 sets of patients' records as well as other documentation. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection.

Medical care (including older people's care)

Summary of findings

- The risk of fire was not being managed appropriately. We found that the older buildings were particular fire safety risks as they were overpopulated, overcrowded and cluttered with narrow corridors and inaccessible fire exits. We had concerns that in the event of a fire, vulnerable patients would not be able to be evacuated safely in a timely fashion.
- The wards in the older buildings were extremely difficult environments for staff to provide safe and effective care. Some of the most challenging and vulnerable patients were being cared for in premises that were no longer fit for purpose. Although the trust had a strategy for managing this, it was not carried out in practice. Risk assessments were poorly completed or out of date and did not provide assurance that all the environmental risks to patients, staff and visitors were identified and managed appropriately. Although the trust had plans to replace the older buildings, the project was planned to take a minimum of five years.
- Although the trust was addressing staff shortages through the recruitment of overseas, this had not been undertaken in a planned way that engaged ward leaders. This was putting an extra burden on already overstretched staff to mentor and induct the nurses. The majority of medical wards reported there continued to be severe staffing shortages. The physical constraints of the older building were also compounded by shortages of competent staff, particularly at night.
- Patients were not always protected from avoidable harm because there was not a system to ensure trust wide learning from incidents or take action where poor infection control practices were identified.
- The different medical directorates operated in isolation with little cross directorate learning or sharing of information.
- The management of incident reporting was variable across the directorates with limited feedback or learning identified. This issue was raised at the previous inspection. Whilst staff knew how to report incidents and told us that reporting was encouraged, we found no changes or evidence of learning as a result of reported incidents.

- Although medicines were usually supplied, stored and disposed of securely and appropriately on the cardiology wards, Albion and Lewes, the clean utility contained various pieces of equipment and the drug cabinet was unlocked and had no means of being locked. We found intravenous fluids stored on open shelves

However

- We saw that patients' care needs were assessed, planned and delivered in a way that protected their rights. Medical care was evidence based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. Patient outcomes were monitored and reviewed through formal national and local audits.
- The patients we spoke with during the inspection told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. During our inspection we observed patients being treated with kindness, respect, professionalism and courtesy. This positive feedback was reflected in the Family and Friends feedback and patient survey results.
- Risk assessments and care plans were in place and were completed appropriately, with appropriate action taken when a change in the patient's condition was detected.
- The hospital measured and monitored incidents or avoidable patient harm through the National Safety Thermometer scheme. The information gathered was used to inform priorities and develop strategies for reducing harm.
- Staff training was prioritised which ensured staff had the skills and knowledge to provide safe care and treatment for patients. Staff were aware of safeguarding principles and able to follow the correct procedures.

Medical care (including older people's care)

Are medical care services safe?

Inadequate



Overall we rated the Royal Sussex County Hospital's medical services as inadequate for safe because

- The risk of fire was not being managed appropriately. We found that the older buildings posed a particular fire safety risk as they were overpopulated, overcrowded and cluttered with narrow corridors and inaccessible fire exits. We had concerns that in the event of a fire, vulnerable patients would not be able to be evacuated safely in a timely fashion.
- The wards in the older buildings were extremely difficult environments for staff to provide safe and effective care. Some of the most challenging and vulnerable patients were being cared for in these premises. Although the trust had a strategy for managing this, it was not carried out in practice. Risk assessments were poorly completed or out of date and did not provide assurance that all the environmental risks to patients, staff and visitors were identified and managed appropriately. Although the trust had plans to replace the older buildings, the project was planned to take a minimum of nine years.
- Although the trust were addressing staff shortages through the recruitment of staff from overseas, this had not been undertaken in a planned way that engaged ward leaders. As a result, this was putting an extra burden on already overstretched staff to mentor and induct the new nurses. The majority of medical wards reported there continued to be severe staffing shortages. The physical constraints of the older building were also compounded by shortages of competent staff, particularly at night when there were less staff on duty.
- The management of incident reporting was variable across the directorates with limited feedback or learning identified. Whilst staff knew how to report incidents and told us that reporting was encouraged, we found no evidence of learning as a result of reported incidents. The response to incidents, safeguarding concerns and complaints also lacked a consistent approach and was different across the directorates including medical services and relied on individual managers to be proactive and disseminate information rather than having acknowledged systems in place.

- Although medicines were usually supplied, stored and disposed of securely and appropriately on the cardiology wards, Albion and Lewes, the clean utility contained various pieces of equipment and the drug cabinet was unlocked and had no means of being locked. We found intravenous fluids stored on open shelves. Intravenous fluids must be stored in a locked cupboard or room.'

However we found:

- Risk assessments and care plans were in place and were completed appropriately, with appropriate action taken when a change in the patient's condition was detected.
- The hospital measured and monitored incidents or avoidable patient harm through the National Safety Thermometer scheme. The information gathered was used to inform priorities and develop strategies for reducing harm.
- Staff training was prioritised which meant staff had access to training in order to provide safe care and treatment for patients. Staff were aware of safeguarding principles and able to follow the correct procedures.
- We found that the hospital was prepared for major incidents and any loss of business continuity. Although the lack of beds at the site would affect the hospital's ability to respond in a timely fashion.
- **Incidents**
- It is mandatory for NHS trusts to monitor and report all patient safety incidents through the National Reporting and Learning System (NRLS). If an incident is assessed as a serious incident it is also reported using StEIS (Strategic Executive Information System). Serious incidents can include but are not limited to patient safety incidents, for example loss of confidential information. Any serious incident which meets the definition of a patient safety incident should be reported to both StEIS and NRLS.
- Between January 2015 and January 2016 the trust reported 21 serious incidents. There were no never events attributable to the medical directorates in the past year. 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 by all healthcare providers.

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- There was an incident reporting policy and procedure in place that was readily available to all staff on the trust's intranet. The staff we spoke with were aware of the policy and were confident in using the system to report incidents, this included bank and agency staff.
- The electronic system involved a manager reviewing each reported incident and escalating where indicated. We reviewed various managers' reports on the online reporting system and noted that the majority of managers had completed their part of the review process and there were few incident reviews outstanding.
- Staff had access to training on incident reporting and this included 'Duty of candour' training.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The staff we spoke with told us that patients and relatives were supported and informed of the outcome in accordance with the trust's duty of candour. Staff were less clear what responsibilities the duty of candour required of healthcare providers and the documentation required. We saw examples where the patients and their families had been informed of incidents including those where no harm occurred. The majority of staff we spoke with were aware of the duty of candour and what it meant for them.
- There was not a trust wide system to disseminate learning from incidents. We found that staff did not always receive individual feedback from reported incidents and learning was inconsistent across the medical services. Staff reported there was very little inter-ward or trust wide learning from incidents. This was different across the directorates including medical services and relied on individual managers to be proactive and disseminate information rather than having acknowledged systems in place.
- The trust produced a monthly safety and quality summary which was sent to each ward and unit. This included details of incidents reported or closed during the past month. Recently the speciality medicine directorate had implemented a safety newsletter which included learning points and actions to take to improve care. We were told there were also various trust wide initiatives in place to share the learning from incidents such as a serious incident directory on the trust's intranet and monthly trust wide safety publications, however none of the front line ward staff we spoke with were aware of these.
- On some wards where staff reported they received little feedback after completing an incident report they told us, "It [the report] disappears into a black hole – there's no feedback." They told us this had made them cynical about reporting as it didn't seem to change anything.
- We were told that low staffing was only reported if it was 'critically low' or if lack of staff compromised patient care. Staff and managers told us across the medical services that they very rarely reported staff shortages on the electronic reporting system. They told us, "It's pointless – it takes up a lot of time and nothing ever changes." We did see several incidences where low staffing had been reported on the electronic system over the past year. We noted the numbers were low and did not reflect the amount of time wards were short staffed.
- Staff gave an example of a near miss drug error which was reported through the electronic reporting system and the patient informed in accordance with the duty of candour. We noted that the incident occurred because of multiple distractions whilst drawing up the medication. There had been no learning or actions from this event such as putting a system in place to prevent disruption for the nurses undertaking medicine administration in the future.
- On other wards such as Howard Two ward, staff told us they always received feedback from their ward manager and that on some wards such as Chichester Ward the whole team undertook scenarios on specific incidents to learn lessons.
- Staff on Howard Two ward gave an example where a drug incident led to a serious incident investigation. They told us how the patient was kept informed and how there was shared learning through the daily safety briefing, weekly nurses meeting, monthly oncology quality and safety meeting and the specialist medicine directorate meeting.
- On other wards such as Grant and Howard One wards, staff explained how monthly multi-disciplinary team meetings were used to discuss risk, complaints and incidents. Any learning at these meetings was then fed back to the rest of the team.

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- The trust had a process in place to review every death of a hospital inpatient in order to identify areas for improvement. There were no mortality outliers or particular risks highlighted for this trust.
- Regular mortality and morbidity meetings and case reviews took place across the medical services. For example the neuroscience and hyper acute stroke team were well organised with monthly trust mortality and morbidity meetings and four monthly regional neurosurgery meetings. The hyper acute stroke service told us that every second Friday there a mortality and morbidity meeting took place, which was attended by the stroke medicine team and medical students.
- We reviewed a sample of morbidity and mortality minutes from across the medical directorates and found there were different methods and formats of recording the findings and the discussions that took place. Some directorates such as cardiology documented the findings and any action and learning points in a standard template; others such as the specialist services had little information about the incident recorded or were more of a discussion without clear action points or learning identified.
- We noted that the mortality and morbidity meetings had been held for several years and although medical staff felt it was a good, non-judgemental environment to discuss cases, the meetings were often cancelled or the full team was not present due to staffing shortages.
- Over 18 months between 2014 and 2015 the acute medical unit (AMU) received three Rule 28 Coroner's reports. These are reports sent to an organisation if there is a risk of other deaths occurring in similar circumstances. The organisation has a duty to take action to reduce the risk. The AMU manager detailed the action that the trust had taken following the reports. This included shutting four beds, increasing the staffing and the management of the unit and reorganising the unit into higher and lower acuity beds. Following these actions the number of calls for medical assistance and the number of complaints had decreased. Staff reported they now felt listened to and the moral within the unit had improved. However recently the four beds were reopened due to capacity issues but an increase in staffing had been agreed.
- **Safety thermometer**
- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- All six directorates which provided medical services collated information for the safety thermometer. Each ward or unit was sent a monthly summary sheet which detailed how the ward and the trust overall was doing on meeting key quality and safety targets. We saw that on most wards this information was displayed so that patients, the public and staff were aware of how the individual ward was doing. On each ward or unit we inspected we reviewed the available data and noted that overall the incidents of patient harm were decreasing.
- For example on Baily Ward over the past year 16 patients had fallen where the expected rate of falls would be 37 patients. The rate of patient falls had decreased on this ward in the past year by 9%. This was part of a campaign to raise awareness of the risk of falls, through staff training and proactive management of risks.
- Pressure damage is localised, acute ischaemic damage to any part of the body caused by the application of external force (either shear, compression, or a combination of the two). Pressure damage had also decreased across the trust and was 68% lower than it was six years ago. The trust reported 132 pressure damage incidents over the past 12 months. Each ward or unit was sent their yearly total in the monthly summary sheet. For example Catherine James and Egremont wards recorded ten pressure damage incidents and recorded 93% of harm free days. In the same period Bristol ward reported 83% harm free days with no pressure ulcers.
- Each of the six directorates that provided medical services maintained performance dashboards which provided safety thermometer details. We reviewed the performance dashboards and noted the specialty medicine directorate reported 91% harm free days for 2015; the cardiovascular directorate reported 91%; cancer services directorate reported 96%; the abdominal directorate reported 80% and the acute floor reported 93%.

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- This demonstrated that there were systems in place to monitor the incidents of patient harm across the trust. There were methods in place to feedback the findings to staff on a regular basis to inform practice and encourage improvement.
- **Cleanliness, infection control and hygiene**
- The trust had infection prevention and control policies readily available for staff to access on the intranet. These included waste management policies which were monitored through regular environmental audits.
- We saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely including the safe disposal of cytotoxic drugs in designated waste bins.
- The trust had arrangements in place to support the management of infection prevention and control. This included an infection prevention team with qualified infection control nurses and a doctor with infection control responsibilities. The team worked across the trust coordinating with other health-care professionals, patients and visitors to prevent and control infections.
- The teams' responsibilities included giving specialist infection control advice, providing education and training, monitoring infection rates and audit infection prevention and control practice. The infection control team reported to the chief nurse and the trust board.
- Each of the medical wards and units we inspected displayed their infection prevention and control audit results. For example, on Bristol ward the information board explained that poor hand hygiene scores in March had led to a repeat audit. Chichester Ward scored 96% in the most recent cleaning audit with hand hygiene scores consistently between 99 – 100%
- We noted that the hospital's infection rates were consistent with the national average for bacterial infections such as MRSA and C. difficile. There were no reportable healthcare associated infections attributed to the trust in 2015/2016.
- Infection prevention and control was included in the trust's mandatory training programme. Those staff we spoke with all confirmed they had completed this training.
- The majority of areas we inspected where patients had access were visibly clean and tidy to the standard expected in the high risk category of the National Specifications for Cleanliness in the NHS. Linen cupboards were clean and tidy with bed linen managed in accordance with best practices. However they were not to the standard reported in the patient led assessments of the care environment (PLACE) results. These scored the hospital as 100% for cleanliness
- In the older parts of the hospital, such as the Barry and Jubilee buildings, we found that environmental constraints and outdated equipment led to poor practice in infection control. There was a lack of storage space so stores and equipment were kept on the floor. This made it difficult to thoroughly clean and keep tidy.
- For example on Baily ward in the Barry Building, the sluice was cluttered with an offensive smell. There was no hand washing sink in the sluice, the one sink was used for both hand washing and the disposal of waste. The macerator was rusty and corroded and not firmly attached to the floor. There were two commodes with 'I am clean' labels attached but both of the commode lids were severely damaged and should have been replaced. We noted personal items such as toiletries were stored in the sluice alongside the bedpans. The clinical waste bin in the ward was broken.
- On Chichester ward in the Barry building the sluice was also an unpleasant area to undertake disposal of waste and clean equipment. It was cramped and very small. There were sheets and incontinence pads stored on the floor in boxes. The manager knew this was an infection control risk but there was nowhere else to put them. The manager had funded plastic boxes out of her own pocket to store these items in order to minimise the risk.
- On Howard One ward in the Jubilee building we found the sluice was dirty and not fit for purpose. There was a contaminated cloth wrapped around the sluice pipework, which was rusty and corroded. We were told that the infection control team had seen the pipes but there was not any risk assessment or action plan in place to address this. Staff told us that the macerator broke down regularly and when this happened the staff used orange bags to dispose of clinical waste. We were told it had been like this for over four years. The toilet facilities for patients had damaged and cracked flooring which was an infection risk for patients. We found bathroom scales and commodes stored in bathrooms due to lack of storage space.
- Lack of appropriate storage space in the discharge lounge meant that clean linen was stored in the sluice area where soiled and contaminated articles were disposed of.

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- None of these risks or hazards were entered onto the corporate or directorate risk registers. There were no action plans in place to address the issues or plans in place to minimise the risks. When we spoke with staff they could only tell us that it would all be resolved with the building of the new hospital.
- The redevelopment was planned to replace all the buildings on the front half of the hospital site. The project was planned to take a minimum of five years and in the meantime patients would continue to be seen and treated in the buildings which were over 130 years old and no longer fit for purpose.
- We found that staff were working hard to overcome the limitations of the building and older equipment. For example on the Stroke Unit (Donald Hall and Solomon wards) in the Barry building, weekly ward quality control cleaning checks took place by a senior housekeeper and a senior nursing member of staff. The findings were documented and recorded. Staff told us that, "The cleaning service on the ward is good unless the regular cleaning staff based on the ward are on leave."
- The trust undertook regular infection prevention audits, however there was little evidence that the findings of the audits resulted in change to practice or improvement of the clinical environment. Our findings at inspection did not always correlate to the findings from cleanliness audits. For example; the wards all recorded high scores in the national cleanliness audits despite the limitations of the site. For example Baily ward scored of 98%.
- The trust was not fully compliant with the national specification for cleanliness (NSC). The national cleanliness audit programme provides a framework for monitoring and auditing cleanliness in NHS hospitals. The NSC requires all staff to have a work schedule, when we asked for this document we were told that the trust does not have these in place. This meant that items may be missed and not cleaned particularly with changing of operatives during the day as they would not know what the other operative had done.
- We questioned the findings of the trusts cleaning audits in view of our findings at inspection. For example in 2015 The Royal Sussex County Hospital took part in the patient led assessments of the care environment led by Healthwatch. The hospital scored almost 100% for cleanliness. This did not include any areas which patients do not use.
- All wards and departments took part in an infection prevention and control audit in January 2016. The audit was part of an annual programme of work to monitor infection prevention and control compliance with The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health 2015). The audit results varied across directorates with some poor and some excellent results. Areas that exhibited poor compliance were given immediate feedback and reaudited. The expectation was that all areas audited would be 100% compliant.
- In December 2015 the trust undertook an audit of commodes. The infection prevention team visited 31 areas across the trust and visually inspected 94 commodes for structural integrity and cleanliness. They found 9% of commodes had unacceptable visual soiling. 10% of commodes had damage to the frames and 21% had damage to the soft seat covers. Only 36% commodes had an 'I am clean' label affixed indicating they had been cleaned after used. We did not see evidence of an action plan to address the shortfall.
- On the wards that specialised in infectious diseases, we were told that regular sepsis audits took place. The consultants told us that antibiotic stewardship was improving.
- We noted that Howard One had a biohazard spill kit readily available to deal with chemotherapy spills.
- The wards and departments in the more modern buildings were spacious, appropriately furnished and decorated with materials that were easy to keep clean. For example in the Cancer Centre we found the sluice to be clean, tidy and clutter free. There were aseptic trolleys for intravenous cannulation with easy to access sharps bins.
- We observed staff following best aseptic practice as advocated by the Department of Health, Royal College of Nursing and Association for Safe Aseptic Practice. We observed staff undertaking aseptic techniques such as inserting cannulas and administering chemotherapy. There were ample hand washing sinks available supplied with soap and hand towels together with sanitising hand gel readily available.
- On the renal wards there were systems in place to test the water weekly and this included the home and satellite units. We observed staff using appropriate aseptic techniques when connecting a patient with a line onto a dialysis machine.

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- In the endoscopy suite endoscopy unit was assessed as compliant with the national Joint Advisory Group endoscopy standards in 2013. The unit was due for reassessment in 2014. There was no information as to its current status.
- We noted that weekly cleaning audits took place in the cardiac catheter laboratories with a system to ensure that the curtains were changed “regularly every couple of months or immediately if soiled.” The curtains were visibly clean at inspection.
- We saw that personal protective equipment such as disposable gloves and aprons were readily available for staff to use. There were hand washing sinks with sanitising hand gel available. The majority of staff followed infection control principles and were seen to wash their hands and use hand gel appropriately. We observed the matron and staff wearing personal protective equipment (PPE) when disinfecting beds between patients and we generally observed good hand washing techniques.
- The majority of staff were bare below the elbows. However we observed instances where the bare below the elbow policy was not adhered to. For example we observed a consultant on the cardiology wards, Albion and Lewes, wearing a long sleeved cardigan and shirt. He was not challenged by staff at any stage and reminded to be bare below the elbows. We also saw a porter wearing a long sleeved jumper onto the wards whilst transferring a patient. When questioned, the porter did not demonstrate any knowledge or understanding of infection control or the need for bare below the elbows and hand hygiene.
 - **Environment and equipment**
- There wasn't an effective environmental risk management strategy in place. Although the trust had a risk management strategy policy detailing the expected risk management actions, in practice this was not happening across all locations in the trust. For example the health and safety, fire risk assessments and fire routines for the Jubilee and Barry buildings were dated between 2003 and 2012. Only two had been updated since then. The fire routines were generic in nature and did not describe the individual evacuation plan for each ward. The fire reports and risk assessments detailed the same findings in 2011 that we found at this inspection in 2016.
- There were a number of high risk environmental issues such as the use of asbestos in the hospital that we did not have assurance had been dealt with. The trust had commissioned a report into asbestos in the environment but there was not an action plan in place as to how the issues would be addressed. We spoke with a pregnant member of staff working in a high risk environment who had not had a pregnancy risk assessment undertaken. There was no evidence that display screen assessments had been undertaken. None of the staff we spoke with were aware of a system to manage the environmental risks. They thought this was facilities responsibility but the staff working in the areas were not aware of how the risks should be managed on a day to day basis.
- We had particular concerns that the risk of fire was not being managed appropriately. We found that the Barry and Jubilee buildings were particular fire safety risks as they were not constructed to modern safety standards and had been altered and redesigned many times during their long history. They were overpopulated, overcrowded and cluttered with narrow corridors and inaccessible fire exits. We found flammable oxygen cylinders were stored in the fire exit corridors. We found that fire doors with damaged intumescent strips which would not provide half an hour fire barrier in the event of horizontal evacuation. We found fire exits which had not been tested to ensure they provided safe, easy and immediate evacuation for the number and acuity of patients accommodated. We raised this with the executive team and requested action to be taken.
- The physical constraints of the building were compounded at times by shortages of competent staff, particularly at night. We had concerns that in the event of a fire, vulnerable patients would not be able to be evacuated safely in a timely fashion.
- We found that on several wards in the Barry and Jubilee buildings, patients were receiving care on balconies where access was restricted. These beds could not be accessed by patients needing a wheelchair or trolley. In order to gain access by wheelchair or trolley the patients nearest the entrance had to be moved out onto the ward when moving the furthest patients. Staff were managing this by prioritising the beds for use by ambulant patients only. Staff told us that due to pressures from the site and bed managers they often found inappropriate patients had been admitted to these beds overnight. This was confirmed in the

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incidents reports we reviewed. During our inspection we found patients with mobility difficulties on the balconies. These patients would be particularly challenging to evacuate during a fire or emergency.

- On the day of inspection we spoke to the Fire Safety Officer who told us the method for escape for patients that were in bedded areas on the balcony beds within the Barry building was via a "ski sheet". We checked the balcony bed on Overton Ward and there was no ski sheet under the mattress.
- These are devices to move patients off beds and out of the hospital quickly in an emergency. We were told that use of the ski sheets was covered in the annual mandatory training update but there had not been any scenario training in evacuating immobile patients off the balconies.
- Each ward had fire wardens in place and the managers told us that there were sufficient for the ward to be covered by a fire warden both day and night.
- We requested individual ward fire safety risk assessments and action plans for the wards and units in the Barry and Jubilee buildings. The trust provided two risk assessments dated 2009 and 2010 and an action plan and fire safety inspection report from the local fire and safety service dated June 2015. Each of these audits and reports detailed the same issues and concerns that we found during our inspection. For example maintaining clear fire exits and damaged intumescent strips and smoke seals. There was no evidence provided that fire safety was audited annually, that each ward or area had an individual fire evacuation plan or a current risk assessment. We were not assured that fire safety was given the resources needed to protect patients, staff and visitors from the risk of fire.
- Following the inspection we raised our concerns with the county fire safety officer who agreed to undertake an urgent review of the fire safety arrangements in the hospital.
- The older buildings also posed a particular hazard regarding legionella as there were multiple areas where pipes and plumbing had been altered, redesigned and decommissioned over the years. The ward managers were very aware of the risks and took action to ensure that little used taps and outlets were assessed and water run through. We looked at a sample of legionella risk assessments and the current action plans that were in place.
- Staff told us that the balconies were cold in the winter and portable heaters were used to keep patients warm. The use of portable heaters is an additional fire hazard.
- We found the medical wards and access corridors were in a reasonable state of repair. We noted that several patients and members of staff told us that much redecoration had taken place immediately prior to the inspection. We saw redecorating taking place constantly during our inspection. Ward staff gave us examples where issues that had been outstanding for some time had been addressed because of the inspection. Patients told us they "would be glad when the inspection was over so the decoration would cease".
- We found the redecoration was taking place without due care for the patients and the safety on the ward. Areas being redecorated were not closed off and the maintenance staff were working around beds and in corridors. We saw cans of paint and ladders placed in areas which could be hazardous to patients, the public and staff.
- Staff told us that it usually took some time to get repairs done. They told us of their frustrations in getting minor maintenance issues dealt with. For example on one ward the hot water boiler (used for making hot drinks for the patients) had not been working for a week awaiting urgent repair. Other staff gave us examples of radiators not working, faulty showers and water leaking through ceilings. They told us they were grateful for the inspection as redecoration and refurbishment that had been outstanding for some time had been prioritised just prior to our visit.
- The more modern areas of the hospital were bright, airy and well-proportioned, making them suitable areas for caring for patients. For example the cancer centre was designed and furnished in accordance with national guidance and best practice. There was a staff shower to deal with any chemotherapy spillages, a quiet room and waiting area all decorated and furnished to provide a comfortable and safe place for patients, visitors and staff.
- The 2015 Patient Assessment of the Care Environment (PLACE) rated the Royal Sussex County Hospital at 77% for the condition, appearance and maintenance which was the lowest acute hospital score.
- We found that the corporate COSHH (Control of substances hazardous to health) risk assessments were available for the cleaning products used in clinical areas.

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- The provision of medical services at the Royal Sussex County Hospital was spread over several buildings throughout the site. Some of the buildings, such as the Millennium Wing where the cardiology services were based and the Sussex Renal Unit, were relatively modern and provided a safe place for patients to receive care and treatment.
- However the Barry and Jubilee Buildings were over 130 years old and were extremely difficult environments for staff to provide safe and effective care. We found that some of the most challenging and vulnerable patients were being cared for in premises that were no longer fit for purpose. This included the elderly, those living with dementia, the acute respiratory, infectious diseases and oncology patients. In total over 180 patients were receiving care in these two buildings. Staff working on those wards told us that the majority of complaints they received were about the environment.
- We noted that in the last six months two incidents were exacerbated because of the poor design and layout of the building. These involved patients falling in areas which could not be accessed by a hoist, which made it difficult to move the patients safely from the floor. One incident involved the use of a balcony bed. Staff at the time raised concerns with the senior management about the criteria and directions for the use of the balcony beds but no action was taken.
- During the inspection staff on Howard One ward told us that they had reported the 'unbearable' high temperatures on the ward. They told us they had raised concerns about the environment and in particular how they could not open windows to relieve the heat for acutely unwell patients who were being treated for cancer. There was no action taken as this ward was due to be relocated in the new build.
- Temperature control was also a problem in some of the newer areas of the hospital. We noted that in December 2015, staff in the acute medical unit had reported such cold temperatures that patients had to wear several layers of clothing in order to keep warm.
- The older wards did not have piped oxygen or suction. This included those wards treating patients with respiratory problems, those being treated for cancer and other acute medical illnesses. For example Howard Two and Grant wards formed part of the clinical infection service which specialised in treating people with newly diagnosed infectious diseases. There was no piped oxygen or suction.
- We were told that all the environmental issues were on the risk register and had been "fed up the line." Staff were told that all the issues would be resolved during the rebuilding of the hospital. In the meantime staff and patients remained at risk from care and treatment being undertaken in an inappropriate environment.
- Managers told us that the acuity of patients in these areas was closely monitored as it was acknowledged the environment was inappropriate. However staff told us that due to pressures on beds their guidelines for admitting patients to these beds were frequently overridden by the bed managers. We saw examples where staff had completed incident reports due to inappropriate patients being admitted to these beds without any additional resources being put in place.
- The wards in the older buildings were cramped, with narrow corridors and insufficient storage available. Several of the wards such as Overton Ward, Baily Ward and the ambulatory care unit (ACU) had corridors and thoroughfares going through them. Egremont ward had an access door that was too small to allow a standard hospital bed through. This meant that patients were transferred onto a trolley to enter or exit the ward and in an emergency would have to be transferred onto a ski sheet to be evacuated
- The ambulatory care unit (ACU) was positioned in a wider part of the corridor partitioned off by a curtain in the acute medical unit. This was an inappropriate area to provide care for patients. The unit had recently moved from a more appropriate area in the emergency department but lack of staff had meant the unit had moved. Patients received care in chairs that were placed very close to each other with no division or screening. This meant there was no privacy for the patients receiving care in the chairs. We were told there were plans for this unit to have more substantial divisions but they were not in place at the time of our inspection.
- Beds in the AMU were very close together and storage of stores and equipment made this a challenging environment to care for acutely unwell patients.
- On the cardiology wards, Albion and Lewes, the clean utility was cluttered with equipment randomly stored; there was a lack of plug sockets and the ambient temperature was very warm. We were told that for over a year numerous requests had been made for extra shelving or storage facilities. This room also acted as a

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link corridor connecting the two wards and there were no locks on either of the two doors leading from the clean utility area back into the wards. The manager told us that locks had been requested but not provided.

- We noted that the respiratory wards (Catherine James and Egremont wards) were located in the old buildings while the acute medical unit and high dependency beds were in the more modern buildings. This meant that acutely unwell patients requiring care and treatment for respiratory diseases had to go outside the buildings to transfer between the wards and departments. This was a particular concern in the cold or rain. Staff reported that it usually took over 20 minutes to transfer patients between the units and during the transfer the wards and units were working short staffed. This was a particular problem for the AMU who reported that with several transfers a day, the unit spent a lot of the time understaffed because of this.
- The discharge lounge was situated in a cramped, old, damp area of the Barry building. There was virtually no storage or cupboard space in the unit. The lack of storage meant that the only space to store clean linen was in the dirty utility area. The chairs in the waiting area were packed very closely together. The staff lockers were in a small, damp alcove in the corner of the lounge. We were told that due to insufficient funding for the unit, the nursing staff had paid for a television set for patients and other small storage items out of their own pockets.
- The staff room on Chichester ward also had visible damp and mould on the walls. Medical equipment was also stored here and we were told that staff had purchased plastic boxes out of their own money to try and minimise the effect of the damp and to aid the storage of medical equipment.
- There was a lack of inpatient beds across the medical services, which meant the wards were often under extreme pressure to provide beds in spaces not designed to accommodate patients. Staff told us that the lack of medical beds throughout the hospital had turned from “a winter crisis to a permanent crisis”. This meant that wards were using any available space to care for patients. For example the balconies originally designed as day spaces now permanently accommodated patients.
- One bed on Jowers Ward was not suitable for patients as it was too close to the next door bed and pushed up against a wall. This posed particular infection control risks for patients and manual handling risks for staff. The bed did not have curtains and used portable screens, which did not protect the patients' privacy and dignity. There was a patient in this bed during the inspection.
- We found anomalies in the reporting of mixed sex breaches. Across the trust the medical wards and acute medical unit reported that there were frequent occasions when male and female patients had to share a ward or bay because of the pressures on beds. The placing of patients in mixed-sex accommodation because of a shortage of beds is considered an unjustified breach. Staff were aware that this was not acceptable practice and moved the patient onto a same sex ward as quickly as possible, usually within 24 hours. The hospital had a leaflet for patients explaining it was sometimes unavoidable due to urgent or emergency situations. Mixed sex accommodation breaches were reported to NHS England who monitored and reported on all unjustified mixing of sleeping accommodation. The data available from NHS England indicated that the trust had reported no mixed sex accommodation breaches. We noted that in the 2014 inpatient survey, 20% of patients reported that they shared a bath and shower area with patients of the opposite sex which was much worse than the national figure of 12%.
- Staff on the speciality wards reported there were frequent delays in obtaining equipment. There were insufficient hoists, drug fridges and other equipment for the number of patients. For example on Overton Ward which was originally designated as an ‘overflow’ ward but was now a substantive ward, they did not have a hoist, weighing scales or drug fridge. They had to borrow this equipment from neighbouring wards. On two of the wards we inspected the drug fridge locks were broken.
- We were told that some of the equipment used was coming to the end of its useful life and now needed replacement. For example the colonoscopies in the endoscopy suite were now considered old and in need of replacing. The Royal College of Radiologists raised concerns about the age of radiotherapy equipment. They told us that the equipment had a maximum life of ten years and the trust had one machine that was 12 years old, one that was 13 years old and two that were 14 years old.
- Jowers Ward had one telephone, which was attached to the fax machine. This meant that telephone access to the ward was restricted. Staff reported they had many

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complaints about relatives and staff not being able to contact the ward. Staff also reported a two week delay in obtaining a replacement battery for the resuscitation equipment.

- In general we found there was adequate resuscitation equipment on each ward. We saw the documentary checks on each ward confirming that the resuscitation equipment was checked daily.
- In some of the areas such as the cardiology wards, Cancer Centre and Renal Dialysis Unit there was appropriate well maintained equipment in place. There was evidence of regular checks and servicing with maintenance documentation available. Staff on the Coronary Care Unit, Cardiology Day Case Unit and cardiac catheter laboratories told us they were well supported by the trust if they needed to buy new equipment. They said there was no problem at all with the funding and they could also access a charitable trust to buy equipment if needed.
- The trust told us how the new hospital and planned improvements would address all these issues in the future. The plans had already been under consultation and review for many years and the current estimate for completion was in five years' time. We noted that the initial phase where a number of wards would be transferred to temporary accommodation had already been delayed from May 2016 to November 2016 because of unexpected delays in the building work. In the meantime vulnerable and acutely unwell patients continued to receive care and treatment in these buildings.
- **Medicines**
 - The hospital had medicines management policies together with protocols for high risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Staff had access to relevant resources on medicines management such as an electronic copy of the British National Formulary.
 - We found that medicines were usually supplied, stored and disposed of securely and appropriately, including patients own drugs, medicines requiring refrigeration and controlled drugs.
 - However on the cardiology wards, Albion and Lewes, the clean utility contained various pieces of equipment and the drug cabinet was unlocked and had no means of being locked. We found intravenous fluids stored on open shelves,
 - We observed staff administering medications and noted generally staff followed the medicines management policy. However we noted the no systems in place to prevent interruptions for staff undertaking medicine administration rounds.
 - We reviewed the untoward incidents recorded over the past year and noted that staff in general reported medicine related incidents. The staff we spoke with understood how to recognise and report medicines related incidents. They described how shared learning had led to improvement in practice in medicine management.
 - We spoke with a number of pharmacists and pharmacy technicians during our inspection and found that medicines on the ward were subject to close scrutiny and regular audit. Each ward was visited on a regular basis by either a pharmacist or a pharmacy technician who undertook regular audits and security checks. Staff told us that the pharmacists were very helpful with advice and support if needed.
 - We undertook random medicine checks on the wards and units we inspected and found that in general medicine management met current best practice guidance. For example on Chichester wards the medicines including controlled drugs were stored securely, were in date and regularly checked. At the Cancer Centre the medicine prescription charts recorded all necessary patient details including allergies.
 - We found that none of the medical wards routinely measured the ambient temperature of rooms where the medications were stored. The majority of medicines have a maximum and minimum temperature which they should be stored at otherwise they may deteriorate more quickly or become ineffective. Several of the clean utility rooms where the medicines were stored were noted to be exceptionally hot and staff told us this became worse in the hot weather.
- **Records**

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- We looked at a sample of records in each of the wards and units we inspected. We found that both nursing and medical records provided an accurate personalised record of each patient's care and treatment.
- Medical notes were found to be legible and well completed in accordance with the General Medical Council guidance 'Keeping Records.'
- Nursing records were generally well completed. We found that signatures were in place, complete with staff designation and date. The records were legible with up to date risk assessments and care bundles. For example there was excellent documentation of the haemodialysis charts on the renal wards and cardiology records were clear and easy to interpret.
- Each ward undertook a monthly documentation audit where ten sets of patients' notes were reviewed to audit the quality of documentation. We noted that the audit scores were measured against the trust as a whole and the wards' past performances. We noted there were high scores across all wards for general documentation, and risk assessments apart from transfer documentation, which scored consistently low across the medical services and for the trust as a whole. We did not see any actions to improve transfer documentation.
- The junior doctors told us there was one clerking proforma system in place which they told us was working well.
- The hyperacute stroke service (HASU) used a telemedicine service which allowed the duty consultant at home to oversee the examination of a patient in the emergency department. We reviewed two sets of notes in this unit and found that the entries were very thorough and provided a full record of the patient's care and treatment including relevant discussions with the patients and their families.
- We noted that last year there had been a security breach with loss of confidential patient information reported and staff in general were very aware of ensuring patient records were kept confidential. We found that patients' records were kept in lockable trolleys. However we found these trolleys were unlocked on several wards we inspected.
- Staff told us that there were plans to streamline the discharge documentation as it frequently took over an hour to complete the discharge information for each patient. We reviewed the current discharge documentation used on Chichester ward and found it presented a comprehensive and complete record of the patient's care and treatment including the discharge arrangements.
- **Safeguarding**
 - The trust had a safeguarding vulnerable adults and children policy with guidelines readily available to staff on the intranet. We saw information on how to report safeguarding was available on the wards. For example we saw a safeguarding poster on Chichester Ward which had relevant telephone and contact details.
 - There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
 - We reviewed the copies of three sets of safeguarding team minutes and noted there was robust oversight of safeguarding in the trust. The minutes confirmed that all aspects of protecting vulnerable patients whilst in hospital were considered. The minutes included an overview of recent safeguarding referrals, staff training, new guidance and reviewing how vulnerable patients, such as those with a learning disability or living with dementia, were cared for in the hospital.
 - We noted that the safeguarding minutes documented that safe discharge and protecting patients from the damage of pressure ulcers remained the top two safeguarding risks. From the minutes we noted that the hospital's safeguarding team worked closely with other hospital teams such as the dementia team, mental health liaison team, hospital social work team and the complaints and patient safety teams. They also worked together with external stakeholders.
 - The safeguarding team monitored the outcomes from local safeguarding board investigations and ensured that any learning was disseminated to staff. The minutes documented the findings from recent safeguarding investigations and the actions to take to reduce the risk of reoccurrence. For example learning outcomes included; raising awareness of the prevention of pressure damage, ward level audits of pressure damage and including 'Lessons learned' tips for preventing pressure damage in an edition of the Safeguarding Adults newsletter.
 - We noted there were 19 Section 42 inquiries over the past year. 58% of these came from the speciality medicine directorate. Section 42 inquiries relate to the

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local authority having specific duties and responsibilities to investigate allegations of abuse. We noted that no themes of specific wards or departments were identified in the reviews.

- Safeguarding training was included in the trust's mandatory training programme. We were told that all staff undertook basic safeguarding training. Those staff with additional responsibilities undertook level two and three training. The trusts safeguarding reports documented a good take up of safeguarding training although the reports detailed specific numbers and not an overall total or percentage.
- All the staff we spoke with confirmed they had received safeguarding training as part of annual mandatory training. They were aware of the safeguarding policy and how to access it and told us they would report their concerns to the nurse in charge and contact the safeguarding lead if needed.
- **Mandatory training**
 - All staff including bank staff had access to on-line and face to face mandatory training. All the staff we spoke with told us that accessing the annual mandatory training was not a problem although finding time was always an issue. We spoke with staff who had recently been employed at the trust. They told us they had undertaken induction training appropriate to their role.
 - The trust had recently moved to an on-line mandatory training system. We were told there had been many problems with implementation of the new system for recording the training. Staff said that the current data around mandatory training was not robust. This was because each member of staff had to manually input past training onto the system and a large number of staff had not yet done this.
 - In the interim the ward managers kept their own systems for monitoring their staff training. We saw that some were keeping manual training records; others held spreadsheets on their computers. They all told us that once the new system becomes fully operational it should be a marked improvement.
 - The site managers confirmed that the electronic training data showed that 50 – 60% had completed their mandatory training. They told us they did not think this figure was accurate but it was also affected by the wards being under establishment for some of the year.
 - For example on Albion and Lewes wards, staff expressed scepticism about the trust's mandatory training figures.

They told us delays in updating the computer system may have skewed the figures. Although this could not be verified the ward manager told us that over 80% of staff on those wards had completed their mandatory training including level two adult safeguarding training.

- **Assessing and responding to patient risk**
 - The hospital used the national early warning scoring system (NEWS) to identify patients whose condition was deteriorating. We reviewed a sample of NEWS observation charts and saw that the charts were routinely used and patients usually escalated appropriately.
 - We reviewed the February nursing metric observations across all the wards we visited and noted that observation documentation usually scored high. This indicated that the observations used to inform the NEWS scores would normally be available. Appropriate escalation was not included in the records reviews.
 - Staff told us they felt well supported by doctors when a patient's deterioration was sudden and resulted in an emergency. There were also clinical outreach teams who could support staff on the wards if needed.
 - There were individual risk assessments in all of the patient records we reviewed. These included assessing the risks of falling, pressure damage, nutrition and continence. In the sample of records we reviewed the risk assessments were completed appropriately and the monthly patient records audits demonstrated that this was usual across medical services. For example in February 93% of patients on Baily ward had appropriately completed falls assessments and on Catherine James and Egremont wards 98% of patients had appropriately completed pressure area assessments.
- **Nursing staffing**
 - The trust used national guidance or the relevant NICE standard to provide information on appropriate staffing levels for each directorate or speciality for example NICE guidance Safe staffing for nursing in adult inpatient wards (2015). A monthly safe staffing report was presented to the board giving the planned and actual staffing hours worked. This report provided the board with a monthly overview and identified any risks that occurred during the month.
 - The chief nurse also presented a six monthly safe staffing report. The most recent report stated that the national guidance was aspirational and used different

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parameters than the trust for calculating staff, which inflated the staffing requirements and could not be universally applied in every setting. This indicated that the trust was not always using the national guidance when calculating safe staffing requirements.

- The trust told us that nurse staffing levels were calculated with the use of a dependency tool. This was confirmed in the August 2015 staffing report to the board. However in reality there were never enough staff available for the tool to be used in a meaningful way. The staff we spoke with were not aware of the acuity tool being used.
- Each clinical directorate and speciality reported the planned and actual staffing levels on a daily basis which then fed into monthly directorate reports. We reviewed the monthly staffing reports from September 2015 to February 2016. We noted that most medical wards reported registered nurse understaffing both day and night while care staff at night were over establishment.
- The March 2016 safe staffing report detailed the wards and directorates that were understaffed and noted that staff sickness levels peaked at 26% and turnover at 22% in September 2015. The report noted that six of the 11 directorates were now working within national staffing guidance although Catherine James Egremont wards was not working within the respiratory staffing guidance. To meet the British Thoracic Society guidelines the ward would need to employ additional eight whole time equivalent nurses to meet the needs of non-invasive ventilated patients.
- The report stated there were 258 whole time equivalent vacancies across the trust in February 2016. At the time of our inspection the trust vacancy rate was below the 8% trust target. Across the trust the staff turnover of 13% was slightly higher than the national average of 11.5% but was largely unchanged from the previous month.
- The data indicated that the medical wards at the Royal Sussex County Hospital were understaffed for registered nurses during the day. According to the data only two wards Overton and Solomon and Donald Hall wards consistently had enough staff on duty both day and night.
- We noted that lack of staff was not included on any of the risk registers apart from on the speciality medicine risk register. The speciality medicine risk register included the lack of bank health care assistants to provide one to one care for individual patients with challenging needs. This was confirmed when we spoke with staff who told us they normally cared for challenging patients within the allocated ward numbers.
- During the inspection the majority of medical wards reported they were short staffed, carrying vacancies or were covering for sickness. During our inspection we visited the care of the elderly, acute medical and specialist medical wards and found shifts had not been covered and staff working short. We looked at a sample of rotas from each of the wards we inspected and these confirmed that few of the shifts were fully staffed.
- Staff gave us many examples where they had worked understaffed. Staff told us how busy they were, how stressful they found the lack of staffing and how this had impacted on patient care. The staffing at night appeared to be a particular problem. On Howard One ward staff told us they were often left on their own at night with no support apart from calling for help on the ward upstairs when they needed a break.
- Working short staffed was a particular problem when patients needed transferring to other wards or needed to be accompanied for investigations. For example on Chichester ward staff gave examples where one of the two nurses needed to leave the ward for over an hour to accompany a patient for an X ray. They told us this left one nurse with 21 patients, two of whom were acutely ill. They raised it with the senior manager but were told there were no extra staff to spare.
- The ambulatory care unit (ACU) had one qualified member of staff on duty after midday. We were told that this made it difficult for staff to take a break or go to the toilet.
- We saw that ratios of the number of staff to patients were displayed on the wards. The ratios were misleading as the nurse in charge was included in the overall numbers, although they were not available to attend to patients' care needs.
- The band seven ward managers told us that there had been an initiative the previous year to make 'Super Sevens', which meant that they were supernumerary and given appropriate management time. They told us that this didn't last long and within weeks they were back to being counted as part of the ward team with little allocated managerial time.
- The trust's incident reporting system showed many examples where staff reported being critically

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understaffed. However staff told us that they did not always report understaffing through the incident reporting system as it was so common and nothing ever changed as a result of reporting the staffing shortages.

- Staffing shortfalls were discussed daily at the operational meetings. Staff working on wards with extra capacity were reallocated to other clinical areas to provide support. We were told us that sometimes a trained member of staff was moved to another ward and replaced with a care assistant. This meant that the skill mix was not always appropriate. These were not recorded as incidents as staff told us it happened so frequently. Managers told us that this had led to a situation where staff were reluctant to volunteer for bank work as they would be moved.
- There was always a stroke nurse from the hyper acute stroke service (HASU) who carried an emergency bleep. When called, they attended the emergency department without delay to oversee the treatment of patients who were suspected of having a stroke. This service was provided out of hours by ward nurses. This could also compromise the level of nursing cover on the ward if they left to attend the emergency floor. We were told that when this happened staff were called in from elsewhere to help on the stroke wards although an additional nurse had recently been appointed because of the additional workload resulting from the closure of the Stroke Unit at the Princess Royal Hospital.
- Staff told us that there were sometimes more patients being treated on the wards than there were beds for example patients having day therapy. There were no additional staff put on duty to care for these extra patients.
- Managers told us the recruitment process often took over three months during which time the wards were working understaffed. Although shifts could be filled with bank and agency staff, the managers told us there were often shifts understaffed.
- All agency use had to be first authorised by the chief nurse. There was a checklist available to provide agency nurses with an induction to the ward. Staff told us that it was frustrating and very time consuming to be consistently orientating new agency staff as they rarely had the same staff. On the cardiology wards staff told us that they had been working short staffed for five weeks due to staff sickness and agency staff had been agreed.
- The trust was addressing staff shortages through the recruitment of overseas nurses. However this had not been undertaken in a planned way that engaged ward leaders. We did not see any risk assessments, controls or strategies in place for the recruitment, competency assessment and integration of the new nurses. Several managers told us that they had no control over the recruitment process and they were allocated staff centrally regardless of any specific competencies needed for their speciality.
- Staff told us that they had raised their concerns about the current method of overseas nurse recruitment but the trust's senior management team were dismissive of their concerns. The induction, mentoring, supervision and support of new staff was putting an extra burden on already overstretched staff.
- The trust had put in some additional measures to support the overseas staff such as a two week English language course. Some of the wards had been able to extend the supernumerary periods until the new staff could demonstrate competency. However this varied between directorates and wards depending on the support the individual wards could offer. On some wards we heard that because of staffing pressures, the new overseas staff had to be part of the ward team within two weeks following induction. We spoke with the overseas nurses from these wards. Some told us how well supported they were while others were finding it more difficult to adapt because of the lack of support.
- The exception to this was the acute medical unit (AMU). Both nursing and medical staff on AMU told us there had been a marked improvement in the patients' experience since the staffing had increased and the unit been reorganised. They told us that doctors were called out less, received fewer complaints and more compliments from patients. They told us they were only able to give the nurses such support because they had dedicated practice development support and the resources available to support them. Staff morale on the unit was much improved. We were told of staff who used to go home crying at the end of each shift that were now happy to come to work.
- On AMU overseas staff received adequate mentoring and support until they completed their competency assessments. We spoke with overseas nurses on this unit who were full of praise for the support they had in learning basic English and adapting to the British nursing model of care.

- **Medical staffing**

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- The trust had a lower percentage of consultants and middle career doctors (4% lower) and a higher percentage of registrars and junior doctors than the England average. For example, the medical staffing percentages for registrars was 44%, higher than an England average of 39% and junior doctors made up 24% of medical staff compared to an England average of 22%. This meant the trust's medical workforce was more reliant on junior staff than the national average.
- The General Medical Council (GMC) informed us that there were 639 doctors working at Brighton and Sussex University Hospitals Trust with 396 trainee doctors. In February 2016 there were 11 open fitness to practice cases and six doctors with ongoing sanctions.
- We noted that following concerns raised in 2013 about unsafe staffing out of hours the Deanery had conducted a follow up visit in 2015 to monitor the situation. No patient safety issues were identified. Although there were some staffing issues during night shifts the GMC did not find this was an issue requiring action. The number of training posts had increased from 27 to 37 in 2015/2016 and all posts were recruited to and filled.
- In the 2015 national training survey general medicine, neurology, respiratory medicine, acute general medicine, cardiology and geriatric medicine at the Royal Sussex County Hospital were below the national average for work load, overall satisfaction, induction and experience. Only emergency medicine was above the national average for handovers.
- This inspection was carried out over the period of the junior doctors' strike. This meant there were less junior doctors available to interview than usual. However most of the doctors we spoke with on the day with felt there was usually adequate numbers of doctors on the wards during the day and out of hours.
- For example on Grant and Howard Two wards the doctors told us they were well supported by consultants and there was enough junior doctor cover. They also told us consultants were supportive when present and contactable by phone if they were needed for support out of hours.
- On the cardiology wards we found that patients were looked after by a number of different consultants. Although this had the potential to be confusing for nursing staff there was no evidence of any problems on the unit. We saw there was adequate consultant weekend cover to each ward every day with each consultant conducting twice weekly ward rounds and every new patient being seen by a cardiology consultant on the morning after admission.
- The hyper acute stroke service (HASU) had one academic consultant who carried out two weekly teaching ward rounds and three full time consultants in stroke medicine. There were daily consultant ward rounds including at the weekends. A seven day trans ischaemic attack clinic (TIA) was provided on the ward by a ward nurse and the duty consultant.
- The emergency rota for the stroke unit and TIA clinic was provided by three full time consultants and two specialist trainees. The stroke unit consultants also looked after any outlier patients in the unit and would refer to the relevant specialist colleagues within the trust if necessary. There were always two junior medical staff on the ward during weekday office hours.
- Although there was not a dedicated doctor allocated to the discharge lounge, staff there told us that junior doctors would attend if bleeped and asked to do so.
- There was a frailty team in place who were on call throughout the week to care for elderly frail patients with complex needs across the hospital. The consultant led frailty team attended the acute medical ward daily and oversaw the care and treatment of elderly frail patients. Staff reported that this was a successful initiative as it improved the consistency of care and treatment by having a lead clinician coordinating the care of this group of patients.
- The level of medical cover was not the same for all specialities. We heard how concerns had been raised about the level of cover over night on the general medical, respiratory and geriatric wards. This was under review.
- We viewed medical staffing rotas and saw these related to the actual medical staffing levels and the established number of medical staff required to staff the department. We reviewed the on call lists for the AMU. The AMU junior doctors told us there were lots of systems in place to support them but they found the rota was disorganised. They told us that there were often gaps in cover caused by last minute changes and this caused problems.
- The patients we spoke with told us they did not have any problems with accessing a doctor when needed.
- We found there were usually sufficient suitably trained and qualified doctors available to provide effective care

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and treatment to patients across the specialities. Where concerns were raised about the level of medical cover, such as in the specialist medicine directorate, there were processes in place to raise concerns and investigate.

• Major incident awareness and training

- The trust had business continuity plans in place which included major incidents, emergency preparedness, cold and hot weather plans, pandemic influenza plans and the patient flow and escalation policy.
- Staff were made aware of these through both electronic and paper means. The current policy was available on the trust's intranet with hard copies on the wards. There was also a major incident planning and business continuity leaflet for staff to act as a prompt for the policy and the actions to take.
- The Royal Sussex County Hospital was designated as the local trauma centre for the south east. This meant that any major incident would have an impact on the day to day activities of the hospital. We found the hospital consistently worked at capacity and bed availability was a constant problem and pressure across the medical services. This may have an adverse impact on the trust's ability to respond in a timely fashion to any major incident.
- Staff described occasions when the major incident policy had been instigated. For instance during a major road accident and during an incident at a local airfield. We were told that following any incident there was a staff debrief and the process was reviewed.
- The medical services would usually be involved in a major incident through either the acute medical unit admitting patients from the emergency department or through taking patients from other areas and specialities to free up trauma beds.
- We saw examples of emergency planning taking effect during our inspection as not only was there a junior doctors strike but the trust was dealing with problems caused by a change in the patient transport provider.
- The hospital had time to prepare for the junior doctors strike and make alternative arrangements. We did not see any incidents where patients' medical care was compromised because of the strike.

Are medical care services effective?

Requires improvement



Overall we rated the Royal Sussex County Hospital's medical services as requires improvement for effective because:

- We found medical care was evidence based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes.
- The medical wards had clinical pathways in place for care for a range of medical conditions based on current legislation and guidance.
- Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found that staff training was good with ongoing training and development opportunities available.
- There were suitable arrangements in place to ensure that further training and development was available for staff to enable them to improve their skills and develop their competencies. The majority of staff we spoke with told us they felt well supported and encouraged to develop.
- Throughout the medical services we found effective multidisciplinary working. Medical and nursing staff as well as support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

However:

- We found that the hospital was not yet offering a full seven-day service. Constraints with capacity and staffing had yet to be addressed. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Accessing valid appraisals was variable depending on the ward or directorate. Not all staff had received an annual performance review or had opportunities to discuss and identify learning and development needs

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through this review. Staff reported that staffing shortages had impacted on the appraisal process and, although this was improving, time to undertake appraisals was still an issue.

- The trust's recruitment strategy for determining the competency of overseas nurses was not robust leading to delays in the nurses being used effectively on the wards.
- **Evidence-based care and treatment**
- Staff were able to access national and local guidelines through the trust's intranet. This was readily available to all staff. Staff demonstrated how they could access the system to look for the current trust guidelines. We noted there were appropriate links in place to access national guidelines if needed. We saw that guideline reviews were included in some of the clinical governance meeting minutes we reviewed and were included in update briefings for staff.
- We reviewed samples of guidelines including the cardiology and stroke guidelines. We noted these were consultant led and were routinely checked by a nurse consultant and updated by the consultants.
- We saw the different medical directorates participated in both national and local audits which demonstrated compliance with best practice and national guidelines such as the National Institute for Clinical Excellence (NICE) clinical guidelines. We reviewed a sample of local audits such as the venous thrombolysis (VTE), diabetes and nasogastric tube audits. We noted that the audits were used to inform practice and improve the quality of care provided. For example following the VTE audit the prophylaxis recommendations had been modified and as a result of the nasogastric tube audit the numbers of PEG tubes had reduced significantly. These local findings were in accordance with a recent national trial.
- The diabetic nurse specialist carried out audits in 2015 to map compliance against best practice in diabetes care. We saw the constant data collection and auditing had identified that improvements had been made since the original audit in 2014 but there remained outstanding areas such as the lack of an inpatient foot team and podiatry service and more work was needed in educating staff.
- The acute medical unit had developed a tool based on the acuity of each bay and the overall acuity of the unit. We saw that data collected over a six month period had helped to demonstrate that the right patient was usually

in the right bay. This information combined with feedback from the shift leader as to how the shift went was being used to ensure that the unit was always staffed appropriately.

- The cancer directorate had a strong clinical research base and was using information gathered in real time to improve the service and the care given to patients. One member of staff told us, "This is our own information, our own dashboard and we know we're on top of it." The cancer directorate participated in a large number of clinical audits most of which demonstrated significant improvements over the last 5 years. For example the lung cancer audit had been used to drive improvements in the tissue diagnostic rate, seeing a Macmillan nurse and treating small cell with chemotherapy.
- The renal dialysis unit had appointed a band seven clinical governance lead who reviewed incidents, helped with the renal registry data collection and conducted monthly audits. We saw that the audits demonstrated that the Royal Sussex County Hospital was not an outlier and performed better than average on the adequacy of patient dialysis.
- The stroke unit achieved a C rating in the Sentinel stroke national audit programme (SSNAP). This was an improvement on the previous year's D rating. This is a national audit programme which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards as well as national and local benchmarks.
- **Pain relief**
- The patients we spoke with told us there was no problem with obtaining pain relief.
- There were protocols and guidance available for staff on managing patients' pain. There was a pain scoring tool available for staff to assess adult pain levels. In the records we reviewed we noted these were completed appropriately and pain relief was given when needed.
- All the patients we spoke with, including those who had recently undergone procedures, told us they had no problems in obtaining prompt, adequate pain relief.
- We saw in patient records that pain scores were recorded where indicated.
- Each month each ward received patient feedback which included responses to the question 'Do you think the

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hospital staff do everything they can to manage your pain?' This enabled the ward managers and staff to make sure they were treating patients' pain management appropriately.

- We reviewed the feedback sheets for each ward for February 2016 and there were no concerns indicated on pain management across the medical services.

• **Nutrition and hydration**

- The trust was using a nationally recognised tool to assess patients' nutrition and hydration. We reviewed a sample of risk assessments on each of the wards we visited which included nutritional assessments.
- We found that in general the assessments were up to date and additional support from the dietician service had been sought when needed. A dietician was available on referral to the hospital's dietetic service. Dieticians provided specialist support to some medical services such as stroke patients.
- The majority of nutrition and fluid balance sheets had been scored and acted upon appropriately. We noted that the wards reviewed a sample of ten nursing records each month and the completeness of nutritional assessments were included in the review.
- We reviewed the monthly patients' notes audits for nutritional documentation across all of the medical wards for February and noted that in general they were well completed. Some wards such as Bristol Ward scored 99% completed appropriately with the acute medical unit scoring worse at 70%.
- The patient-led assessment of the care environment (PLACE) survey showed the trust scored 93% which was better than the England average (88%) for the quality of food.
- Patients were offered three main meals and snacks were available if needed. There was a choice of food available and the hospital was able to cater for specialist diets if required. The menu lists included the patients' dietary requirements and food choices.
- For the patients voice survey 2015 when asked 'How would you rate the hospital food' the service performed similar (3.77) to the trust (3.76)
- The discharge lounge was able to provide food and drinks to patients and had their own discharge menu.
- There was not an overarching protected mealtime policy although some wards ensured that patients were not interrupted during mealtimes.

• **Patient outcomes**

- The trust routinely reviewed the effectiveness of care and treatment through the use of performance dashboards, local and national audits.
- Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator). The SHMI score of 94.2 for 2014/2015 indicated that the Trust had 5.8% fewer deaths than expected. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues. There was little evidence of cross directorate or cross speciality learning or sharing of information.
- The hospital episode statistics (HES) covering the period September 2014 to August 2015 showed the standardised relative risk of readmission at Royal Sussex County Hospital were within expectations apart from general medicine.
- The standardised relative risk of re-admission at 112 was mostly the same as England averages compared with the England average of 100. For example clinical haematology was 86 compared with the England average of 100 and for non-elective geriatric medicine this was 101 compared with the England average of 100.
- However, an outlier was elective general medicine, which scored 301 against the England average of 100. Staff we spoke with told us this did not reflect their experience of emergency readmissions. They did acknowledge that pressure on beds meant that elective admissions were sometimes cancelled but could not provide a definitive reason for this.
- The hospital demonstrated improvement in the sentinel stroke national audit programme (SSNAP) from previous audits. The Royal Sussex County Hospital's overall SSNAP score from July 2014 to June 2015 had improved from a D to a C rating (A is the highest and E the lowest level of attainment) for both patient centred and team centred key indicators.
- In the 2012/13 Heart failure audit Royal Sussex County Hospitals scored below the England average for in hospital care measures and mostly the same for discharge care measures.
- We discussed the audit results with staff on the cardiology wards. ST Segment Elevation Myocardial Infarction (STEMI) is the name cardiologists currently use to describe a classic heart attack. They told us that 700 patients with non-STEMI symptoms were audited last year against national guidelines. They said, "We

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were out in about one third of the patients, one half of those because of co-morbidities and the other half because of cross-site delays". The chest pain unit was opened six months ago to address the problem of cross site delay. This meant the trust could now take patients within 24 hours from the Princess Royal Hospital and other secondary providers that referred to Brighton.

- The 2013/2014 National Heart failure audit data indicated a delay in inpatients receiving an echocardiogram. This was reviewed and it was concluded that the tests were being done at the bedside with only an informal report handwritten in the patient notes afterwards. The tests were now formally reported which should show an improvement in the next audit.
- The Myocardial Ischaemia National Audit Project 2013/2014 scores at Royal Sussex County Hospital were lower for two of the three measures compared to 2012/13 scores and lower than the England average for two of the three measures. The data indicated that the non-STEMI angiography rate was low. Staff told us this was undergoing a full review at the time of the inspection as it was thought that coding errors were largely responsible.
- Scores in the National Diabetes Inpatient Audit 2015 at Royal Sussex County Hospital were worse than the England average for 10 of the 20 measures audited but improved for 10 measures since the 2013 audit. For example 51% of diabetic patients were visited by the specialist diabetes team against an England average of 35%; whereas 29% of inpatients had a foot assessment during their stay against an England average of 33%.
- We spoke with staff in the cancer care directorate about the most recent cancer audit results. They told us they needed more diagnostics in order to deliver a faster service to patients. The audit results demonstrated that 98 – 99% had their treatment within 30 days but that sometimes the diagnostic testing could take up to 30 days. They told us that they missed the February cancer waiting times by 0.2% which they said was very frustrating and the major contributor to non-compliance.
 - **Competent staff**
- The trust had in place recruitment and employment policies and procedures together with job descriptions.

Recruitment checks were made to ensure new staff were appropriately experienced, qualified, competent and suitable for the post. On-going checks took place to ensure continuing registration with professional bodies.

- All new employees undertook both corporate and local induction with additional support and training when required. We spoke with newly appointed staff who confirmed their induction training gave them a good basic understanding of their role and responsibilities. One newly qualified member of staff said that they had had a good induction since starting although the HR department had been very slow in getting everything ready.
- We found that staff had access to further training and development. The only constraints were the lack of staff to cover, to allow them to be released for training.
- Staff throughout the medical services told us of the additional training and development they undertook to improve their skills and develop their competencies. Staff working for the cancer care directorate told us of the chemotherapy competency work books they completed and the chemotherapy training with designated modules at Brighton University.
- On the renal wards staff told us how the staff rotated between wards and the dialysis unit in order to develop their skills.
- The rapid discharge team told us about their monthly in service training which covered a range of relevant topics. They held reflective practice sessions where they reviewed various case studies.
- Learning and development needs were identified during the appraisal process. The trust collected data on this and used this to inform managers. As medical services spanned six of 12 directorates it was difficult to obtain overall compliance rates for the medical core services. Many of the staff and managers we spoke with told us they had recently had their appraisals or they were planned within the next week. They told us either the data wasn't available or was incomplete. For example on Solomon and Donald Hall wards all the appraisals were booked for the week following the inspection. We spoke with staff on Howard One ward who told us they had had their appraisals last week.
- The trust gave an overall appraisal completion rate of 44% for medicine which did not meet the trust target of 85%.
- We had varying reports from staff about accessing valid appraisals. Some staff, such as the site managers, told

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us that although there were no problems with accessing training although they did not get sufficient time to undertake appraisals. One site manager told us, "They [appraisals] just don't happen." They did not have formal supervision but had found ways to support each other such as reflective practice.

- The majority of staff we spoke with told us they felt well supported and encouraged to develop. On Chichester ward one member of staff told us how they were encouraged to gain more experience at a more senior level by working supernumerary and shadowing a more senior member of staff.
- Registered nurses we spoke with told us they were supported with preparing their revalidation. Revalidation is the process that all nurses and midwives need to go through in order to renew and maintain their registration with the nursing and midwifery council (NMC). Only nurses and midwives who are registered with the NMC may legally practice in the UK.
- Most staff we spoke with told us they had regular team meetings and were supported with their continuous professional development. However, endoscopy staff told us they could not remember when a team meeting had last been held.
- Junior medical staff reported good access to teaching opportunities and said they were encouraged to attend education events. The junior doctors we spoke with told us they received good educational supervision and said the consultant staff took an active interest in their learning and development.
- **Multidisciplinary working**
- Throughout the medical services we found effective multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and GPs. Medical and nursing staff, and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- We found the handover sheets provided comprehensive information with good clinical and discharge escalation plans in place.
- We observed positive and proactive engagement between all members of the multidisciplinary team (MDT). We attended multidisciplinary ward rounds on

Bristol Ward, acute medical unit (AMU) and Chichester Ward. We found that the ward rounds were well organised and well attended by all members of the multidisciplinary team.

- For example the AMU ward round was well organised, efficient and well chaired. The team demonstrated a collaborative approach which was noted to be safe and inclusive.
- On Emerald Unit which cared for patients living with dementia, staff told us that the multidisciplinary team often brought other cases to the MDT meeting for discussion in order to improve their care and identify any learning points. The MDT meetings were not minuted.
- Consultants we spoke with told us how multidisciplinary team work had improved and gave the diabetes team as an example. The diabetes team conducted regular audits and were able to demonstrate how care for diabetic patients had improved since the team had been put in place. The diabetes team also undertook teaching and education which helped staff with management of patients with diabetes. We also heard how the dietician linked with the diabetic nurse specialist to provide accurate information to patients and staff regarding mealtimes.
- We heard how the rapid discharge team joined in many of the MDT board rounds to facilitate patient discharge.
- There were also outreach teams of specialist staff who attended patients who had not been admitted to their speciality ward but were placed elsewhere in the hospital. These were called outlier patients. For example the oncology and frailty teams attended outlier patients to provide support to both the patients and staff on their care and management.
- The cancer teams told us of the work they undertook both in the hospital and in the community. Because of the elderly population and poor local travel links they tried to travel to patients as much as possible. The trust had worked closely with the McMillan Cancer Support Centre to coordinate care and services for cancer patients such as providing a wig service, hairdressing, massage, social services and a café.
- Staff told us of the good working relationship with the local community trust where information was shared to improve communication and the links between inpatient services and the community. Staff from both

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trusts attended joint 'away days' to foster good communication and joint knowledge. There were concerns raised about electronic sharing of information in the future as they would be using different systems.

- We heard how there was a high turnover of patients in the hyper acute stroke unit and the community services were generally excellent. Staff told us that working with three separate CCG's was sometimes a challenge to multidisciplinary working as they each provided different levels of support for patients once they were back in the community.
- Regular meetings were held with the community CCG providers to foster good working relationships and improve patient care. For example in December 2015 a regional clinical senate report into the future of stroke services in Sussex highlighted the importance of multiagency collaboration and recommended more formalised, high level coordination and cooperation between the Sussex commissioners, providers and stroke networks including those in other counties.

• Seven-day services

- Seven day cover was not available for all of the support services such as psychiatric support, radiology and therapy services. Pharmacy support services were available Monday to Friday 9am until 5pm and on Saturdays from 9am until midday.
- The weekend and out of hours services were provided by either on-call, agency or locum staff supplementing the permanent members of staff. We were told there were challenges related to capacity, staffing and the financial implications of providing additional seven day services. Managers told us, "Management can only firefight until the new development is complete."
- General and specialist medical consultant cover was available every day including weekends, with on-call arrangements for out of hours and ad-hoc cover on bank holidays.
- The trust provided a hyper acute and acute stroke service. The emergency rota for the stroke unit and the transient ischaemic attack clinic was covered by three full time consultants and two specialist trainees. A seven day service for the stroke unit started around two years ago.
- The renal unit provided a weekend consultant rota which ensured consultant cover every weekend.
- On Howard Two and Grant wards there was an HIV registrar on call 24 hours a day.

- The discharge lounge was open every day including weekends.
- Where seven day cover was not available for the support services such as radiology and therapy services, the weekend and out of hours services were provided by either on-call, agency or locum staff supplementing the permanent members of staff.

• Access to information

- The hospital used mainly paper based records. This meant there were sometimes delays when sharing information with other providers who used electronic records and means of communication. We found that access to information was a problem in the older buildings which did not always have sufficient electronic communications.
 - In general the ward staff told us there was prompt access to the results from medical tests.
 - The cancer services directorate had produced their own newsletter to keep patients and staff up to date with any new developments and current news.
 - We were told by some staff that departmental and ward meetings took place on a regular basis. They told us that this was a good forum for disseminating information. We saw the minutes from many different meetings which confirmed this. We were also told us that these were sometimes cancelled because of pressure of work. We found some inconsistency as several of the wards told us that ward meetings had not happened for some time.
 - We saw that most clinical information and guidance was available on the intranet. Staff also had access to information and guidance from specialist nurses, such as the diabetic, stoma and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.
- ## • Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
- The trust had a consent policy in place which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
 - Training on consent and the Mental Capacity Act 2005 was available and staff reported there was no problem with accessing the training.

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- We observed that consent was obtained for any invasive procedures such as endoscopy investigations and patients undergoing cardiology procedures in the cardiac catheter laboratories.
- Across the medical division we saw that staff had a good awareness of the legislation and best practice regarding consent, the mental capacity act and deprivation of liberty safeguards (DoLS). Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment. We saw several instances where vulnerable and confused patients had their capacity appropriately assessed and safeguards were put in place to protect their rights.
- Staff demonstrated good understanding of consent of both written and verbal consent where consent was implied, such as taking of bloods.
- We were told that best interest decisions and DoLS decisions were taken where indicated and these were formally documented. We saw this in practice on the Emerald Unit where three patients had a DoLS in place. Urgent authorisations had taken place with good information provided on the forms.
- In November 2015 a safeguarding report noted that there had been an increase in DoLS applications which had led to a problem with notifying CQC in a timely fashion. The legislation states CQC should be notified without delay. However the report also highlighted an increased staff awareness and better communication with staff around capacity and consent issues.
- The trust had produced a 'handy hints' guide for staff to aid them in following the correct procedure when assessing capacity and considering a DoLS application.

Are medical care services caring?

Good 

We rated The Royal Sussex County Hospital's medical services as good for caring because:

- During the inspection we observed staff treating patients with compassion and saw evidence that patients' needs were being anticipated and met. The patients we spoke with during the inspection told us that they were treated with dignity and respect and had

their care needs met by caring and compassionate staff. Staff worked hard to ensure that, even when staffing levels were challenging, this did not impact on the care and treatment patients received.

- We received positive feedback from patients who had been cared for at the Royal Sussex County Hospital over the past few months. This positive feedback was reflected in the Family and Friends feedback and patient survey results.
- Patients reported they were involved in decisions about their treatment and care. This was reflected in the care records we reviewed. There was access to counselling and other services, where patients required additional emotional and psychological support, including a number of specialist nurses who provided emotional support to patients and made referrals to external services for support if necessary.

However

There were areas where patients received care and treatment behind moveable screens and in close proximity to each other, where it would be difficult to maintain patients' dignity.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. We noted that the percentage who would recommend the trust was lower than the England average for last year until the most recent data for December 2015, when it was rated above the England average.
- We saw that Friends and Family information was displayed on notice boards around the wards and departments.
- Each ward and department collected the feedback monthly and this was displayed for staff, patients and visitors to view. The overwhelming feedback was positive across all the medical wards. Patients and their relatives praised the staff for their kindness and consideration in looking after them or their relative. For example we saw comment such as; "All the staff are wonderful, friendly and helpful", "Everyone tries hard to meet my needs, the doctors and nurses are so kind" and "No problems at all its first class".

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- A score above 50 is considered a positive indication that patients would recommend the hospital to family and friends. We saw that across the medical services the feedback was consistently positive with between 80% and 100% of patients happy to recommend the hospital to their family and friends in 2015.
- All the wards scored well but some wards scored particularly well, for example Howard Ward One achieved a score of 100% for eight out of the 12 months between January and December 2015
- There were also 'patient first' boxes on all wards. These gave patients the opportunity to give immediate feedback. We looked at 25 responses and all were positive about the care received.
- Patient Voice feedback from June 2015 to December 2015 showed some concern over the quality and variety of food comments also commonly mentioned a need for more staff across both the Princess Royal Hospital and the Royal Sussex County Hospital.
- In the endoscopy suite all 15 of the Patient Voice responses stated they would be extremely likely to recommend the service.
- In all areas we inspected we observed staff treating patients in a sensitive and considerate manner. We also heard several patient stories where staff had demonstrated exceptional care and compassion towards patients and their relatives. One example was where a vulnerable patient became agitated and distressed during a ward transfer. A member of staff took the time to find out the cause of the patient's distress and stayed with them during the whole transfer process explaining what was happening and helping them to settle into the new environment.
- Staff performed comfort rounds several times a day. A comfort round was where patients were asked if had everything they needed, were comfortable, pain free and had adequate hydration. The majority of patients told us they had a quick response when they pressed the call bell for assistance.
- All the staff we observed were consistently respectful towards patients and mindful of their privacy and dignity. They demonstrated this by knocking on doors, asking before entering behind curtains and obtaining consent from the patients before undertaking any task.
- However we observed patients being cared for in locations where it would be difficult to maintain their privacy and dignity such as in beds without curtains only portable screens, in chairs placed very close together on the ambulatory care unit and on balconies where access was restricted.
- The patients we spoke with who were currently receiving care, as well as some of their relatives, all told us of their positive experiences. For example on Howard Two and Grant wards patients described their care as "second to none" and told us how staff all communicated with them using their first name and they very much felt part of the "family".

Understanding and involvement of patients and those close to them

- We spoke with patients receiving medical care on most of the wards and units we inspected. They told us that staff explained care and treatment plans and they were provided with good information. The patients we spoke with told us they were given adequate information about their treatment telling us that the risks, benefits and alternatives were explained to them. One patient described their involvement as, "I feel in total control over my treatment."
- During the inspection we observed staff members introducing themselves to patients and relatives and explaining any treatment they would be receiving.
- The Francis report was a report on the inquiry into the failings at Mid-Staffordshire NHS Foundation Trust. The report contained many recommendations for both public bodies and the NHS on keeping patients safe and improving patient care. Following the publication of the Francis report in 2014 it was recommended that every hospital patient should have the name of the consultant and nurse responsible for their care above their bed. This was recommended in order to ensure that there was a clinician with overall responsibility for the patient's care and there was a nurse who was directly available to provide information about their care. We were told that the medical wards did not operate any form of a 'named nurse' programme. Although patients were under the care of a consultant this was not always displayed.

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- Staff photographs were displayed at the entrance to bays so patients could see who would be treating them. The patients we spoke with could name their consultant and the nurses and healthcare assistants in line with the NICE QS15 statement three: which states 'Patients are introduced to all healthcare professionals involved in their care'.
- At the Sussex Cancer Centre we saw evidence of a nutrition week to help patients receiving chemotherapy and radiotherapy gain useful knowledge about the importance of nutrition while undergoing treatment. We saw two books that had been developed by the consultant, who empowered patients by asking for their input and engaging them in activities around food and nutrition problems.
- We heard how patients on Solomon ward were invited back two months after discharge to share their experiences during their hospital stay and the recovery period at home. This initiative helped staff to reflect on patient care in order to improve the patients' experience and patients felt valued and that their opinion and experiences mattered.

Emotional support

- The Royal Sussex County Hospital had arrangements in place to provide emotional support to patients and their families when needed. This included support from clinical nurse specialists, such as the diabetes nurses, renal counsellor and dementia specialist nurses.
- Patients also had access to physiotherapists and occupational therapists who provided practical support and encouragement for patients with both acute and long term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them. We observed positive interactions between physiotherapists and patients on a neurological recovery ward that was both kind and encouraging.
- We saw there were many different ways the staff provided emotional support to patients and their relatives throughout the hospital. Patients and their families had written to staff expressing their gratitude of outstanding care and staff had displayed the many thank you notes and cards on cloud pictures called 'Proud clouds'. On the dementia ward we heard how the staff often "went the extra mile" in supporting patients and their families. For example on one proud cloud we read about a dementia patient who was previously a ballroom dancer. Staff had danced with him around the ward which had made him more settled and we read about the pleasure this personal level of care had given the patient and his family.
- There was also a carer support service on the dementia ward where patients could include a family member or carer to help support them in their daily routine where appropriate. This helped them to feel more settled and avoided unnecessary stress.
- A relative on the dementia ward spoke to us positively about how involved they felt in their mother's care, mentioning that helping her to eat at mealtimes was encouraged.
- Staff working in the discharge lounge had to overcome many challenges with the environment but showed an exceptional level of care. One example was where they had part funded the purchase of a television for the discharge lounge as they were noticing that patients were often waiting for longer than expected. They also often had to stay late to provide support and care for patients who were waiting for transport home.
- The trust and Clinical Commissioning Group had recently commissioned a report on improving support for patients with learning disabilities. It aimed to provide intelligence from Brighton and Hove residents with learning disabilities on their experiences of health services and how these could be improved. It was too soon for any actions to have been identified from this report.
- We heard how the trust worked with a group of local actors who attended Solomon ward three times a week for a few hours to talk, read or sing with patients on topics the patients chose. We spoke to staff and patients who felt this improved their wellbeing as they benefited both emotionally and socially by encouraging them to interact with the actors and each other.
- There were also quiet areas available for patients to use if needed. However these were not always attractive areas to sit and relax as they were often small, dark, cramped and used for other purposes such as staff handover and training.

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- There was a hospital chaplaincy service which provided spiritual, pastoral and religious support for patients, relatives, carers and staff. Chaplains were available 24 hours a day throughout the week and were contactable by staff, relatives or carers through the hospital switchboard.

Are medical care services responsive?

Requires improvement



Overall we rated The Royal Sussex County Hospital's medical services as requires improvement for responsive because:

- The referral to treatment times had got worse since the transfer of neurosciences from the Princess Royal Hospital to the Royal Sussex County Hospital. Although urgent cases were given priority there were waits of up to 40 weeks for all routine and non-urgent cases.
- The data available for average cancer wait times was not site specific and reflected the overall performance of the trust. Just over 91% of patients saw a specialist within 14 days. This was worse than the England average and below the 96% national standard.
- The trust faced significant capacity pressures. Although patients felt well looked after they were not always able to be placed on the most appropriate ward on admission to meet their needs. The patient's journey to the right ward often meant them moving several times until a bed became available.
- Patient flow through the hospital was an ongoing concern as this impacted on length of stay, timely discharge and capacity. Outliers were a problem across the medical wards. The hospital had clear local processes to address how outlying patients would be cared for.
- The discharge lounge at the Royal Sussex County Hospital had suffered as a result of the change in the patient transport services contract. The inspection highlighted that this was an area that, despite the best efforts of the staff, was situated in an unsuitable part of the Barry building. The lounge was small dark and cramped and the patients arrived there some time before they were ready for discharge meaning they still required some care or treatment.

However

- There was good provision for those living with dementia and their ranges of different needs had been taken into account. There was a range of activities available for those living with dementia and clear signage as well as different coloured floors so patients could differentiate where they were and where they were going.
- The average length of stay overall on the medical wards was better than the England average although that was not consistent across all specialities.
- **Service planning and delivery to meet the needs of local people**
- The Brighton and Sussex University Hospitals NHS Trust provides services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.
- The Royal Sussex County Hospital is the tertiary and trauma centre for the region, whilst the Princess Royal Hospital is the centre for planned medical care.
- The cancer services across the trust consisted of four specialities. These were: end of life care, oncology, haematology and breast care. The services were Sussex wide and operated from five hospitals; these were the Royal Sussex County Hospital, The Princess Royal Hospital, Worthing Hospital, Eastbourne District General Hospital and the Conquest Hospital in Hastings. The team made efforts to travel to where the patients were located due to the elderly demographic and poor travel links in the area. This presented a challenge in terms of managing the service.
- Flow through the hospital and delayed discharges continued to be a concern. This was complex and reliant on both internal and external factors, including intake through the emergency department and lack of suitable beds or funding for support in the community on discharge.
- There had been improvements supported by various initiatives internally and supported by external partners for example: 'Discharge to Assess', the implementation of 'Right care, right place, each time' with leadership from the clinical director from speciality medicine; and 'Safer start' rounds supported by commissioners, community staff and the voluntary sector.
- The trust acknowledged there was a continued need for a more proactive approach to discharge planning across all wards. For example they needed to continue to work

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towards timely planning for complex discharges, maximising communications with patients and relatives as well as working closely with the external support agencies to ensure timely discharge.

• Access and flow

- There was no site specific data for The Royal Sussex County Hospital. In the 12 months from September 2014 to August 2015 the trust had a total of 43,455 admissions to medical services
- The average length of stay at The Royal Sussex County Hospital for all elective stays at 3.6 days was slightly better than the England average of 3.8 days. The average length of stay at the hospital for non-elective stays, 8.1 days, was worse than the England average of 6.8 days.
- Elective stays in cardiology (3.3 days) was worse than the England average of 1.9 days. The elective stay in gynaecological oncology (3.5 days) was better than the England average of 4.1 days. The average length of stay for nephrology (3.3 days) was significantly better than the England average of 7.5 days
- Non elective stays in general medicine (6.6 days) was slightly worse than the England average of 6.3 days. Non elective stays in geriatric medicine (12 days) was worse than the England average of 9.9 days. Non elective stays in cardiology (5.5 days) was slightly better than the England average of 5.6 days.
- Referral to treatment within 18 weeks was within the 90% standard and England average for seven of the eight specialties for nine of the 12 months from December 2014 to December 2015. At 89% dermatology was only slightly below the 90% standard.
- In November and December 2015 the trusts performance fell and this coincided with the transfer of neurosciences from the Princess Royal Hospital to the Royal Sussex County Hospital. As a result wait times had increased to 40 weeks for non-urgent cases.
- There were no site specific figures for cancer wait times for this trust. Of the 4,286 patients seen in between October and December 2015, 3,914 were seen by a specialist within 14 days. Of the 372 who were seen outside 14 days, 91 were seen within 15-16 days, 168 within 17-21 days, 71 within 22-28 days and 42 after 28 days. This meant that 91% of all patients were seen within 14 days. This is worse than the England average of 94.76% and did not meet the 96% national standard.
- Across the hospital we heard that lack of bed capacity was impacting on the care and treatment patients received. For example there were outliers on many of the wards we inspected. Outliers are patients who are admitted to wards outside of their speciality.
- During our inspection the stroke ward had five outliers. All were looked after by the stroke unit consultants who would refer to the relevant specialist colleagues within the trust if necessary.
- Oncology patients were outliers in wards across all the medical wards but were cared for by the oncology team. The oncology team did not have separate end of life beds.
- Staff told us that across the specialty medical services patients were frequently admitted to inappropriate beds because of the hospital's lack of capacity and the ongoing struggle to find a bed. They told us that the outlier patients were often transferred several times before they had a bed on the right ward and sometimes did not get admitted to the right ward for their entire stay.
- The medical directorates recognised that it was not best practice for complex elderly patients to be admitted to outlier beds and be subject to several moves during their stay. Managers told us that negotiations took place between the site managers and the care of the elderly consultants to minimise this happening and where it was unavoidable they were visited daily by the relevant teams rather than weekly.
- The Royal Sussex County Hospital medicine department made 1249 transfers out of hours in the 6 months prior to the inspection. Out of hours mean patients transferred after 10pm.
- On the renal wards we heard how medical outliers hindered the renal dialysis service and meant that sometimes elective operations were cancelled. There was a good outlier service with a dedicated registrar who called daily to see medical outliers in the renal unit. This helped with the access and flow of renal patients through the system.
- During the inspection there were unexpected problems with the non-emergency transport service. This had resulted in patients missing their dialysis treatments and chemotherapy appointments. The discharge lounge reported long delays in patients being discharged home. We noted that staff worked hard to ensure that patient safety was not compromised by staying late at night to care for patients awaiting transport home and

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organising alternative means of transport for patients. The patients we spoke with were full of praise for the way staff had coped and gone out of their way to look after them during the patient transport emergency situation.

- The acute medical unit (AMU) had a specific frailty team where an elderly care consultant visited the unit every day to see those patients over 65 with complex needs. This improved the continuity of care and had been found to improve discharges. Decisions could be made promptly improving the flow of patients through the unit.
- The hospital had a discharge lounge which was open every day including Saturdays and Sundays. Food and drinks were available to patients from the discharge lounge's own menu. The unit consisted of 12 chairs and two beds and was located in the older part of the hospital. We noted the unit was small, dark and cramped with no storage space for equipment.
- There was a good system in place for ward staff to refer patients to the discharge lounge. However patients often had long waits due to delays in discharge medication, discharge letters or waiting for patient transport services.
- The rapid discharge team had an arrangement with the Red Cross who provided a service called 'Home and Settle' which was available from 10am to 10pm. The care provided was low level support and included help with shopping and ensuring the patient was safe at home.
- We heard there were sometimes more patients than beds on the wards. This was because of 'over boarding', the practice of admitting a patient before a bed was available or because day cases were being treated on the wards or in the day room. On Catherine James ward patients requiring quick treatment procedures such as antibiotic trials, injections or directly observed treatment for tuberculosis were seen and treated in the ward or in the day room if there was no room on the ward. The trust told us that they did not collect data on the number of patients affected by the use of this policy and there were no additional staff put on duty to care for these extra patients.
 - **Meeting people's individual needs**
- There was a lack of capacity across the medical services. We found there was constant pressure on the bed and site managers to find beds and this was leading to additional beds being placed in inappropriate areas and staff stress in managing the challenging situation. Staff told us of the measures they had taken to prevent inappropriate spaces being turned into bed spaces such as screwing equipment to the floor.
- We heard of confused patients being admitted to side rooms and subsequently having unobserved falls; of immobile or confused patients being admitted to balcony beds. We saw incident reports where patients had fallen unobserved but this did not include information as to the patient's location. When immobile or confused patients were admitted to balcony rooms this was not documented as an incident so information about numbers of patients placed inappropriately was not collated.
- There were inadequate facilities, equipment and support for bariatric patients. Staff gave an example where a bariatric patient had received care and treatment in an inappropriate environment with inadequate washing, bathing and toilet facilities because the hospital was unable to meet their needs on the ward.
- Interpreters were available for those patients whose first language was not English. This was arranged either face to face or through a telephone interpreter. Staff told us that under no circumstances would a family member be able to act as an interpreter where a clinical decision needed to be made or consent needed to be given.
- During the inspection we saw several initiatives where staff had put extra care and consideration into meeting patients' individual needs. For example patients on the dementia unit had their names on the board at the bedside. There was a clock on the wall with large figures, this also displayed the temperature. There was an activity table in the middle of the bay with knitting, books and puzzles.
- We saw examples of wards other than the dementia care ward that operated the butterfly scheme. The butterfly scheme is a UK wide hospital scheme for people who live with dementia. We also saw that they had a dignity champion. This is someone who works to put dignity and respect at the heart of care services.
- We spoke with the dementia lead for one ward where they cared for confused patients. They had provided a memory box for patients to use as well as board games. There were also different coloured floors to assist patients with differentiating where they are and where they are going.

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- We heard how staff on a ward that dealt with infectious diseases had started an outpatients' clinic for patients who had HIV and syphilis. This resulted from a high demand from the local population and was dealt with by staff who had a good understanding of the conditions and who regularly treated patients living with HIV.
- Across the hospital we saw that there were leaflets and useful information available to help patients and their relatives understand their conditions and the treatment options available. These were easily accessible and prominently displayed on most of the wards we inspected.
 - **Learning from complaints and concerns**
- The complaints process was outlined in information leaflets which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected with access to the Patient Advice and Liaison Service (PALS).
- We were told that complaints were monitored and discussed at departmental clinical governance meetings but when we looked at the minutes from these meetings we found they rarely included complaint monitoring.
- We saw that the monthly 'Patients' Voice' feedback sent to each ward included the number of complaints and PALS referrals. The reports did not identify themes or trends.
- The 'Patients' Voice feedback included some of the comments patients had made which could be used to inform care and practice, but did not indicate that action had been taken on any of the comments.
- Ward managers could not identify what the complaint themes and trends were for their ward or unit. We did not find any information to suggest that themes and trends were identified from complaints or that there had been a change in practice because of a complaint. The staff we spoke with told us that the majority of complaints were dealt with informally or were made through PALS and they did not have much to do with them.
- Staff were aware of the complaints process and knew how to direct patients to the complaints process. They told us they rarely received cross directorate or whole trust feedback from complaints unless the complaint directly to the ward or their practice.

Are medical care services well-led?

Requires improvement 

Overall we rated The Royal Sussex County Hospital's medical services as requires improvement for well led because:

- The trust had a complex vision and strategy which staff did not feel engaged with.
- We did not identify a cohesive strategy for the medical services either within their separate directorates or within the trust as a whole.
- The frequent changes of management at senior level had led to stasis where nothing had happened for a long time. Those staff who were looking to innovate and move the trust forward found this very frustrating.
- Although there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership bringing the many directorates together.
- The trust had not dealt effectively with poor staff behaviour. There was a culture of fear of doing the wrong thing so nothing was done. There had been allegations of bullying and lack of support from the HR department and senior management which led to staffing issues not being addressed early. We heard how many of the HR policies were ineffective.

However

- The staff generally felt supported by their immediate managers but told us there was a disconnect between the wards and senior managers. Managers spoke enthusiastically about their ward or department and were proud of the hard working and committed staff they had working with them.
- There were systems in place to gather information and produce data sets and dashboards.
- **Vision and strategy for this service**
- The trust had developed five key objectives and seven 'fundamentals' that were needed to meet the objectives. In addition there were ten programmes to support the 2015/2016 objectives. The trust's annual plan also identified six challenges that the 12 new directorates would work to address.

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- This was a complex vision and strategy and none of the staff we spoke with could articulate what it was. When we asked ward staff what the trust's vision and values were they mainly told us about the new building that was planned and the constant change and reorganisation of the past few years. They were unaware of any corporate or medical directorate strategy they could be working towards or that might impact on how they delivered care in the future.
 - Senior managers told us they felt that whatever the strategy said, money and flow were the trust's priorities rather than quality and safety and this led to tensions.
 - We spoke with the divisional leads and they told us there was no vision or strategy for the individual medical directorates but they were included in the overall organisational strategy.
 - We looked at the organisational strategy and noted the acute medical unit, stroke, digestive diseases and renal services were the only medical services specifically identified with key impact programmes in the 2015/2016 annual report. The business as usual functions were not included.
 - The other medical services did not have a formal vision, strategy or direction of travel included in the annual report.
 - We heard that a recent senior management away day had included reviewing the strategic direction of the trust but staff still did not feel engaged with the process.
 - Staff working in the cancer services directorate told us they did not know what the future plans for the directorate were. They told us there had been a lot of changes "at the top end of management". They were concerned about future changes to the directorate structure as they felt that currently their voice was heard at the senior level and they didn't want this to change. They were not sure that their concerns reached board level.
 - The staff on Howard Two and Grant wards had developed their own team ethos which explained that the patient was at the centre of everything they did. There were printed copies of this ethos to remind staff.
 - The neuroscience directorate held monthly meetings with the trust executive however they told us they had not been involved in strategic planning following the neurosurgical move from Hayward's Heath. They told us there was now an urgent need to review the numbers of high dependency and intensive care beds for neurosurgical patients at The Royal Sussex County Hospital.
- **Governance, risk management and quality measurement**
 - The trust introduced twelve new disease based clinical directorates in 2014 with a new trust-wide governance structure put in place in 2015.
 - The medical services were included in six of the different directorates: the acute floor, abdominal surgery and medicine; cancer services; cardiovascular; neurosciences and stroke services and the specialty medicine directorates. We found that there was little cross directorate working with the directorates spending much of their time firefighting and dealing with urgent issues within their own directorate.
 - Ward and department governance meetings fed in to the six directorate's safety and quality meetings. Each directorate had different formats for conducting their governance meetings. The directorate governance meetings reported to the executive safety and quality committee. We saw minutes of meetings where quality issues such as complaints, incidents, risks and audits were discussed.
 - The Executive Team (ET) was the main committee for approval of trust policy and procedure, and for discussing and agreeing major strategic and policy decisions prior to approval by the Board of Directors.
 - The Clinical Management Board (CMB) reported to the ET and was responsible for the delivery of operational, income and budgetary performance, co-ordination between clinical services, and changes to operational and clinical practice required as a result of decisions made by the Board of Directors. The membership included the executive directors and clinical directors.
 - The Change Board (CB) reported to the ET, and its key functions were approving new change initiatives, subsequent plans to move into delivery, monitoring delivery of against delivery plans, and providing oversight to trust-wide developments, including agreed objectives and priorities. The CB's remit was to ensure alignment between all the various programmes of work and identify opportunities for improved efficiency and quality in the delivery of clinical services. The

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membership of this committee was drawn from the executive directors, director of strategy and change, operational director of HR and two appointed clinical directors.

- The trust board received quarterly progress reports on the action plans for the five trust objectives. This was underpinned by the board assurance framework and the monthly trust dashboard showing progress against key national and local quality standards.
- The divisional dashboards provided clear indicators for quality measurement in the trust.
- We found that there was a corporate risk register available but there was no system of recording risks at ward and divisional level that fed into the corporate risk register. We noted that two of the medical services were on the corporate risk register and that Howard One ward was considered 'not fit for purpose'. The action was to move the ward in May 2016 however this time table had already slipped.
- Each directorate maintained a risk register however the majority of managers we spoke with were unaware of this, what was on it or the actions needed to mitigate against the risks.
- We noted several risks had been on the individual directorate risk registers for several years. For example the cancer risk register identified in 2006 that the Barry Building was recognised as an unsuitable environment to treat patients and it was expected that patients would be moved out by 2010. In 2009 the bays on Howard One ward were considered no longer appropriate for patient care due to the dependency and acuity levels of patients and equipment required in their management and mixed sex wards. Risks included unavoidable trailing wires close to sinks (which was a known risk following electrical incident). The toilets had inadequate space for staff to assist wheelchair patient and there was a risk of harm to patient from slip, trip or fall. There were no controls identified apart from to rebuild the hospital. These areas were still in use during our inspection.
- We noted that the provision of patient transport for renal patients was included on the risk register due to recent changes in the service provided. We noted that this demonstrated the risk register was kept current and up to date.
- Several wards had developed their own action plans for specific risks such as for the CQC inspection. There was no formal process to escalate these risks to corporate level.
- The divisional leads told us they felt the biggest risk was triangulation of evidence and the lack of shared learning from incidents. They told us they worked closely with the head of patient safety as there were often anomalies in the data which didn't help when assessing patient risk. These issues were not documented on any risk register
- The acute medical unit as part of the emergency services directorate had regular local governance meetings where data and clinical events were discussed. We were told that all the emergency floor consultants were involved in the change management programme.
- We had concerns that several safety issues had been consistently raised by staff and not actioned or included on any risk register or action plan. For example on the cardiology wards safety issues such as drug cabinets without locks, lack of plug sockets and lack of safe storage facilities had been brought to managers and facilities attention over a year ago and no action had been taken.
- The stroke wards had regular governance meetings where incident, patient feedback and safety issues were standing agenda items. Staff told us they could raise any concerns at these meetings and this was confirmed in copies of the minutes we reviewed.
- Staff felt there was an inequality of allocated resources with those services who "shouted the loudest" and those that generated the most funding received better facilities and equipment. As a result many services had developed their own set of values and ethos and looked at alternative means to raise funds.
- We reviewed a sample of clinical governance meeting minutes across the medical directorates and noted there was no standard template used or standing items to be discussed at every meeting. For example some minutes documented audit results, others the findings from mortality and morbidity meetings. Some such as the respiratory clinical governance meeting did not include details of any incidents or complaints, others such as the cardiac clinical governance meeting minutes detailed incident investigations but the format was disorganised and did not always make clear what the actions or recommendations were. Some

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directorates held monthly clinical governance meetings; others were bi monthly or quarterly. This meant that it was difficult to benchmark the different directorates and gain a clear picture of the current clinical governance arrangements within the trust.

• Leadership of service

- Each of the directorates had a clinical director, a nurse director and a manager director supported by clinical leads although the different directorate organisational strategies gave them different reporting responsibilities. For example the manager director and lead nurse director reported to the clinical director in the cancer, specialist and the neuroscience directorates, whereas in the cardiovascular directorate the clinical director, lead nurse director and director manager had joint responsibilities across cardiac, renal and vascular services.
 - Across the medical directorate staff and managers told us that they needed a period of stability as they had been in constant reorganisation and change for many years. One manager told us, "I've had three or four chief executives and eight managers since I started – it leads to a state of paralysis every time there is a change at the top"; others told us, "There's no continuity," "No direction or leadership".
 - Senior staff, managers and directorate leads told us that the trust was 'very lean' on management and a better governance structure was needed. They gave examples where issues were raised but no action was agreed such as the junior doctor rota. They told us they were continually 'firefighting'. They told us they felt they needed a 'go to' person at board level who had influence as they frequently had issues where quick decisions were needed but nothing happened.
 - Staff told us there was a real problem with stability of leadership within the trust. There were several long term vacancies of key staff such as matrons and clinical leads. We were told of managers that had left and not been replaced. During the inspection we noted a number of senior management staff had taken leave for the period of the inspection.
 - Senior staff told us of their concerns that many experienced staff were due to leave or retire in the next five years and there was little forward thinking or succession planning.
 - Across the medical directorates staff told us that everything was 'knee jerk' and reactive in nature. One manager told us, "It's too complex, the trust is in meltdown."
 - We saw from minutes of board meetings that members of the executive and non-executive team visited hospital wards and departments and gave verbal feedback to the board on what they found during their visit. For example the acute medical unit (AMU) staff told us how board members of the trust had visited the emergency department twice during February. They told us that following three adverse incidents in 2014 they had regular visits from the executive team. However staff and managers from other medical services told us they rarely received visits from the executive team.
 - There was a strong feeling that some of the trust board were not accessible or accountable. Ward managers told us that they raised concerns at the monthly ward managers meetings and their route to escalate their concerns to the board was through the chief nurse. They told us that they did not always feel listened to and that nothing changed. Some wards such as Chichester Ward told us that the chief nurse or her deputies visited the ward and were approachable but others reported little senior engagement in their department or ward.
 - Staff across the specialty medical directorate reported that leadership up to matron level was clear and supportive. Staff knew their managers and felt free to contact them. They felt valued and that their opinions counted. All the ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their ward faced in delivering good care. For example the managers on Grant and Howard Two were praised by the doctors who told us the wards were well run.
 - Staff working in the cancer services directorate told us that there was currently a good structure in place, there was a supportive group with autonomy to make things happen. We were told that this directorate team met monthly and included all staff around the table.
- ## • Culture within the service
- We heard from all staff groups throughout the hospital that the trust had not been effective in challenging of poor behaviour and performance. This had created significant tensions and a culture of fear of doing the wrong thing.







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- Ward managers and senior staff reported that they received little support from the trust's HR department in managing difficult consultants or with staff disciplinary and capability issues. They told us that HR advised staff to put in a grievance as a first step in resolving any issue.
- We were told that the HR policies lacked clarity and were open to interpretation. Many policies stated "at the manager's discretion" which they felt was open to misinterpretation, allegations of favouritism and lack of consistency.
- The trade unions confirmed that it was difficult to manage staff behaviours and address poor behaviour when the trust's HR policies were ineffective.
- We spoke with site managers, consultants and ward staff who told us that due to the stresses and challenges of managing the bed capacity there had been incidents of poor behaviour. They told us that following the trust introducing values and behaviours training the bullying and harassment had largely stopped and was an exception now. There were no incidents of bullying on the electronic reporting system and no current grievances for bullying within the directorate.
- We were told that in some areas there was still a blame culture and staff did not always feel supported at the executive level.
- We heard how staff at the front line worked hard and were passionate and caring about what they did. They told us we all want to "make it happen" but it was exceptionally frustrating that nothing changed as the resources were not available.
- The culture varied between the different wards and directorates. There was a genuine appreciation of the ward manager on Howard Two and Grant wards. We were told how they had established an open culture and how morale was generally good. Nursing staff on the hyper-acute stroke ward were praised as being amazing, happy, highly motivated and very caring". The turnover of nurses and therapists on this unit was minimal and the numbers and skill mix were generally adequate.
- However on Howard One, morale was low due to staffing problems. Staff told us they had escalated the problem but nothing happened to change the situation.
- We heard about tension and conflicts between some of the consultant teams and specialties within the hospital and this had the potential to delay patient care. Staff gave us examples where the gastroenterologists were not willing to take on patients as they felt they were doing the surgeons work.
- We heard how there was now an on call consultant rota for the renal unit. Medical cover for the unit had suffered because of tensions with other specialities. There had been recent improvement following close working with the vascular surgeons but emergency cover was still provided on an ad hoc basis.
- **Public engagement**
 - The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.
 - The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys, complaints and the 'How Are We Doing?' initiative.
 - We were told that the patient experience panel was to be refreshed with an integrated experience report being developed for each clinical directorate. This was not in place for our inspection.
 - We heard how the board met patients to listen to their stories. The aim was to improve the board's understanding of the issues that were important to patients. The board minutes included examples of patient stories and these were also included in the trust's newsletters.
 - Results from the patient voice feedback were shared with the wards and departments monthly. This information was feedback to staff to improve understanding of how their actions and attitude impacted on the patient's experience. A new specialist divisional newsletter had been started which included the patient voice feedback.
 - We heard how the cancer directorate held Sussex patient groups on Saturdays. Usually 25 to 30 patients attended to discuss issues. These included issues from the national cancer patient survey, old patient workshops and interviewing new patients to see what could be done to improve the patient experience.
 - The hyper acute stroke unit held monthly meetings where patients could meet with a stroke unit consultant, senior nurse and social worker to discuss any issues.
- **Staff engagement**

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- In the NHS Staff survey 2015 the trust had improved its scores across most measures. For example the trust scored better than other trusts in 17 of the measures compared to the 2014 survey, when the trust scored worse than other trusts for 20 of the measures and was found to be similar to other trusts for all other questions. This indicated that there was an improvement in how staff perceived working at the trust.
- The staff survey 2015 action plan indicated that the main areas which required improvement were employee engagement, working conditions, reporting errors and near misses, relations with others, feedback, promoting respect and low job satisfaction. These scores were in the lowest 20% nationally. The action plan devolved responsibility to the local directorates for improvement.
- We spoke with matrons who told us they had been fully involved in the design and plans for the new buildings. They told us they felt valued as their contributions had been included in the design.
- Staff told us that there was no cross over or communication between the 12 different directorates. They told us there were no communication systems in place and that if certain key members of staff were not available there was a real problem with communication.
- Other senior staff and directorate leads told us they did not always feel listened to. They told us although there were forums where concerns could be raised such as the performance reviews these felt disjointed and all the issues could not be discussed in this one session.
- Several of the medical wards such as Baily and Overton wards had not held team meetings for some time due to staffing pressures. Other directorates such as the neuroscience directorate held monthly staff meetings.
- There was a monthly managers' meeting held which was for senior nurses. However staff told us this was often cancelled.
- Staff told us they felt able to raise concerns with their immediate line managers but very little ever changed.
- The Royal College of Nursing told us that the trust were open to listening to concerns and engaged with the trade unions in addressing issues.
 - **Innovation, improvement and sustainability**
- Across the specialty medical directorate senior managers and directorate leads told us that, "The poor state of the buildings should not be an excuse for poor care - and it isn't". We saw many examples where staff had found innovative ways of working around the environmental limitations and were delivering good care.
- The trust had received numerous national awards for the specialised care and support they provided for in patients with dementia.
- The HIV service was nationally recognised as being a high performing service.
- On Overton Ward we heard how junior staff had developed diagrammatic flow charts to help the newly arrived overseas nurses understand access and flow to the different county council areas. These were now being shared with the practice educators as useful tools across the frailty wards.
- On Catherine James and Egremont Wards the ward manager told us how the staff were constantly thinking of new ways to improve patient care and weren't afraid to try things out. They gave the example of having a consultant available to talk to patients and relatives at a specific time each week. Although there had been a poor uptake they felt it demonstrated staff commitment to improving patients' experience.

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

Information about the service

Brighton and Sussex University Hospitals Trust surgical services (the service) delivers services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and some specialised services for patients across Sussex and the south east of England.

The service provides surgical services across two sites, the Royal Sussex County Hospital (RSCH) at Brighton and the Princess Royal Hospital (PRH) at Haywards Heath and is made up of four directorates, head and neck, abdominal surgery and medicine, musculoskeletal and perioperative directorates.

The head and neck directorate manage audiology, ears, nose and throat (ENT), oral and maxillofacial, clinical media centre, ophthalmology and out patients department (OPD).

The abdominal surgery and medicine directorate provide urology, gastro-intestinal (GI), neurosurgery, cardiac surgery and medicine services.

The musculoskeletal directorate provides trauma, major trauma, orthopaedics, pain management and rheumatology services and the perioperative directorate provided operating theatres, anaesthetics and general surgery.

Between September 2014 and August 2015 there was a total of 35,173 spells (a spell refers to a continuous stay of a patient using a hospital bed) across both sites with 12,900

taking place on the RSCH site. Approximately 160,000 operations were carried out yearly, 34% was day case activity, 15 % elective activity and 50% emergency activity across both sites.

There is a pre assessment clinic based at the PRH and assessed approximately 13,000 patients per year for all elective and day surgery patients for both sites apart from vascular services which are carried out on the RSCH site.

The service has 30 theatres split between its two principal sites, enabling surgery provision in all major disciplines. Both centres undertake emergency, elective inpatient and day case surgery. There are 151 surgical beds on the RSCH site across four wards (L8, 37 beds for vascular surgery, L8a east 24 beds trauma and orthopaedics, L8a west 32 beds neurosurgery and L9a 58 beds colorectal surgery) and a three bay surgical assessment unit (SAU).

The service's neurosurgery unit had relocated 10 months previously from the PRH site to the RSCH main theatre group, in order to provide a fully-integrated major trauma surgery service and the fractured neck of femur (broken hip) service had relocated to PRH from RSCH.

We visited all surgical services as part of this inspection, and spoke with 45 staff including staff on the wards and in theatres, nurses, health care assistants, doctors, consultants, therapists, ward managers, porters and other health care professionals. We spoke with 15 patients, and examined 17 patient records, including medical and nursing notes and medication charts.

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Summary of findings

Overall we rated the service as good for safety and caring and requiring improvement for, effective, responsive and well led.

The service had experienced seven never events over a seven month period in 2015, five of these took place at the RSCH and involved three wrong side nerve blocks, one wrong tooth extraction and one wrong route of medication. These had been rigorously analysed and changes had been made in order to ensure they were not repeated.

The services, wards and departments were clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of a patient was clearly documented.

There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts. Generally this was well managed but patients' needs were not always met.

Treatment and care were provided in accordance with the National Institute of Health and Care Excellence (NICE) evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. There were examples of effective multidisciplinary working.

The service was not always responsive to people's needs and may not be able to make reasonable adjustments to enable patients to receive care or treatment that is appropriate to their needs. Patients were being kept in the recovery area of operating theatres for significant periods of time due to the trust attempting to reduce its target of moving a patient within 12 hours out of the emergency department (ED), lack of beds on the high dependency unit (HDU) and lack of beds in other areas of the trust.

Some patients could be kept in the recovery area for over four hours and up to two days with some patients being discharged home directly from the recovery area. This meant patients did not have their privacy when

they needed it and did not have free access to washing and toilet facilities, could not move freely around the recovery area and could not see their relatives whilst in this area.

Not all staff had received annual appraisals and very few staff had the opportunity to complete statutory and mandatory training provided by the trust. Staff in the recovery area did not have the skills to look after emergency medical patients who were transferred to the recovery area directly from the (ED) or (HDU).

Other development and clinical training was accessible and there was evidence of staff being supported and developed in order to improve outcomes for patients.

Performance against national audits such as patients with a fractured neck of femur (broken hip) audit showed evidence of good outcomes for patients but adherence with the national emergency laparotomy audit (NELA) 2014 standards were poor with 14 of the 32 standards not being met. However the service had put systems in place which was starting to show significant improvements in outcomes for this group of patients.

The service worked well with its seven clinical commissioning groups (CCGs).

The service was also not meeting its referral to treatment targets of being seen by the service within 18 weeks, the only specialty to meet this target was cardiology surgery.

Some patients waiting for a follow up appointment did not always get one in a timely manner. The service did not fully understand why these patients appointments had been missed and had started work to identify them and review their treatment.

The service had experienced a reconfiguration of its services and had started to get its governance systems in place but this was in its early stages and needed further embedding. Additional reconfiguration was being planned to further focus elective and non-elective activity onto specific sites.

Leadership at a local level was good and staff told us about being supported and enjoyed being part of a

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team. There was evidence of innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.

Are surgery services safe?

Good



Overall we rated the service as good for safe

This was because:

- Staff knew how to report incidents and felt confident that when incidents were reported they were listened to and acted upon. We were given examples where learning had taken place and had changed practice. All incidents were analysed and reported to the monthly departmental meetings for further discussion and action.
- Medicines including controlled drugs and medicines related stationary (prescription pads) were held securely and appropriate records were kept. There were regular safe and secure storage of medicine's audits which included fridges, medicines trolleys, drug cupboards, controlled drug cabinet and storage of intravenous drugs.
- Staff used Schwartz ward rounds which meant that once the ward round was completed each case was reviewed to check what had been agreed and a plan of action was put in place.
- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering Safer Nursing Care Tool. The planned and actual staffing numbers were displayed on the wards visited.

However we also found

- The service at RSCH had experienced five never events over a seven month period in 2015 and involved three wrong side nerve blocks, one wrong tooth extraction and one wrong route of medication. These had been rigorously analysed and changes had been made to ensure they were not repeated.
- There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts. Generally this was well managed but patients' needs were not always met.

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- Uptake of statutory and mandatory training across the service was poor with the majority of training being less than 50% compliant.

Incidents

- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents both at junior and senior level. The incident reporting form was accessible via an electronic online system.
- The service reported a total of 52 serious incidents in the period January 2015 to January 2016 with five classed as a never event. Never events are serious wholly preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2015).
- The five never events occurred between June 2015 and December 2016.
- Of the five never events, three were due to the wrong site nerve block, one due to the wrong route of medication and one due to the wrong tooth being extracted. A nerve block is the injection of numbing medication (local anesthetic) near specific nerves to decrease pain in a certain part of the body during and after surgery.
- A human factors scientist and forensic investigator from an external safety industry had jointly investigated the never events with an investigator from the trusts safety and quality team. Staff told us this had helped to provide assurance regarding the robustness of the root cause analysis investigations as well as providing independent scrutiny.
- There had been a number of changes made as a result of learning from these investigations. Changes from the three wrong site nerve blocks resulted in a local standard for correct side surgery/procedures including anaesthetic blocks being written based on the National Safety Standards for Invasive Procedures (NatSSIPS). NatSSIPS aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur. Additional steps to the anaesthetic component of this standard such as learning from incidents suggested extra safety measures would further mitigate the risk of this error.
- Marking of the site for the nerve block had been added to the theatre care pathway and the world health organisation (WHO) sign-in form; signposts for the ultra-sound machines to remind staff to 'Stop before you Block' had been added and a change of approach to nerve blocks by marking the site at the WHO sign in after confirmation of operative side were also included.
- The service was also trying to reduce the distractions in the anaesthetic room through signage on the doors and writing a code of conduct for looking after patients in the anaesthetic room. There was a plan to audit and measure compliance with these changes.
- Changes from the never event relating to oral medication given intravenously resulted in further drug administration training and assessment for all recovery staff, a review of stock ordering of oral syringes by all areas was carried out and a question regarding the stock of oral syringes had been included in the six monthly medication security audit.
- Changes from the never event relating to the wrong tooth extraction incident were fed into the work being undertaken regarding consent processes. A revised list had been made of the minimum information required before patients were added to the waiting lists for surgery and a community referral form to include interpreter information was being developed.
- These incidents had been discussed at the Perioperative Standards Forum and learning and action plans had been agreed. The learning from the never event reports had been distilled into teaching sessions and shared with all theatre staff.
- Staff told us learning was shared at the morning theatres meetings, at clinical governance sessions and at unit meetings. The wrong side nerve blocks had been discussed at the anaesthetic quality and safety meetings and the learning and the implications for practice agreed.
- We were told that specific training on 'Human Factors' had been developed for the perioperative theatres teams which linked the theory of human factors with the incidents in theatres. This was a three hour session which had been delivered to approximately 80 staff.

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- Two training films had also been produced, to show the new standard for WHO sign in and 'stop before you block'. This was going to be used in future teaching sessions and a film showing the prosthesis verification procedure was being planned.
- In early April 2016, we were told there was a multi-disciplinary clinical governance session where learning from never events would be shared and the full launch of the services NatSSIPs work. All theatre staff, surgeons and anaesthetists had been invited with 180 members of staff already booked to attend.
- We saw the services Perioperative Safety Newsletters, which highlighted the learning from the never events.
- The learning from the never events was shared with the Trust Board on 29th March 2016. An update was also provided to the Trust's Quality and Risk committee (a subcommittee of the Board) and regular updates had been given to QRM (the trust's monthly safety and quality assurance meeting with the CCG) regarding these incidents and actions arising.
- To provide further assurance to the trust board the service had commissioned a revisit to theatres in 2016 following a review in 2014.
- Of the 15 serious incidents reported, 40% of all incidents were attributed to surgical invasive incidents, 27% to slips/trips and falls and 13% of incidents were due to confidential information leaks. These were reported through the Strategic Executive Information System (STEIS).
- There were a total of 1619 incidents across both sites one resulting in death, six rated as severe, 20 moderate, three unpreventable adverse incidents, 261 low and 1,348 causing no harm with 554 incidents related to the RSCH site. It could not be determined which site the remaining 556 took place.
- The highest number of incidents reported was in trauma and orthopaedics (643) followed by operating theatres (281) and digestive diseases (202).
- The service used the trusts internal safety alerts when a serious incident had occurred to share the incident with all staff and to ensure staff were updated in the actions taken from the incident. There was also a 'Patients First' monthly bulletin which told the story of specific patient incidents.
- An example where learning had changed practice included using a falls alarm for those patients who had been assessed to be at risk of falling and the introduction of post falls review form.
- Mortality and morbidity meetings took place on a monthly basis and reviewed any deaths that had occurred in the surgical division. Root cause analyses following incidents were discussed, and any lessons to be learnt were shared and distributed to the staff team.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw evidence that the processes for the duty of candour were in place and documented within the incident reporting system.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.
- The ward sisters and theatre managers described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives.
- Junior staff could describe what they would do in the event of an incident but were not always aware of the further duties about informing relatives.

Patient Safety Thermometer

- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harm including new pressure ulcers, catheter urinary tract infections (C.U.TIs) and falls.
- The NHS Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. We saw this information was displayed on the wards, such as number of falls and pressure ulcers. For example Level 8a east displayed 12 patients had fallen in the last 12 months which was a 46% reduction in falls, five pressure ulcers (developed on the ward) in the past 12 months which was 69% better than in 2010.

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- We saw staff levels for each shift were also displayed on the entrance to each ward area with photos of the ward managers and their teams also displayed.
- For the period January 2015 to January 2016 there were ten new hospital acquired pressure ulcers, 11 falls with harm and 16 new catheter acquired urinary tract infections (UTI's) reported across the service.
- Venous thromboembolism (VTE) assessments were recorded on drug charts and were clear and evidence-based, ensuring best practice in assessment and prevention. 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.
- A recent audit in 2015 had found a small number of patients that had not been reassessed 24 hours after admission for VTE which was not compliant with guidance from the NICE 2010 for reducing the risk of venous thromboembolism in adults. There was a plan in place to improve this assessment.
- In September 2015 the trust had a Patient Led Assessment of the Care Environment (PLACE) survey and visited L8awest, L9a and L7a and scored them 99.77% for cleanliness.
- Hand hygiene gels were available throughout the wards and theatres. There was access to hand-wash sinks in bays and side rooms on the wards.
- Personal protective equipment (PPE), such as gloves and aprons were used appropriately and were available in sufficient quantities.
- Operating theatres had separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for re-processing by the trusts decontamination service.
- We observed that the NICE guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008) was followed by staff in the theatre environment. This included skin preparation and management of the post-operative wound.
- The decontamination of surgical instrumentation was managed by the trusts internal sterilisation department. Procedures were in place for storage of dirty and clean instrumentation, with equipment items scanned and tracked accordingly.

Cleanliness, infection control and hygiene

- Guidelines on infection control were in use and staff adhered to the trust's infection control policies.
- There was awareness amongst staff about infection control and we observed staff washing their hands, complying with the 'bare below the elbows' policy and using hand gel between treating patients. We observed all staff using alcohol hand gel when entering and exiting wards and theatres and we saw medical staff washing their hands between patients when on ward rounds.
- The ward areas had cleaning schedules available for cleaning all the equipment. We saw daily cleaning schedules but not defined cleaning schedules for other equipment. Defined cleaning schedules and standards are recommended by the Department of Health 2014 document 'Specification for the planning application, measurement and review cleanliness services in hospitals'.
- Staff told us they cleaned equipment as they used it. We saw 'I'm clean' sticker on some equipment but not all. Therefore we were not assured that all equipment was cleaned regularly.
- We observed that theatre staff wore the appropriate theatre attire, such as theatre blues, hats and masks. We were told there was a zero tolerance for staff leaving the theatre in their blues. We did not see any theatre staff leaving the theatre environment in their theatre attire.
- There was no documentation of the curtain changing having actually been carried out on the wards. A lack of curtain changing could be a risk to cross contamination from curtains to hands when staff open and close them.
- We saw signage on side room doors indicating when a patient had an infection and equipment to support barrier nursing. Barrier nursing is a set of infection control techniques used in nursing. The aim of barrier nursing is to protect medical staff against infection by patients, particularly those with highly infectious diseases.
- The service had no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) in the last 12 months.

Surgery

- Between April 2015 and January 2016 hand hygiene audits demonstrated the musculoskeletal directorate was 96% compliant, head and neck 94% compliant, abdominal surgery and medicine 93% compliant and perioperative 95% compliant.
- L8a east was 100% compliant, L8a west 94% compliant, the SAU 100% compliant, L9b east 99% compliant, L9b short stay 100% compliant, L9e 100% compliant and L9 west 100% compliant.
- Staff told us about using aseptic techniques when changing a dressing using a non-touch technique to avoid any cross infection. Staff on the cardiology ward told us they followed NICE guidance (QS49) for patients using antimicrobial (an antimicrobial is an agent that kills microorganisms or inhibits their growth) products when showering prior to surgery and any removal of hair from the body was done with a clipper and as near to the surgical site as possible.
- The cardiac ward used a skin cleaner which provided antimicrobial preparation for pre-operative surgical hand disinfection, antiseptic handwashing on the ward and pre-operative and post-operative skin antisepsis for patients undergoing surgery.
- The cardiac ward used nasal creams to prevent infections and a chlorohexidine (used as an antiseptic) mouth wash to prevent MRSA and ventilated associated diseases.
- The service used a visual phlebitis scoring tool for monitoring infusion sites and is recommended by the Royal College of Nursing (RCN). An audit of visual infusion phlebitis was undertaken in July 2015 which found the documentation was not always completed. Feedback was given at the time of the audit and a re-audit was planned to check this had improved.
- The service had participated in surgical site infection data collection for knee replacement and fractured neck of femur. There were no issues identified from the fractured neck of femur surveillance.
- Surgical site infection data between July 2015 and September 2015 indicated that infection rates for knee replacements were 1.8% which was slightly worse than the national benchmark of 1.6%. A review was conducted by medical staff and there were no common factors found between the cases highlighted.
- Staff told us action plans had been implemented to reduce surgical site infection rates such as ensuring theatre doors remained closed during the operation and regular wound reviews.
- The service had not carried out surgical site surveillance on hip replacements as it was not mandatory to conduct this for all subspecialties within orthopaedics each year.
- From the patients voice survey when asked 'How clean is the ward' the service performed worse (4.47) than the trust (4.53).

Environment and equipment

- There were 10 main operating theatres and a recovery area with 10 bays. Standard theatre environment was provided, with anaesthetic rooms, scrub facilities, clean preparation rooms and dirty utility.
- Wards and theatres were accessible to individuals living with a disability and technical equipment was available to support individuals where required. This included operating tables being appropriate for bariatric patients to meet the needs of patients with a high body mass index (BMI). Bariatrics is a branch of medicine that deals with the causes, prevention, and treatment of obesity.
- We saw areas of non-compliance with Health Building Note (HBN) policy 00-09 for floor covering. In ward L8 Millennium building there were holes in the flooring (bay 2) particularly at the threshold of bathrooms and toilets (Bay 7 and 8). HBN 00-09 for flooring states: The quality of finishes in all clinical areas should be readily cleaned and resilient and flooring should be seamless and smooth, slip-resistant, easily cleaned.
- The standard of finish in these areas meant that suitable and sufficient cleaning could not take place. The holes in the flooring when mopped would potentially leave moisture which could become an ideal area for bacteria to multiply. Therefore potentially increasing the risk of a Hospital Acquired Infection (HAI).
- There were bare walls and plaster missing (bays 2 and 3). The finish to the walls should be readily cleaned and non-porous, the missing paint and bare plaster meant that there were areas potentially that would not be able to be cleaned effectively. This makes cleaning of walls more difficult and potentially leads to the rough surfaces harbouring bacteria.

Surgery

- The SAU had three trolley spaces and a waiting area with room for approximately 12 chairs which was used for patients and relatives. Male and females were not segregated and the SAU was used as a thoroughfare for other patients attending the rapid access cardiac outpatient clinics.
- We saw on one ward (Level 8 east) the security door did not always lock and we were told by staff that the door was often left open. This may present a risk to those patients who were confused. A nurse reported this to the ward manager at the time of the inspection.
- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, was checked daily and documented as complete and ready for use. Whilst the service had standardised crash / emergency trollies they were not tamper evident therefore a daily check may not provide assurance that all equipment and medicines were always available
- There was a medical equipment and devices management group which met every three months which was led by a clinician where capital replacement plans would be discussed.
- There were systems to maintain service equipment as required. Equipment had portable appliance testing (PAT) stickers with appropriate dates. PAT is an examination of electrical appliances and equipment to ensure they are safe to use.
- The perioperative risk register noted there were surgical washing equipment in theatres that were old and spare parts were hard to acquire. Should certain components fail such as the control screen, this would render the machines unusable. A business case had been produced in order to gain funding for new equipment.
- Two of the three sterilisers in the sterile services department were broken due to the failure of pressure leakage. This has been assessed as beyond economical repair.
- The service was addressing this and one steriliser had been installed, commissioned and put into service, a second steriliser had been installed and commissioned and the commissioning report had been received at the time of the inspection and the machine should be in service by mid-April 2016. A third steriliser was being requested as part of the 2016/17 capital programme.
- The tender process for the replacement washer disinfectors had finished and all bidders had been informed of the result, the service was currently at a 10 day standstill (procurement process). The replacement washers were due to be installed early June 2016.
- Storage of equipment in operating theatres was raised as a concern on the perioperative risk register as equipment was being stored in front of fire exits and prevented access to medical gas isolation valves. Actions such as making sure there was clearer signage about storage and an instrument cupboard had been moved to try and reduce the risk. There were no further risks of fire due to storage.
- The service undertook an audit of commodes with the result that Level 8 west were found to be damaged and grubby looking and Level 9a and Level 8 east were found to be clean and structurally good. New commodes were in the process of being procured.
- The perioperative risk register included concerns about the inhalation of surgical smoke from the use of diathermy. Diathermy is a surgical technique which uses heat from an electric current to cut tissue or seal bleeding vessels. Diathermy emissions can contain numerous toxic gases, particles and vapours and are usually invisible to the naked eye. Their inhalation can adversely affect surgeons' and theatre staff's respiratory system. The risks vary according to individual circumstances, such as the procedure, equipment, environment, technique and patient. The trust was trialling some smoke extractors with the intention of purchasing systems to reduce smoke emissions.
- There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed and were emptied regularly.

Medicines

- Medicines including controlled drugs and medicines related stationary (prescription pads) were held securely and appropriate records kept.
- Some prescription medicines were controlled under the Misuse of Drugs legislation 2001 and called controlled drugs (CDs). We examined the CD cupboards and found that storage was appropriate with no other items in the cupboards. The CD registers on the wards were found to be appropriately completed and checked daily.

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- We observed nursing staff locking medicines trolleys when they administered medicines to patients. Nursing staff wore a red apron to indicate they were administering medicines to alert staff not to disturb them to prevent drug errors.
- We saw medicines were checked and reconciled by pharmacy staff on a weekly basis, and an audit was completed monthly to check stock and utilisation.
- Staff used a tracker cupboard for storage of CD and medicines cupboard keys. Access to the cupboard was by a 'swipe card'. Two staff would have to use a swipe card to access the keys which ensured medicines management was more secure. This also ensured staff would not spend time looking for the nurse who was holding all the keys.
- Minimum and maximum medicines refrigerator and current room temperature records provided assurance that medicines requiring refrigeration were kept within their recommended temperature ranges.
- The temperature of medicine fridges were monitored daily. Medicines requiring refrigeration can be very sensitive to temperature fluctuation and therefore must be maintained between 2°C and 8°C. We saw all areas complied with this as daily temperatures were recorded. The room temperatures were also monitored and were within the desired limits of 15°C and 25 °C.
- Monthly patient first bulletins were circulated across the trust when there had been medication errors such as an oral medication being given intravenously by mistake. This anonymised incident was used in pharmacy teaching sessions to highlight the importance of prescriptions being written for a single route only.
- There was a total of 277 medication errors across the service, the highest number in trauma and orthopaedics (135), followed by 48 in digestive diseases and 28 in vascular services with 263 rated as causing no harm to the patient and 14 causing low harm.
- We looked at seven medication charts which were completed comprehensively, dated, signed and had no missing doses.
- The trust carried out a medicines security audit in October 2015 audit with Level 9a east scoring 96% and Level 9a west scoring 84%. Both were better than the trust standard of 80%.
- We looked at 10 sets of patient's records. These were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with the patient and families.
- The records we reviewed showed that the Five Steps to Safer Surgery checklist record, designed to prevent avoidable harm was completed for all patients. An audit of the WHO checklist was reported to the trust board which showed compliance of 98% for signing in, time out documented was 98% and sign out was 94% which did not meet the standard of 100%.
- Medical records were stored securely in trolleys behind the nurse's station; nursing notes were stored at the patient's bedside.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms. Records were legible, accurate and up to date. The service used a number of patient pathway documents which followed the path the patient took through a specific surgical episode such as a fractured neck of femur, knee and hip replacement and cardiac surgery.
- National early warning scores (NEWS) were regularly audited for completeness. Where there was some information missing this was fed back verbally at the time of the audit.
- The service carried out an audit of post-operative medical notes which demonstrated they did not comply with the Royal College of Surgeons Good Standards of Clinical Practice for record keeping 2014. The audit consisted of 52 sets of medical case notes and included 14 consultants, five registrars and three senior house officers. Of the 52 notes audited 48 sets of notes were not signed, 49 sets of notes were not dated and 45 sets of notes mentioned what the indications were for surgery. Teaching sessions were being planned to improve practice.

Safeguarding

- The chief nurse was the executive lead for safeguarding. Adult safeguarding was managed by the deputy chief nurse and had 1.6 whole time equivalent (WTE) band seven nurses for safeguarding, learning disability and Mental Capacity Act and Deprivation of Liberty.

Records

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- The trust had a safeguarding adult's policy. Safeguarding was part of mandatory training for all staff and this was monitored by managers. Safeguarding adults training across the overall service was 50% ranging from 30% in the head and neck service, 39% in the abdominal surgery and medicine service, 49% in the musculoskeletal service and 63% in the perioperative service. These did not meet the trust standard of 90%.
- Overall safeguarding children level one training across the service was 47%, level two was 85% and level three 46%.
- Training levels in the Mental Capacity Act (MCA) was perioperative directorate 69%, musculoskeletal directorate 70%, abdominal surgery and medicine directorate 67% and head and neck directorate 70%.
- **Mandatory training**
- The trust had a trust wide induction programme for permanent and temporary staff and a mandatory and statutory training plan. There was a combination of E learning and face to face learning.
- The services mandatory training was 46% which was lower than the trust standard of 100%. For example basic life support (BLS) training was 33% and infection control training (for clinical staff) was 58%.
- Statutory training overall for the service was 50% which was lower than the trust standard of 95%. For example patient moving and handling training was 24% and equality and diversity training was at 42%.

Assessing and responding to patient risk

- Patients having elective surgery attended a preoperative assessment clinic where all required tests were undertaken. For example, MRSA screening and any blood tests. If required, patients were able to be reviewed by an anaesthetist.
 - Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
 - Venous thrombo-embolism (VTE) risk assessment documentation audits were undertaken monthly which showed a fall in performance over the period April 2015 to February 2016 compared with April 2014 to March 2015. For example the overall average was 97% for 2014/2015 but in 2015/2016 the average was 84%. Staff told us this was due to a change in reporting to their CCGs and would now be back in line with national targets.
- Schwartz ward rounds were carried out daily which provided an opportunity for professionals from all disciplines to come together and review their work. Schwartz ward rounds meant each patient would be reviewed at the end of each ward round and actions agreed.
 - The service used a communication tool called Situation Background Assessment Recommendations (SBAR) for both medical and nursing staff to use when escalating concerns about a patient's condition to their seniors.
 - We saw staff completing the NEWS scores and watched one nurse escalate to a doctor as the score was indicating the patient's condition was deteriorating.
 - Nursing handovers occurred at the change of shift. We observed a handover which were carried out in the ward office for all staff. Therefore patient privacy, dignity and confidentiality were maintained. Staff were allocated to bays and a more detailed handover took place at the patient's bedside, when staff introduced themselves to patients and involved the patients in discussion. The ward sister reviewed the nursing notes to ensure all assessment and care plans were up to date.
 - The handovers were well structured and information discussed included patients going to theatre, patients requiring appointments for investigations, patients being discharged, pain management, medication and Deprivation of Liberty Safeguards (DoLS) assessments.
 - We spoke with staff in the anaesthetic and recovery areas, and found they were competent in recognising deteriorating patients. The NEWS tool was in place across the service to monitor acutely ill patients in accordance with NICE clinical guidance CG50.
 - We followed a patient through their surgical pathway from being admitted to the ward, to the operating theatre and into the recovery area. Staff followed a systematic enquiry as per the division's pre assessment proforma. The patient was seen by the consultant carrying out the operation who marked the operation site. All details were checked with the patient, nil by mouth was confirmed and the patient was seen and checked again by the anaesthetist.

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- Staff had access to the trust's critical care and outreach team for patients that had deteriorated or required additional medical input. Staff told us they were very supportive to staff on the ward and visited the patients on the wards and in the recovery areas when required.

Nurse staffing

- Nurse staffing across the service was variable with some wards and areas being understaffed and some being over staffed.
- The overall vacancy rate for the service for trained nursing staff was 8% which ranged from 1% in the abdominal surgery and medicine directorate, 9% in the general surgery and perioperative directorates to 15% in the head and neck and musculoskeletal directorates. For other clinical services the rate ranged from 4% in the musculoskeletal directorate to 11% in the abdominal surgery and medicine directorate.
- The overall sickness rate was 9% for trained staff and 4% for other clinical staff. The highest sickness rate was 9% in head and neck and perioperative directorates for other clinical services and 9% in the abdominal surgery and medicine directorates for trained nursing staff which was above the trust standard of 5%.
- The overall turnover rate for the service was 12% which ranged from 9% in the musculoskeletal directorate for trained nursing staff to 20% in the head and neck directorate and for other clinical staff the turnover ranged from 15% in the perioperative and musculoskeletal directorates to 25% in the abdominal and medicine directorate.
- Both staff groups had a turnover rate higher than trust average of 12%, though the rate for nursing were only slightly higher than the trust average.
- Sickness rates for both staff groups (clinical and non-clinical) were slightly higher than the trust averages of 5%.
- The average staffing across all wards in surgery was 94%. Out of the 40 wards 20 were understaffed by more than one whole time equivalent (wte) and of these nine wards were understaffed by more than five wte's. However ten wards had more staff in place than planned for.
- The overall use of agency and bank staff for the service was 14% across both sites which was better than the 21% trusts performance.

- Level 8a east only had 5.4 wte's in place. This was 36.7% less wte's than planned for and meant the ward was only 13% staffed.
- Cardiac theatres at the RSCH site were 57% staffed and was covered by staff working extra hours.
- The average vacancy rate for both additional clinical services and nursing was 10% and better than the trust average of 11%.

Medical staffing

- The overall average of locum staff across the service was 7% which was above the trust average of 5% with 17% use in digestive diseases service, 15% in the trauma and orthopaedic service, 11% in neurosurgery, 8% in the ENT service and 6% in the ophthalmology service. The remaining services for vascular surgery, urology, maxilla facial and anaesthetics were significantly better than the trusts average.
- The service had a higher percentage of wte consultants and registrars and a lower percentage of middle career and junior doctors in place than the England average.
- The overall service had 310.5 wte medical staff, 143.8 wte consultant staff, 9.5 associate specialists, 10.1 wte specialist doctors, 24 wte foundation level one house officers, 7 wte foundation level two house officers, 109 wte specialty registrars and the remaining were specialist doctors.
- The abdominal digestive diseases surgery service had three teams in place; emergency, upper gastro-intestinal and lower gastro-intestinal. Core Trainees and Foundation Year 1s support these rotas.
- For the emergency service there was a consultant of the week with two days as theatre lead, two days on the SAU and one day administration. There were specialist associate specialists doctors per week with two days theatre, two days SAU and one day administration.
- There was no consultant at night or at weekends for digestive diseases. Staff told us there was a plan to extend this service in order to cover the nights and weekends but there were no current plans at the time of the inspection. There was a consultant on call from home so would be able to cover any emergencies when necessary.
- For the upper and lower gastro-intestinal service there was one consultant and registrar covering ward duties on a one week in five rota.

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- Nights were covered by a consultant and one registrar on a one week in ten rota plus an additional registrar on a long day shift.
- For the perioperative directorate there was a total of 108 wte medical staff, with 61.4 (56.9%) wte anaesthetic consultants, 39.2 wte speciality registrars, 2.2 wte associate specialists, 3.1 wte speciality doctor, 1 wte Foundation level one and two house officers.
- Scheduling of anaesthetists (66 consultants and 40 trainees plus some locums and intensivists) was carried out using a software package by a team of four administrators.
- Job plans were maintained on the electronic system by an anaesthetist “rota master” who also supported the administration team and “starred anaesthetist” with day-to-day issues such as selecting locums and rearranging of duties in the case of unplanned changes to lists or availability.
- Leave was managed so that no more than 25% of consultants in any one subspecialty (paediatric, neurology, cardiac surgery, orthopaedic and generalists) to have leave on the same day.
- The head and neck directorate had 55 wte medical staff, 20.7 wte consultants, 22 wte specialty registrars, with the remaining doctors completing the numbers.
- The musculoskeletal directorate had 64.3 wte medical staff with 32.2 wte consultant staff, 20.8 wte specialty registrars with the remaining doctors completing the numbers.

Major incident awareness and training

- There was a trust wide Major Incident Plan (2015) which set out a framework for ensuring that the trust had appropriate emergency arrangements which were in line with the Civil Contingencies Act 2004 statutory duties.
- Emergency planning was a mandatory training subject for all staff. Staff told us there was a major incident exercise planned for July 2016.
- Command and control training was being presented with the aim to understand the principles of command and control in order that staff were able to respond appropriately in their role during an emergency.

Are surgery services effective?

Requires improvement 

Overall we rated the service as requiring improvement for effective, this was because:

- Staff working in the recovery area were not trained to look after emergency medical patients who were being transferred directly to the recovery area from ED and HDU.
- Consent practices and records were monitored and reviewed to improve how patients were involved in making decisions about their care and treatment but audit activity showed poor compliance with recording consent procedures.
- The service had a good pain service which supported medical and nursing staff in maintaining effective pain relief for patients but the service did not work out of hours or at weekends and had a restricted chronic pain service.
- Staff had an awareness of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) but the uptake of training was poor.

However we found;

- The treatment by all staff including therapists, doctors and nurses was delivered in accordance with best practice and recognised national guidelines and patients received treatment and care according to guidelines.
- Policies and procedures were in line with national guidance and were easily accessible on the intranet.
- Patients’ pain was addressed and national nutritional tools were used to monitor those patients who may be at risk of malnutrition.
- The nutritional needs of patients were assessed at the beginning of their care in pre-assessment through to their discharge from the trust. Patients were supported to eat and drink according to their needs. There was access to dieticians and medical or cultural diets were catered for.
- The service had a consultant-led, seven day service, with some elective lists on Saturdays and Sundays.

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- There were a range of Clinical Nurse Specialists and Advanced Nurse Specialists who supported teams and patients in specific areas, bringing their own expertise and knowledge to develop innovative and individualistic ways of improving services.
- Staff and teams were committed to working collaboratively and found ways to deliver more joined-up care to patients. There was a range of examples of working collaboratively and the service used efficient ways to deliver more joined-up care to people who used services. There was a holistic approach to planning people's discharge and transfer to other services.
- **Evidence-based care and treatment**
- Patients' care and treatment was assessed during their stay and delivered along national and best-practice guidelines. For example, the use of NEWS with a graded response strategy to patients' deterioration complied with the recommendations within NICE guidance 50 acutely ill patients in hospital.
- Policies were up to date and followed guidance from NICE and other professional associations for example, the Association of Perioperative Practice (AfPP). Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- The service participated in the National Hip Fracture Database (NHFD) which is part of the national falls and fragility fracture audit programme.
- The service took part in other national audits, such as the elective surgery PROMS programme, and the National Joint Registry.
- The service participated in the National Bowel Cancer Audit 2014 and the ophthalmology service was preparing to participate in the National Cataract Audit programme which was due to start in 2017. The service also used the national irritable bowel disease (IBD) standards and participated in the National IBD audits.
- In the National Emergency Laparotomy Audit (NELA) 2014 data was not available for 14 of the 32 questions. For example there was no policy for surgical seniority to according to risk, no pathway for the management of patients with sepsis and no pathway for the enhanced recovery of patients having emergency general surgery.
- The service had recently launched its emergency laparotomy collaborative based on the outcomes of the NELA. There were new processes introduced such as a new sepsis screening tool, a new emergency surgery model, compulsory p-POSSUM testing and new booking criteria. (p- POSSUM is a predictor of survival prior to surgical intervention).
- Staff followed the NICE guidance on preparing and prevention of surgical site infection prior to surgery.
- **Pain relief**
- We observed that consideration was given to the different methods of managing patient's pain, including patient controlled analgesia (PCAs) pumps. PCA is a method of allowing a person in pain to administer their own pain relief. Nurses on the medication ward rounds would ask each patient if they were in any pain and would give prescribed analgesia if necessary.
- The service had a nurse led acute pain team (APT) with two named consultants to support the team and covered both sites.
- The consultants had not completed the advanced pain training which was a recommendation from the Faculty of Pain Medicines core standards and were not always available to attend ward rounds. There were no plans to undertake this training. However members from the APT attended the wards daily and would check on all post-operative patients and other patients as needed. However members from the APT attended the wards daily and would check on all post-operative patients and other patients as needed.
- The APT was available Monday to Friday and did not provide cover out of hours and at weekends due to the lack of staff. This did not comply with the Faculty of Pain Medicines core standards and was on the services risk register for review. Trainee anaesthetists covered the out of hour's provision. There was also a small inpatient chronic pain service but this was due to finish due to the lack of staff.
- The APT had written a paper for the perioperative directorate on the vision for the pain management team based on the 2015 Core Standards for Pain Management in the UK highlighting the need to increase staffing so pain management could be covered out of hours and weekends. This was an action on the risk register.
- The APT told us they worked with the surgical and orthopaedic consultants and fed into the enhanced recovery plan. They told us they felt they were able to make suggestions about pain relief and the consultants listened.

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- The service undertook a PCA pump audit in 2015. This was a re-audit from 2011 and demonstrated action plans had been achieved in all areas except improving compliance with hourly checks. The trust medical devices policy required compliance of 60% and there was an overall reduction with the PCA policy since 2011.
- The conclusions from this audit showed documentation as per the trust policy and hourly pump checks were poor.
- Action plans to improve this position included continuing education via the acute pain study day and continuing education in recovery areas on completing the essential documentation.
- The service also undertook an epidural (an injection into the back which produces loss of sensation below the waist) chart documentation audit in 2014 which demonstrated an improvement from a previous audit in 2012. However the audit showed poor compliance in areas such as sensory testing on the start of an epidural pump (38%), further testing at 12 hours (26%), sensory check after a bolus and rechecked after a rate change (43%). A re-audit was agreed and further education was to be delivered in the recovery area
- We saw patients' records which showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner and staff returned to ask if their pain had been relieved.
- The APT told us about their work with the ortho-geriatrician (a consultant with a combined role in orthopaedics and elderly medicine) and finding that reducing opioids (a type of medicine to treat moderate to severe pain) for elderly patients resulted in the patients being less confused and a reduced length of stay in hospital.
- For the patients voice survey when asked 'Do you think the hospital staff do everything they can to manage your pain' the service performed similar (4.66) to the trusts performance (4.74).
- **Nutrition and hydration**
- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition and if a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician.
- Dietitians attended the wards daily and staff on the wards used a referral book so the dietitians could pick up any concerns and would then see patients on the day.
- The dietitians attended the wards daily where patients were receiving parental nutrition. Parental nutrition is a method of getting nutrition into the body through the veins.
- We saw food was delivered to the patient's bedside and patients told us the food was hot. Some patients told us they often did not receive the meals they requested and if they were out of the ward having tests and missed being able to order their food, and then they would get what was on offer.
- We saw a patient having pureed food due to being unable to take solid food, the patient told us this food was tasty.
- We saw one patient who had their operation cancelled and had to stay overnight, was given meals and drinks up until four hours before their surgery was due.
- The patient-led assessment of the care environment (PLACE) survey showed the trust was better than (93%) the England average (88%) for the quality of food.
- For the patients voice survey 2015 when asked 'How would you rate the hospital food' the service performed similar (3.77) to the trust (3.76).
- **Patient outcomes**
- The Hospital Standardised Mortality Ratio (HSMR) for the trust was 97.3% for 2013/2014 and 90.5 for 2014/2015. HSMR is a calculation used to monitor death rates in a trust and is based on a subset of diagnoses which give rise to around 80% of in hospital deaths. The trust's ratio for HSMR was better than the national average of 80%.
- Mortality and morbidity meetings occurred monthly across the surgical specialities. The information was reported through the governance structure to ensure early intervention. The trust had an action plan to improve its mortality and morbidity rates.
- Since the implementation of the emergency surgery team we saw evidence that showed outcomes for patients was improving. For example the length of time patients stayed in hospital after having their appendix removed was down to one day, the time to be seen by a consultant within two hours of admission was being

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met, the time for patients going to theatre was now well within the two to six hour standard and their predicted mortality was 2% which was better than the predicted mortality of 5%.

- Scores were mostly better than the England average in the 2014 Lung Cancer Audit. A multi-disciplinary team (MDT) lung cancer meeting had started in October 2015 and was attended by a consultant chest physician, consultant radiologist, consultant surgeon, a clinical nurse specialist in order to improve outcomes for patients with lung cancer.
- In the National Bowel Cancer Audit 2014 the service had a good case ascertainment rate and a fair data completeness rate for patients having major surgery. Scores were better than the England average for three measures audited.
- The service had started a flexible sigmoidoscopy screening service, their 90 day unplanned hospital readmission rate was better than the national 20% rate. Flexible sigmoidoscopy is a procedure that allows the examination of the rectum and the lower (sigmoid) colon. Over 50% of colon resections were key hole surgery which was better than the national figure of 48%.
- An area of improvement from the Bowel Cancer Audit was to improve on the standard of 65% of patients having their stomas reversed within 18 months. A stoma is an opening on the front of the abdomen which is made using surgery. It diverts faeces or urine into a pouch (bag) on the outside of the body. A stoma is a bud-like structure, which sits on the surface of the skin on the abdomen. The service did not know the percentage of patients that were waiting over 18 months but we were told anecdotally that the figure was significantly worse than 65%.
- The standardised relative risk of re-admission was mostly the same as England averages for both elective and non-elective patients. For example elective cardiac surgery readmissions were 98% compared with the England average of 100%.
- PROMs data were collected, which were responses from a number of patients who were asked whether they felt things had 'improved', 'worsened' or 'stayed the same' in respect to four surgical procedures at the trust
- PROMS are a series of questions or a questionnaire that seeks the views of patient on their health, or the impact that any received healthcare has had on their health. For this trust during the period April 2014 to March 2015, there was no evidence to indicate any risks related to surgery when assessed as part of PROMS for hip and knee surgery, as well as varicose vein and groin hernia surgery undertaken.
- However recently published data (May 2016) indicated that for the period April to December 2015, there was evidence that the trust achieved outcomes worse when compared to the England average for hip replacement, knee replacement and varicose vein procedures. The trust scored much worse than the England average and was seen as a negative outlier against 95% of services audited for groin hernia procedures.
- We were told the directorate teams were meeting to review the published data over the next month and would make add any further additional actions following review of the data and would update the action plan at that time.
- The Hospital Episode Statistics (HES) data September 2014 to August 2015 the average length of stay at service level was mostly worse than the England average for both elective and non-elective patients. For example all elective surgery was 6.1 days compared with the England average of 3.3 days. For all non-elective surgery the length of stay was 7.5 days compared with the England average of 5.2 days.
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently worse than the England average of 5% from quarter four 2013/14 to quarter three 2015/16. In the most recent data (quarter three 2015/16) the trust was three times higher than the national average at around 15% and had been as high as six times above the average in quarter three during the whole time period.
- The ophthalmology service had developed a daily one stop treatment clinic for wet macula degeneration (**an age-related painless eye condition that causes a loss of central vision, usually in both eyes**) and proliferative retinopathies (an eye disease and occurs when there is damage to the retina due to diabetes). This service had expanded rapidly over the past three years and performed over 400 intravitreal (injections into the eye) per month.
- In April 2010, the United Kingdom's Medicines and Healthcare products Regulatory Agency (MHRA) issued a medical device alert that included specific follow-up recommendations for patients with metal on metal (MoM) hip replacements. The recommendations included blood tests and imaging for patients with

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painful MoM hip implants. In February 2012, MHRA published a medical device alert and updated it in June 2012 with advice on the management and monitoring of patients with MoM hip systems.

- The musculoskeletal directorate was compiling a database of patients who had metal on metal implants so they could review their patients and ensure they receive the most effective care if they were experiencing signs of MoM symptoms. This was on the directorates risk register and data was still being collated.
- **Competent staff**
 - Staff had the skills, knowledge and experience to deliver effective care and treatment to patients. Whilst staff working in the recovery area were highly trained in looking after patients recovering from an anaesthetic they were not trained to look after emergency high dependency medical patients and ventilated patients when they were transferred directly to the recovery area. The recovery nurses were responsible for the care and clinical stabilisation of a patient in the immediate post-anaesthetic period until they were fit for discharge to the ward.
 - The training recovery staff received was to support their knowledge and clinical skills to practice efficiently and competently within the recovery setting and not in the more intense and longer term setting.
 - However recovery staff had a comprehensive training plan which included competencies in airway management, fluid and electrolyte (electrolytes are salts and minerals, such as sodium, potassium, chloride and bicarbonate, which are found in the blood), tracheostomy care (a **tracheostomy** is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe), blood gas analysis, renal functions and care of patients with an epidural.
 - Overall compliance with appraisal rates for surgery was 72% with abdominal surgery and medicine 44%, head and neck 83%, musculoskeletal 77% and perioperative 79% which did not meet the trust target of 85%.
 - Of the 38 medical staff, 22 had revalidated and 16 were deferred and the service had monitoring processes in place to ensure consultants were supported through their revalidation periods.
- Junior doctors within surgery all reported good surgical supervision, they each had a specific personal development plan which they felt enhanced their training opportunities.
- Junior medical staff told us they felt supported and had access to their consultants when needed.
- We spoke with four newly appointed nurses who were happy with the support they received by their mentors. They told us their mentors were easily accessible, spent time with them explaining each patient with them and what plans there were to care for each patient. They felt confident they could go to their mentor if they were unsure about what they had to do.
- The service had five nurse educators, two nurse educators in the abdominal surgery and medicine directorate, two nurse educators in the musculoskeletal directorate and two junior sister practice development posts in the perioperative directorate.
- Newly appointed staff and staff from overseas were given a session on nutrition and hydration by the dietetic team.
- Bank staff had an induction to their area prior to starting work on the ward. We spoke with one bank nurse who told us she had been given an orientation to the ward as she hadn't worked on the specific ward for four weeks.
- Health care assistants had started a competency based learning programme which was a national programme validated by Health Education England. This was a four month course with 15 core standards such as the Duty of Candour, privacy and dignity, safeguarding basic life support and infection control and prevention.
- **Multidisciplinary working**
 - Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required. We observed a good working relationship between ward staff, doctors, physiotherapists and the pain team.
 - There were a number of multi- disciplinary meetings (MDT) taking place across the service for example weekly lung cancer pathway meetings that included consultants in radiology, chest physicians, surgeons and clinical nurse specialists .
 - There were daily trauma meetings at both sites. These were established to review the unscheduled care admissions admitted over a 24 hour period and to plan the day's activity. These were attended by the trauma

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and orthopaedic (T&O) and emergency department (ED) consultants, T&O registrars, T&O junior doctors, poly-trauma nurse practitioners, trauma nurse co-ordinators and poly-trauma physiotherapists.

- Poly-trauma multidisciplinary meetings were held every Tuesday and Thursday. This meeting was attended by the poly-trauma MDT which included the physiotherapist, occupational therapist, trauma nurse practitioners and the poly-trauma consultant of the week.
 - Ward 9a east was a 58 bedded general and digestive disease ward which had daily MDT meetings with medical and nursing staff, stoma nurses, a discharge coordinator, inflammatory bowel disease (IBD) specialist, physiotherapist, occupational therapist and dietitians. Each patient was discussed in detail with those with more complex conditions preparing for discharge and agreeing care packages and funding arrangements for care when in the community.
 - The service was working in partnership developing an operational delivery network (ODN) with other NHS providers and external agencies such as the substance and misuse services and drug and alcohol teams to improve the care of patients living with hepatitis C.
 - Staff could access the learning disability lead, critical care team, pain management team, intravenous infusion team, social workers, homeless teams and safeguarding teams who were able to provide advice and support to the surgical teams.
 - Staff within the stoma care services were working the CCGs to improve communication with GPs in relation to using the most effective stoma products for patients.
 - The service provided a multi-disciplinary super clinic for patients living with IBD with IBD doctors, surgeons, nurses, pharmacists and stoma nurses. This allowed cross referrals and advice between disciplines within one clinic and improved the patients experience and reduced the number of attendances for the patients.
 - **Seven-day services**
 - Theatres had a staffed NCEPOD (national confidential enquiry into perioperative deaths) list 24 hours a day, seven days a week. Trauma had one staffed list every Saturday and Sunday. There was also a poly-trauma team available 24 hours a day, seven days a week.
- Currently there were no permanent elective lists at weekends but occasional lists were provided and staff were exploring the possibility of this becoming permanent.
- The perioperative directorate used dedicated NCEPOD co-ordinators to help co-ordinate the department's NCEPOD activity. These co-ordinators were trained to undertake this role. All coordinators worked alongside trained during which time they would work through a scenario booklet and were given enhanced training on emergency surgery live database system and e-oasis. The co-ordinators would lead in communicating between ED, the wards and theatres staff to ensure patients would be operated on as quickly as possible
 - Pickford ward (eye care) provided day and elective care and 24 hour emergency care.
 - All theatres were run 50 weeks per year, Monday to Friday 8.00am to 5.30pm. In addition emergency and trauma services were maintained 24 hours seven days a week at the two main sites, with elective activity scheduled at weekends to cope with increasing demand when it outstrips planned weekday capacity.
 - Approximately 100 staff serviced the theatres with sterile instruments, providing a 24 hour turnaround cycle when required to meet tight operating schedules.
 - The service had access to the physiotherapy service 24 hours a day and seven days a week. The out of hours such as weekends and public holidays was provided by 13 physiotherapists and six assistants. From 4.45pm to 8.30am, three physiotherapists were on-call. Pharmacy cover was Monday to Friday and on call over the weekend period.
 - The Patient Advice and Liaison (PALS) office was open Monday to Friday 9am to 5pm.
- **Access to information**
 - There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
 - Staff had good access to patient-related information and records whenever required. We saw staff using the services electronic emergency surgery theatre system where staff on the ward could see where their patients were in the surgical process. For example green showed

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the patient was in theatre, white showed the patient was in recovery, aqua showed the patient had returned to the ward and yellow told staff that the patients operation had been cancelled.

- Medical staff used the Patient Archive and Communication System (PACS) system to download and view images of patients x-rays and tests. The PAC system is a central repository for radiology and medical images and objects.
- Staff had access to an electronic system (bloodhound) for requesting and receiving blood tests. The service had seconded a band three nurse to manage the process of requesting and receiving blood tests to see whether these could be managed quicker, expedite decision making and reduce the workload for junior doctors.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
 - The trust had consent to examination or treatment policy dated November 2014.
 - The trust wide consent audit in July 2015 included 89 patients (81 elective and eight emergency) and showed a number of patients consented on the day of procedure (68%). However there was a lack of written patient information (7%), alternatives/consequences of not having treatment were not discussed/recorded and there were a number of abbreviations on the consent forms (12%).
 - Concerns were raised via the audit as 68% of patients were consented on the day of surgery and there was a lack of patient's information given to the patients. This audit resulted in consent champions being identified from each directorate and consent workshops had been instigated.
 - We spoke to staff on the wards who told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
 - We saw five DoLS in place which was completed correctly and the patient's family had been informed and were involved in the patient's care.

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect.
- Patients and relatives told us they received a good care and they felt well looked after by staff.
- The staff on the wards and in theatre areas respected confidentiality, privacy and dignity.
- Surgical and nursing staff kept patients up to date with their condition and how they were progressing.
- Information about their surgery was shared with patients, and patients were able to ask questions.

• **Compassionate care**

- Patients were treated with respect and dignity when receiving care and support from staff.
- Patients told us they felt supported and well cared for. Staff treated them compassionately, responding to them in a timely and appropriate manner.
- Patients told us they thought staff were excellent and couldn't praise them enough for their care and attention to detail. They told us their privacy was respected and staff spent time talking with them and those people close to them.
- We saw the results of the Friends and Family Test displayed on all the wards we visited. The NHS Friends and Family test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. We saw posters encouraging patients to give feedback so the service could improve the service it provided.
- We saw that the response rate varied across the service. The response rate for friends and family test across the service was below the national average of 36% with a response rate of 29% between December 2014 and November 2015. Of the 36% response 64% of patients that did respond would recommend the hospital to family and friends.
- Scores for the cardiac surgery ward from October 2015 to December 2015 were 100%.
- In the wards and theatres we saw patients cared for with care and dignity.
- We received positive comments from the majority of patients we spoke with about their care. Examples of their comments included "staff are very kind", "the nurse work very hard and come quickly when we call", "staff are fantastic".
- **Understanding and involvement of patients and those close to them**

Are surgery services caring?

Good



Overall we rated the service as good for caring because

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- Patients told us they felt involved in their care and had been given the opportunity to speak with the doctors and other staff looking after them.
- Doctors explained the patient's diagnosis and patients told us they were fully aware of what was happening to them.
- We saw a surgeon explaining to a patient about the procedure they were about to perform and ensured that the patient understood what they had told them.
- We observed nurses, doctors and other professionals introducing themselves to patients at all times and explaining to patients and their relatives about their care and treatment options.
- We saw the 'patient voice' post box was placed at the ward reception area for patients and relatives to post their comments about their care.
- There were various information leaflets on display about different types of conditions and treatments with some available for translation in different languages.
- From the patients voice survey when asked 'Are you being involved as much as you want to be in decisions about your treatment and care' the service performed similar (4.4) to the trusts performance (4.5).
- **Emotional support**
 - There were a number of services for patients needing psychological support for the condition such as IBD, poly-trauma and cardiac surgery.
 - Contact detail cards were available for visitors to take away and use if they wanted to enquire about their relatives when they went home.
 - Staff told us about a patient who had suffered multiple traumatic amputations and needed emotional support to come to terms with their injuries. Staff had arranged for a patient with a similar limb loss to come and visit this patient in order to support them through this difficult period.
 - The service used the Butterfly scheme on its wards. This scheme supports patients with dementia and memory impairment. It aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment. Butterfly symbols are put by the patient's bed and remind staff to follow a special response plan.
- The service could access the chaplaincy team which had Christian staff plus Roman Catholic provision and over 30 ward-based volunteers from variety of faith traditions, who made weekly visits to most of the hospital.
- There was also access to 28 volunteer on-call representatives of a variety of faith and belief groups from the immediate area.

Are surgery services responsive?

Requires improvement



Overall we rated the service as requiring improvement because

- The admitted referral to treatment time (RTT) was consistently below the national standard of 90% for all specialties apart from cardiac surgery.
- Patients waiting for a specific colorectal surgery and follow up of patients with an eye disease caused by diabetes could not be found in the outpatient system. The service did not fully understand why these patients were not on the system and had started work to identify them and review treatment.
- Bed occupancy levels across the service were high and the lack of available beds was resulting in patients spending longer periods in the theatre recovery areas. Also due to the lack of HDU beds patients were being transferred directly from the ED into the recovery area in the operating theatres. Patients had stayed anything from four hours to over three days. Patients did not have their privacy when they needed it and did not have free access to washing and toilet facilities, could not move freely around the recovery area and could not see their relatives whilst in this area.

However we also found:

- The service had reconfigured its vascular and plastic surgery so as to support the major trauma service.
- Amalgamating the care and treatment for patients suffering from a fractured hip onto one location with dedicated theatres and wards showed a significant improvement in outcomes for these patients.

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- The service regularly carried out operations on Saturdays and Sundays to meet local need.
- There was support for people living with a learning disability and a variety of specialist nurses and practitioners to care for those patients with complex trauma and complex diseases.
- **Service planning and delivery to meet the needs of local people**
- The service understood the different needs of the people it served and acted on these to plan, design and deliver services. There was a range of appropriate provision to meet individual needs and to support people to access and receive care as close to their home as possible.
- The service had reconfigured its major trauma service to include neurosurgery and plastic surgery on one site to enable a more patient centred approach to patients suffering major trauma.
- Virtual clinics were being provided for patients suffering orthopaedic traumas resulting in the reduction of attendances for patients allowing care and treatment to be provided in or near the patient's home.
- In order to improve the patient experience and meet the needs of local people the service had opened a SAU in September 2015. The SAU was opened to reduce unnecessary surgical admissions to the surgical wards by providing quicker access to a surgical medical team and improve the flow of patients through the surgical pathway. However the SAU only had three beds as the remainder of the unit was used by the rapid assessment cardiac outreach team. This reduced the opportunity to fully utilise this service and assist in addressing the issues concerning the flow of patients through the system.
- **Access and flow**
- Referral to treatment within 18 weeks was below the 90% standard and England average for the whole time period January to December 2015. Seven out of eight specialties fell short of the standard only meeting it for cardiothoracic surgery. For example oral surgery (31%), general surgery 64%, trauma and orthopaedics 69.5%, urology 71.5% ENT 75.5% and neuro surgery 77%.
- We were told directorates met with the executive team at performance review where issues relating to RTT were discussed directly. The directorates had weekly meetings which linked into the trust wide patient access meeting and were completing capacity and demand modelling for all subspecialties. Daily monitoring was undertaken by the access team to ensure patient access policy was being adhered to.
- Patients with diabetic retinopathy were not being followed up in an effective manner and staff still could not determine if there were other patients still waiting to be seen in OPD. Diabetic retinopathy can eventually lead to blindness and affects up to 80 percent of all patients who have had diabetes for 20 years or more.
- The percentage of patients whose operations were cancelled and not treated within 28 days was 20% which was consistently higher than the England average of 5% from quarter four 2013/2014 to quarter 2015/2016. In the most recent data quarter 2015/2016 the service was three times higher than the national average at around 15% and had been as high as six times above the average at one point during the whole time period.
- Cancelled operations as a percentage of elective admissions had been variable over the time period, and been above the England average for four quarters between quarter four 2014/15 to quarter three 2015/16. Average theatre utilisation rate was 81% which was below the trust standard of 85%.
- Between March 2015 and February 2015 there were 24% of operations cancelled with an average of 32 patients cancelled every month. Of these cancellations 40% were due to the patients cancelling themselves.
- The overall average length of stay for elective surgery was 6.1 days which was worse than the England average of 3.3 days. For colorectal surgery the elective length of stay was 6.4 days which was worse than the England average of 6.0 days and vascular surgery was 2.5 days and was also worse than the England average of 4.5 days.
- Length of stay for non-elective surgery was 7.5 days and was worse than the England average of 5.2 days. Both vascular and colorectal specialities were worse than the England average with vascular surgery having a length of stay of 12.2 compared with the England average of 11.8 days and colorectal surgery was 5.9 days compared with the England average of 4.7 days.
- The service had implemented new ways of working and new process to improve the length of stay. For example in October 2015 the emergency surgery team was launched to manage the non-elective workload Monday to Friday 8am to 5pm for general surgery. All patients attending the SAU during these hours were reviewed by

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a consultant surgeon or equivalent senior doctor to put a surgical plan in place. All out of hours acute admissions were reviewed by the emergency team the next morning to ensure there was a continuity of care.

- The vascular team had action plans in place to improve their length of stay. For example reviewing their care policy and ensuring equipment needed for use on discharge was in place prior to admission.
- During our inspection we saw a number of surgical outliers across the service. Surgical outliers are where patients are receiving care on a different speciality ward. For example Pickford ward (ophthalmology) had a patient with a broken leg waiting for discharge
- We saw there were systems in place to monitor surgical outliers throughout the trust. Nursing staff on these wards told us these patients were reviewed on a daily basis by the ward doctors and had access to specialist consultants when required.
- For the period September 2015 to December 2015 there were 507 patients cared for as an outlier taking 1,189 bed days with an average stay of 2.3 days.
- The trauma and orthopaedic speciality had the most number of outliers (546 patients) with an average length of stay of 2.2 days, followed by ENT with 104 patients and an average length of stay of 2.8 days.
- The service told us that between January 2015 and December 2015, 31% of admitted patients moved wards per admission, of which 1,633 took place during the night; (between 10 pm and 6 am) 77% was attributed to RSCH.
- For the period 5th April to 15th April 2016 there were three patients who were kept in the recovery area for over one day, five patients were kept over 20 hours and 23 patients were kept over 12 hours.
- Medical staff told us that since the reconfiguration of neurosurgery onto the RSCH site, availability to the operating theatres had reduced from three theatres to two which was creating problems with carrying out elective surgery as emergency surgery took precedence. However, one extra list per week had been made available for spinal trauma
- **Meeting people's individual needs**
- The service had 36 specialist nurses in post to meet the individual needs of specific patients. There were 26 in

the abdominal surgical and medicine directorate, one in the head and neck directorate, eleven in the musculoskeletal directorate and three in the perioperative directorate.

- The abdominal and medicine directorate had 10 digestive diseases clinical nurse specialists, six bowel screening nurse specialists, four urology nurse specialists, four stoma nurse specialists and two endoscopy nurse specialists.
- The head and neck directorate had one specialist ophthalmology nurse practitioner.
- The musculoskeletal directorate had three trauma practitioners, two nurse practitioners, one major trauma lead and three trauma coordinators.
- The perioperative directorate had five pain nurse specialists.
- The service used the trusts butterfly scheme where a butterfly symbol was placed by the patient's name to identify those patients living with dementia or memory-impairment. Its purpose was to improve patient safety and well-being in hospital.
- The recovery area in the operating theatres was being used for emergency medical patients due to having to reduce the pressure on an overcrowded ED and to help meet the emergency departments targets such as 12 hour waits. Some patients were transferred from the HDU to allow admission to that area and some patients were remaining in recovery when there was no post-operative bed available. We were told that some patients were discharged home directly from the recovery area.
- Some patients were kept in the recovery area for anything between four hours and up to three days with some patients being discharged home directly from the recovery area. This meant patients did not have their privacy when they needed it and did not have free access to washing and toilet facilities, could not move freely around the recovery area and could not see their relatives whilst in this area.
- We raised our concerns about the length of stay in the recovery area formally with the trust with the patient who had stayed in the recovery area for over three days. The trust raised this specific case as an incident and were investigating the care and treatment this patient received. The trust had put an immediate block on any direct transfers into the recovery area and had informed

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staff that any admission into the recovery area for purposes other than surgery would be logged as unacceptable and raised as an incident. The criteria for admission to the recovery area had yet to be agreed

- The trust had a policy for caring for adult patients with a learning disability in the acute hospital which included responsibilities and duties. The learning disabilities team would accept referrals from any source whether it was direct from the patient, their carers, community services, ward staff or GP's.
- Staff told us about their intravenous therapy and outpatient parental anti-microbial therapy (OPAT) service. OPAT is the administration of intravenous antimicrobial therapy to patients in an outpatient setting or in their own home. The team would insert intravenous lines on patients needing intravenous anti-biotics and assist with expediting their discharge into the community. Their data would be kept on a database and there were fixed dates for blood tests and virtual meetings with the microbiologist and acute and community teams. Patients would be contacted if there were any issues needing to be followed up. This reduced the number of attendances for patients and they would be able to have their therapy within their own home.
- Bariatric patients were assessed at pre assessment and any specialist equipment would be organised prior to the patient's admission. For example a patient who did not want to go to theatre on a theatre trolley was taken on their own bed.
- Pickford ward (the eye ward) had signs with a yellow background and yellow name badges which made it easier to read for those patients living with a visual impairment.
- The Brighton and Hove 'speak out' advocacy agency report January 2016 noted surgical services needed improvement in order to meet the needs of people living with a learning disability. Such as one patient feeling lonely as they had a single room and wanted to be able to talk with other patients and another felt the consultants on their ward didn't have time to talk with them and they didn't have time to ask questions.
- However there were examples of positive feedback from the report such as a person described as being afraid of having an anaesthetic, staff were able to keep the patient awake and said the nurses were reassuring and talked to the patient throughout the procedure.
- The service had action plans to address these issues which included the actions needed to be taken and who was responsible to complete the actions.
- Thank you cards were on display on the wards along with the details on how to contact Healthwatch and the CQC.
- We observed a patient who was anxious and wanted to go home. They approached a nurse and the nurse took the patient into a side room so they could talk in confidence. The nurse escalated the patient's concerns to the doctor and clarified the situation. The nurse then explained when they could expect details of a new appointment to be sent and made sure the patient had some tea before they left for home.
- **Learning from complaints and concerns**
 - The chief nurse was the executive lead for patient experience and complaints. The chief of safety and quality and deputy chief nurse shared the responsibility for the line management of the head of patient experience, PALS and complaints who were responsible for the operational management of the services and line management of the complaints and PALS teams.
 - The patient experience, PALS and complaints team comprised of six complaint investigation managers, two complaints/PALS coordinators and three PALS advisors who worked closely with the complaints team.
 - There was a monthly serious complaints and safeguarding meeting held by the head of patient experience, PALS and complaints, deputy chief nurse, patient experience, safeguarding lead nurse and chief of safety and quality.
 - A patient experience report was produced quarterly for submission to the quality and risk committee and the board. An annual report was produced and shared at both meetings.
 - The chief executive officer received copies of all complaints relating to clinical treatment and care. These were discussed at monthly meetings with the head of patient experience, PALS and complaints to discuss actions arising, themes and learning.
 - Patient information that advised patients how to make a complaint or raise a concern with PALS was available on the trust website. There was an easy to read leaflet 'comments, concerns and complaints' which was

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available throughout the trust and was available in other languages upon request. A poster 'Have you got a concern or complaint and don't know where to turn' was displayed throughout the hospital.

- Between March 2015 and February 2016 there was a total of 404 complaints across the service, 166 within the abdominal and medicine directorate, 134 musculoskeletal, 60 head and neck, 42 neurosurgery and two in the perioperative directorate.
- For the RSCH site the abdominal surgery and medicine directorate was 145, the head and neck directorate 25, musculoskeletal directorate 54 and two for the perioperative directorate.
- There were 30% of complaints related to cancellations and waiting times, 27% clinical treatment, 19% treatment pathways, 14% communication, five staff attitude and four classed as other complaints.
- The trust had a lessons learned folder on its website where examples of learning from a complaint would be presented.
- Staff told us the complaints team also met with each of the directorates monthly to discuss their incidents and the safety and quality team provided a monthly report. The teams then used this within their areas to share learning. Some wards do this through nursing handovers, some wards attach to their staff boards and some use in team meetings.

Are surgery services well-led?

Requires improvement



Overall we rated the service as requires improvement for well led. This was because

- There was no overriding strategy for the service and each directorate had their own individual strategy, this gave a perception of the service being disjointed.
- The service had experienced a reconfiguration of its services and had started to get its governance systems in place but this was in its early stages and needed further embedding. For example governance meeting and processes differed across each speciality and the management of delayed discharges and inappropriate stays in the recovery area had not been addressed in a timely manner.

However we found

- Leadership at a local level was good and staff told us about being supported and enjoyed being part of a team. There was evidence of excellent innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients
- The service had four risk registers which were reviewed monthly.
- Staff engagement was good and there was positive feedback from staff about being involved with the trusts services.
- There was evidence of the public being engaged in some specialities.
- **Vision and strategy for this service**
- There was no one overriding strategy and vision for the surgical services. However each directorate had either a strategy or business plan for their services. For example the perioperative directorate had future objectives for their service such as the expansion of opening times of the temporary theatres admissions unit to improve flow and patient experience, building a new theatre admissions unit at the RSCH and reviewing inappropriate placement of patients in the theatre recovery areas.
- The ENT service within the head and neck directorate had a strategy based on increasing medical staffing, improving its activity and referral to treatment performance, reviewing its estates facilities and reviewing its communication processes.
- The abdominal surgery and medicine directorate did not have a specific strategy document as there were multiple specialities within the directorate.
- However the abdominal surgery and medicine directorate's had objectives which included creating a strong leadership team, implementing a new model which split emergency from elective activity in the digestive diseases surgery, realigning urology to deliver the best outcomes in newly designed facilities and recruiting the right staff and implement a variety of other new service improvements.
- The musculoskeletal directorate did not have an overarching strategy; however their objectives aligned to the trust clinical strategy and the safety agenda. They

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were continuing to embed their site reconfiguration for fractured neck of femur pathway, developing a spinal/pain service and developing a Sussex musculoskeletal partnership.

• **Governance, risk management and quality measurement**

- Departmental governance meetings fed in to the four directorate's safety and quality (S&Q) meetings. How frequently and in what format was determined by the individual directorate management teams. The directorates had S&Q reviews which reported into the executive S&Q committee. Other concerns/issues raised between these quarterly reviews were reported into the executive by the S&Q facilitators. The service had regular board meetings with representation from all areas of surgery including consultants, matrons, and theatre managers. We saw minutes of meetings where quality issues such as complaints, incidents, risks and audits were discussed.
- Clinical leaders in the directorates told us they had oversight of all incidents and met with matrons and ward sisters to discuss these. We saw minutes of these meetings where incidents and complaints were discussed.
- Staff said they received information regarding serious incidents but did not always receive feedback on all incidents they had raised.
- The service had completed local as well as national audits. For example, a regular audit had been completed to ensure that compliance with the consent process and pain control was monitored and acted upon in line with the trust's policy and national standards.
- Each directorate had its own governance and performance monitoring systems. For example the perioperative directorate had ten governance meetings per year, directorate meetings and S&Q meetings every two months and a trust theatre group meeting every two months.
- The head and neck directorate had monthly governance meetings and planned to have quarterly directorate wide governance meetings, and had their own quarterly newsletters and included 'you said we listened' forums and gave the opportunity for staff to contribute to the newsletter.
- The musculoskeletal directorate had monthly clinical governance for T&O and a subspecialty monthly

governance arrangement for the fractured hip service. Pain and rheumatology clinical governance meetings were in place, however they were not monthly but run to meet the needs of the services.

- There were comprehensive risk registers for all surgical areas, which included all known areas of risk identified in surgical services. These risks were documented, and a record of the action being taken to reduce the level of risk was maintained.
- The service had risk registers for the four directorates with a total of 37 risks across the service. Abdominal surgery and medicine directorate (9), head and neck directorate (12), perioperative directorate (13) and musculoskeletal directorate (3). These were reviewed monthly with the main risks relating to lack of equipment and lack of adequate staffing levels.
- The register was up to date, identified the risk, the impact to the patient, the controls in place, with a nominated lead for each risk. The risk register was discussed at each directorate clinical governance meetings.
- Matrons and ward sisters also had daily meetings to discuss staffing levels, patients' safety concerns and bed occupancy.
- The service had completed local as well as national audits. For example, a regular audit had been completed to ensure that compliance with the consent process and pain control was monitored and acted upon in line with the trust's policy and national standards.
- **Leadership of service**
- Each of the four directorates had a clinical lead, nursing lead and directorate manager.
- We saw strong leadership, commitment and support from the senior team at ward level within the service. The senior staff were often responsive, accessible and available to support staff during challenging situations but there was a poor response to supporting staff at local level for areas such as the backlog of patients in the recovery area and the need to open additional beds.
- Senior managers we spoke with appeared knowledgeable about their patient's needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities. Members of the directorate and local leadership teams were visible.

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- Staff said they attended the engagement events held by the service which updated them of what was happening in the trust.
- Ward staff told us that senior nursing staff, consultants and doctors could be seen on the wards and they were approachable and helpful.
- Each ward had a ward sister, supported by a surgical a matron who provided day-to-day leadership to members of staff on the ward. Staff told us they thought leadership at that level was very supportive and that there was clear leadership from ward sisters and the matron.
- We observed the theatres were well managed with good leadership. There was evidence of good team working to comply with NCEPOD recommendations which was starting to show significant improvements for patients.
- The starred anaesthetist of the day and trauma coordinators was also helping to manage emergency cases more effectively.
- **Culture within the service**
- Staff told us morale was improving since the reconfiguration and things were starting to settle down with teams starting to work together.
- Ward 9a had a values and behaviours graffiti wall where staff could write their thoughts onto the wall for others in the team to read. There were comments such as “my team are amazing, we work together in really challenging situations, looking after each other giving the best care we can. “Thank you, “every shift someone makes me laugh out loud and brightens up the day” and “it’s not the ward where I usually work but I’m very lucky to stay here today; supportive and friendly team”.
- The perioperative directorate recently undertook a culture audit in the operating theatres which showed improvements were needed and plans were being developed. A detailed analysis was to be published for all staff to access so staff could see the service had listened to their staff.
- As a result of the audit 'You said, we did, poster campaign was to be published to clarify responses to issues. For example leadership development and communication strategy , running a multi-disciplinary perioperative safety conference in April, running focus group sessions with staff to discuss concerns, seeking agreement and funding for multidisciplinary simulation training for all theatre staff.
- The service was also continuing to run Human Factors training sessions, continuing with the roll-out of local versions of NatSSIPS and carrying out a repeat audit in 2017 to ensure improvements were made.
- Junior staff were left to cope with looking after patients for longer periods of time than they were resourced or qualified to care for. They were left unsupported and had to fight to try to ensure patients were not admitted to the recovery area and we were told that at times senior staff shouted at them and then bullied into taking patients inappropriately.
- **Staff engagement**
- Staff told us about the significant changes when the neurology and fractured hip services had been reconfigured. There had been challenges around staff relocation and managing the new structures. Some staff moved in order to continue in the specialty of their choice and some staff stayed at their original hospital site but moved specialty. This caused a lack of structure and cohesion for the teams resulting in a large number of vacancies through August 2015 to November 2015.
- Staff told us these vacancies were now being filled, the majority being newly qualified staff. Leaders had set up protected time for away days for these services in order to promote better team work and support the newly formed teams. Staff told us about now feeling more positive about their futures. Leaders told us how proud they were about how staff responded to the changes.
- The service was continuing to run Human Factors training sessions, continuing with the roll-out of local versions of NatSSIPS and carrying out a repeat audit in 2017 to ensure improvements were made.
- A 'You said, we did', poster campaign was to be published to clarify responses to issues . For example leadership development and communication strategy, running a multi-disciplinary perioperative safety conference in April, running focus group sessions with staff to discuss concerns, seeking agreement and funding for multidisciplinary simulation training for all theatre staff.
- Staff told us they were able to request support from their managers or from the HELP team if emotional support was needed.
- The service had recruited a number of nurses from overseas and offered lessons in English for those nurses who needed additional help with speaking the language.







Surgery

- **Public engagement**

- Since April 2015, the ENT department had a group called the 'Head and Neck Buddies' whose aim was to provide support to patients suffering from head and neck cancers. The buddies were trained Macmillan volunteers who had gone through head and neck cancer themselves, or have cared for loved ones who have been affected by head and neck cancer. This was the first site specific group of buddies in the United Kingdom to provide emotional support to current head and neck cancer patients and their families. So far, the volunteers had supported 107 head and neck cancer patients and 172 family members, friends or carers.
- The service used a number of volunteers to assist with some areas of work across the wards. For example one volunteer had been a patient and was now assisting with some paperwork and helping feed patients where appropriate.

- Patient satisfaction questionnaires were available on each ward and patients were encouraged to complete these. This provided the opportunity for patients to give feedback on any areas they felt needed improvement.
- The average response rate in the friends and FFT for the period January 2015 to December 2015 was worse than the England average; 29% compared with 35%. Response rates for individual wards were, L8 12%, L8aeast 23%, L8awest 16% and L9 28%.
- **Innovation, improvement and sustainability**
- The team won a national NHS innovation prize for setting up virtual clinics for patients suffering hand injuries where there was a multidisciplinary team working to reduce the number of attendances of patients attending hospital and caring more patients at home or nearer to their homes.

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

Information about the service

Critical care at the Royal Sussex County Hospital (RSCH) consists of a cardiac high dependency unit (CICU), a general intensive care unit (GICU) and a mixed general and neurosurgical ICU. The three units are geographically separate and the CICU has a different governance structure to the other two units. The CICU has eight beds and provides care for cardiac and thoracic surgery patients pre and post-operatively. This unit can care for up to four ventilated level three patients and four level two patients. The GICU has 16 beds and provides care mostly for level three critical care patients. The mixed unit has 15 beds, which can be used flexibly for general and neurosurgical intensive care (neuro ICU) patients at both level three and level two. Five side rooms are available, two of which are equipped as negative pressure rooms with anterooms for infection control. 'Level three' and 'level two' refers to the acuity of a patient. For example, a level three patient will likely be ventilated and need intensive, 24-hour one-to-one care. A level two patient is considered to be high dependency and requires significant nurse input and is usually cared for on nurse to patient ratio of two to one.

In June 2015, the trust relocated neurosurgical ICU services from Hurstwood Park in Haywards Heath to the RSCH in Brighton. Since the move, the numbers of neuro ICU patients cared for has risen by 140%.

Patients are admitted to critical care through the medical take from specialist inpatient services, including for patients who present with chronic obstructive pulmonary disease, diabetic ketoacidosis or drugs overdoses. RSCH is a major trauma centre and critical care services are

provided for trauma services. Patients are also admitted following elective surgical work and as an inter-hospital transfer if their care cannot be met at the Princess Royal Hospital.

Several GICU and mixed ICU staff roles and responsibilities, clinical governance and some care pathways and protocols are shared with the units' sister site at the Princess Royal Hospital. This includes a shared nurse practice educator team, critical care outreach team and consultant team. Both sites contribute to national and local data audits, led by a dedicated audit nurse

Between December 2014 and December 2015, critical care occupancy was above 82% every month and was over 95% in two months.

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Summary of findings

Overall we rated critical care as inadequate. This reflects consistently poor staffing levels of nurses that breached national critical care guidance and resulted in unsafe levels of care. Mandatory training did not meet minimum trust standards and due to sickness absence and the volume of new nurses, the nurse practice educator team were able to provide only limited support to staff. Incident reporting was sporadic and poorly investigated and there was limited evidence senior staff used investigations to improve practice.

There was inconsistent input from a multidisciplinary team of specialists due to short staffing, including amongst pharmacy, occupational therapy and dietetics. The standard of medicine management was variable and 37% of incidents on the general ICU and mixed ICU were medication errors. Critical care services did not fully meet the National Institute for Health and Care Excellence guidance on the rehabilitation of patients. The mixed ICU was also not fully compliant with national best practice on the care of patients with a head injury. There was a significant gap in the ability of the service to provide specialist care and treatment to neurosurgical ICU patients because of a lack of available staff and the lack of clinical governance oversight.

There was a demonstrable focus on providing individualised care based on feedback from patients and their relatives. Additional support for critical care patients was provided by a critical care outreach team, who also provided a cross-department education programme.

There was room for improvement in infection control practices and hand hygiene audit results were particularly poor.

Governance and risk management were not fit for purpose and the lack of a relationship between the clinical leadership team and the trust executive team meant a culture of disrespect and bullying had emerged, in which some nurses felt devalued. Clinical leads did not demonstrate an understanding of this, which was reflected in consistently high rates of sickness absence and staff turnover.

Are critical care services safe?

Inadequate



We rated critical care at Royal Sussex County Hospital as inadequate for safe:

- Staffing levels on the mixed ICU and cardiac ICU units were frequently and significantly short of enough nurses to provide safe care. This unit also frequently breached the minimum staff to patient ratios set by the Intensive Care Society and the Royal College of Nursing.
- The skill mix of nurses on the mixed ICU unit was often insufficient to provide specialised care to neurosurgery patients. The trust had systematically failed to respond to staff concerns about this and mitigating strategies had failed.
- Medicines management was poor and we found numerous examples of out of date liquid medicines in use. Medication errors accounted for 37% of the incidents reported in the general ICU and mixed ICU. The units had inadequate cover from pharmacy and the trust had failed to address this despite the escalation of risk from senior clinicians.
- The incident reporting culture was impacted by staff reluctance to report incidents due to a lack of time and the perception that nothing was changed as a result.
- The unit did not have a safer sharps policy and staff used needles against national and European best practice guidance.
- Infection control practices were not robust and hand hygiene practices and audits, particularly in the mixed ICU unit, placed an unacceptable risk on patient safety.
- As a result of low staffing levels, particularly amongst neuro ICU nurses, patient risk assessments were not consistent and did not always protect patients from avoidable harm.

However, we found some areas of good practice:

- Medical staff cover in all critical care areas met the requirements of the Faculty of Intensive Care Medicine.
- Consultant intensivists led critical care services.
- The reporting of safety thermometer data was good and there were very low instances of Clostridium difficile and MRSA.
- **Incidents**

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- From February 2015 to January 2016 critical care reported 331 incidents. The majority of incidents related to medication errors and staff shortages. The senior team had categorised most incidents as resulting in no harm or being low risk. This was despite significant miscalculations in prescriptions and on-going evidence of inadequate staffing, in terms of expertise and staff levels. In 51% of cases, the investigator had identified a learning opportunity from the incident report.
- There were numerous examples of a lack of robust investigations. For example, in many cases, there was no documented action taken and in other cases the investigating member of staff stated they were unable to trace the patient concerned or the error reported.
- The matron and clinical lead assigned incidents for grading and investigation to an appropriate member of staff after submission.
- A senior nurse in the cardiac high dependency unit (CHDU) told us they did not know how incidents were investigated or learning disseminated and said they were not aware of any changes in practice as a result of incident investigations.
- A consultant led monthly morbidity and mortality (M&M) meetings with a multidisciplinary team made up of individuals involved in the care of the cases presented. The M&M meetings were used to improve practice and standards of care but very few members of staff were able to tell us about any changes as a result of the meetings. This was particularly the case amongst the nursing team and meant findings from the meetings were not widely distributed.
- Several nurses told us they had stopped submitting incident reports because they did not feel the feedback was useful. One nurse said, “The people who view the incident reports have nothing to do with neurosurgery.”
- In another instance, a senior nurse told us short staffing was now so common, some nurses did not complete an incident report when they had breached Royal College of Nursing guidance by looking after two level 3 patients at the same time. They said, “Because we’re so busy during the shift, we don’t have time to write an incident form. So if we do one, it’s after the shift in our own time, which some people don’t do.”
- Some incidents indicated a lack of multidisciplinary working and specialist input into neuro ICU patients. For example, a Speech and Language Therapist (SaLT) had asked a consultant not to cannulate a patient with a head injury due to their specialist needs in weaning. The consultant cannulated the patient after the SaLT specialist had left the unit, which they reported. This incident indicated a culture of arbitrary decision-making and lack of cross-specialty work processes, which resulted in higher clinical risks to patients.
- A general ICU (GICU) nurse gave incorrect fluids to a neuro ICU patient and did not understand the significance of giving dextrose to a neuro patient, which should be avoided because of the risk of swelling to the brain. A senior nurse said they felt there was a lack of understanding of the situation from critical care doctors.
- A critical care risk team met every two months to discuss incident reports. This was attended by the critical care pharmacist due to the relatively high number of drug errors reported. However, learning from errors was not shared appropriately and the lead pharmacist was not able to explain how the meetings contributed to better practice or any specific outcomes. We were referred to the matron, who was not available during the inspection.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person.
- Some staff had a basic awareness of the duty of candour but this was inconsistent. No staff we spoke with were able to explain how they used this in practice.
- Theatre recovery staff had previously submitted incident reports when critical care patients had been transferred there due to a lack of capacity elsewhere. However, one member of staff told us this was now not common practice because it happened so often and senior staff had not implemented risk mitigation strategies.
- **Safety thermometer**
 - Staff in critical care contributed to the NHS Safety Thermometer programme. Information was collected on a monthly basis and clear, easy-to-read information was displayed for staff, patients and visitors.
 - A clinician assessed each patient for their risk of venous thromboembolism (VTE), falls and malnutrition on admission and reviewed this at regular intervals.

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- Between January 2015 and February 2016, the unit reported harm-free care in 100% of patients, with 12 instances of harm recorded for the whole period. In 10 cases, the harm recorded was a pressure ulcer or urinary tract infection (UTI) acquired outside the unit. One new pressure ulcer and one new UTI was acquired on the unit. There were no instances of falls with harm or VTE.
- A monthly quality audit identified if staff completed appropriate risk assessments for infection control and falls risks. This included measures such as if patients had a falls risk assessment and a waterlow score within 24 hours of admission. The trust target for all measures was 100%. Critical care was 100% compliant in only one measure, nutrition, in one month between January 2015 and December 2015. In the same period the CHDU reported an average of 63% compliance in the three measures.
- **Cleanliness, infection control and hygiene**
- A dedicated housekeeping team provided cleaning and hygiene services for critical care areas. The manager of this team conducted monthly spot checks on the standard of their work and also helped them to maintain best practice by giving monthly infection control quizzes. The lead housekeeper in the GICU and mixed ICU units provided guidance and practical training for new staff, including clinical staff, on the need for a high standard of general cleanliness. Not all of the units were visibly clean although staff used daily checklists to ensure they regularly checked areas known for a build-up of dust. For example, there was dust on the shelving in equipment rooms and the floor of the staff toilet in the mixed ICU was dirty. In addition, one bed space in the GICU was ready to receive a patient but the pendant above the bed was dusty. This presented a risk to ventilated patients.
- The cleaning checklist was visual and there was no documented record it took place. However, there was an established level of accountability amongst housekeeping staff that ensured checklists were completed.
- There was limited use of green 'I'm Clean' stickers to indicate when an item of equipment was safe to be used. This included an equipment room which staff told us was used for equipment they could use. However, there was no indication this equipment had been cleaned and disinfected.
- Housekeeping staff had posted signs in the sluice room to remind staff to label commodes when they had been cleaned. However, staff did not always follow this instruction which meant it was not always possible to identify items that were clean and disinfected.
- Alcohol hand gel was available at every entrance and exit to the units, as well as in each bed space. Staff used this inconsistently. For example, the staffroom on level 5 was outside the main unit but we observed some staff did not routinely gel their hands on entering the unit after leaving the staffroom.
- Staff did not consistently adhere to or enforce the trust's 'bare below the elbows' policy. For example, we observed clinical staff who visited the unit, including the point of care team, wore long sleeves and did not gel their hands on entry or exit. A nurse in charge was speaking with a colleague at a patient's bedside and was wearing a long-sleeved fleece.
- The GICU and mixed ICU units assessed cleanliness against the national cleanliness score. In the latest result for April 2016, the units scored 98.8%. The score for the permanent neuro ICU bay was 99.4%.
- The infection control team audited critical care monthly for hand hygiene compliance. Results for this on the mixed ICU unit had been consistently poor. The March 2016 result was 65%. This was below the trust target of 100% although was an improvement on the previous result of 46%. Although the latest result was displayed in the unit, there were no action points or corrective plans with it and four nurses we spoke with said they did not know about it. This meant hand hygiene audits were not being used effectively. The deputy infection control lead for the trust told us they were unaware of the poor scores or of action taken and said the matron would correct this. We were unable to identify any action taken.
- Hand hygiene overall in critical care was monitored inconsistently and demonstrated poor standards. From April 2015 to January 2016, hand hygiene data was missing for three months and compliance ranged from 85% in September 2015 to 31% in October 2015.
- There had been no incidents on unit-acquired C. Diff in the twelve months prior to our inspection. One case of unit-acquired MRSA had been reported in the same period.
- The unit did not comply with the Health Safety Executive (HSE) classification regulations for infectious substances and clinical waste. This was because staff

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used yellow clinical bags for waste identified by the HSE as UN3291 instead of the required orange hazardous bags. Although all full bags were locked in an area outside the unit awaiting collection, not all bins were labelled as required by the HSE Carriage of Dangerous Goods Manual.

• Environment and equipment

- The mixed ICU unit was fully self-contained and had no natural light or natural airflow. This presented a risk to patients with head injuries who needed to be cooled. As the unit's temperature was controlled centrally by one air conditioning system, staff found it difficult to ensure patient temperatures were managed effectively. Senior staff had authorised the use of fans, which are normally prohibited in critical care units because of the risk of infection they carry.
- Nurses in the mixed ICU unit had presented a case to the executive board to ask for special lighting to be installed in a bay used by neuro ICU patients. This was based on their concerns the lack of natural light and other natural time indicators meant patients did not recover as quickly as they usually would. This had resulted in the bay being fitted with an artificial lighting system that more closely matched the time of day.
- Space on GICU was very restricted and some bed spaces were very close together. This breached Department of Health building guidelines and presented an elevated risk of cross-infection and health and safety hazards to staff.
- A technologist, a lead support assistant and two support assistants provided a dedicated and specialist support service to clinicians. This included the maintenance of equipment and troubleshooting support when equipment malfunctioned.
- The unit was not compliant with the Health and Safety Executive Sharp Instruments in Healthcare Regulations 2013 or the EU Council Directive 2010/32/EU with regards to a safer sharps policy. This was because needles were not covered with a protective sheaf. The deputy lead for infection control was not able to provide an update or action plan for this, although did acknowledge it was a recognised risk for the service.
- Staff documented daily checks on resuscitation trollies, defibrillators and intubation trollies. However, this was

inconsistent. For example, there was no recorded daily check of the CHDU resuscitation trolley on 10 days between January 2016 and March 2016. There was no documented corrective action.

- A sluice room was unlocked in the mixed ICU unit with chemicals visible and accessible. This contravened the national requirements for the Control of Substances Hazardous to Health .
- Staff did not consistently cover cleaned ventilators with protective plastic dust covers. As we found areas of dust accumulation, this meant we could not be sure ventilators were always clean enough for use.
- Access to the mixed ICU unit was through an intercom that did not have camera capability. A ward clerk verified each visitor's identity Monday to Friday and on a weekend clinical staff were responsible for this. There was not always good oversight of security on the unit. For example, access was granted remotely from the clinical station, which did not have direct sight of the entry door. A treatment bay was also fully accessible between the entry door and the clinical station. This meant if a member of staff granted access, there were no further checks in place to make sure unauthorised people did not access the clinical area.
- **Medicines**
- Medicines management did not always follow best practice. For example, in the mixed ICU, neurosurgery staff had been trained to administer propofol, a sedative, as a bolus using a syringe pump instead of a volumetric pump. However, senior staff had issued a new standardisation protocol to instruct nurses to only administer the medicine using a syringe pump. Neuro ICU nurses had raised a concern regarding this as it meant there was an increased risk of errors and dangerously high intracranial pressure in patients with a brain injury.
- Staff did not always label liquid medicines with the opening date. We found six bottles of medicine in the mixed ICU unit without an open date. There were multiple bottles of an anti-psychotic drug opened and unlabelled despite trust policy stating only one bottle should be in use at the same time for each patient. In addition a bottle of liquid medicine had expired but was still in use. In the general ICU unit we found staff were using a bottle of insulin that had passed its useful date after opening. In addition, a bottle of eye drops were

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open but staff had not labelled it with a patient name or opening date. The lack of labelling on time-limited liquid medicine meant there was a risk staff used items that were no longer effective or safe.

- The trust was not able to demonstrate consistent accuracy in medicine documentation. This was because an internal audit identified that 62% of drug chart transcriptions had errors in them. An audit lead was trying to establish if this was a true figure or was due to errors in the audit methodology.
- The matron had used the April 2016 briefing to remind staff of the need for double-checking when administering infusions. We saw this in practice during bedside handovers.
- Errors in medication administration and prescribing accounted for 37% of reported incidents.
- New staff undertook two days of training in the administration of intravenous fluids, followed by an annual refresher day.
- Medicines management in the CHDU was good and we found an adequate stock rotation system and documented checks of Controlled Drugs (CDs). A previous incident had occurred where a member of staff found a discrepancy in CDs. As a result of the investigation, a new system of purple syringes was being trialled to help staff differentiate between intravenous drugs.

• Records

- Patient records were electronic and each bed bay had a computer staff could use to update notes whilst observing patients.
- Neuro ICU nurses had not received timely initial training on the electronic records system and had been given patients to care for without adequate support in relation to the system. This was rectified in time but created an unnecessary risk initially.
- Staff could access the records of any patient in the unit from any bedside computer. This meant nurses could support each other when providing care for a patient they needed extra support with, such as when a general ICU nurse was allocated a neuro ICU patient.
- Handover documentation from the emergency department, neurosurgery, general surgery and other departments followed a standard structure, which included vital signs and observations.
- Staff did not always maintain appropriate control of documents in relation to information governance. For

example, we found a confidential set of patient notes left unattended on the nurse's station on one day of our inspection. This area was accessible to visitors and there was not always a member of staff present. This meant private patient details could be at risk.

- Staff could not always use the electronic patient records system effectively to track patients, which caused delays in finding them. For example, on three occasions on one day of our inspection, doctors and surgeons came into the mixed ICU trying to find their patients but were unsuccessful. The trust told us they could have used the patient information boards in the units but we did not seem them do this in practice.

• Safeguarding

- Staff demonstrated a good awareness of safeguarding and how they could ensure patients were protected from avoidable harm. For example, staff had liaised with a patient's family when they had become concerned about the behaviour of a caller on the telephone. Staff demonstrated proactivity in protecting the patient by setting up individual passwords for each family member so they could verify the person calling was authorised to discuss the patient.
- Staff had completed safeguarding adults training to level one and 91% of staff were up-to-date. All staff had up-to-date training in child safeguarding to level one and 61% had child safeguarding training to level two.
- There was evidence of inappropriate use of safeguarding policies due to some poor working relationships. For example, a nurse had submitted a safeguarding report after a doctor helped a patient to eat and alleged they had force-fed the patient. There had been a distinct lack of support, oversight and direction from the executive team and human resources. Both teams demonstrated wholly inadequate knowledge or understanding of the principles of safeguarding.
- **Mandatory training**
 - A nurse practice educator team and band seven team leaders supported critical care nurses to be up-to-date with their annual mandatory training updates. The trust target for completion was 94% and at the time of our inspection, 71% of critical care nursing staff had up-to-date mandatory training.
 - Some nurses told us they often found it difficult to access mandatory training. For example, each nurse was responsible for booking their own mandatory training

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sessions but did not have time to do this during a shift. One nurse had been removed from their mandatory training day in February 2016 due to short staffing on the unit. They were not able to attend a new date until August 2016. This meant some of their mandatory training had expired and they were non-compliant with trust training requirements. Senior staff had not implemented a mitigation strategy for nurses when this occurred.

- In December 2015, critical care staff were 76% compliant with mandatory training needs. This was supported by 121 mandatory training places trust-wide offered by the practice educator team. However, uptake of the places was low due to short staffing and the cancellation of some sessions due to a major incident, staff sickness and service reconfiguration.
- On the CHDU, 50% of nurses and healthcare assistants were fully up-to-date with mandatory training.
- **Assessing and responding to patient risk**
- The trust recognised the detection and management of deteriorating patients could be improved following a number of concerns raised by a coroner. To address this, a deteriorating patient steering group was established in March 2016. The critical care nurse consultant was part of this team and was actively involved in improving the identification and care of sick patients across all hospital wards. This included debriefs and learning sessions following emergency and cardiac arrest calls and a pilot project to determine the effectiveness of treatment escalation plans as a method to improve the rapid assessment of patient safety.
- Eight nurses in the mixed ICU unit told us they were concerned patients stayed in the unit longer than necessary and developed delirium more quickly because of the lack of natural light and airflow. We asked a senior clinician about this. They said they were aware of the concerns and acknowledged the environment presented an elevated risk to patients but there was no substantive data collected or audited to support the concerns. The clinical lead had recorded a 40% increase in activity amongst neuro ICU patients since the transfer of services.
- There was a lack of team working and skills competence in the mixed ICU unit that meant patient risks were not adequately assessed. This situation occurred when the nurse in charge overruled more junior neuro ICU nurses about specific treatment for high acuity neurosurgical patients. Several neuro ICU nurses raised this with us and told us they felt it was a dangerous precedent to set. For example, one individual said a nurse in charge, who was not trained in neurosurgery, disagreed with them about the ventilator settings used for a ventilated neuro patient. When the bedside nurse was not present, the nurse in charge changed the settings without a discussion. The patient's condition deteriorated and the bedside nurse then returned the settings to their original level. Staff told us this was a common occurrence but the department did not monitor such events.
- One bay in the mixed ICU was cluttered and short-staffed. During an observation we saw two high-acuity ventilated patients were left unattended and unobserved when the two nurses in the bay provided care for a third patient behind a closed curtain.
- The mixed ICU unit did not have immediate access to a category 1 computed tomography (CT) scanner, which neuro ICU patients often needed. A standard operating procedure was in place which staff used to safely transfer patients to the CT scanner in neurosurgery. Some critical care registrars were trained in patient transfer and could assist this. If there was not a suitably trained doctor available, the patient had to wait for an anaesthetist to be able to attend.
- Patients were sometimes cared for in theatre recovery. However, staff in this unit were not trained to provide care for level three patients and depended on support from an anaesthetist and the critical care outreach team (CCOT).
- Staff used the national early warning scores system to identify sick patients who were deteriorating. CCOT monitored this system and responded to patients across the hospital who may need to be admitted to critical care. The guidance and protocol used by ward staff for contacting CCOT and used by nurses to prioritise patients for review was well established and robust.
- **Nursing staffing**
- A team of 152 nurses delivered patient care in the GICU and mixed ICU units, including 13 senior band seven nurses, 12 healthcare assistants (HCAs) and 21 neurosurgical ICU nurses. Six overseas nurses worked in the general ICU under supervision and two military nurses provided additional support.
- A team of 42 nurses, supported by 10 health care support workers provided care in the CHDU.

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- Senior band six nurses often led shifts instead of more experienced band seven nurses. This was part of a nurse professional development programme, which band six nurses took part in alongside completion of an NHS Leadership Academy course. The critical care outreach matron and critical care matron planned and administered nurse development in this area.
- GICU and the mixed ICU did not always have a supernumerary nurse coordinator on shift, due to frequent short-staffing. This meant the department did not always comply with the core standards of the Intensive Care Society (ICS).
- The neuro ICU team had no current senior band seven team leader nurses, due to long-term sickness and staff attrition. A number of band six nurses acted as shift leaders, which they told us was “unofficial”.
- The ratio of appropriately-skilled staff to patient acuity was variable between units. There had been a 58% attrition of neuro ICU nurses following the move of the department from Hurstwood Park to RSUH. Clinicians and managers had not adjusted the number of neuro ICU patients that were admitted. The trust had failed to recruit any new nurses to replace the significant and sustained shortfall. In the month following the relocation, there was a sickness absence rate of 26% amongst the relocated nurses and this rate remained significantly higher than the trust target of 2% to January 2016, where the overall sickness absence rate was over 10%. This meant there were often more neuro ICU patients who needed specialist care than nurses to care for them. We spoke with 23 nurses and clinical staff about this. In every case staff told us they believed patients were at significant clinical risk because of a lack of skill and specialised training amongst existing staff. Patients were allocated bed spaces as they were admitted, which meant there was no protected area that neuro ICU patients could be treated in, which further reduced the ability of specialist nurses to provide appropriate care.
- On one day of our inspection the mixed ICU unit had nine neuro ICU patients and only one neuro-trained nurse. A booked agency nurse had not turned up and the nurse in charge was not able to arrange a replacement. The unit was unsafe because it breached the minimum staffing requirements of the ICS and RCN, which require a nurse to patient ratio of one to one for level 3 patients. On this occasion one nurse was responsible for two level 3 ventilated patients at the same time. The nurse in charge said there was no-one to escalate this to and there was nobody in place of the matron while they were on leave. We spoke with senior directorate managers about this who told us they felt the clinical director put pressure on senior nurses to take patients regardless of staffing.
- On the same day we observed a four-bedded bay with a single HCA in attendance to observe patients. This occurred for less than 10 minutes but the nurse in charge had left the unit to speak with colleagues on the general ICU floor, which meant the nurse cover at that time was inadequate.
- The impact of short-staffing included tiredness and fatigue amongst nurses. This was reflected in some incident reports and resulted in some nurses working continuously for seven hours with only a 10 minute break. We spoke with nurses about this. One individual said, “I’m functioning but I’m very tired. We’re having to work even harder to make sure patients are safe.”
- Staff had submitted incident reports relating to the unsafe operation of the CHDU due to short staffing. This included an incident in January 2016 when a nurse submitted a report because the unit had only five staff nurses to care for eight ventilated patients. This was a breach of the safe staffing levels for intensive care but there was no evidence of input or action from the senior team and the report investigator had categorised this incident as ‘no harm’.
- We returned to the mixed ICU unit as part of a weekend unannounced inspection. At that time, there were nine neuro ICU patients with level three acuity needs, which meant they needed one-to-one care. On this occasion there were only five neuro ICU nurses on shift. Four general ICU nurses provided care for the other four patients, with support where possible from the neuro ICU team.
- We were not able to speak with the matron about this as they were unavailable during both the announced and unannounced inspections. Nurses, doctors and managers were not able to tell us what the matron’s strategy was for improving the nurse staffing problems. One senior nurse said, “We get an occasional e-mail of thanks after a shift when we didn’t have enough staff but that’s it. That’s not good enough and it doesn’t help.”
- Between September 2015 and December 2015, the unit was staffed by between 82% and 88% of the number of nurses established by the senior team as needed to

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operate it safely. The shortfall in nurses was most often made up with agency staff. The GICU and mixed units sometimes relied on more than 20% of total staffing from a nurse agency. This was in breach of ICS guidance. Agency staffing was also common in the CHDU but in this unit senior staff were more responsive to the concerns of nurses and would cancel elective admissions if nurses said short staffing meant the unit was unsafe.

- Senior nurses who led shifts showed us the system for requesting agency staff and then having this approved was time-consuming and complex. For example, it involved clinical staff and administrators and there was no way to find out if agency staff had been confirmed until they turned up. We observed a nurse handover on the mixed ICU unit and saw an agency staff nurse was expected but did not turn up. There was no failsafe to this system and so the unit operated for the following 12 hours with an unsafe number of nurses, which breached ICS and RCN requirements. The nurse in charge did not have an escalation policy to follow in such situations. They told us they stopped submitting incident reports relating to short staffing and agency nurses because they felt it made no difference. The senior team did not have a formal plan in place to handle unsafe staffing levels and feedback to agencies was inconsistent and could be completed only by administrators, who were not based on the unit.
- We asked nine nurses about this situation. In every case we were told this was a regular occurrence and safe staffing levels in this unit were often breached. Shift handover logs included a list of agency staff used. We reviewed 35 handover logs for the mixed ICU unit. Misinformation about agency staff, including no-shows and too many staff showing up and being sent home, was a regular problem. Some nurses told us they were working their notice period because of unsafe staffing levels. One individual said, "I don't want my name attached to a department [that I think is] so unsafe. I'm going now before that happens."
- As part of our inspection, we observed three nursing handovers. In some cases staff demonstrated good practice during handovers, such as highlighting to nurses when two patients had very similar names. The nurse in charge also asked if any of the incoming nurses had previously worked with patients so they could be allocated for consistency. However, there was room for improvement in the conduct of staff in handovers and

the leadership demonstrated by the nurse in charge in some cases. For example, we saw a nurse used their personal mobile phone to send a message whilst the handover was taking place. In another handover, considerable disrespect was shown to the nurse in charge by the body language and tone of voice of more junior nurses. There was a lack of leadership from some senior nurses that allowed this to continue, which meant we were not confident staff allocation was based on the needs of each patient or the skill mix of the nursing team.

- Following overall unit handovers, nurses conducted their own bedside handovers. We observed three of these. During one bedside handover on the mixed ICU unit, we observed nurses follow an exemplary, structured and individualised handover. This included consideration of the patient's social and mental health needs as well as a strategy for meeting their emotional and personal needs. Nurses visually checked intubation tubes and discussed risks they had identified, such as a valve that had fallen off when the patient coughed. The two nurses considered input from the multidisciplinary team, including a dietician, SaLT therapist and tissue viability nurse and asserted the need to check for pain levels.
- A band 8b nurse consultant led the CCOT team of 10 nurses. This team included a developmental band six nurse who was planning to rotate between CCOT and the critical care units, to provide a clinical link between the two teams.
- The senior team assessed new nurses using the clinical simulation suite. This meant they could assess the clinical knowledge and ability of applicants in real time and using practical scenarios.
- A team of HCAs supported nurses with patient care, including taking echocardiograms and blood gases. HCAs had training appropriate to their responsibilities and were supported by a mentor and nurse team leader. There were usually three HCAs per shift on the general and mixed ICUs and this team conducted a daily shift 'huddle' to ensure their workload was manageable and they were supporting nurses appropriately.
- An analysis of nurse staffing indicated agency staff could not always evidence their competence to work in a critical care environment. This presented a significant

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risk to patient safety and the skill mix of nursing teams. The senior leadership team indicated there were addressing this issue with nurse agencies but did not specify the outcome of action taken.

• **Medical staffing**

- A team of 18 consultant intensivists led medical care in the critical care units. Consultants were supported by 24 trainee doctors including from specialities including anaesthetics and respiratory medicine as well as core medical trainees, core surgical trainees and clinical fellows.
- The department met the standards of the Faculty of Intensive Care Medicine (FICM) for the ratio of consultants to patients and all consultants were accredited with FICM.
- We were told by multiple members of staff they were concerned there was no designated clinical lead for the neuro ICU. However, after our inspection the trust provided the name of a clinician in this post. We were not able to identify why staff were not aware of this member of staff or their remit.
- Clinical oversight for neuro patients was provided jointly by neuro-surgeons and critical care consultants. There was not a robust structure in place within which this arrangement was placed and critical care consultants were not specialists in neuro patients. This meant patients did not consistently receive the most appropriate clinical supervision and nurses did not receive consistent support from doctors. The neurosurgical clinical director provided support for critical care doctors and neuro-surgeons with patients in the level five unit and acted as a liaison between the neurosurgical lead and spinal surgery lead. A senior clinician described the experience of medical staff in treating neuro ICU patients as “variable”, which we saw was the case in practice.
- Some neurosurgical junior doctors chose to undertake a critical care rotation but this was not a formal process and happened only based on their own interests.
- Critical care provided training for all grades of trainee doctors and had been appointed a Fellowship for echocardiography.
- Medical teams handed over twice daily. A morning handover we observed was attended by a multidisciplinary team, including a neurosurgical

registrar, three consultants, a bed manager and a theatre manager. They discussed patients based on clinical need and identified where specialist input was needed.

• **Major incident awareness and training**

- A major incident plan and business continuity protocol was in place in all critical care areas. This included details of specific actions to be taken by each individual, establishing communication with the trust command centre and using a ‘communication cascade’ to call in extra staff. The policy was up-to-date, fit for purpose and all of the staff we spoke with understood their responsibilities in line with it.

Are critical care services effective?

Requires improvement



We rated critical care as Requires improvement for Effective:

- The lack of neurosurgery trained ICU nurses in the mixed unit meant patient care was often delivered by staff who lacked the competency to care for them safely. A plan to ‘up-skill’ general ICU nurses to be able to effectively care for neuro patients was poorly managed and provided inadequate support to nurses.
- Multi-disciplinary teams did not work together consistently because of low levels of staffing in some specialities.
- There was no permanent dietician allocated to the critical care units, which was not compliant with the British Dietetic Association’s national guidance.
- Occupational therapy services were provided for the core hours with no regular occupational therapy service on both sites.
- Staff in the mixed ICU did not always provide evidence-based care to neuro ICU patients because of a lack of training and competence in caring for patients with head injuries.
- Pain management and auditing was inconsistent and patients did not always receive appropriate pain relief in a timely fashion.

However, we found some areas of good practice:

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- There was consistent leadership and support for deteriorating patients from a critical care outreach team that was proactive in delivering specialist training to clinical staff across the hospital.
- The clinical team in the cardiac high dependency unit followed a shared model of care that improved decision-making.
- **Evidence-based care and treatment**
- Clinical care on the cardiac high dependency unit (CHDU) followed a model of nurse-led percutaneous coronary intervention whereby nurses and doctors made care and treatment decisions together.
- Staff used a custom-made selective decontamination of the digestive tract (SDD) gel on all intubated patients and those with a tracheostomy. The use of SDD can reduce the occurrence of ventilator-associated pneumonia.
- Ventilator care bundles were in use and staff recorded daily checks on the electronic clinical information system.
- The trust did not routinely audit compliance with the ventilator care bundles. However, audits of incidences of catheter related blood stream and ventilator-acquired pneumonia were used to measure patient outcomes. Catheter related blood stream infection rates were consistently below the Matching Michigan project targets at 0.25 infections per 1000 catheter days. This was better than the national standard of 1.4 infections per 1000 catheter days.
- Staff monitored the use of central venous catheters against national NHS guidelines for preventing healthcare-associated infection and used only single-use insertion packs.
- Clinical staff followed an algorithm for IV fluid therapy in accordance with National Institute for Health and Care Excellence (NICE) guidelines.
- Treatment for neuro ICU patients did not always comply with NICE clinical guidance 176, which refers to national best practice in patients with head injuries. This was because general ICU nurses were not trained in the management of intracranial pressure (ICP) in neuro patients. This presented a significant risk to patients and staff told us was a recurring problem. One nurse told us a general ICU nurse had mistaken a higher ICP score for delirium and had therefore not acted appropriately and placed the patient at risk of stroke and death. We were told this incident had not been recorded because of time and clinical oversight present in the unit. In another incident, a general ICU doctor had extubated a patient with a critically high ICP score three times, causing them significant additional trauma. The unit did not have a robust ICP protocol for ICU doctors to follow and there were no actions taken to ensure practice in this area followed best practice guidance.
- There was some evidence the clinical team had identified areas for improvement in the care of neuro ICU patients. For example, a consultant had identified there was poor use of an established tool to identify delirium in patients. To address this they began bedside education sessions with neuro ICU nurses, including the use of the confusion assessment method tool.
- **Pain relief**
- Staff knew how to access and used trust protocols and guidance on pain management, which was in line with national guidelines. This included the management of pain, agitation and delirium.
- A trust wide pain-scoring tool was in place to assess adult pain levels. In the records we reviewed, we saw evidence these were completed appropriately and pain relief was given when needed.
- An appropriate clinician recorded pain scores within four hours of admission and reviewed these at intervals appropriate to patient need. Where a pain score was higher than three, analgesia was given.
- Pain management training for nurses was provided on analgesics, such as patient-controlled analgesia (PCA) pumps and epidural and local anaesthetic wound infusion. Nurses were required to complete a patient-administration competency assessment and competency checks on their use of equipment. At the time of our inspection, 95% of nurses had up-to-date competency checks on the use of pain management equipment, 55% had an up-to-date patient competency check in epidural and local anaesthetic wound infusion and 69% up-to-date patient competency checks in PCA. A plan was in place to focus training on patient competency checks in 2016.
- The critical care outreach team (CCOT) received the same competency checks, with an average 71% compliance for pump equipment competency and an average of 34% had completed patient competencies.
- A monthly quality audit identified compliance with pain relief standards, for which the trust had a target of 100% compliance. Measures included if each patient had a pain score documented within four hours of admission

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and if patients who required regular analgesia had a pain score documented at least every four hours. Between January 2015 and December 2015, the overall compliance for pain measure was poor and critical care achieved 100% in only one month. In all other months compliance was less than 70% and was 0% in two months. The average in the same period for the CHDU was 55%.

- After our inspection the trust supplied action plans for the ICU and CHDU to improve pain management as a result of the audits. The plans included sharing of audits between senior nurses and the data team with new pain questions from the trust's safety team, which would improve the documentation of pain management. An improvement to the frequency and content of staff training by the practice educators and the trust pain team was also part of the plans. Both action plans were due to be completed by October 2016.

- **Nutrition and hydration**

- Critical care did not have dedicated full time dietician cover. This meant the department was not compliant with the British Dietetic Association recommendations of between three and four whole time equivalent dieticians for the number of beds. However, staff told us they had on-call access to a dietician when required. Dietetics services were available 9am to 5pm Monday to Friday.
- A dietician identified patients who would benefit from total parenteral nutrition post procedure and organised this with nursing staff.
- High dependency patients on the mixed ICU unit and CHDU were able to order food and drink from a menu. Staff offered appropriate options to people based on their swallowing ability. However, staff knowledge and ability to encourage patients to eat was variable. For example, one patient went without food for several hours because they told the nurse they weren't hungry. However, the consultant was able to gently encourage the patient to eat. This meant there was room for improvement in the consistency of how nurses were trained to ensure patients received adequate nutrition. For example, where a patient needed encouragement to eat and drink, we saw a nurse take time and patience to sit with them and successfully support them to eat breakfast. This meant some nurses possessed good skills in this area and there was a need to ensure this was practised routinely.

- Staff ensured patients had access to drinks at regular intervals and recorded fluid balance at regular intervals.
- Clinical staff demonstrated good awareness of patients' nutrition and hydration needs during handovers. For example, they discussed patients who were having difficulty eating or who refused to drink and the support they needed to provide to improve this.

- **Patient outcomes**

- The department contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The cardiac unit was not part of this data audit.
- A consultant led an ongoing audit programme to assess the amount of prescribed enteral feed neuro ICU patients received. The initial audit indicated approximately 67% of feed was delivered and the consultant was establishing a national benchmark figure and a drive to improve this.
- The CHDU reported seven falls in the previous twelve months and no unit-acquired pressure ulcers.
- Critical care was part of the Surrey and Sussex Local Clinical Research Network organised through the National Institute of Healthcare Research (NIHR) Critical Care research network to benchmark practice and drive quality improvements.
- In 2014/2015, the critical care team supervised several research projects with Brighton and Sussex Medical School including a project looking at the outcomes of 400 patients admitted to the ICU after a cardiac arrest between 2010 and 2012. The results were presented at European Society of Intensive Care Medicine in 2015.
- Between April 2015 and December 2015, patients spent an average of 129 days in critical care, compared to a national average of 111 days.
- Less than 1% of transfers out of critical care were for non-clinical reasons, which was better than the national average.
- Unplanned readmissions were reported at less than 1% of total discharges in the twelve months prior to our inspection.
- Mortality rates in the unit were significantly better than the national average between April 2015 and June 2015, the period for which data was available. During this period, average mortality was 14%.

- **Competent staff**

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- The trust target for the completion of appraisals was 100% annually. Staff on the GICU unit were 54% compliant with this, the mixed ICU unit was 48% compliant and the CHDU was 78% compliant.
- The department exceeded the Royal College of Nursing (RCN) and Faculty of Intensive Care Medicine Core Standards for Intensive Care Units standard that at least 50% of nurses with a post-registration qualification in critical care as 66% of nurses had achieved this. In the outreach team, 93% of nurses had the post-qualification award. However, compliance with the RCN guidance was undermined by the recruitment of 8 new staff nurses from outside the European Union and 10 new staff nurses. This new intake, along with long term sickness in the practice educator team, meant resources for routine training would be significantly reduced. A new band six development post for an existing nurse had been implemented to try and mitigate the risks.
- A team of five nurse practice educators (NPEs) led education, teaching and practical learning in critical care in close collaboration with the Head of Nurse Education. The practice educators supported qualified nurses within critical care with their mentorship responsibilities by delivering annual mentorship updates. However, the NPE team were available Monday to Friday during daytimes only. Nurses told us this reduced their access to the education team and often meant there were delays in obtaining clinical supervision.
- A clinical simulation suite was available for critical care staff and was used by the NPE team as well as other clinicians for practical training. The suite was equipped with a separate computer control room, which senior staff used to control the live electronic equipment in the suite. Simulations were recorded and used for debrief discussions with participants and video-based training for other staff.
- Due to long-term unavailability, the neurosurgery team of nurses in the mixed ICU did not have a dedicated NPE who was competent in patient care and treatment specific to neurosurgery. This meant the neuro team of nurses had not received any specialist training updates since September 2015. The senior clinical team had no immediate plans to address this situation. The previous neuro ICU NPE had been replaced with an NPE competent in critical care but with no specific experience or remit for the neuro team.
- The trust had an active revalidation process in place.
- To address the need for more band six nurses, NPEs were supporting a number of band five nurses to progress through a leadership route, including through engaging in local audits and research.
- NPEs provided twice weekly bedside teaching sessions for nurses in line with their competency requirements. Nurses gave us very mixed feedback about this. The majority of nurses said getting time to have bedside supervision was very difficult and the NPE team was so short staffed this rarely happened in practice. One nurse said they had asked several times for bedside learning support from the education team and had been told they were too busy with new trainee nurses. One nurse said, "When you can get time with them they're great. But they're mostly office-based now, dealing with new overseas nurses." Nurses were increasingly expected to manage and organise their own training. There was no provision for bedside learning specific to the neuro ICU team and the NPE team had been unable to provide ventilator training on request.
- A new intake of overseas nurses added significant pressure to the NPE team as they needed constant supervision. This took time away from the qualified nurses who often could not attend planned training because of short staffing. For example a senior nurse said, "Daytime teaching requires me to release nurses for 50 minutes at a time. I can rarely do that because we are so short-staffed there is no-one to cover. So they [nurses] don't get the regular training they need."
- A NPE acknowledged these issues. They told us sickness in the team and the employment of a large number of new nurses without the involvement of the education or management team had led to insurmountable pressures on the team's ability to provide consistent learning opportunities.
- To address the lack of neuro ICU nurses, senior staff had introduced a neurosurgery rotation for general critical care nurses. This involved nurses working shifts with neuro ICU patients and undertaking study modules to increase their specialist skills. However, this process did not have a clear structure or clinical framework. The rotation period had increased from four weeks to three months following feedback from staff. However, senior clinicians and nurses of all grades told us this was still insufficient. One nurse said, "This process is causing

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tremendous stress on everyone involved. The nurses on rotation are supposed to get trained by neuro ICU nurses. But there are too few of them to give any training so it all seems a bit pointless.”

- One neuro ICU nurse told us they tried their best to offer bedside support to nurses on the neurosurgery rotation but did not get support from the nurse in charge. They said, “I was told by a nurse in charge it wasn’t my job to train another nurse and they wouldn’t let me help.” This comment was representative of over 15 interviews we held with nursing staff and a clinical manager who had experience of the mixed ICU unit. In every case they gave examples of how the lack of neurosurgery competence available meant patients did not receive safe or effective care.
- A nurse told us they felt the neuro ICU rotation was “poorly organised.” They said, “The neuro ICU training sessions have been poorly attended and we don’t get protected time for them so most of us can’t attend.”
- The leadership of the neurosurgical rotation programme for nurses was inconsistent and not fit for purpose. This was because although they were qualified ICU nurses, those on the rotation programme had no direct or structured supervision. During our unannounced inspection, we looked at the staff rota plan for the day. A neuro ICU nurse had been redeployed from the neuro unit to the GICU so that a nurse on the neuro rotation could gain some experience. This meant there were not enough competent staff in the mixed ICU unit to care for patients safely and the nurse on the neuro rotation programme had inadequate supervision. This situation resulted in neuro ICU nurses caring for general ICU patients, general ICU nurses caring for neuro ICU patients and neuro rotation nurses working unsupervised with sick and ventilated patients.
- The trust did not routinely enable neuro ICU nurses to undertake a post-registration qualification in critical care. This meant they were not equipped to provide support for patients with specialist needs, such as renal failure.
- There was no neurosurgical nurse input into the rotation training programme because the NPE team was made up of general ICU nurses and the neuro NPE was unavailable and there were no plans to replace them. This meant competency checks on rotation nurses were completed by inappropriate staff.
- Staff were trained in life support to a level appropriate to their grade and responsibilities. For example, band seven nurses were trained in advanced life support (ALS) and band six nurses were trained in intermediate life support, with some also trained in ALS. Band five nurses and healthcare assistants were trained in basic life support.
- An NPE or senior nurse ensured agency staff received an induction before working on the unit. The induction included a clear outline of their duties, equipment competency checks and recording evidence of their intravenous fluids training.
- Healthcare assistants (HCAs) received a formal induction and supernumerary period and regular training. One HCA told us their induction had been “brilliant, very informative” and said the NPE team were “always available for formal and ad-hoc training.”
- The induction programme for new staff nurses included one hour and 45 minutes of neurology-specific education, including one hour of observation skills and 45 minutes of drug education. This programme was generalised for both ICU and neuro ICU nurses.
- One nurse who had raised concerns about their lack of specialist knowledge to care for neuro ICU patients said the matron had told them that the only difference between patients was the level of observations they needed to complete. The individual concerned had spoken with a senior allied health professional regarding this, who had been able to provide bedside learning for them.
- Staff in the CHDU had more consistent access to teaching and learning from nurse practice educators. For example, a band six nurse had 25% protected time in their rota for study.
- **Multidisciplinary working**
- The CCOT team was available seven days a week between 7.30am and 8pm. Outside of these hours, nurse practitioners from the site management team provided care and support for sick patients on the wards. The CCOT team also visited patients after discharge from critical care to a ward. Between April 2015 and January 2016 they provided 542 follow-ups.
- Daily ward rounds were not always attended by a multidisciplinary team due to short staffing in pharmacy, occupational therapy and dietetics. A single multidisciplinary meeting took place once each week to review patients who had been in the unit for over two weeks and was attended by a critical care consultant, physiotherapist, speech and language therapist and a

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nurse from the critical care outreach team. The team used this meeting to assess patients with complex needs, including respiratory needs and patients who had tracheostomies. Staff had access to microbiology, pharmacy and pain specialist services although these were not typically provided daily.

- A multidisciplinary team led a weekly rehabilitation meeting to discuss discharge plans and rehabilitation targets.
- The critical care link pharmacist had submitted two business cases to the trust to recruit additional pharmacists and the clinical lead recognised the current lack of staff as a risk and a breach of the Intensive Care Society Guidelines for the Provision of Intensive Care Services. Despite this the trust had not agreed to additional funding for more pharmacy cover.
- Microbiology input was available daily through a ward round. However, a documentation audit found microbiology input to be inadequate. This resulted in the introduction of a new standard operating procedure for microbiologists that would enable them to enter patient data at the bedside workstation to reduce delays.
- A critical care outreach nurse had established weekly medical emergency team meetings, for which they had been awarded an academic health network safety award in 2015.
- Physiotherapists visited critical care daily and contributed to rehabilitation care plans through the completion of outcome strategies and practice based on the NICE rehabilitation pathway. This team also attended the critical care rehabilitation group to benchmark their work. The physiotherapy team was short staffed and did not achieve the minimum requirements recommended by the ICS.
- Occupational therapists were available Monday to Friday between 9am and 5pm but due to short staffing this service was ad-hoc and on-demand only. The senior team responsible for occupational therapists and the senior directorate team were aware of this shortfall and had submitted a business case to the executive team to increase the size of the team urgently.
- There was no robust protocol for the sharing of clinical decision-making. This meant decisions about treatment and medicines could be made by a critical care consultant and a neuro-surgeon. Seven nurses we spoke with told us this was problematic. One nurse said, "They [clinicians] rarely agree. One will write their notes and

then the other comes along and tells us to do something else. It's a ridiculous situation. Whatever we do, we'll get in trouble because one of them [clinicians] will challenge us for not following their instructions." We asked a senior doctor about this. They told us critical care consultants had the final decision in treatment plans for neuro ICU patients, which they said presented a significant risk to patient safety because they did not necessarily have neurosurgical experience. In addition, although neurosurgeons visited the neuro ICU on a daily basis and were available on call, they were not part of ward rounds.

- Although specialist allied health professionals visited patients daily, critical care clinicians did not always engage with them to ensure patients received the most appropriate care. For example, the SaLT team prepared feeding guidance for nurses for patients who had dysphagia. This was displayed using bedside posters for neuro ICU patients but staff told us some critical care consultants did not agree with SaLT input and arbitrarily removed the posters without discussion.
- In all seven patient notes we looked at for evidence of joint decision making, a critical care senior doctor and a neurosurgical registrar had documented their contribution.
- Critical care had a lead pharmacist who visited the unit on a daily basis. The pharmacist supported staff and junior doctors to liaise with microbiology for the prescription of antibiotics and also provided ad-hoc training and bedside learning sessions on demand.
- Two consultants, a critical care physiotherapist, a CCOT nurse and a SaLT therapist formed a multidisciplinary follow up group. This group reviewed all patients who had been in critical care for longer than 14 days or those with complex rehabilitation needs, such as patients with learning difficulties as well as each patient who had a tracheostomy. The group established a 'rehabilitation prescription' for each patient, which included goals and action plans.
- The CCOT team referred patients on discharge to the ICU Steps programme. This programme is operated nationally by a charity and supports patients and their relatives after discharge from critical care. The programme was in place of a formal follow-up clinic and was shared with other critical care units. However, a critical care consultant, senior critical care physiotherapist and CCOT nurse attended this. Local volunteers for the ICU Steps programme worked with

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the National Outreach Forum to further ensure it met the needs of discharged patients during their rehabilitation. However, the department did not fully meet the requirements of clinical guidance 83 from the NICE rehabilitation after critical illness policy. This was because patients were not assigned a key worker and did not have access to an integrated care pathway on discharge. In addition, the department performed poorly against critical care network guidance that a short clinical rehabilitation assessment be completed within 24 hours of discharge. In December 2015, 48% of patients received this assessment and in January 2016, 74% of patients had this assessment. There was also low compliance with the use of delirium screening on discharge.

- There was a positive working relationship between critical care staff, transplant coordinators and the end of life care team. Consultants actively engaged with specialist nurses in organ donation to speak with relatives and patients about organ donation.
- Nurses considered multidisciplinary staff input in depth during a bedside handover. For example, nurses reviewed the latest physiotherapy report as well as dietician recommendations, SaLT team input and advice from a tissue viability nurse during one of our observations.
- **Seven-day services**
 - A neuro-surgery consultant and a spinal surgery consultant was available seven days a week to support patients in the neuro-ICU.
 - Access to imaging was available 24-hours, seven days a week.
 - There were no dietetics, pharmacy or occupational health services routinely provided out of hours. Staff had access to an on-call pharmacy service out of hours and the dietetics team provided guidance for staff on their intranet pages, which supported critical care staff to maintain patient nutrition, including for patients on enteral and parenteral regimes.
 - Physiotherapy cover was provided seven days a week and on-call physiotherapists were available 24-hours, seven days a week.
 - A microbiologist undertook a daily midday ward round, seven days a week.
- **Access to information**
 - The electronic patient records system was compatible with clinical systems across the hospital and staff could

review past medical notes and test results easily. Staff in the critical care unit at the Princess Royal Hospital had access to this, which meant staff could access records at either site if they were transferred.

- Patient social history, mental health needs and multidisciplinary health records were available on the electronic system and staff could access this rapidly from each bedside.
- Diagnostics could be ordered and the results received on bedside electronic equipment. This helped ensure diagnostic tests were processed quickly.
- **Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)**
 - Staff routinely obtained and documented consent from patients before performing care tasks, investigations or giving medicines. Where consent could not be obtained, for example from a sedated patient, staff provided care and treatment in their best clinical interests. We observed staff seeking consent from patients in all critical care units.
 - Consultants completed and documented mental capacity assessments in patient notes and also had access to online policies and prompts relating to the Deprivation of Liberty Safeguards (DoLS), the Mental Capacity Act (MCA) (2005) and the trust's policies relating to mental health and vulnerable adults.
 - Staff knowledge of DoLS and MCA was variable. Some staff were able to describe the principles behind DoLS but were unclear how this was applicable to the critical care setting. A member of staff completed a DoLS authorisation request for a patient who had been fitted with soft mittens to stop them from hurting themselves. This was in line with trust policy. However, the level of knowledge amongst senior nurses was inconsistent with their role. For example, a senior nurse in CHDU said they had no knowledge of DoLS or the MCA. The clinical lead was aware of the need for an improvement in knowledge and had prepared a straightforward process for staff to follow when assessing if a DoLS was necessary.
 - Doctors had a good understanding of their responsibilities under the MCA and in regards to best interests assessments. Some senior nurses supported doctors with this but more junior nurses said the trust gave them only basic knowledge in this and they were not always aware of how their care could be individualised to look after a patient with reduced

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mental capacity. For example, in a bedside handover, one nurse explained to their colleague the patient had a “mental health issue.” They were not able to explain this further and told us mental health was an area monitored solely by clinicians.

Are critical care services caring?

Good



We rated critical care at Royal Sussex County Hospital as Good for Caring:

- Staff consistently treated patients and their relatives with dignity, kindness and compassion.
- Families we spoke with told us staff were courteous and respectful and they felt involved in the decision making process.
- Staff routinely introduced themselves and gave clear explanations to patients about their care. Emotional support was readily available for patients and families and an active bereavement support group was available in the hospital.
- **Compassionate care**
- Staff were proactive in contacting another hospital where a patient’s relative had also been admitted to critical care. This helped to provide compassionate support to both patients.
- Patient diaries were in use and patients were encouraged to have pictures of family and pets by their bedside. Nurses and relatives had contributed to diary entries with positive messages of clinical improvement and encouraging personal messages. The patient diaries were given to patients on their discharge from the unit and they were encouraged to use them to help recall and understand their experiences in critical care.
- Throughout our inspection, we observed the privacy and dignity of patients were maintained. We saw the use of ‘This is me’ documentation for patients with dementia.
- On the cardiac critical care unit 99% of patients, family or carers said that they would recommend the hospital while 90% said they were treated with kindness at all times.
- We saw many thank you cards and letters from patients’ friends and families on all critical care units.
- One family member describe the care and treatment give as “second to none” and praised staff for the care and treatment given to their family member.
- Staff understood patient’s anxieties when in the unit and addressed these whenever they could. For example, one nurse was particularly gentle and kind to a patient who aspirated and needed some suction. The nurse explained what they were doing, told the patient they knew it was unpleasant and then praised them when it was finished. This had a demonstrable calming effect on the patient.
- **Understanding and involvement of patients and those close to them**
- An information booklet called ‘A guide for patient and relatives in intensive care’ was available in all units. The booklet gave detailed explanation and information to relatives, friends and visitors about the critical care environment and how they cared for the patients. There was also information on how relatives could obtain more information.
- In the Friends and Family Test for the period January to March 2016, 88% of family and friends felt welcomed by the staff on the critical care unit when they first visited. Also, 71% said that the staff on the unit introduced themselves when they first visited the unit and were kept informed of their relative’s progress.
- During a bedside handover we saw the nurse taking over introduced himself to the patient by name and explained what was happening. He also told the patient how long it would take and it when he would be back by the bedside.
- Patients, families and friends overwhelmingly reported they felt involved in their care and were given explanations about their treatment. One family member told us that staff had “communicated at every stage”. It was easy for patients to identify staff, we observed all staff introducing themselves and patients told us staff identified themselves before talking to them.
- One nurse had noted the frustration of a patient who could not communicate verbally and had given the patient a pen and piece of paper so they could write messages. This had worked well and had reduced the patient’s anxiety. The nurse explained this during a handover to a colleague so it could be continued.
- **Emotional support**

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- Counselling services were available and staff showed an acute awareness of the psychological distress and anxiety that patients in critical care had and demonstrated strategies to mitigate these. However, an on-site clinical psychology service was not available.
- There was access to a multi-faith chaplaincy service and staff told us that they signposted families and patients to this service when they needed to.
- We saw staff helping families to cope emotionally with the care and treatment of their family and taking time to discuss and understand their social needs. Where necessary families were signposted to support services in the community.
- Staff provided genuine emotional support whenever they had the chance. For example, one patient was very anxious and did not like being alone in the unit. The nurse taking care of them frequently reassured them and told them when their partner was coming to visit, to help them have something to look forward to.
- Staff had a good understanding of the psychological needs of patients. For example, a nurse on the general ICU noted in a handover that a patient who had been in the unit for several weeks had witnessed a number of deaths. As such the nurse felt the patient would benefit from a visit from the trust psychologist.

Are critical care services responsive?

Requires improvement



We rated critical care as requires improvement for responsive:

- There was limited accommodation or comfort provision for visiting relatives.
 - Critical care performed poorly in audits relating to admissions and discharge paperwork and only 46% of patients had received an assessment of rehabilitation needs on admission.
 - Patients did not have access to on-site mental health or psychology services and provision for patients with learning disabilities was low.
 - The service did not comply with Intensive Care Society requirements on the management of delirium.
- Access and flow in the hospital was generally poor and this was reflected in the high numbers of delayed discharges and out of hours discharges from critical care.
- However, we found some examples of good practice:
- Following patient feedback, staff worked to reduce the noise on the general ICU unit by displaying a responsive 'blue ear' sign that changed colour when noise levels increased.
 - There was a positive relationship between critical care nurses and the organ donation team.
 - A hospital rapid discharge team was available on site and provided support in planning timely discharges.
 - **Service planning and delivery to meet the needs of local people**
 - Critical care consultants worked with surgical colleagues to plan complex elective admissions. This process was not fully established for neurosurgical patients and formed part of the clinical lead's development plan for 2016/17.
 - Information leaflets were available in critical care that explained common procedures and misconceptions as well as what different items of equipment were for.
 - Accommodation for relatives and visitors was limited, particularly in the mixed ICU unit. There was one small quiet room and a waiting area in a corridor outside the unit. Neither area had natural light, ventilation or facilities for food and drinks.
 - There was a lack of appropriate facilities in the theatre recovery area for critical care patients. There were no refreshment facilities, showers or toilets. This meant patients had to use staff toilets. It was common practice for critical care patients to be cared for in this area and staff said this added pressure to them and resulted in poor patient experience because the unit was not equipped to support them properly.
 - A box of toys was available for young children who visited with relatives although space was very limited for them to play and there were no risk assessments relating to this.
 - The general ICU unit was cramped and noisy. To try and reduce the impact on patients, staff had introduced a responsive 'blue ear sign'. When this sign turned red, it indicated noise levels were unacceptably high.
 - Staff in the unit liaised with a hospital specialist nurse in organ donation to successfully complete a multi-organ donation process for local patients awaiting a

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transplant. We spoke with two transplant coordinators who were working with staff in the critical care unit. This service was part of an organ donation team that covered the south of England and adhered to NICE clinical guidance 135 in organ donation for transplantation.

- Staff had access to 27 different specialities in the hospital and locally to which they could refer patients for consultation and review. This included a burns service, nephrology and obstetrics. All services were available within 24 hours of first contact by a referring clinician. Staff demonstrated awareness of the needs of the local population with substance misuse behaviour, such as drug overdoses. Specialist liaison services were available from a drug and alcohol team.
- **Meeting people's individual needs**
- Easy to hold cups, straws and cups with drinking sprouts were offered to patients who had difficulty drinking out of cups.
- Staff did not consistently meet trust targets for the completion of admission and discharge assessments. In the twelve months prior to our inspection, an admission assessment had been completed in 65% of cases and a discharge assessment in 27% of cases.
- The department did not meet the requirement of the critical care network that all patients have an assessment of their rehabilitation needs within 24 hours of admission. The latest audit data showed only 46% of patients had such an assessment.
- Patients did not have access to on-site psychology or mental health services. This meant the department did not comply with the requirements of the critical care network.
- Staff used the confusion assessment method and the Richmond Agitation-Sedation Scale to assess delirium and mental state. We saw a doctor completed the assessments for each patient on admission but the department was not able to evidence this was completed routinely or consistently. This meant the department did not comply with standards set by the Intensive Care Society regarding the management of delirium.
- Staff did not routinely have access to translation or language services. A nurse had spent time with a patient who did not speak English as their first language and had been able to work with them to interpret basic

expressions and needs. Although this helped the patient reduce their anxiety significantly, it demonstrated there was little understanding from the senior team in relation to meeting such needs.

- A senior nurse in the cardiac high dependency unit told us they did not know what support was available for patients with learning disabilities and was not able to tell us how they would contact the hospital's link nurse for this.
- Clinicians and managers discussed the social status of each patient ready to be discharged during morning handovers. This information was used to identify anyone at risk and if additional support was needed, such as from social services.
- **Access and flow**
- From December 2014 to January 2016, an average of 12% of patients were discharged between the hours of 10pm and 7am. This was significantly worse than the maximum target of 6.3% set by the critical care network.
- During the same period, an average of 63% of patients experienced a discharge delay of up to four hours and an average of 37% of discharges were delayed by more than 24 hours. In each month, this was worse than the national average and significantly worse than the target of 20% set by the critical care network.
- All patients were seen by a consultant intensivist within 12 hours of admission in the 12 months prior to our inspection.
- The trust cancelled 17 elective surgery admissions between November 2015 and January 2016 due to a lack of critical care beds.
- Emergency care for neuro-ICU patients was available on-site. This meant the service had reduced the number of patients who needed to be transferred for emergency treatment since this service moved to Brighton.
- A nurse told us there was a constant problem with lack of flow. They said, "Every day we have patients who need to go out but don't. It's incredibly stressful when there's no flow – patients need to come in but there's no movement out. How poor flow is managed depends on how much scrutiny we're under from those above the matron. If the chief executive is walking around, we are not allowed to move patients into theatre recovery then the next day we do the opposite because the executive team aren't here."
- A Hospital Rapid Discharge Team was available in the mixed ICU and provided a multidisciplinary service to

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clinicians in planning the safe discharge of patients. This team had input from social workers, community psychologists and specialist nurses and provided a service 24-hours, seven days a week. Referrals were triaged and prioritised when the teams returned on Monday morning. Referrals were completed on line and received into a generic inbox on each site.

- Theatre recovery was used to care for critical care patients when the main units were full to capacity, including ventilated patients. 90 patients had been cared for in this area between September 2015 and March 2016. In the same period, 98 patients had been discharged from critical care to theatre recovery because of a lack of ward beds. Critical care consultants were responsible for patients cared for in recovery and worked with anaesthetists to ensure monitoring was appropriate.
- A bed manager and theatre manager attended the daily morning medical handover. They used this to identify planned discharges and assess the risks of discharge delays due to lack of capacity elsewhere in the hospital.
- **Learning from complaints and concerns**
- Critical care reported one formal complaint in the 12 months prior to our inspection. Senior directorate managers were not able to tell us how complaints were investigated and formally signed off and the matron was unavailable during our inspection.
- Staff acted on previous complaints from patients about noise and bright lights at night by embedding a strict evening routine into their schedule. This included a target time for the completion of safety checks and dimming lights.
- The complaints policy and information about the Patient Advice and Liaison Service (PALS) were readily available in the unit.

Are critical care services well-led?

Inadequate



We rated critical care as Inadequate for Well-led:

- During our inspection an unprecedented number of staff approached us anonymously and on the condition

of confidentiality. Staff came from multiple roles, groups, units and departments to tell us about their serious worries and concerns about patient safety, staff welfare and poor leadership.

- The relocation of neurosurgery intensive care from Hurstwood Park to Brighton in June 2015 had been inadequately managed and lacked evidence of robust staff consultation. This had led to a culture in which nurses did not feel valued and there was significant and sustained evidence of non-functioning governance frameworks.
- Senior staff did not have oversight of the problems on the critical care risk register and had not acted to address the risks raised by staff in relation to unsafe patient care.
- The clinical leadership team were not visible and the acute floor management structure had systematically failed to provide support and guidance to staff during a period of intense uncertainty and challenge.
- The vision and strategy for the service was idealistic and did not reflect the daily challenges staff reported in the units.
- Relationships between neuro ICU nurses and senior general ICU nurses were fractured and staff reported a culture of bullying and intimidation. The trust did not have a functioning human resources team with the competence to address this.
- The executive team failed on multiple occasions to provide resources or support to clinical staff to improve safety and working conditions and there was no acknowledgement from this team that they understood the problems staff identified.
- **Vision and strategy for this service**
- The vision and strategy at the acute floor level for 2016/17 did not reflect the significant problems we found in nurse competencies, nurse staffing or leadership and governance. The two key priorities in the vision were to improve medical staffing cover with the recruitment of advanced nurse practitioner and to consolidate nursing and education. This was reflective of the lack of understanding and involvement from the executive team. The local vision and strategy, led by the clinical lead, was more robust and included the identification of some of the problems in the mixed ICU unit. This however, did not adequately explain how nurses would be protected from losing their skills or how short staffing across specialties would be addressed.

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- The trust had turned down two business cases for an increase in funding for pharmacy staff and drug errors remained relatively high in the general and mixed ICUs. In the interim, the critical care pharmacist planned to introduce a new policy to support staff who made multiple drug errors. This included a staged process of risk management and retraining.
- None of the staff we spoke within the cardiac high dependency unit (CHDU), including a senior clinician, were able to tell us about the unit's vision and strategy.
- Senior managers acknowledged recently published clinical research that indicated neurosurgery intensive care (neuro ICU) patients should not be treated in a mixed unit. However, they said the trust executive team had no strategy to investigate this further, despite the problems with staffing and patient safety.
- **Governance, risk management and quality measurement**
 - Critical care was part of the acute floor directorate, which also included accident and emergency and acute medicine and had its own governance structure. The CHDU had its own governance structure separate from the other critical care areas.
 - A lead nurse from the cardiothoracic directorate and a matron led the CHDU. A directorate lead nurse and matron led the general and neurosurgical units. This matron also had responsibility for the critical care unit at the Princess Royal Hospital.
 - There had been a sustained lack of governance oversight and risk management in the neuro ICU since it relocated from another site. A senior clinician told us the original transfer plan had capped the number of neuro patients at nine, who would only be accepted if nurse skill mix met patient needs. They told us this plan had not been maintained and the established specialist team at the previous location had not been replicated at this site.
 - Project plans and minutes from the board of directors indicated there had been minimal consultation with nurses over the relocation of services. The action plan for the completion of the relocation did not include evidence of consultation with nurses and indicated mitigation plans for problems predicted with access and capacity remained overdue and unresolved at the time of the relocation. We asked the programme manager about this. They said a full consultation had taken place but the trust was not able to provide documented evidence of this. To address staff concerns about commuting from the original site to the Brighton site, a bus service had been provided. However, this was being withdrawn and instead staff without a car were told to take a public service bus, which added significant time onto their journey.
- Ten nurses we spoke with told us they felt the general unit was regularly short staffed, which was unsafe. We confirmed this by looking at staff rotas for the six months prior to our inspection. There was no evidence of action from the senior leadership team regarding this and some nurses told us they felt the senior clinical team did not have a good awareness of the risks. One senior nurse said, "The team is too stretched. It is not safe for neuro patients and general ICU nurses are having to manage without specialist training."
- There was a risk associated with the neuro ICU and the need to transfer patients out of the unit for a CT scan. The senior leadership team responsible for the transfer of neurosurgical services to the Brighton site had not provided an adequate mitigation strategy for this. However, they had implemented a standard operating procedure for staff to use when transferring patients for a scan.
- Risks associated with underskilled staff were not adequately managed because the nurse practice educator team rarely had time to provide clinical supervision or bedside teaching as their focus was on a group of new overseas nurses who required a lot of support.
- Senior staff had re-started a neuro ICU rotation programme for general ICU nurses as a risk management strategy to ensure there were numbers of suitably trained staff in the level five department to care for neuro patients. This programme had no governance or risk structure and was poorly managed.
- Clinical leaders had escalated the poor performance of the department regarding delayed discharges and out of hours discharges and reported they received no direct support from a senior executive level.
- The minutes of a neurosciences division safety and quality committee meeting from October 2015 highlighted that a senior neuro ICU nurse had escalated the concerns of their team around the unsuitable environment and staff training to the critical care consultant lead. It was recorded the clinical lead had

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dismissed the problem as there had been no patient deaths as a result. Several staff we spoke with were aware of this meeting and told us it had significantly contributed to their feelings of low morale and support.

- The clinical leadership team managed a risk register for critical care services. The highest risks included the lack of air conditioning in the mixed ICU unit, the lack of pharmacy staffing, a cap on the use of agency staff and delayed and out of hours discharges. The department could not provide a track record of robust and consistent mitigation for the risks but this was in significant part due to the lack of oversight and support from the trust at executive level. Some of the mitigating factors were not appropriate. For example, the senior team acknowledged that hospital-wide problems with capacity impacted on discharges from critical care but in response had noted staff had stopped reporting out of hours discharges. Senior managers acknowledged that poor nurse training to take care of neuro ICU nurses “should be” on the risk register but were not able to explain why this was missing.
- The CHDU had a risk register that contained only one item, which related to the lack of storage space on the unit. However, this unit experienced significant staffing problems, including the lack of a consistent supernumerary nurse coordinator.
- Staff in other services raised concerns with us about the safety of the mixed ICU unit due to the governance problems. For example, a clinical manager told us they often provided bedside support to nurses caring for neuro ICU nurses because they said they did not have enough training and were worried about caring for patients with complex needs. They told us this was part of an overall lack of understanding and oversight from the clinical leadership team. For example, they said consultants often argued about the correct line of treatment for neuro ICU patients and would not ask for help from other specialist teams who had experience in neuroscience. They said, “It’s often very muddled. No-one knows what’s going on.”
- The trust had a whistleblowing policy in place but staff knowledge of this was inconsistent. Seven nurses we spoke with told us they did not have enough trust in the executive team, clinical leadership team or human resources to report serious problems.
- **Leadership of service**
- Neuro ICU nurses did not have direct leadership or supervision from senior clinicians or nurses with neuro experience and were instead led by the general critical care matron. A senior neurosurgery clinician told us the senior hospital team were aware of staff concerns about the lack of training, supervision and support for neuro ICU nurses. They said strategies to re-engage nurses and focus on their training were being discussed but no progress had been made. One neuro ICU nurse told us they had received no professional development for the last 18 months and felt they were giving patients a substandard level of care. They told us the senior team had declined their request for additional ICU training and told them this had to be in their own time if they wanted it. Senior staff did not keep a record of training requests from nurses.
- We did not find evidence the neuro ICU rotation programme had been effectively led or had an impact on the skill base of staff on the level five unit. A senior clinician told us they had not seen any change in how neuro ICU patients were cared for or that neuro ICU nurses had more specialist support from colleagues. Seven nurses we spoke with who worked regularly on the mixed ICU unit said the training rotation had made no difference and they felt had been affected negatively by a lack of management and clinical oversight.
- In the initial phase of the transfer of the neuro ICU to the Brighton site, a ‘neuro expert’ role was created. This was a senior neuro ICU nurse who acted as a mentor and educator to all ICU staff, to help the integration of services and to ensure neuro ICU nurses adapted to their new environment and the electronic patient records system. This post had since been disbanded and not replaced. Every clinical member of staff we spoke with about the neuro ICU told us this had left an unacceptable gap in support and training for the neuro team. One neuro nurse we spoke with told us they had escalated this as a risk to the critical care leadership team and had been told the neuro expert was responsible for coordination and training, despite the removal of the post some time ago. They said, “The expert role was removed but the matron told me they were responsible for our education. I’m concerned the senior team don’t know who is doing what.” Another nurse said, “The transfer was very poorly planned and the expectation is we’ve got to pick up the pieces ourselves.”

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- There was no evidence the clinical leadership team had acted on the lack of education provision for the neuro ICU team. This included failure to replace a dedicated neuro nurse practice educator (NPE) after they left the unit and the lack of an interim post to ensure the nurse team had on-going support for learning.
- A staff briefing document from February 2016 indicated the neuro expert role was in place and the daily responsibility of the shift leader was to work with this individual. This contradicted the information given to us by staff we spoke with and we did not find this role filled during our inspection.
- One nurse told us although they were full time, they had seen the matron once between October 2015 and April 2016. Another nurse said, "I've been asking to meet [matron] for the last six months but they will not match their schedule to mine so I've never met them."
- There was a lack of day-to-day support for the nurse in charge of the mixed ICU unit when they needed management input. For example, on one day of our inspection the unit did not have a safe staffing level. The nurse in charge on this floor could escalate the situation to the overall nurse in charge of critical care, who was based on the general ICU unit, but this did not mean action was taken or more staff found. The matron was unavailable and senior nurses did not know who else they could contact about this problem. As a result a unit was left short staffed and without any oversight of a senior manager.
- A recognised international research clinician in CHDU had reduced their responsibilities due to on-going and poor leadership and governance in the unit, particularly from senior executives and human resources. This meant the trust could not provide evidence it valued the knowledge and skills of senior clinicians.
- Senior managers in the directorate told us they felt the clinical director "keeps his distance". This corroborated information from 12 nurses we spoke with who did not know who this was or what their responsibilities were.
- **Culture within the service**
- Ten nurses we spoke with reported a "fragmented team" in the mixed ICU in which bullying and disrespect were common. They said this most commonly occurred when general ICU nurses led shifts with a mixture of ICU and neuro ICU nurses. Staff told us they had escalated this to the NPE team and the matron but felt no action had been taken. A senior nurse said, "I've tried to meet with [NPE team] to talk about the problems the differences in skills is causing. They just told me 'this isn't how we do things here; you're in a general ICU now.' Yet we're still treating neuro patients so I don't understand how this attitude makes the unit safe." Another nurse said, "The nurse in charge often ignores our neuro specialist knowledge and just changes treatment arbitrarily because they don't have any neuro knowledge themselves." Other staff we spoke with described a positive team culture and one individual said, "There is a great working relationship between nurses and doctors, there's nothing we can't ask each other when we need help."
- Several of the nurses we spoke with described a culture of unsafe practice, absent leadership and a lack of understanding from senior staff. One nurse said, "Some of the senior nurses are rude and abrasive. I don't want my name attached to poor, unsafe care. There is no support, I have no idea where the matron is, and we haven't seen her for over a month."
- The trust had stopped providing resources for staff away days, which had contributed to the feelings of disconnect amongst staff.
- There was no forum for staff to get together regularly and weekly unit meetings were poorly attended because they were not mandatory and often staff could not be released to attend. One nurse said, "Staff are isolated and completely on their own." Six nurses we asked about this told us they hadn't been to a meeting in "months" because they were always too busy to be released during it. Staff were not aware of how information from meetings was shared with them and said they most often received information informally from their nurse team leader.
- A senior nurse of significant experience said there had been a sustained lack of support from the senior leadership team to support the two nurse teams in their integration. They said this overshadowed the whole operation of the unit and meant senior staff, including the matron and clinical lead, did not offer praise or positive feedback to anyone doing a good job.
- The trust had approved the recruitment of eight international nurses without consulting the critical care leadership team. This resulted in significant extra pressure placed on the practice educator team and unit leaders reported they struggled to get support to understand their responsibilities to get the nurses registered with the NMC.







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- Junior and trainee doctors told us they felt the culture was positive and nurturing and they had adequate protected time for training and professional development.
- Staff in CHDU reported a supportive and positive working environment and told us they felt the team was cohesive.
- **Public engagement**
- The board of directors decided not to conduct a patient engagement project prior to the relocation of neurosurgical services to Brighton. In the minutes of this meeting, the decision was attributed to the low perceived risk of the move.
- **Staff engagement**
- The matron produced a monthly briefing for all staff, which focused on highlighting good practice and plaudits as well as reminding staff about policy and practice changes as a result of incident reports.
- In all of our conversations with staff who had experience of working in the mixed unit, a lack of planning or formal introduction of staff following the move of the neuro ICU unit to the Brighton site was evident. Neuro ICU nurses and doctors and nurses already at the RSCH site at the time of the move all told us they felt it “just happened”, with no notice or involvement with them from the executive team or clinical leadership. A senior nurse told us this caused problems initially because the two teams had no formal introduction to each other. They told us, “When we realised the managers weren’t going to do anything to introduce us, we tried to build new relationships ourselves. We tried this socially, outside of work as well as on a shift-by-shift basis. But we all feel lied to by the trust and it was difficult to move past that.” Another member of staff said, “Oversight was poor, no-one was consulted. We didn’t even have an introductory meeting.”
- Eight overseas nurses were recruited externally from the unit with no engagement between HR and unit staff. NPEs raised concerns about the level of support they would need and said this was ignored by the executive team. They requested the nurses be redeployed as they did not have the resources needed to train them but the trust refused this.
- There was a significant risk of nursing staff attrition from the neuro ICU team following the loss of 58% of the team that transferred from another site. There was no evidence the trust’s executive team, human resources department or clinical leadership team had engaged with staff to identify contributing factors to this or to strategize a plan to reduce further loss. We asked a member of staff who was about to leave the trust about this. They said, “No, we don’t have exit interviews and I’ve heard nothing from HR. The matron informally asked why I was leaving but she didn’t write anything down or seem very interested.”
- There was a clinical lead consultant and a clinical director in post. We asked staff about the level of support and clinical oversight they provided as a result of the on-going problems in the mixed ICU unit. Ten nurses told us neither member of staff was involved or visible and said because very few incidents were recorded formally, they felt the senior clinical team did not have a view of the severity of the situation.
- **Innovation, improvement and sustainability**
- Executive-level leaders demonstrated a sustained and substantive disinclination to invest in the development of nurse specialist training and professional development. For example, there were no advanced nurse practitioners in critical care after a board-level decision to remove funding previously earmarked for that. In addition, the gaps in nurse skills and competency in the mixed ICU unit also applied to neuro nurses who wanted to take a post-registration critical care course. Three nurses had applied for funding for this, which would enable them to work competently with all of the critical care patients at this site. However, the trust had agreed to fund this from September 2017. This would prolong the gap in nurse skill mix in this unit significantly.
- A junior physiotherapist described one innovative practice of taking patients that are able to sit in a wheel chair outside the hospital when the weather permits; this was beneficial to patients on the mixed ICU because the unit has no windows.
- Morning multidisciplinary and evening ward round checklist to embed best practice for weaning, delirium prevention and ensuring targeted blood tests.
- A critical care simulation suite in the ICU for training and feedback has demonstrated its importance in improving multi-professional team working and training on the ICU.

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- A critical care outreach nurse had been awarded the KSS Academic Health Network Safety award 2015 for implementing medical emergency team and cardiac arrest safety meetings.
- As a strategy to ensure nurse recruitment was robust and consistent, new applicants took part in practical exercises using the clinical simulation suite. This enabled senior staff to assess competency and human factors in a more detailed way than could be achieved through verbal interviews.
- The clinical lead acknowledged the challenge of sustaining the unit with appropriately-qualified doctors in the future. To mitigate this risk, they had the support of the local health education network to appoint critical care nurse practitioners, who are able to take on many of the responsibilities of junior doctors. The trust had not responded to a request for funding for recruitment.

Maternity and gynaecology

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

Information about the service

Brighton and Sussex University Hospitals NHS Trust's maternity and gynaecology services are managed across two main sites: Princess Royal Hospital at Haywards Heath and The Royal Sussex County Hospital in Brighton. The two main sites are approximately 15 miles apart. In the 12 months between July 2014 and June 2015, 5,763 women delivered their babies across the trust, either in hospital units or at home. That was an average of approximately 480 deliveries each month.

The rate of births has remained constant in the nine months between April and December 2015, with an average of 484 births a month. From April 2015 to December 2015, there was an average of 277 deliveries a month at Royal Sussex County Hospital. Assuming deliveries continue at the current average rate, there would have been approximately 3,324 deliveries by the end of March 2016.

Royal Sussex County Hospital provided maternity and gynaecology on levels 11 to 13 of the Thomas Kemp Tower. Emergency and acute gynaecology services, which included Gynaecology Assessment Unit (GAU) and outpatient clinics, are provided on level 11. There was a nine-bedded gynaecology ward for women recovering post operatively and patients admitted in an emergency.

The Hospital provided antenatal services; a 24-hour, seven days a week, triage service; an early pregnancy unit for women having trouble in the first few weeks of pregnancy, six to 17 weeks, and a day assessment unit for any difficulties later on. There was an 11-bedded labour ward on level 13, which included three rooms with birthing

pools. There was also an operating theatre and recovery facilities. On level 12 there was a combined antenatal and postnatal ward with 29 beds. The postnatal facilities consisted of six side rooms, two with ensuite bathrooms, and four bays of four beds. Seven beds were used for antenatal care.

There was a neonatal intensive care unit, the Trevor Mann Baby Unit, for babies delivered before 34 weeks gestation on level 14.

Three teams covering the whole of the Brighton and Sussex University Hospitals NHS Trust community area provide community midwifery services.

Maternity and gynaecology

Summary of findings

Midwives reported on staff shortages and some staff expressed their concern about the potential risks to women and their babies. They told us staff routinely covered vacant shifts, could not always take breaks during 12-hour shifts and provided the scrub practitioner role in theatre. The service identified risks from the shortage of medical staff, the high use of locum cover and the failure to achieve waiting time targets in gynaecology.

The lack of a second theatre had been identified as a risk. There was no reliable plan to resolve this issue. There was no plan or timetable in place for the development of midwife-led unit. The main theatre had problems with its ventilation and was an infection control risk.

Staff did not meet the trust target for mandatory training.

However, the service had some of the best rates across England, for home birth and for breast feeding. In addition, the trust had appointed three new consultants and they were making a positive contribution to the service. Patient records were up-to-date and accurate and the areas we visited were clean. The service had responded to the local demand for variety of menus and alternative treatments in the form of aroma therapy. The service had introduced an enhanced recovery programme in gynaecology and obstetrics. They ran one-stop clinics for women and their babies who were vulnerable as a result of their circumstances.

The service had a committed team of midwives and nurses and an active Maternity Services Liaison Committee with participation from local parents and their families.

We held a focus group at the Royal Sussex County where 20 staff attended. In addition we spoke with a further 40 staff from all areas of gynaecology and maternity. We spoke with the leadership team, specialist midwives and managers working at ward level. We spoke with ten patients from gynaecology and maternity. We also looked in detail at 10 sets of patient records.

Are maternity and gynaecology services safe?

Requires improvement 

We rated safe as requires improvement because;

- Midwives at the Royal Sussex County Hospital told us that they were finding low staffing levels a challenge. Staff failed to achieve 1:1 care in labour. They were constantly busy in maternity and gynaecology. They did not always report the shortage of staff as a safety incident as it had become a routine occurrence.
- Staff shortages resulted in poor attendance at mandatory training and compliance from medical staff was particularly low.
- Attendance at level 3 safeguarding training was worse than the trust target of 100% for all staff groups
- Midwives had to attend the obstetrics theatre to provide assistance for all elective and emergency caesarean sections. This meant that two midwives were required for each operation, one to be the scrub practitioner and one to take the baby following delivery.
- The trust had recruited additional medical staff, but the service still used a high level of locum doctors. On some occasions, two locum doctors worked a shift together.
- We saw staff investigated incidents and shared lessons in a timely way in obstetrics, but not in gynaecology.
- The trust identified that the lack of a second obstetric theatre on level 13 of Thomas Kemp Tower was a risk to women and babies. Infection control risk was identified with the theatre on level 13, which was still in use. We saw a cramped environment and cluttered corridors on the labour ward.
- We saw an examination area where patients could be seen and overheard.

However;

- The wards and units were clean and infection controls in place. Medicines were stored safely and there was a high standard of record keeping.
- **Incidents**
- Managers told us a backlog of incidents had been investigated by March 2015 and all serious investigations were conducted on time throughout 2015 and early 2016. We saw this in a newsletter listing “Key Project Achievements”.

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- There were no never events reported in maternity and gynaecology at Royal Sussex County Hospital in the year from January 2015 until April 2016. A never event is a serious incident that is wholly avoidable if systems were working as they should.
- In the same period, staff in obstetrics and gynaecology reported 1,620 incidents. The maternity department accounted for 1,400 incidents and 220 incidents were from gynaecology services. These incidents were all categorised as causing either no harm, or low to moderate harm. We saw the service had a trigger list for incidents that should be reported.
- We spoke with staff at a focus group who said that they always reported any issue relating directly to patient care and safety on the electronic incident reporting system. However, some staff said that, as staff shortages occurred most days, they no longer completed an incident report routinely for this on every shift. Several midwives explained that, after a long shift when they were busy and short staffed, they did not want to spend time completing a detailed form. They told us the form required them to list all the possible implications arising from being short staffed. They had completed many incidents forms in the past without seeing any improvement. Staff told us about staff shortages and said, "In the last few years staff are frightened to come to work because of the risk of incidents".
- Midwives told us they did not always complete an incident form when they saw a consultant not following a protocol or trust guideline. They reported that their working relationships with consultants were not all "harmonious". They were fearful of putting their name on an incident form as they did not want to get involved in a dispute. We asked for an example of where guidelines were interpreted differently by different consultants or locums. They said that the guideline for Induction of Labour was an example and "often babies were delivered too early".
- We saw from the minutes of the Safety and Quality meeting held in September 2015 that the Directorate Manager raised concerns about staff not having time to complete incident reports in gynaecology. This could account for the low number of incidents in gynaecology. In December 2015, 105 incidents were reported in maternity and 18 in gynaecology. In January 2016, 112 incidents were reported in maternity and 17 in gynaecology. At the February 2016 meeting, we saw there was gynaecology nursing representatives at the meeting to discuss the incidents reported.
- In gynaecology, the main trends with incidents were in relation to inadequate and missing documentation, medication errors and a lack of cover by consultants. There were also incidents relating to falls involving frail and older medical patients accommodated on the gynaecology wards.
- There were no serious incidents reported in gynaecology from January 2015 to April 2016, three were reported in maternity services during this period. All three incidents had investigations to establish the facts, to determine whether failings occurred in care or treatment and to identify lessons learned from the incident. Two of the serious incidents occurred at the Royal Sussex County Hospital.
- Incidents were analysed to identify trends. The recent trends from incidents in maternity included the transfer of babies requiring neonatal services, avoidable repeat new born blood spot screening and communication issues surrounding individual and multidisciplinary team working.
- We saw from the notes of the women's services safety and quality meeting in February 2016, that action was taken in relation to the trends identified. For example, we saw the continuous audits recording the reason for a repeat new born blood spot screening and a note from the Antenatal Screening Coordinator about quality control changes that would affect spot samples. Two senior midwives had taken responsibility for on-going work designed to improve adherence to the protocol in order to reduce the number of repeat screening tests.
- In the monthly newsletter for staff in maternity and obstetrics, we saw reminders about the importance of effective communication and involving women in all aspects of their care. We also saw bulletins showing what lessons had been learnt. Staff told us the service had a process of highlighting, "Lessons for the Week" from the weekly incident review meetings. We saw the, "lesson of the week" on staff noticeboards. In addition, we heard discussions at handover meetings of the lesson for the week of our visit, which was about protecting a woman's confidentiality when discussing her clinical history if she is not alone during a consultation.

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- Staff informed us that the process of learning lessons and improving practice from individual birth stories was being re-introduced within the service. We saw examples of the birth stories and the lessons for the service.
- Staff told us about a serious incident, leading to a neonatal death, which occurred at the Royal Sussex County Hospital in 2012. We saw a business case, version 2, drafted in September 2015, which indicated that the lack of a second theatre available on Level 13 of the Thomas Kemp Tower was a cause. The business case also referred to an Independent Review of Theatre and Safety Culture carried in June 2014. It described the lack of an easily accessible second theatre as a “material risk”.
- We saw from the Women’s Services Incident Review Meeting, held on 5 April 2016, that there had been an incident involving a category 1 (most serious) emergency caesarean section. Midwives told us about this incident, where the ‘override key’, which was needed to stop the lift stopping on all floors, could not be found. There was a delay getting a woman to the theatre on the 5th floor for an emergency caesarean section. Midwives told us that there was a poor neonatal outcome. Staff subsequently found the override key, and was now kept readily available in the key holder at all times.
- Managers shared lessons from this incident in a number of ways. For example, we saw a presentation on the clinical governance learning from lessons on noticeboards. Safety and Quality meeting monitored the actions put into practice. We saw minutes of these meetings which confirmed this happened regularly.
- **Patients safety thermometer**
- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harm including new pressure ulcers, catheter urinary tract infections and falls.
- The NHS Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care is collected monthly.
- We saw a poster on the noticeboard of the gynaecology ward, level 11, at the Royal Sussex County, setting out safety thermometer data. This poster said it had been 108 weeks since the last case of Clostridium Difficile (C. diff) and there had been no cases of Methicillin-resistant Staphylococcus Aureus (MRSA).
- We saw safety thermometer data for the 12 months from April 2015 to March 2016 on the gynaecology ward, level 11, at the Royal Sussex County. This indicated, in that time, there had been one pressure ulcer, no falls, no infections arising from the use of a catheter and no venous thromboembolism incidents.
- There were no incidents recorded on the safety thermometer for obstetrics on level 12 or 13 for the same period.
- **Cleanliness, infection control and hygiene**
- We saw the ventilation system in the obstetric theatre on level 13 had failed the recommended air change levels within an hour. This meant there was a risk of infection for patients in this theatre. We saw this identified as a major risk on the risk register, and almost certain to happen, but was still in use.
- The national specifications for cleanliness (NSC) requires all staff to have a work schedule, when we asked for this document we were told that the trust does not have these in place.
- The NSC states: ‘Management of staff - All levels of the cleaning team should be clear about their roles and responsibilities. Each member of staff should have a clear understanding of their specialised responsibility, in a form of a work schedule’. The risk of not having a work schedule is that staff do not know what another has done and areas could be missed.
- The environment on the gynaecology and maternity wards and units at the Royal Sussex County Hospital looked clean. We looked in some of the empty side rooms with ensuite bathrooms and found that they had been cleaned and check lists were in place.
- We saw cleaning scores for March 2016 displayed on the noticeboard for the antenatal and gynaecology services on level 11. Compliance was 99.4% for gynaecology and 97.3% for the antenatal and postnatal ward. Patient feedback from the gynaecology ward revealed some concerns about the cleanliness of the toilets.
- We spoke with a care assistant on the labour ward whose role included cleaning rooms, theatre and pools. She told us about flushing the taps regularly, but was not clear about the process.
- Clinical staff were required to comply with the, “five moments for hand hygiene” as set out by the World Health Organisation (2009) and with the Trust’s own

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hand hygiene policy. We saw alcohol based hand sanitizer available on the wards and units in maternity and gynaecology at the hospital. We saw staff and patients' visitors use the hand sanitizer.

- Hand hygiene scores for gynaecology, level 11, the postnatal and antenatal ward on level 12 and the labour ward on level 13 were consistently between 98 and 100%. There were two months in the period where the score had fallen to 94 on the gynaecology ward. This indicated the service was not consistently meeting the trust target.
- We saw staff in clean uniform, bare skin below the elbows with long hair tied back. This was in line with the trusts uniform policy.
- We saw that in some areas, the service was using "I am clean" stickers and we saw plastic covers protected clean equipment.
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed, by whom and on what date.
- We saw a trust wide audit in line with the trust's MRSA screening policy. This policy required patients, admitted as emergencies, were screened within 24 hours. The policy required that elective admissions were screened at least two weeks before admission.
- During December 2015, the Infection Prevention Team visited and audited 14 patient areas across the trust. They asked 34 patients if they were screened for MRSA and all said they had. However, the documentation for six patients had not been completed fully.
- **Environment and equipment**
- Because of a lack of storage space, equipment, such as blood pressure monitors, cluttered the corridors. We spoke with a midwife who said, "It is a bit cluttered, but there is nowhere else to store equipment where it can be readily available". On the labour ward, we saw equipment was stored in the corridors.
- There was one obstetric theatre on 13th floor for both emergency and elective caesarean sections and second was available on the fifth floor. The second theatre was temporary and for use only if there was risk of life. It was set up in a recovery area and remained on the risk register.
- The triage area was cramped. Women were having examinations in the same room as the midwife answering the telephone and discussing the private and confidential details of a caller to the triage area. The triage area it opened directly on to a public corridor.
- Most of the staff we spoke with mentioned the lack of space and funding for a midwife-led birthing centre. A manager we spoke with said, "The birth centre is pivotal to moving low risk women out of the labour ward, which would give extra capacity for high risk women and space for a second obstetric theatre".
- We saw that portable appliance testing was up-to-date on the gynaecology ward. We saw that a suction machine was had a sticker which indicated it had been serviced in the last 12 months. However, some equipment was overdue for servicing on the labour ward, including three intravenous drug infusion pumps. This indicated not all equipment was regularly serviced. We saw staff completed equipment checks completed daily on the labour ward. We saw checklists were complete.
- On the postnatal ward we checked the adult resuscitation trolley and was found to be adequate.
- On the labour ward, we saw cots were available and ready for use in an emergency.
- When we attended the morning handover meeting on the labour ward, we heard that one of the delivery rooms was not being used. A midwife said: "Everything is broken in there and the sink has come off the wall". We saw this had been reported. We saw the maintenance service team came to inspect the room and assess the work required whilst we were still in the handover session.
- We saw that there were three birthing pool rooms on the labour ward, two were slightly apart from the rest of the ward and not used as often. We saw evacuation equipment was ready for use in the pool rooms.
- Cars were available for community midwives and equipment was checked in the car at the shift changeover. The cars were available for staff to respond rapidly for a home birth.
- **Medicines**
- We saw emergency medication trolleys in the corridor on the labour ward. They had stocks of equipment and medicines for blood loss, administering epidurals and for other neonatal and adult emergencies. The trolleys were clean and secure and checklists we saw completed checklists.

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- We looked at the arrangements for storing medication on the postnatal ward. We found that they had a locked controlled drug cupboard, inside another cupboard, and all the drugs were in date. The ward manager told us that the pharmacist visited daily and checked the drugs and charts. We saw checks of controlled drugs were complete.
- We also checked the storage and management of medication on the gynaecology ward. We saw drugs were locked in a cupboard in a room with key code access.
- The drug fridge was locked and we saw temperatures were checked daily.
- Women had their own medication in kept in wall mounted lockable cupboards, beside the bed in their room. Registered nurses accessed medication at the bedside and administered to women.
- **Records**
- In the one-stop clinic at the Royal Sussex County, we reviewed patient records for women with a history of substance abuse. We found the records were kept securely in a locked drawer. Records we reviewed indicated multi-disciplinary reviews and communication occurred between the mental health nurse, midwives, GP's, medical and child protection teams. There were medical histories, blood test results and clear birth plans.
- Pregnant women had handheld records that they kept with them and they took to antenatal appointments and a "red book" for their baby's medical records. We looked at four sets of patient records on the postnatal ward and a further four sets on the gynaecology ward.
- We found a high standard of record keeping. We found records contained reason for admission, an initial assessment of needs, short and long term goals and care plans.
- **Safeguarding**
- The service had a dedicated midwife for safeguarding, who worked 30 hours a week, covering maternity and the neonatal service. The lead was also a supervisor of midwives. The lead told us that if safeguarding issues arose, the community midwives would make an electronic referral.
- Staff completed a Common Assessment Framework and, where a woman had serious or complex needs, the safeguarding midwife would support the community midwife. Staff sent copies of the referral form to children's social services. The Safeguarding Midwife told us that there were different pathways for East and West Sussex.
- The safeguarding midwife attended case conferences and core group meetings in the absence of the community midwife. Discharge planning meetings did not take place at the Royal Sussex County Hospital. Instead, comprehensive pre-birth plans were developed and these were in place from 36 weeks of pregnancy.
- Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patient's health record. We saw a clear process in place to facilitate this reporting requirement. We saw the protocol on Female Genital Mutilation (FGM). Staff received training on FGM as part of their mandatory training days.
- Staff gave us an example of identifying a baby at risk and raising a safeguarding alert. The case was discussed at the Safety and Quality meeting and we saw the minutes to confirm this. We saw safeguarding was a standing agenda item at these meetings.
- The safeguarding midwife told us community midwives received group supervision each month from the safeguarding midwife and 1:1 supervision from a community team leader. Midwives attended level 3 training as part of the mandatory training days.
- We saw attendance at level 3 safeguarding training was worse than the trust target of 100% for all staff groups. It was 86% for maternity management and specialist midwives and 84% for community midwives. Attendance was 36% for medical staff at Royal Sussex County Hospital. Nursing staff on gynaecology ward completed level 2 training and had a completion rate of 40%. This was not in line with in the Safeguarding Vulnerable Groups Act 2010 or the Royal College of Paediatrics' Child Health Guidance, 2010 which recommends staff interacting with children to attend level three safeguarding training.
- **Mandatory training**
- Average completion rates for mandatory training overall for the 12 months from April 2014 to March 2015 were 70% for the gynaecology Ward, 35% for community midwives and 49% for midwives overall at the Royal Sussex County Hospital. This was worse than the trust

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target of 95%. Obstetrics and gynaecology medical staff at the Royal Sussex County Hospital only achieved a 26% completion rate, which was much worse than the trust target of 95%.

- Completion rates for the gynaecology ward at the Royal Sussex County for individual modules were 68% for equality and diversity, 53% for fire safety, 60% for safeguarding adults and 65% for safeguarding children. Completion rates for training on sharps and splash injuries were 60% on the gynaecology ward. This was much worse than the 100% trust target.
- Completion rates for individual modules for midwives overall at the Royal Sussex County Hospital were 38% for equality and diversity, 72% for fire safety, 78% for manual handling and 91% for safeguarding adults. Completion rates for training on sharps and splash injuries were 50% for midwives at the Royal Sussex County Hospital, which was much worse than the 100% target. The average rate of attendance for obstetrics and gynaecology medical staff for all individual modules was 35%. This was much worse than the 100% target.
- We saw training attendance was a standing item on the Safety and Quality meeting agenda and managers monitored this. Areas of concern were overall completion rates, attendance by consultants, e-learning, equality and diversity and training on the mental capacity act.
- The trust told us the service allocated staff with study time for mandatory training. However, we spoke to midwives, who told us it was difficult to attend training when the service was so busy.
- **Assessing and responding to patient risk**
- Staff used obstetric early warning charts, knew what to look for and how to respond to concerns. We saw completed charts, with scores calculated, observations documented and escalated as required.
- We saw other systems were in place to assess and manage risk, including venous thromboembolism (VTE) assessments for the risk of a blood clot forming. However, we saw that compliance for VTE risks assessments completed across the trust in Women's service was 65%, which was below the target of 95%.
- Low midwifery staffing numbers meant the unit was unable to maintain a 24-hour maternity triage service. Insufficient staff numbers on the wards meant staff were unable to respond to women's needs.
- We saw that the service used the Modified Early Warning Score (MEWS) to help identify a deteriorating patient. Where surgery had been involved, we saw staff completed the checklist for 5 steps to safer surgery and anaesthetic records.
- Staff used monitors to assess the foetal heart during pregnancy and labour for women with a pregnancy regarded as high risk. Such as those undergoing induction of labour or women with twin pregnancies
- There had been just over 3,000 births each year at the Royal Sussex County Hospital over the last five years. The Obstetric Standards for Perinatal Care produced by the British Association of Perinatal Medicine requires one dedicated obstetric theatre for every 3,000 deliveries that take place over a year. These standards also require that the theatre should be on the same floor as the delivery suite and in close proximity. In the Royal Sussex County hospital, the nearest alternative theatre was on Level 5 of the tower block and accessible via a lift, which indicated the standard was not being met.
- The service had been using incompatible epidural connectors since 2014 and remained on the risk register. This was part of a national supply issue. Controls had been put in place, but described as inadequate on the risk register.
- Staff told us the trust had conducted an audit of five steps for safer surgery at the hospital in March 2016. This audit included 14 theatre cases and found that the service was not compliant in any of the areas audited. For example, only 9 of the 14 women had a briefing before going to theatre and just 8 out of 14 had a debriefing in the recovery room. However, the audit did show that in all cases, the anaesthetist was present, the patient identity was confirmed in theatre and the procedure was discussed.
- **Midwifery and nurse staffing**
- We looked at the trust's data for planned and actual staffing on the gynaecology ward and for maternity at from September to December 2015. This indicated the actual staff hours on the ward night and day, were less than the planned hours from September to December 2015. In gynaecology, the planned and actual hours were the same from September to December 2015.

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- During our inspection, the actual staffing on the gynaecology ward was just below the funded establishment. The staff we spoke with said, “These staffing levels are good and we have no concerns today”.
- Staff told us they sometimes felt stretched on the gynaecology ward if they had been under pressure to accept non-gynaecology patients who required a different level of care. For example, they told us that if patients had dementia or limited mobility they needed more support. They told us they had a dementia link nurses and a dementia champion to help.
- The Trust reported a midwife to birth ratio of 1:30 across the trust and at both of the main sites. This was equal to the trust target, but worse than the national average of 1:27. The Trust had a target of 100% 1:1 care in labour. The average rate for the Royal Sussex County Hospital between April and December 2015 was 85%. The rate for December 2015 was 65%.
- Midwives said staffing had been difficult in the last six months. They said that staff were, “always being moved” from the postnatal ward to help on the labour ward and the triage area was often closed.
- Staff told us because of staff shortages, they were unable to carry out observations regularly and there was a delay in responding to call bells. The service was sending women to the Princess Royal Hospital several days a week. Some midwives told us it frequently felt unsafe because, although the service send women to another hospital, some still came in without telephoning first.
- The Women’s Services performance scorecard for April to September 2015 demonstrated an average vacancy rate of 3.7%, which was below the target of 8%. In addition, staff told several members of staff were taking maternity leave with no cover provided. The sickness absence rate of just over 5% was worse than the trust target of 2.9% and the trust overall average of 4%.
- The average proportion of shifts filled by staff doing a shift via the bank in maternity was 23% of the total number of shifts available. This was slightly worse than the trust average of 21% for bank and agency staff. However, the maternity service did not use agency staff and relied on their own staff, who were familiar with the service’s systems and processes, to undertake additional shifts through the bank.
- The average turnover rate in maternity was 24%, double the trust rate of 12%. This was due to a high turnover rate of 52% for students.
- Staff told us they regularly attended the obstetrics theatre to act as a scrub midwife for the obstetrician. This could be for elective or emergency operations and at any time of day or night. Some midwives told us that, despite training, they did not always feel confident in this role.
- In addition to the hospital based midwives, there were also 52 whole time equivalent (WTE) community based midwives divided into three geographical teams. The full-time community midwives each had a caseload of approximately 110 women. Full-time staff also held two clinics a week. There was also a home birth team made up of a midwife from each team completing a 12½ hour shift. The home birth midwife could also work on the ward at night time until they received a call to attend a home birth. There were also several maternity support workers and they could help with breastfeeding support.
- The ratio of supervisors to midwives was 1: 14. The service had a supervisor of midwives on call 24-hours, seven days a week. We saw the most recent annual audit from the local supervising authority was 90 – 95% compliant.
- The Community Manager said that the service was safe, but sometimes were over stretched and had to cancel postnatal visits. Parent education sessions had been reduced to a one-day workshop due to staffing shortages.
- Staff told us the trust’s maternity service had only closed once in the last 18 months. We saw from the trust’s maternity dashboard that this happened in April 2015. However, the closure of one site and diversion to the other was a frequent occurrence.
- **Medical staffing**
 - Overall, there were 59 doctors, which included 15 consultants. The mix between consultant, middle grade, registrar and junior doctors was similar to the England average. Some doctors worked across both sites, others just at one site. Most of the consultants covered both obstetrics and gynaecology.
 - Lack of obstetric staff was an item on the risk register that had been rated as a major risk and “was almost certain to happen. There was no action plan for the management of this risk.
 - The Clinical Director told us, they had recently altered the rotas on both sites to introduce 24-hour consultant cover. This meant that the consultant on duty during the

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day time was also on-call for the rest of the 24-hour period. The Clinical Director said that this had improved patient management during the day and overnight. Not all consultants carried pagers; some had mobile phones and could not be contacted if in an area of poor phone reception. Not all consultants could be on-call and five consultants were contributing to an on-call rota designed for 7 to 8 consultants.

- We saw that, for the 12 month period from April 2014 to March 2015, obstetrics and gynaecology made the greatest use of locum medical staff across the trust with an average of 11%. This was much worse than the trust average of 5% for the same period.
- **Major incident awareness and training**
- We saw a copy of the trust wide emergency preparedness, resilience and response policy which included a business continuity plan. Staff we spoke with told us major incident planning information was available to all staff on the trust intranet and one of the managers showed us how to access it.
- Staff had not received any major incident training. They told us one of the maternity and gynaecology managers for Princess Royal Hospital had attended a major incident training day on behalf of the service. This manager was due to feedback to colleagues from both trust sites at the next departmental meeting.

Are maternity and gynaecology services effective?

Requires improvement 

We rated effective as: “requires improvement”.

- This was because 78% of the services clinical guidelines and protocols were due for review in February 2015. Staff told us doctors did not interpret protocols in the same way, which caused variation in patient management.
- The gynaecology service failed to meet the target for patients receiving treatment within 18 weeks of referral.
- Multi-disciplinary working within the service was effective in some areas, such as in the ‘one-stop clinics’. However, despite improvement, some challenging behaviours were still an obstacle to team working

- The service was rated as one the top ten maternity services in the country for breastfeeding. In addition, the home birth rates were one of the best in the country and first bookings were occurring within 12 weeks and six days of pregnancy for 92% of women.
- **Evidence-based care and treatment**
- Women using the services of the trust were receiving care in line with the National Institute for Health and Care Excellence (NICE). For example, routine antenatal care was delivered in accordance with NICE standard 22, including screening tests for complications of pregnancy.
- We saw from the review documents, in February 2015, 78% of maternity and gynaecology clinical guidelines were out-of-date. This matter was entered on to the risk register and an action plan prepared to bring all clinical guidance up-to-date by December 2015. We saw a report dated March 2016 which reported that the majority of guidelines had been reviewed and updated, however 19 guidelines were still outstanding.
- We also saw patient leaflets were produced in line with national institute for health and Care Excellence (NICE) guidelines. For example, one we saw provided information on procedures, such as induction of labour and nausea and vomiting in pregnancy, which was in line with NICE guidance.
- The trust had an ongoing programme of local audits, which we saw. The audits demonstrated achieving outcomes in line with national standards. The trust also used audits to monitor the implementation of new programmes and ways of working.
- **Pain relief**
- A variety of pain relief was available to pregnant women. Nursing and medical staff could give a range of medicines, women could bring their own transcutaneous electrical nerve stimulation (TENS) machine and three birthing pools were available. Doctors were available to insert epidurals if required.
- Pregnant women had hand held notes which provided information on pain relief. There were also leaflets available in the clinics and on the trust website. The leaflets set out options such as using transcutaneous electrical nerve stimulation (TENS) or Entonox or pethidine.
- We spoke to patients on the gynaecology ward who told us they had received good pain control after surgery.
- **Nutrition and hydration**

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- The service was in the top ten maternity services in the country for encouraging and supporting women to breastfeed their babies following birth. Figures released by NHS England showed the Trust had a breastfeeding initiation rate of 91%, which was the tenth best nationally and the best in the Kent, Surrey and Sussex area.
- At the time of our inspection, breastfeeding initiation rates at the hospital were on average 88%, which was better than the trust target of 85%.
- We saw drink machines on the wards all day to supply hot drinks for patients. Meals could be ordered from the kitchen outside normal meal times. Bread was available on the ward for making toast. Special diets could be catered for from a set menu.
- Women we spoke with on the gynaecology ward said that they were happy with the food and the nurses were attentive in providing drinks. We saw feedback on the food at the hospital collected by the, “patients’ voice for gynaecology” in November 2015. Patients reported there were a wide variety of food options available on the ward.
- The trust used the “malnutrition universal screening tool” to identify patients who are malnourished, at risk of malnutrition or obese. A dietician was available to support patients identified in those categories.
- There were midwives, maternity support workers and nursery nurses available to help mothers with feeding their babies.
- **Patient outcomes**
 - The most recent data available indicated there were no reported patient outcomes that fell considerably outside of the England averages the trust.
 - From April 2015 to December 2015, there was an average of 258 deliveries a month at Royal Sussex County Hospital.
 - On average, 13 babies a month were transferred to the neonatal intensive care unit at the Royal Sussex County Hospital from April 2014 to December. This was on average 4% of all deliveries. In the same period, there were 10 stillbirths across the trust and one early neonatal death.
 - Deliveries for the first quarter of 2015/16 across the trust were 1,378 compared to 1,391 for the first quarter of 2014/15. This indicated the birth rate had been relatively stable in the last two years.
- The trust home birth rates were on average 4% from April 2015 to December 2015, the highest number was in July 2015 at 9.1%. The trust told us they achieved this by replacing the traditional on-call shift rota for community midwives with dedicated home birth shifts.
- The elective caesarean rate at Royal Sussex County Hospital was 14.3% of all births, which is worse than the Trust target of 10% and worse than the England average at that time. The proportion of elective caesarean section births appeared to be rising with a peak of 18.2% in October 2015. The emergency caesarean section rate was an average of 12.1% at Royal Sussex County Hospital from April to December 2015, better than the Trust target of 13%.
- This success rate for women opting for a normal delivery following a caesarean section was 58%. This was worse than the target success rate of 75%.
- From April to December 2015, the third or fourth degree tear rate was 5% for all patients.
- The trust recorded postpartum haemorrhage above 2.5 litres on the dashboard and there were 12 such haemorrhages which equated to 1% of patients at the hospital.
- Women at higher risk of complications attended the hospital for a termination of pregnancy. For example, women with epilepsy. Most did not go to the ward and would be discharged the same day. Between April 2014 and March 2015, there were 23 medical and 68 surgical abortions carried out at the hospital.
- **Competent staff**
 - The service employed three clinical skills facilitators to support staff in Women’s Services. They supported 13 newly qualified members of staff and eight more were due to start shortly. The maternity, obstetrics and gynaecology newsletter provided updates on learning opportunities on antenatal screening, for example, and on developments within the service.
 - There was a staff development package which involved working through a competency booklet over one year involving three study days a month on, for example, suturing, cannulation, time management and interpretation of investigation results. Staff told us this was required for promotion.
 - The ‘lesson of the week’ was circulated in bulletins and discussed at daily handover meetings. This covered areas for attention such as the Mental Capacity Act. This helped staff stay up-to-date in a busy service.

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- There were quarterly 'away days' for staff working in gynaecology and we saw from meeting minutes that these were well attended. Staff told us that they were able to attend every other session as they needed to provide cover on the ward and the gynaecology assessment unit. Staff told us previous themes at away days had included mental capacity, audits, completion of patient records and preparation for this inspection. This contributed to maintaining their registration with the nursing and midwifery council (NMC).
- Staff told us they felt a mentorship programme for students was effective. The clinical skills facilitators monitored a student's progress.
- We spoke with midwives on the postnatal ward who told us ten midwives were trained in Neonatal Infant Physical Examination (NIPE).
- Staff felt encouraged to learn new skills to assist women such as aromatherapy.
- The trust told us the director of medical education was the education lead for doctors across the trust.
- The rate of completion of appraisals across Women's services in November 2015 was 78.8%, which was better than the Trust target of 75%.
- We saw the antenatal screening report for the Trust dated January 2016 and this included several areas of good practice. These involved shared learning for screening including induction of new staff and an e-learning module.
- **Multidisciplinary working**
- Staff told us multidisciplinary working was poor between some consultants and the rest of the team. We spoke with several consultants who confirmed that these problems were ongoing and team working was still difficult.
- However, managers and staff told us there had been improvements following the intervention of an external facilitator at directorate meetings. They told us a multi-disciplinary review of incidents took place every Tuesday and covered maternity and gynaecology. We saw minutes of these meetings.
- We observed effective team working in the antenatal clinics where there was a 'one-stop-clinic' for women who were vulnerable as a result of their circumstances. They were from three client groups: substance and alcohol misuse, travellers and homeless people. The staff involved included midwives, a mental health nurse, a Doctor, advanced neonatal practitioner and social

workers. They told us they had a multidisciplinary review meeting with the whole team at the end of the clinic and a review after each woman was seen. The midwife completed a one-stop clinic care plan which was ready for when the woman went into labour. Midwives from the clinic also visited women on the postnatal ward after their babies are born.

- **Seven-day services**

- Consultant cover and midwife support was available 24 hours a day, seven days a week at the hospital. The community midwife team also ran a homebirth team, 24-hours a day and seven days a week.
- The gynaecology assessment unit provided a service 24-hour a day and seven days a week.
- A 24-hour, seven days a week telephone triage service was available and was transferred to the labour ward when staffing levels were low.

- **Access to information**

- Guidelines and protocols were available to staff on the Trust intranet. The same guidance was used across both sites.
- Community midwives had remote access to the trusts information systems.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We saw the trust's policy on the Mental Capacity Act, 2005 and we saw that a session on the Act was included in the midwives induction training.
- Staff told us the community midwife completed the consent paperwork for antenatal screening at the woman's first booking appointment. We saw copies of signed consent forms in records we looked at.
- We saw the results of an audit of a procedure used to examine the inside of the womb, which was carried out in September 2015. The audit found not all women gave written consent to the procedure.

Are maternity and gynaecology services caring?

Good



We rated the service 'good' for 'caring'.

- We saw staff behaving in a kind and compassionate manner on the Obstetrics and Gynaecology wards and

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units. Women told us the midwives, nurses and doctors were sensitive and caring. They felt involved in their own care and staff gave good, clear explanations when they could.

- Some women reported that they did not feel that the midwives were really listening to them when they called triage and they were not always invited into the department in a timely way.
- Emotional support was good for pregnancy loss and following a bereavement.
- **Compassionate care**
- We saw feedback from patients on the gynaecology ward, level 11, collected via the 'patient voice for gynaecology' in November 2015. The feedback was positive about the care. One patient said, "the kindness and caring is nothing but outstanding", another said, "Nothing was too much trouble, they were nice and friendly, caring and compassionate. I cannot praise them enough."
- We spoke with patients on the gynaecology ward. They told us staff had been mostly kind and helpful and the care was good..
- The Brighton and Hove Maternity Services Liaison Committee (MSLC) provided feedback from a 'walk the patch' questionnaire on the postnatal ward and at 'baby and you' groups across Brighton in May 2015. Comments were mainly positive about care, but some women told us they felt, "left to get on with it - not getting any support". We also spoke with a woman who had lost her baby early in the pregnancy and she said, "The care was good, sensitive and appropriate."
- We also saw anonymous patient satisfaction surveys for the early pregnancy unit (EPU) at the gynaecology assessment unit (GAU), conducted by the trust in 2015. The survey for the EPU revealed that 98% of patients reported that they were treated in a sensitive way by the doctors and nurses. When asked to comment on anything particularly good with the EPU, the majority of comments were focused on the staff; "very friendly helpful staff" and "brilliant staff". Eighty-one per cent of patients attending the GAU said that, overall, they would rate the care on the unit as excellent or very good.
- The friends and family test feedback varied across the period from December 2014 to December 2015 for the postnatal wards and for postnatal community provision.

It had been below the England average for five of the 12 months in this period. However, antenatal, birth and postnatal scores were better than the England average for the majority of the time period.

- The Care Quality Commission (CQC) maternity survey results for 2015 demonstrated the trust performed as well as other trusts in response to all the areas of questioning. In two areas, it performed better than other trusts. The areas the trust performed better than the England average were both in relation to labour and birth and was about mothers having early skin to skin contact with their babies.
- **Understanding and involvement of patients and those close to them**
- We saw from the patient survey in the GAU that 95% of patients reported, when they had important questions to ask the doctor, they received answers they could understand. Sixty-two per cent reported that staff explained what was to happen after their appointment.
- The MSLC for Brighton and Hove reported that, "a lot of women felt that they had not been listened to when contacting or attending triage – being sent away and then being in advanced second stage labour". They also reported that they felt that there was a lack of information about the options for induction of labour. However, there were positive comments from women who had planned caesarean sections, where they felt they had time with a midwife to talk through the processes.
- We saw mixed comments from the 'patient voice for gynaecology'. One said, "All consultants, nurses and staff were very informative, helpful and kind". Another said "It would help if you did not have to arrive at 7am and then not be told any information. I didn't know if I was in the right place."
- **Emotional support**
- There was a specialist bereavement midwife at the hospital working one day a week to cover the maternity and the gynaecology wards. The bereavement midwife offered support to women with subsequent pregnancies after a pregnancy loss. In addition to this, staff could refer women and their families to local charitable organisations offering bereavement counselling.
- We spoke with a woman who had been transferred from the Princess Royal to the Royal Sussex County Hospital because of previous pregnancy loss. She said she was anxious and wanted to know what was wrong and the

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explanations she had received "were not comprehensive" but she also said, "I appreciate that it is not always that simple." She said that the staff offered "fantastic emotional support".

Are maternity and gynaecology services responsive?

Requires improvement



We rated "responsive" as "requires improvement" for maternity and gynaecology services because;

- Some people were unable to access services for treatment when they need to. The hospital did not take the needs of some patients into account when planning services.
- Because patients from different specialities were admitted to the gynaecology ward, women transferred from the gynaecology assessment unit (GAU) experienced delays waiting for a bed on the ward. This resulted in cancellation of elective surgery for gynaecology patients due to a lack of beds.
- The trust failed to meet national referral to treatment (RTT) waiting time targets for gynaecology.

However;

- The service provided specialist antenatal services for women who were vulnerable as a result of their circumstances. This included homeless people and those with recreational drug or alcohol addiction. Translation services for women who spoke limited English were widely accessible. The service used complaints as an opportunity to learn.
- **Service planning and delivery to meet the needs of local people**
- For women who chose to give birth at home, the trust's community midwives ran a homebirth service that won the Royal College of Midwives Award for Better Births in 2016.
- Brighton and Sussex University Hospitals NHS Trust is one of the few remaining trusts in England that does not have a midwifery-led birth centre. This restricts choice over place of birth for low-risk women planning a normal birth in their local area.
- A manager told us that the trust was no longer able to deliver antenatal clinics from GP premises. The service

had set up satellite clinics in Hove and was looking new locations for antenatal clinics. Clinics were running from Tuesday to Friday from three rooms. The next phase of this work was to open up a fourth room and offer clinics Monday to Friday.

- The trust offered aromatherapy, including aromatherapy massage, in labour for low-risk women who met criteria. The trust trained approximately 130 midwives to deliver this service, and it was available for women giving birth at home as well as those birthing in the trust's hospitals. We saw lots of positive feedback from women who used aromatherapy in labour. Women said they found aromatherapy "relaxing", that it provided an "immediate relief/distraction" and that it was "very calming". We saw clear patient information sheets describing the benefits, risks and availability of aromatherapy in labour.
- The hospital had three rooms with birthing pools in. Two rooms of these rooms were located outside the main doors to the labour ward on the same level. Staff told us they did not use these rooms often and we saw that both rooms were unoccupied during our visit. Staff told us they felt isolated when caring for women in these rooms due to their separation from the labour ward. We saw this concern documented in the minutes of the MSLC meeting. On average 16 women, a month delivered their babies in a birthing pool. This was 6% of all deliveries.
- There were two cots available for use following bereavement. These were stored in the "butterfly room" and allowed parents to spend time with their babies.
- There was a feeding room and women told us that it was particularly useful to be able to feed their babies in the feeding room at night so that they did not disturb other mothers on the ward.
- There were rooms without beds which enabled women to be active throughout labour.
- The day assessment Unit was open Monday to Friday 8.30am to 7pm and 9am to 5pm on Saturday.
- **Access and flow**
- The trust failed to meet its waiting times for referral to treatment (RTT) for the majority of the last year.
- In gynaecology, the trust failed to meet the standard of 92%. In March 2016, 89.3% of patients were waiting within 18 weeks. At that time, 1,564 patients were waiting to start treatment.

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- The most recent data for suspected gynaecological cancers indicated 96% of patients were seen in two weeks. This was better than the England average of 95% and the standard of 93%.
- Trust data indicated from January to September 2015, 33.3% of patients waited six weeks or longer for diagnostic tests. This was considerably worse than the trust target of 1%.
- During the same period, 3.1% of patients had their operation cancelled at the last minute, worse than the target of 1%.
- Between July 2014 and June 2015, 5,763 women gave birth within the trust. This was higher than most other NHS trusts in England. The labour ward at Royal Sussex County Hospital (RSCH) saw women with ‘high-risk’ pregnancies within the trust as they had a level three neonatal intensive care unit. High-risk pregnancies include women with underlying medical conditions, such as gestational diabetes or pre-eclampsia, as well as women with multiple pregnancies.
- The maternity unit often delayed elective caesarean sections because the labour ward only had a single obstetric theatre. The unit needed to prioritise emergency cases in the theatre. An audit showed that theatre capacity issues delayed 31 elective caesarean sections from January 2015 to December 2015. Of these, the unit sent 21 women home and delayed their operation. The unit performed the remaining ten operations out of hours. Staff told us the unit performed planned caesarean sections out of hours at the discretion of on-call staff.
- The target for patients receiving outpatient treatment within 18 weeks of referral was 95% and the trust achieved this in 92.8% of cases.
- The maternity unit often sent women in labour to the Princess Royal Hospital (PRH) in Hayward’s Heath. Unit data for January to March 2016 showed that staffing and capacity issues were the most common reasons for diverts. Transfer to a different hospital during labour prevents women from receiving care at the settling of their choice and may cause anxiety for some women.
- During our inspection, we saw the labour ward sent women to PRH due to lack of staff. The hospital maternity dashboard showed the labour ward sent women to another hospital on 83 occasions between April and December 2015.
- We spoke to 15 midwives, who told us managers often closed triage. We also saw that staff logged some triage closures internally via the incident reporting system between February 2015 and January 2016.
- Between April-December 2015, 92% of maternity patients accessed antenatal care within 12 weeks and six days of pregnancy. This was better than the trust’s target of 90%.
- Occupation of beds on the gynaecology ward by medical patients caused problems for women who required admission from the Gynaecology Assessment Unit (GAU). The trust risk register stated that patients used seats and waiting areas in the GAU, as well as the “quiet room” - a private room for breaking bad news- while they waited for a bed on the ward. The trust identified that this was an inappropriate waiting area for patients who needed inpatient care.
- **Meeting people’s individual needs**
- The trust provided a multi-disciplinary, “One Stop” clinic on the second and fourth Thursdays of every month at the hospital for maternity patients with recreational drug or alcohol addiction in pregnancy. Patients who attended this clinic benefitted from additional time for antenatal appointments if they needed it. They were able to meet with other professionals involved in their care, such as mental health nurses and social workers, at the same times as their antenatal appointments. This reduced the number of separate appointments for patients and made it easier to access all the care they needed. Patients using the “one stop” saw the same midwife on each visit, and one of the two midwives coordinating the service told us she even visited patients on the postnatal wards after their babies were born.
- The midwives coordinating the “One Stop” clinic also provided specialist antenatal care for travellers and homeless women living in hostels or other temporary accommodation. A midwife told us they sometimes visited traveller’s homes for routine antenatal appointments at a patient’s request. A community midwife was the designated lead for teenage pregnancy. Teenage girls also had antenatal home visits. Staff told us any woman who was vulnerable as a result of her circumstances was able to request antenatal appointments at home.

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- The Lead Obstetrician ran a multidisciplinary mental health clinic at the hospital once every two weeks, along with a psychiatrist, mental health nurse and administrator. Community midwives referred women with complex issues, such as phobias.
- Interpreters of many different languages were available throughout the trust from Sussex Interpreting Services. Staff told us the hospital used them to translate for patients who spoke limited English. We saw a patient attend a gynaecology clinic with an interpreter provided by the hospital.
- We saw some written information in different languages, including a patient booking form and an information sheet about vitamin K for new born babies. Trust maternity services provided lots of information for their patients on their website and advised patients who spoke other languages to copy and paste information from this website into an on line translating service. This enabled patients to access all the information they needed in their first language. The Community Midwifery Manager told us the trust plans to update the website with direct links to information leaflets in different languages.
- The Trust had lead midwives for teenage pregnancy, travellers alcohol and substance misuse. There was also an independent domestic violence advisor in the trust. They accepted referrals directly from women.
- **Learning from complaints and concerns**
- Trust data showed that maternity and gynaecology services at RSCH received 51 complaints between February 2015 and February 2016. Of these, 25 related to maternity and obstetrics. The remaining 26 complaints concerned gynaecology. Some complaints concerned long waiting times for planned surgery. We saw that the hospital responded to complaints in line with the trust's complaints policy. We also saw that staff learnt from complaints. For example, we saw that the unit planned additional staff training following one complaint, and a change in procedure following lessons learnt from another.
- The trust website provided clear information on how to complain, as well as details of local advocacy services available to support patients and carers who wish to pursue a complaint. The trust website also gave information and contact details for patient advice and liaison service (PALS). This information was also available on the units we visited.
- Brighton and Hove MSLC met regularly. MSLCs provide a forum for women who have used maternity services and their representatives to meet with hospital staff and work together to drive improvements in services. We saw recent MSLC meeting minutes, which showed representation from community groups, service users and hospital staff. We saw an MSLC poster displayed outside the labour ward on level 13. This gave information and contact details for women who wanted to join.
- On the gynaecology ward, we saw a "You Said, We Did" poster. This indicated the ward valued patient feedback, and used it to improve service. For example, the poster stated that patients wanted detachable showerheads, and the service installed them. It also said some patients felt that catering services did not adequately cater for special dietary needs. The Catering Manager subsequently visited the ward at a mealtime, and was using patient feedback to update menus.

Are maternity and gynaecology services well-led?

Requires improvement



We rated well led as 'requires improvement' because;

- A vision and strategy for the service had been developed, but the senior leadership team staff within the directorate had not been involved. The strategy did not address the immediate issues of staff shortages and there were no timescales for any of the strategic initiatives.
- Processes for incident reporting and investigations had been put in place and some guidelines brought up to date. However, governance in gynaecology had no clear structure and staff from gynaecology rarely attended the safety and quality meetings for Women's Services.
- **Vision and strategy for this service**
- We saw a copy of the document entitled 'developing a clinical strategy' produced in January 2016 by the management team of the Women's Directorate. This document included an analysis of current strengths, such as, the home birth rate, links with the University of Brighton midwifery school and the out-patient hysteroscopy service. Examples of weaknesses included the lack of a midwifery-led birthing unit, a constant

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caesarean section rate and the lack of a separate gynaecology and obstetrics on-call rota. The document also set out a vision for the service and some plans for the development of the service, particularly in foetal medicine and combining the day assessment units and triage at both sites.

- We asked the clinical director and head of midwifery how staff within the service had been involved in developing the strategy. The Head of Midwifery said that the Directorate was set up in its current form in May 2015, and that engagement with staff had been limited.

- **Governance, risk management and quality measurement**







- We saw a copy of the maternity risk management strategy. It was out of date for review. This strategy required the service to undertake prompt reporting and investigation of serious incidents and escalation to the Safety and Quality meeting. The strategy also required the service to identify trends within incident reporting in general and to conduct an annual review of safety and quality minutes to ensure trends were reported. These processes were now in place.
- The governance lead reported that there was no clear governance structure for gynaecology. We saw from the minutes of the safety and quality meetings that attendance from gynaecology staff was poor.
- The governance lead reported that lessons learnt were highlighted and a special edition newsletter was produced to share the lessons with the service. We saw copies of these newsletters and they contained lessons around continuous foetal monitoring, repairing faulty equipment and the impact of good multi-disciplinary team working.
- We saw from the Women's Services safety and quality meeting in November 2015 that incidents were closed within the required period of 45 days, monthly statics and trends were reported and lessons shared in a timely manner.
- In addition, the service had established a weekly multidisciplinary incident review meetings with clear terms of reference to act as a quality assurance, educational and development forum. The January 2016 update for staff reported "excellent nursing and midwifery attendance" and that the meeting time had just been changed to "enhance and enrich attendance from medical colleagues".

- We asked the governance lead on the attendance of medical staff at these meetings and she said "progress was slow" but some staff were participating fully. Assurance could not be given that all staff were engaged with the governance systems.
- The governance lead had introduced a new process for panel investigations that was intended to be seen as "just" and "fair" because it has a clear protocol, made full use of accepted national guidelines. Panel members were selected on the basis of the clinical expertise required for the investigation.
- There were monthly safety and quality meetings, weekly incident review meetings and regular meetings on audit and morbidity. We saw minutes of these meeting.
- Staff told us perinatal mortality and morbidity meetings were held monthly with women's services and neonatology. We saw minutes of these meetings. Foetal loss was reported to, "Each Baby Counts". This is the Royal College of Obstetricians and Gynaecologists (RCOG's) national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. Foetal and maternal loss was also reported to, "Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK". This is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.
- **Leadership of service**
- The trust had a manager based at each site and in the community. They reported to a directorate lead nurse along with the governance lead. Patient access managers reported to a directorate manager. The directorate lead nurse, directorate manager and principal lead consultants reported to the clinical director of the service.
- Staff felt a strong, committed and effective leadership was needed to tackle a legacy of challenging behaviours from some members of staff in the service. Overall, it was felt that, in recent months, there had been some progress but more was required. We found that, following an external review, a culture of mistrust amongst some members of staff persisted, which was an obstacle to team working, learning and development.

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- The staff we spoke with in maternity and gynaecology felt that, at the time of our inspection, there was a lack of strong, visible leadership from both the clinical director and the head of midwifery.
- Staff told us, “Our manager is very visible and supportive” they are “highly visible and approachable.” A senior nurse told us that training opportunities were available and she had recently attended the trust’s two day course on leadership skills called ‘leading the way’.
- Staff felt directors were occupied with other areas of the trust and were not able to give much attention to maternity and gynaecology.
- **Culture within the service**
- The midwives we spoke with said that the conduct and attendance at meetings was better than it had been. A mediator had been engaged to attend the meetings, but had now left. Several members of staff referred to the continuation of bullying behaviours. One senior midwife said, “We carry on in spite of the behaviour of the doctors”.
- We asked several doctors, midwives and managers about the professional relationships between consultants. The majority view was that there had been some improvement, but there was further work to do. One consultant said, “I feel I am being treated with contempt”, another said, “the same people are doing the same things since the last CQC inspection and they are still driving staff to go off sick with stress”.
- The clinical director, governance lead, head of midwifery, several senior midwives and two consultants told us the reluctance to participate in serious investigations was due to a “mistrust” amongst consultants. Staff told us, consultants were fearful of appearing to be critical of colleagues as this had led to a climate of “grievance and counter grievance”. A letter, we saw from an external agency confirmed this view and said, “The culture is more about defensiveness and self-protection than about individual and collective learning.”
- Managers told us there had been problems arising out of cultural issues and the lack of engagement and teamwork amongst a group of consultants in obstetrics and gynaecology
- We also saw an action plan written in response to these issues and we saw that the recommendations to involve an external mediator and develop a leadership training programme, ‘leading the way’, had been implemented.
- Some midwives felt they formed an effective team at each site and worked well with the community midwives. However, some staff told us that there were tensions between the teams on each site and they struggled with staff shortages within the service. This happened when the service was busy and one site sent women to the other.
- **Public engagement**
- The service supported an active Maternity Services Liaison Committee (MSLC) at both sites. Patient representatives were able to support the service and contribute ideas and feedback. We saw minutes of these meetings.
- We saw some evidence of the NHS friends and family survey on the wards and units during our visit.
- **Staff engagement**
- We saw little evidence of staff engagement with the developing the clinical vision and strategy for the service.
- Staff told us that they completed the NHS staff survey. We saw an analysis of the report for the Women’s Services Directorate which compared the responses with those from other Directorates. The Women’s Directorate scored significantly better than the Trust average on eight questions including questions around support from immediate manager and recommending the organisation as a place to work.
- The service was worse than the average across the trust on two questions. The first was about “not having enough staff to do the job properly” and “putting myself under pressure to come to work despite not feeling well enough.” We did not see the response to this staff survey from the service.
- The manager informed us that, in order to integrate the hospital and community based midwives, an arrangement for buddying had been introduced. There were currently six pairs where hospital and community based midwives swapped roles every month to experience the role of their buddy.
- **Innovation, improvement and sustainability**
- The buddy scheme for the hospital-based and community midwives was an innovative way of reducing any feelings of ‘them and us’ between these groups of staff. The arrangement had six pairs of buddy’s there were plans to recruit more.

Services for children and young people

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

Information about the service

Services are provided for children and young people up to the age of 19 at both the Royal Alexandra Children's Hospital (The Alex) in Brighton and the Princess Royal Hospital (PRH) in Haywards Heath. Although part of the Brighton and Sussex University Hospital NHS Trust The Alex is housed in a separate, purpose built building with its own identity as a children's hospital. The hospital comprises seven levels, each with a different brightly painted animal theme to form part of the overall design of the hospital as an ark. Neonatal services are also provided in RSCH. At the PRH site there is an eight bedded special care baby unit and a children's walk in service within the adult Emergency Department.

Within The Alex, the children's safeguarding team, respiratory care, orthodontics and paediatric dentistry and liaison health visitors are located on level 4. Magnetic Resonance Imaging facilities are also on level 4 along with the X-ray department which provides diagnostic X-ray and ultrasound services for neonates, babies, children and young people up to the age of 19. Level 5 houses physiotherapy, outpatients, the diabetes team, speech and language therapy, psychology, the children's community nursing team, and dietetics. Level 6 houses the Oasis quiet space and the children's emergency department (ED) which opened January 2012. This sees children up to 16 years old and includes a six-bedded observation unit. In the period from 28 December 2015 to 31 January 2016 the ED saw 2,344 children, with just under 100% seen within four hours.

The Alex provides a range of elective and emergency surgical services. Level 7 is the medical and surgical day case ward with 25 beds for children who will be going home the same day. There are three surgical lists every morning, and two to three every afternoon with an average of 20 children per day. Level 8 is the surgical ward and has 12 beds. The surgical High Dependency Unit (HDU) is for medical and surgical cases and has 10 beds, including four in HDU. The HDU works closely with the South Thames Retrieval Service and the Paediatric Critical Care Unit at the Evelina London Children's Hospital, at Guy's and St Thomas's Hospital NHS Trust. This floor also houses the school room although it was not in use during our inspection as it was half term. Level 9 is the medical ward with a medical HDU with 31 beds, including a four bedded oncology day care ward which sees patients up to the age of 19. There are approximately 30 new childhood cancer diagnoses each year.

Level ten is home to the Ronald McDonald parents' accommodation, play centre, and the Clinical Investigation and Research Unit. The neonatal intensive care unit, the Trevor Mann Baby Unit, has 27 beds and is located within the main hospital on level 14 of Thomas Kemp Tower. There is no paediatric intensive care unit because the low volume of patients means it would be difficult to maintain the clinical skills of staff needed to provide safe care. Paediatric audiology appointments take place within the adult audiology department in the Barry Building at the main hospital, with an average of 44 appointments attended each week.

Services for children and young people

There were 10,304 stays from September 2014 to August 2015 at The Alex, of which 57% were emergency admissions, 38% were day cases, and 5% elective. There were 24 spells at the PRH of which 92% were emergency and 8% day cases.

According to figures from the Office of National Statistics (2014), there are an estimated 54,100 children and young people under 18 years of age living in Brighton. Deprivation is higher in Brighton & Hove than it is on average across England. Children and young people from minority ethnic groups account for 21% of all children living in the area. On average over the year ending March 2015, 2,235 children received support from children's services. There are approximately 309 children who have a child protection plan, and approximately 481 children in care in the city.

During our inspection we visited the neonatal units at RSCH and the PRH, and at The Alex visited theatres, medical and surgical wards, high dependency units, oncology day care ward and the play centre. We went to the outpatients and imaging departments, spoke to the social work, community nursing and safeguarding teams, and visited the audiology department.

The inspection team spoke with 99 members of staff at all levels in the hospital: consultants, nurses of all grades, health care assistants, receptionists, housekeepers, music therapists, physiotherapists, occupational therapists, play staff, speech and language therapists, radiographers, dieticians, and Child and Adult Mental Health Service (CAMHS) staff. There was a junior doctors' strike during two days of the inspection and so there was limited opportunity to engage with junior doctors. We also spoke with 23 parents and patients and reviewed 17 sets of notes, including safeguarding notes, pain relief charts and a Paediatric Early Warning System score card.

Summary of findings

We rated the children and young people's services at Brighton and Sussex University Hospital NHS Trust as good for safety and responsive, outstanding for care and effectiveness and good for well-led.

The service had a clear and robust process which ensured that incidents were reported and investigated and that lessons learned were shared with all staff to reduce the risk of recurrence. All ward areas were visibly clean and all exceeded the required standard in regular hygiene checks. Staff had a clear understanding of their safeguarding role and responsibilities and there was an excellent system to provide high quality child protection medicals when needed. Patient risks were appropriately identified and acted upon with clear systems to manage a deteriorating patient.

There were innovative and pioneering approaches to care with evidence-based techniques and technologies used to support the delivery of high quality care and improve patient outcomes. Patient outcomes were consistently better than the national benchmark, including patients with asthma, diabetes, referral to treatment times and readmission rates. Staff adopted a holistic approach to assessing, planning and delivering care and treatment to children and young people who used the service.

Staff at all levels were highly motivated to provide reassuring and compassionate care to both patients and their families, including siblings, and demonstrated a passionate commitment to this. Staff used innovative ways to ensure that the views of children were heard and made use of this to develop the service in ways which improved their experience. Parents were unanimous in their praise of the service and reported that staff went "the extra mile" to support them as well as their child.

Parents were considered to be active partners in their child's care, and staff took great care to ensure that individual needs of both patient and families were met.

We rated the responsiveness of the service to the needs of patients and their families as good. The service was tailored to meet the needs of individual people and was delivered in a way to ensure flexibility, choice and

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continuity of care. Services were flexible, provided choice and ensured continuity of care. Integrated person-centred pathways were developed with other providers that ensured the holistic needs of children and young people were met through shared working and information sharing.

We rated leadership as good. There was clear evidence of dynamic and innovative leadership within the nursing teams. We saw numerous examples of innovative developments to improve the patient experience and patient care. The ED was a particular example of the role of clear leadership in developing a highly innovative and patient centred service. However, the vision and strategy of the service was not well communicated within the hospital and there was some evidence of teams working in silos. Links with the trust were limited with no non-executive director lead on the Board and no formal mechanism for ensuring that the voice of children was represented at board level.

Are services for children and young people safe?

Good



We rated the children and young people's services at the Brighton and Sussex University Hospital NHS Trust as good for safety.

This was because:

- The service had a clear and robust process which ensured that incidents were reported and investigated and that lessons learned were shared with all staff to reduce the risk of recurrence.
- All ward areas were visibly clean and all exceeded the required standard in regular hygiene checks.
- Staff had a clear understanding of their safeguarding role and responsibilities and there was an excellent system to provide prompt child protection medicals when needed.
- Patient risks were appropriately identified and acted upon with clear systems to manage a deteriorating patient. This included mental health risks as well as physical.
- Although there were nursing shortages at times, the nurse to patient ratio was enough to protect children from avoidable harm.
- Nursing roles had been developed to reduce the risk from shortages in middle grade doctor posts.

However, we also found:

- There was no dedicated children's waiting area in the audiology department and this had been identified as a risk on the risk register.
- Resuscitation trolleys were not always checked according to the prescribed schedule.
- Mandatory training figures were not up to the trust standard for several key areas.
- **Incidents**
- There were no never events and two serious incidents in this service in the period February 2015 to January 2016. 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 by all healthcare providers. Both serious

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incidents were thoroughly investigated and staff were informed of the lessons learned. One related to safeguarding and risk assessment and the second related to clinical management. The Duty of Candour was applied as required. The investigations led to changes in practice for staff. Staff of all grades were aware of the incidents and explained to us what had changed to prevent any recurrence.

- There were no pressure ulcers, falls or catheter urinary tract infections reported under the Safety Thermometer from December 2015 to January 2016. Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to monitor local and system progress in providing a care environment free of harm for patients.
- The trust scored similar to other trusts for all five measures of the safe questions within the Children's Survey 2014.
- Any staff member could report an incident affecting staff or patients through an online reporting system. There were 545 incidents reported last year, of which 35% related to medication errors. Staff throughout the hospital spoke confidently about the system, told us they were encouraged to report incidents and were able to demonstrate how to use it. Those who had reported incidents described how they had received feedback about it. Where appropriate, learning was also shared with the wider trust.
- Following any serious or major incident, after action reviews were held where all those involved in the incident were invited to discuss lessons learned. We saw minutes for two meetings which clearly indicated lessons learned for example, the introduction of regular water checks to reduce the risk of waterborne infections. Common themes from recent incidents were displayed quarterly on staff noticeboards and themes were discussed at handovers and team meetings throughout The Alex.
- In the Trevor Mann Baby Unit, there was a newsletter, Babywatch, produced four times a year which clearly documented the outcomes of neonatal incident reports and promoted the learning from these. We saw the newsletters on display in the staff training room and staff spoke confidently about the lessons that had been learned from incidents.
- Clinical skills facilitators were employed in June 2015 on a one year contract as part of a skills enhancement strategy to develop learning from incident reporting. They have been able to effect practice change, for example verbal orders being taken by nurses now have to be heard by two nurses and signed by a doctor within 24 hours. There was good evidence of learning from incidents throughout The Alex with audits planned to check improvements.
- Mortality and morbidity meetings were held by specialty, minuted and well attended. In the HDU, meetings were monthly and we saw laminated learning points from these which were available to all staff. In the day surgery ward, mortality and morbidity meetings were held four times a year.
- A Child Patient Safety Quality Forum reviewed all cases on the electronic reporting system every month and a bulletin was sent out to all staff so that learning was shared throughout The Alex. This forum was attended by lead clinicians from all departments within the hospital. For outpatients and the day ward, a spreadsheet was circulated to all staff and updated every two months to inform staff of recent incidents and the lessons learned. The latest edition was April 2016 and was available for staff to read.
- Staff spoke knowledgeably about the duty of candour and were able to explain how this was put into practice. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw a leaflet for patients and carers available on wards which described this and what happens if something goes wrong. The directorate lead nurse held the responsibility for informing a patient and their family when there was an incident.
- **Cleanliness, infection control and hygiene**
- The Alex has a dedicated lead nurse for infection prevention and control (IPC). Clinical staff of all grades knew the name of the IPC nurse and demonstrated good awareness of infection control policies and practices. IPC meetings were held quarterly on wards with regular updates in between. We saw the minutes of the last meeting in March which showed information was being shared appropriately with staff.

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- New staff completed an IPC workbook as part of their induction. We saw samples of the workbook and certificates of completion. We viewed up-to-date IPC policies on the trust intranet and saw IPC audits online. Audit results were emailed to all staff as well as paper copies sent to each ward. IPC information was clearly visible throughout the hospital with lots of promotional information aimed at patients and families using the monkey story. The monkey theme was part of a wider scheme of illustrated booklets and posters aimed at reassuring children attending hospital, created originally by the parent of a child who was a patient at The Alex.
 - Cleaning schedules for domestic staff followed NHS standards and used the national colour coded cleaning equipment. We saw the cleaning protocols and guidance for domestic staff on the frequency of cleaning for specific areas. Domestic staff could explain the schedule of cleaning and demonstrated knowledge of the different coloured mop heads to be used for different cleaning activities. We witnessed domestic staff cleaning a ward, and observed that they were considered by clinical staff to be part of the ward team.
 - There was a weekly cleaning audit throughout all wards to measure cleanliness against national standards. This was signed off by a band 6 nurse who checked that the cleaning met the standard. We saw environmental audits related to cleanliness which had high scoring results against a target of 95%, for example in the x-ray department it was 100%, in HDU the score was 99.8%, on the surgical ward it was 98.8%, on the medical ward it was 99.6% and 99.9% on the oncology day ward. We did not see any areas which had not met the required standard. All clinical areas were visibly clean and we heard parents spontaneously commenting on the clean state of the hospital.
 - We also saw guidance for staff on the cleaning of patient equipment, with the frequency and method covered in induction. We noted signs indicating when toys and equipment had last been cleaned and observed staff and volunteers cleaning play equipment appropriately. Staff followed protocols for decontaminating equipment and we saw dated stickers on commodes to indicate they had been cleaned.
 - A full range of single use equipment, used for nursing procedures, was readily available including purple syringes to be used with enteral feeding tubes, which are used to provide nutrition to patients who cannot obtain nutrition by mouth.
 - Hand hygiene was audited under the '5 moments of hand hygiene' policy: before patient contact, before aseptic techniques, after patient contact, after contact with the patient environment and after body fluid exposure. We saw staff throughout the hospital following correct hand hygiene practices, and were shown audit results demonstrating 100% compliance.
 - Hand hygiene gel was available in all areas with hand washing signs visible throughout the hospital. The use of the monkey strategy as a way of communicating with children was commendable. We observed parents washing their hands and using hand sanitisers and staff of different grades prompted parents to follow the correct IPC procedures.
 - There were appropriate numbers of handwashing sinks as well as hand gel in the neonatal unit including a non-touch hand washing sink at the entrance for staff and visitors to use before entering the unit. We noted that staff had placed lines on the floor around patient beds to indicate where the patient environment began so that staff could take care to avoid stepping into the area on their way to and from another patient. Nurses were in charge of cleaning the bed space for their patients and had to sign an online database. Both examples seen of this were fully completed. We observed that the milk preparation room scored 10/10 with all cleaning schedules and was compliant with milk storage requirements.
 - All staff we saw during our inspection followed the bare below the elbows policy and used appropriate protective equipment such as gloves and aprons to carry out procedures and personal care.
 - Clean linen was stored correctly and very tidily so that it was easily available. We checked a sample of equipment used by patients such as blood pressure cuffs and bedside tables and these appeared clean. Sluice areas were well maintained and we witnessed staff correctly handle and dispose of urine.
 - The Alex had up-to-date isolation procedures and at the time of inspection, there was a case of norovirus on a ward, which was being barrier nursed appropriately.
 - During 2015, nine children had to be readmitted following surgery, one with a wound infection and two with MSSA line infections. We saw that action had been taken to remind staff of the appropriate management of lines when a child left theatre.
- **Environment and equipment**

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- Stock rooms were mostly well organised and had robust stock management systems. This ensured that stock was used in the correct date order and that replacement stock was ordered in a timely manner.
- The play centre had a wide range of toys for children to play with and we saw the toy cleaning schedule which was up-to-date for March. There were no soft toys because of the difficulty in cleaning these and other items had been carefully selected with safety in mind.
- In the neonatal unit at the PRH, all the necessary equipment was by the cot, for example air and suction. This was all in good working order apart from one item which was awaiting repair.
- We noted that waste management followed national protocols regarding separate colours/receptacles. We saw that sharps bins were correctly labelled, assembled and not overfilled.
- Children attending for an audiology appointment had to attend the adult audiology department in the Barry Building. This meant that a child had to move from their appointment in the children's ENT department in The Alex, through to the adult hospital, and then back again. This had been put on the trust risk register. The National Deaf Children's Society had issued guidance that only services with Improving Quality In Physiological Services (IQIPS) programme accreditation should be commissioned and this was not thought to be achievable with the current location of the service. This meant there was a risk of the service being decommissioned by the Clinical Commissioning Group with a subsequent loss of income and reputation to the trust.
- There was no separate waiting area for children in the audiology department. There were limited toys, and no information or support materials for children on the walls in the corridor where patients and their families had to wait. Both staff and parents commented on the inappropriate environment for children. One parent had formally complained about the "dark, foreboding and depressing" environment and had commented that it was particularly frightening for a deaf child to have to attend there.
- Staff expressed concern around safeguarding issues because the children, many of whom had special needs, had to wait in an inappropriate environment with adults, including prisoners from a nearby prison and adults with significant facial disfigurements. There was no evidence that a risk assessment had been done to consider the possible risks to a child attending there.
- There was a lack of suitable storage space in the day surgery ward which meant that stock was being kept inappropriately in other locations on the ward. Some items were not stored to IPC standards, both on the floor and open to the air, and some items had to be disposed of because they had expired or they had been stored incorrectly.
- Resuscitation equipment was available in all areas and was kept clean and tidy. Records showed that the resus trolleys in the Trevor Mann Baby Unit (TMBU) intensive care nursery were checked daily for tags and had a full inspection weekly. There were no missed days. However, one weekly check was missed in March elsewhere in the TMBU. Other trolleys elsewhere in the hospital also had missed checks. There were six days in February and six days in March when the resus trolley was not checked in day surgery, and one weekly check was missed in February for the major care trolley.
- The TMBU had a difficult airway box which was to be checked twice daily. We saw that seven 12 hour episodes had been missed within one month, with a maximum of 36 hours passing without checks. This meant that there was a risk that the box would not be fully stocked in an emergency which could impact on care for a child.
- **Medicines**
 - There was a robust system on HDU which ensured that staff correctly checked medication before giving it to a patient. This included training and supervision of staff.
 - There was a non-medical prescribing forum which held study days, to ensure that nurse prescribing was supported and safe.
 - Medicine pods were available for patients with their own medication.
 - Medication stock on the wards was checked and updated weekly by a pharmacist.
 - On the TMBU, we saw that medication was stored correctly and securely. Controlled drugs were locked in the drugs cabinet with documentation present and filled in appropriately. Separate drug books for the

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transfer team were also present. An electronic patient record and prescribing system had reduced the number of prescription errors, which formed a large part of reported incidents.

- A memo on how to do a correct prescription was available to staff in the children's ED to ensure that the details on a prescription were all correct.
- In the oncology department, we saw electronic prescribing and noted that there was a dedicated pharmacist for the service. We saw that prescriptions were signed, coded and batches double checked before being given to the patient.
- At the PRH, we saw that all drugs fridges were checked twice daily. However, at The Alex, the number of fridge temperatures recorded in March 2016 ranged from 70% in oncology to 100% in the community team, and two medicine cupboards had been left unlocked in the medical room on level 9. The matron in the TMBU had already taken steps to ensure that drug fridges and the milk fridges were checked fully and had devised a new allocation method to encourage checking and documentation of this.

• **Records**

- There were both electronic and paper notes in use across The Alex, and paper records at the PRH. Paper records were kept on the unit for three weeks and then scanned onto an electronic system. When previous medical notes were needed, they could be requested urgently from central stores. Patient information and records were stored securely on all wards.
- On the day surgery ward, 90% of patients had a discharge summary written by a doctor and emailed to the GP upon discharge. If a doctor was not available to do this, the parent was given a copy of the operating notes and the doctor's summary posted to them and to the GP as soon as possible. This ensured that the details of attendance and the outcome were shared promptly with the child's GP.
- On the TMBU, all observations were taken and automatically generated onto the electronic system. These had to be approved every hour by a nurse. Observations could then be seen by any doctor or nurse with access to the system regardless of their location. This meant that a doctor could view observations, laboratory results and x rays from home when they were on call and so provide a prompt opinion and advice to staff on the ward with the patient.

- The system contained the entire patient record from the whole of the multi-disciplinary team. Staff told us the system was easy to use and meant there was no problem with legibility. All bed spaces on HDU and ITU had their own computer so that staff could input data regularly. The computers were cleaned by nursing staff daily and they documented when this was done; we saw up-to-date records of this.
- We reviewed 17 sets of patient notes in total, and saw that entries were dated and signed but not always timed. Consent forms had been signed by both doctor and parents. Pre and post operation observations had been completed and documented appropriately. Fluid balance charts had been completed and ward round notes documented.
- We saw a copy of a GP letter ready for a patient about to be discharged. The notes of a child on a child protection plan were comprehensive and well thought out. The safeguarding form was a yellow sheet which made it easy for staff to spot within the body of the notes. Pain assessment forms had been completed in all six of the medical notes reviewed with regular assessments using a self-assessment tool. Documentation was clearly written and fully completed. We also saw the perioperative care metrics from February 2016 which showed good documentation from a sample of 10 sets of day case patient notes.

• **Safeguarding**

- The hospital had a named nurse and a named doctor in post as dictated by statutory guidance. Staff were aware of who they were and how to contact them. A safeguarding team provided support, advice and guidance. We saw good evidence of child protection with audits and deep dives, both local and with the Local Safeguarding Children Board (LSCB). The named doctor and named nurse ensured that regular audits covered most areas of work.
- There was safeguarding group supervision available to staff depending on need, provided by a responsive team every six to eight weeks. Only the named professionals and safeguarding team received one to one supervision from designated professionals in the CCG. There were no supervision contracts or records kept of child protection supervision of nursing staff. The trust lead

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nurse chaired a monthly safeguarding committee and the named nurse presented an annual report to the board, so there were strong safeguarding links to the board.

- The trust responded to the call for evidence by the Lampard review following the Jimmy Saville investigations. Access to wards was secure with swipe card access for staff and patients and families had to use an intercom to be allowed in by reception. Training had been introduced for staff on how to respond to an allegation of abuse by a member of staff.
- The trust worked closely with a Local Authority Designated Officer (LADO) following a case where a member of staff was involved in a grooming incident with a patient. The named professionals showed clear awareness of possible risks, and we saw evidence of lessons learned.
- All the staff we spoke with were fully aware of what to do if they had safeguarding concerns, and how to make a referral, although they were not necessarily aware of this responsibility falling under section 11 of the Children Act 2004, which places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.
- There was a monthly safeguarding newsletter on the trust intranet and the named doctor had produced a summary of intercollegiate documents to support staff understanding of their role and responsibilities. The lead nurse circulated links to newspaper articles and television programmes to provide realistic examples of how safeguarding could be applied.
- There was good evidence of multi-agency working. There were case discussions held each week and multi-agency raising awareness sessions held every three months on issues such as the Mental Capacity Act and modern slavery. The police and local domestic abuse services participated in these.
- Any member of staff could refer someone to the local Multi Agency Risk Assessment Conference following a comprehensive risk assessment and there were good links with the local domestic abuse team.
- The Multi Agency Safeguarding Hub (MASH) began three years ago and was working well, with social services, police and health involvement. However, when the named professional was on leave, immediate advice was only available by telephone. However, if a strategy meeting was required while the named professionals were on leave, cover was provided by the consultants who carried out child protection medicals. Information was shared with social services and the police as required.
- There was an excellent system for undertaking child protection (CP) medicals with a consultant lead. There was a rota which meant there was someone available each afternoon to complete a physical medical with the report typed the next day. We saw an audit of CP medical reports which showed they do not always meet the **Royal College of Paediatrics and Child Health** guidance of 48-72 hours for reports to be written but there were good reasons evidenced when this was not met.
- All the consultants who undertook safeguarding medicals met each week to peer review reports. This counted towards CP supervision and promoted learning and best practice. There was a quiet room set aside for CP medicals, with toys and all the relevant paperwork. The medical itself followed best practice guidelines. In the evening, CP medicals were carried out by the consultant of the day in the ED. There was an average of one CP medical per day which was very high, with children attending from three local authorities. Community doctors attended child protection medicals once or twice a month, depending on their availability which promoted good communication between the hospital and community services.
- There was a flagging system in place at PRH to alert staff to a child on a protection plan, but it was a different system to the one in use at The Alex and the systems did not interlink. All parents were asked on arrival questions about social worker and health visitor involvement with the family and consent was obtained and documented if contact with social services was required for the family.
- The safeguarding team carried out daily ward rounds which ensured that any outstanding issues could be addressed promptly, and all safeguarding notes were reviewed daily. We reviewed safeguarding notes and saw that the appropriate action had been taken. Each ward had red safeguarding information folders for staff with clear advice on who to contact for advice and support. There was also excellent safeguarding information on the intranet which was very easy to

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access. There were posters throughout The Alex giving parents and visitors telephone numbers of who to contact if they had safeguarding concerns, and leaflets on issues such as what is normal bruising.

- Staff were trained to level three safeguarding, but this was a two hour session which was not as long as national guidance would recommend. However, a wide range of other training sessions took place in the Thursday peer review meetings and Monday child protection training, multi-disciplinary meetings and multi-agency meetings which were not included in trust figures.
- Consultants demonstrated good awareness of the Child Death Overview Panel process, but this knowledge was not consistently shared by nurses. This could be a missed opportunity to disseminate learning amongst all staff.
- On level 10 in The Alex, there was a Clinical Investigation and Research Unit. This used to be housed alongside the adult ED but moved to The Alex last year. Staff expressed concern that this meant that adults participating in research and clinical trials were present in The Alex without having gone through any background checks. A risk assessment had been carried out for this, and an alternative route devised so that adults could reach the unit without having to go through the main atrium of the children's hospital. However, this was not always used. The unit was close to the play centre and this represented a possible safeguarding risk.
- In the Adult ED, 85% of clinical staff had completed safeguarding level 3 training and there was a link nurse for CP. There were good systems on place to keep children safe.
- We saw evidence in patient records of a child protection assessment being carried out, a CP specialist being called and a care plan being put in place with the involvement of the mother, including support for her.
- **Mandatory training**
- Mandatory training covered a range of topics including fire safety, health and safety, child and adult safeguarding, paediatric immediate life support (PILS), manual handling and equality, diversity and human rights. There was a clear system to encourage uptake of mandatory training. Staff did not get study leave until

they were compliant with all mandatory training. Managers told us that mandatory training days were well attended but workbooks were not always completed due to time constraints.

- Most staff we spoke with told us they were up-to-date with their mandatory training and expressed frustration that the figures generated by the trust did not reflect this accurately. We were shown local mandatory training attendances which did not tally with those provided by the trust, indicating that for some areas, a higher number of staff had in fact completed their training. For example, the trust reported that 64% of staff had completed safeguarding children level 3, whereas the local figures showed 81%, against a target of 100%. However, both trust and local figures showed that staff failed to meet the targets for almost all areas. Of particular concern were the figures for PILS (51%), information governance (46%) and infection prevention (clinical) 58%.
- **Assessing and responding to patient risk**
- A Paediatric Early Warning System (PEWS), formulated for four different age ranges, was used to identify deteriorating patients. Observations which were outside the normal range were shown as shaded boxes to provide an immediate visual alert to an abnormal result. Clinical escalation pathways were embedded in the patient charts to make it clear what to do when a child was deteriorating, with the severity of the escalation colour coded green, amber and red. The chart prompted staff to use the Situation Background Assessment Recommendation structured method for communicating critical information when following the escalation plan which contributed to effective escalation and increased patient safety. The chart included a section for staff to complete when the PEWS score had reached a specified point so that action could be tracked and matched to a specific staff member.
- A sample of PEWS audits from January and February 2016 showed that in 100% of cases, there was evidence that the PEWS score had been escalated if required.
- We reviewed a PEWS escalation score card for a child in HDU, and found it to be fully compliant and complete. We saw that PEWS charts were completed for all children presenting as medically unwell with vital signs recorded hourly.
- In the ED, the electronic patient record had a compulsory Sepsis 6 assessment. Sepsis 6 is a toolkit to

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make it easier to recognise severe sepsis promptly and to deliver six simple elements of care in a time-critical manner. Research has shown that using the Sepsis 6 care bundle is associated with decreased mortality, decreased length of stay in hospital, and fewer intensive care bed days. A pathway for those with symptoms of sepsis had been adapted for local implementation. This included a section on why you do not do something, which improved patient safety by prompting staff to fully reflect on the occasions when they did not take action. We saw examples of records where the sepsis assessment had been fully completed.

- In the ED, patients were assessed using the Manchester Triage System. This ensured that patients were seen in order of clinical priority and not in order of attendance and allowed clinicians to safely manage patient flow. Pain score was a compulsory assessment for all children during this process.
- There was an outreach nurse team operating from the HDU which provided support throughout The Alex for staff managing a deteriorating patient. This extended to the adult Intensive Treatment Unit if a teenager presented there as well as the TMBU. However, this was only available Monday to Friday 9am to 5pm. Staff told us that the team was called out to see up to ten children per day but no data had been collected to show the outcomes for the service.
- The outreach team was not formally part of the response to a medical emergency team (MET) call, but would attend to support staff and parents. The MET call is a hospital based system, designed for a nurse (or other staff member) to alert and call other staff for help when a patient's vital signs have fallen outside set criteria.
- If a child had deteriorated to the point where they needed to be admitted to a Paediatric Intensive care Unit (PICU), staff used the South Thames Retrieval Service (STRS) to take the patient to an appropriate PICU. The STRS is a children's acute transport service which specialises in the inter-hospital transfer of critically ill children in London (south of the River Thames) and operates from the paediatric intensive care unit of the Evelina Children's Hospital, located at St Thomas' Hospital.
- The diabetes Clinical Nurse Specialist was on call 24 hours a day and a consultant was always available. Diabetes guidelines were seen on the intranet with a clear escalation policy for a deteriorating child.
- The Paediatric Mental Health Liaison Team operated seven days a week 9am to 8pm and could be contacted via telephone or bleep for emergencies. The team aimed to respond within one hour and there was a pathway which included informing MASH and CAMHS. An urgent referral to CAMHS received a same day response. In the five months since it started, the team had seen 138 children. Questionnaire feedback from parents and staff had rated the service very highly. Staff had found it to be particularly good for supporting children and young people who self-harm.
- At the PRH, there were good links with CAMHS to provide an urgent response to a child at risk.
- We observed the completion of safer surgery checklists, and saw the perioperative care metrics for January 2016 which showed that 100% of surgical safety 'check ins' were completed, 90% of 'time outs' were completed, and 70% of 'sign outs' were documented.
- We noted that there was always a nurse in the recovery room who was trained in European Paediatric Life Support. This training provided the knowledge and core skills required to intervene to prevent further deterioration towards respiratory or cardiorespiratory arrest. This improved the safety of the child.
- The perioperative care metrics for January 2016 showed that 100% of patients in recovery had observations recorded at least every ten minutes, 100% had a Modified Early Warning Score recorded before being discharged from recovery and 100% met the recovery discharge criteria before being discharged to the ward.
- Clear information was provided to parents when their child was discharged, including details on who to contact should they need advice.
- Children attending for day surgery were risk assessed at pre-admission. If a child was considered to be at high risk of needing a HDU bed after surgery, staff would check the day before the scheduled surgery that there was a HDU bed available. If there wasn't, the surgery would be cancelled and rebooked.
- **Nursing staffing**
- Children's services had an average staffing level of 92% compared to the trust average of 94%. Out of 14 units, five units were understaffed by more than one whole time equivalent and seven units were overstaffed. The TMBU had slightly fewer registered nursing staff available both night and day than budgeted for (95% and 96%). Challenges exist in paediatric intensive care

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nationally because insufficient nurses are currently trained. We reviewed an off duty roster for February 2016 and saw that generally the ward exceeded the recommended minimum of staff but made use of bank staff to do so.

- Trust figures showed that the average bank and agency staff use in The Alex was lower than the trust average of 21% in most areas with only 4% for children's ED, 7% for day case ward and outpatients and 8% in theatres. However, it was above trust average for the medical ward, surgical ward and HDU at 25%. We were told that agency staff were rarely used and most of this additional staffing came via the bank with staff who are substantive post holders within the different units.
- Most of the expenditure on bank staff (70%) arose because of vacancies. From January to December 2015, the day case ward and outpatients had a 17% vacancy rate.
- The average staff turnover for children's services at 14% was higher than the trust average of 12%. This was mainly due to additional clinical services which had a turnover rate of 19% compared to 12% for this staff group in the trust overall.
- Sickness rates for the service were in line with trust averages.
- Bed manager meetings were held twice daily which all ward managers attended to discuss staffing, acuity and transfers from other hospitals and between wards.
- We observed staff using a very efficient method of matching the severity of illness of a patient with staffing levels.
- We saw rotas which showed that on three occasions in a month, there had been no band 6 nurse on the ward at night. This was a breach of Royal College of Nursing (RCN) guidelines which stated that there should always be a band 6 nurse for every shift. However, the risk was reduced by the presence of senior band 5s and a band 6 available elsewhere in the hospital.
- The British Association of Perinatal Medicine (BAPM) recommended a ratio of registered nurses to infants of 1:1 for intensive care patients, 1:2 for high dependency and 1:4 for special care. Nursing levels for the TMBU were reported via the sector wide reporting system. We saw that these standards were not met on 69% of shifts in January and 45% in March, both months when the number of occupied cots had exceeded 27. In the first week of April, when the number of occupied cots ranged from 19 to 21, the BAPM standards were met for 100% of shifts. The risk was controlled by making use of the band 7 who was scheduled to have a non-clinical day, the matron and the nurses from the transport team.
- Not all neonatal nurses were fully qualified in their specialty. At the time of inspection 64% of nursing staff had an intensive care qualification with more people on the course which would bring it to 70% by September.
- Handovers took place twice a day with medical staff participation, including a consultant. We observed handovers which followed the Situation, Background, Assessment, Recommendations protocol with a comprehensive verbal report given using printed handover sheets. The nurse gave precise instructions and staff discussed child safeguarding issues and date of discharge. At completion, the band 5 in charge allocated patients. We saw evidence of care for patients from juniors and support for staff.
- The handover on the TMBU happened in two stages, with an initial group handover from the nurse in charge to all night staff with an overview of all babies and any potential admissions. Then there was a bedside handover from nurse to nurse for each baby. We observed an effective group handover and noted that team morale was high. We saw that staff asked questions if unclear about any aspect of the handover. Whilst there was a potential confidentiality issue around handover of patients in front of other parents, we noted that nurses took care to speak very quietly to minimise any chance of parents overhearing confidential details.
- We noted that all levels of staff were involved in ward rounds, including consultants, nursery nurses and registrars. We were told that the consultants listened to nurses as they know the babies best.
- We saw evidence that attention was paid to the skill mix on ward rotas. There was always a band 8 nurse practitioner or the nurse consultant to provide senior cover. No adult nurses were employed in permanent posts, only on secondment and all substantive postholders were trained children's nurses. In the oncology department, there was a specialised community nurse dedicated to paediatric oncology, the equivalent of a MacMillan nurse.
- Nursery Nurses (band 4) and HCAs (band 2) supported the nurses on the wards. In the ED, senior HCAs (band 3) and HCAs (band 2) supported the nurses.

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- The staff ratio of 1:2 or 1:1 for some children in HDU met the RCN guidelines. If there was pressure on staff levels, surgery would be cancelled to ensure safe staffing levels were maintained.
- **Medical staffing**
- The medical skill mix for this service had slightly more consultants and fewer registrars compared to the national average. This trust had 40% consultants compared to an England average of 35%, and 47% registrars compared to an average of 51%.
- The difficulties in recruiting sufficient junior medical staff in paediatrics were highlighted as an area of concern in the Quarterly Report for Directorates January 2016. The clinical director identified the lack of middle grade staff as an "omnipresent challenge". We were told there was a national shortage of registrar level doctors and a lack of training posts at the trust.
- Medical staffing rotas were a challenge with an ongoing need for regular locums, usually from the existing workforce (including consultants) or those known to the service.
- Two advanced paediatric nurse practitioners (APNP) were in post and were expected to contribute to the tier 2 rota by April 2016. A hybrid consultant role had also been created to address the shortage of middle grade doctors. This role divided its time between providing middle grade cover and doing clinical work in their specialty. These were both innovative and appropriate methods of providing adequate medical cover in the absence of middle grade doctors.
- The out of hours rota was covered by a combination of registrars and APNPs. There was a minimum of the equivalent of an ST4 in the department 24 hours a day. There was a consultant presence from 8:30am to 10pm seven days a week.
- Consultants were available to babies on the neonatal unit 24 hours a day, seven days a week either in the ward or on call at night. There was always a doctor of sufficient seniority on the ward at all times.
- At the PRH, the neonatal unit was nurse led, with consultant cover on Monday, Tuesday, Thursday and Friday from 9am to 5pm, with Wednesdays and out of hours cover provided on the ward by a rotation of appropriate level staff and a consultant on call.
- The anaesthetic service was consultant led, with 99% of cover provided by paediatric consultants.
- There were six consultants who covered ED, HDU and East Grinstead (for burns). The children's ED was a consultant led service; a consultant was present in the ED until midnight every day and there were two registrars on the out of hours rota when a consultant was available on call.
- The directorate had highlighted the difficulties in releasing consultants for child protection medicals in their quarterly report (January 2016) because this took senior staff away from their areas, leaving them short staffed. This situation had been addressed through the recruitment of an additional consultant.
- **Major incident awareness and training**
- The trust had a major incident plan and we saw the policy and actions cards dated February 2016, showing actions to be taken in the event of a major incident. The trust plan included children's services, for example specifying that child casualties contaminated with chemical, biological or radiological material would be treated in main ED with paediatric support.
- Major incident training was included in the annual mandatory training, but the records we saw on the ward showed that only 26% had attended this training.
- Local seasonal plans were in place to increase the nursing establishment and number of beds in the HDU in winter. However, staff told us The Alex was not included in the trust wide winter plan. We saw that the increased activity in the ED during the winter with higher numbers of more serious admissions without additional winter pressure resources had been put on the paediatric risk register. The increase in activity had led to a shortage of areas in which to undertake care and not enough staff to manage care. The ward manager and others had had to work clinically and additional costs had been incurred in paying for bank staff.
- Staff were aware of the impact of increased numbers of visitors to the town in summer and we saw evidence of good practice in managing a safeguarding referral for an out of area child.

Services for children and young people

Are services for children and young people effective?

Outstanding



We rated the children and young people's services at the Brighton and Sussex University Hospital NHS Trust as outstanding for effective.

This was because:

- There was a truly holistic approach to assessing, planning and delivering care and treatment to the children and young people who used services. The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. New evidence-based techniques and technologies were used to support the delivery of the highest quality care and improve patient outcomes.
 - Our observation of practice, review of records and discussion with staff confirmed highly effective multidisciplinary team working practices. Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to children and young people who used services.
 - There were outstanding external links to tertiary centres and specialist networks, particularly in regards to children and young people with eating disorders.
 - Staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued. High performance was recognised by credible external bodies.
 - Patients and families stated pain was well managed. Staff provided a highly responsive service that used innovative ideas and the latest technology that either reduced the need for sedation or provided pain relief in a more effective way.
 - The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
 - Mutual respect was apparent at all levels and across professional boundaries, which promoted high performance and exemplary care.
- Staff actively monitored and reviewed consent practices to improve how people were involved in making decisions about their care and treatment.
 - The legal framework and trust policy on consent was robust and well understood by staff.
 - **Evidence-based care and treatment**
 - Staff followed national best practice guidance in the care of children they treated. The hospital services met the Department of Health guidance 'Getting the right start: National Standards Framework' (2003) as children and young people received care that was integrated and co-ordinated around their particular needs, and the needs of their family.
 - We saw an audit programme for 2015/16 for children and young people's services which included both national and local audits. The department provided an audit report detailing the status of each local or national audit, as well as outcomes. The report included an action plan for the audits where the set benchmark was not met, including expected dates of completion and dates for re-audit. For example, on lumbar puncture documentation, it was unclear which procedures a patient had undergone, and so the emergency department introduced adding a procedure sticker to clinical notes. A re-audit was planned to check the effectiveness of this action.
 - Policies were based on the requirements and recommendations of recognised evidence-based organisations. For example, head injury pathways followed The National Institute for Health and Care Excellence (NICE) guidance and wheeze management was based on the recommendations of the British Thoracic Society.
 - The hospital was working towards achieving Level 3 accreditation for UNICEF's Baby Friendly Initiative. At Level 3, staff focus on ensuring that baby friendly standards are implemented for all pregnant women and new mothers and would mean trained staff could support the experiences of parents in feeding their babies.
 - The Royal Alexandra Children's Hospital is one of 25 hospitals around the country taking part in the Emergency Treatment with Levetiracetam or Phenytoin in Status Epilepticus study (ECLIPSE). Currently children and young people with long lasting seizures are treated

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with phenytoin or levetiracetam (brand name Keppra) medicine in an emergency setting. Phenytoin and Keppra have been used for a long time and the ECLIPSE study is looking into which is more effective.

- The hospital, in conjunction with Great Ormond Street Hospital, introduced surgical pathways for complex keyhole surgery for patients undergoing laparoscopic repair of oesophageal atresia. This procedure has historically been very invasive, with extensive surgery to the chest. National data has shown keyhole surgery reduces the length of time patients stay in hospital, reduces complications and readmission rates and has a lower mortality rate than traditional surgical outcomes.

- **Pain relief**

- We observed a variety of tools being used to assess pain depending on the age of the child and their ability to understand information. Staff recorded pain scores in patients' records; all patient records we looked at showed pain scores with management plans if the patient was in pain. Children selected the tool they wished to use to communicate pain thresholds, for example, a child could point at a scale line from 0-10, ten being the most painful, or they could use 'smiley faces', where the child chose a face that best described their own pain. In the neo-natal unit, where children were too young to assess their own pain, staff developed an innovative pain assessment tool, which measures expressions, movement, sleep state and crying levels to assess appropriate pain relief. We observed these tools being used effectively. Children with behavioural issues were assessed using the FLACC pain scale, which measured the child's facial expressions, leg movements, activity and crying levels and consolability to monitor pain. Staff told us that the outreach service (a specialist team who respond to emergency calls within a hospital to give advanced clinical advice or treatment) was always available to support staff in controlling pain.
- Patient records confirmed pain relief was assessed on admission and discharge and was regularly monitored during admission. When analgesia was required, staff regularly monitored the patient to assess the effectiveness of pain relief and took appropriate action when required. Children, young people and parents we spoke with all stated staff responded quickly when their child was in pain and praised the service.

- Children attending outpatient clinics could choose their preferred method of pain relief. They could either have anaesthetic cream which would take an hour to take effect, or what staff referred to as "magic spray" (ethyl chloride) which provides immediate pain relief. The hospital had systems in place to ensure the safe usage of ethyl chloride, however as it had only been recently introduced it was too soon to monitor its effectiveness. Staff said they would liaise with the day case unit if a child required stronger pain relief and that support from the unit was prompt.
- Staff used innovative techniques to reduce the need for sedation. For example, children in the ED and outpatients who required an MRI scan had access to a fibre optic TV with a mirror, which was used as a distraction technique. The child could watch TV during their procedure, reducing the need for conscious sedation. The hospital had not produced figures to confirm this, however all staff we spoke with said it was effective in reducing sedation rates and we observed the technique being used to good effect.
- Staff utilized play specialists in providing distraction techniques when a child required a procedure that may be painful. We saw a play specialist play Where's Wally, a game about finding a hidden character in a book, with a child so effectively they did not require pain relief.
- A patient group directive was in place for nurses. This meant children requiring urgent access to over-the-counter pain relief could receive these medications without the need for a doctor to attend and prescribe.
- **Nutrition and hydration**
- Staff were proactive in monitoring the nutrition and hydration needs of children and young people admitted to wards. All children admitted were assessed using the screening tool for the assessment of malnutrition in paediatrics (STAMP). The STAMP assessment was completed in patient records we looked at.
- The Protected Mealtimes Review by the National Patient Safety Agency showed protected mealtimes improved patient outcomes in terms of increased weight gain where required, reduced food wastage and a reduced number of food complaints. We observed protected meal times at the hospital, which allowed patients to eat their meals without unnecessary interruption and enabled staff to provide assistance to patients unable to eat independently.

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- Staff ensured patients who required fasting before a procedure were timed and closely monitored in order that the patient would not go for too long a period without food or fluids. We saw evidence of this from patient records and audit results.
- Milk rooms were located on wards and provided numerous alternatives to breast and formula milk if a baby was lactose intolerant or had allergies. There were robust systems in place to ensure expressed milk was stored correctly and given to the appropriate baby. Strict guidelines supported mothers who could donate breast milk, as well as those babies who received it.
- Policies for alternative feeding methods were robust, followed clinical guidelines and provided step-by-step instructions. We saw detailed policies for gastro feeding, milk administration, nasogastric/orogastric feeding procedures and nasojunal tube feeding (an effective method of feeding babies with high reflux where you feed directly into the small bowel).
- Facilities were available for parents to make drinks and snacks. Families were welcome to bring in particular food for their child, if they wanted. The hospital also provided snack and lunch boxes for patients when they were hungry outside normal meal times.
- Staff were trained and were able to identify when total parenteral nutrition, a method of getting nutrition into the body which is given through a catheter into a vein, might be required. This meant babies who could not tolerate nutrition in their digestive tract still had their nutritional needs met.
- All children we spoke with on the wards said they liked the food and were regularly asked by staff if they had enough to eat and drink, which was reflected in data from the Children's Survey 2014. No adolescents were available to provide their opinion.
- **Patient outcomes**
 - Performance in the National Neonatal Audit showed year on year improvement within the trust. The trust was either in line with or better than other trusts and had clear action plans for improvement where audit results were not 100%. All action plans had re-audit dates to measure their effectiveness.
 - The hospital took part in The National Paediatric Diabetes Audit, which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and managed by the Royal College of Paediatrics and Child Health (RCPCH). Results from the audit showed The Alex performed better than other paediatric diabetes units in the South East, as well as paediatric diabetes units across England and Wales. The only area the hospital performed slightly worse than the England and Wales average was for their share of patients with glycated haemoglobin (HbA1c) under 58mmol/mol, that is the number of patients at risk of hypoglycaemia which is monitored by a blood test that measures the amount of glucose being carried by red blood cells in the body.
- The hospital took part in the Asthma in Children Clinical Audit. The audit looked at children presenting in A&Es around the UK with moderate or severe asthma and compared the findings against the clinical standards published by the College of Emergency Medicine (CEM) and Quality in Emergency Care Committee. The results from the audit showed on average The Alex performed better than other A&E departments taking part in the audit. However, it still did not meet all CEM standards. In response to this, the department implemented modifications to asthma pathways, sepsis action plans, initiated hourly Paediatric Early Warning Scores (PEWS) monitoring for patients with fever and modified systems to clearly show vital signs.
- Hospital Episode Statistics from September 2014 to August 2015 showed emergency readmission rates within two days of discharge were slightly higher and therefore worse than other trusts in England. However, it also showed the rate of multiple (two or more) emergency admissions within 12 months among children and young people with asthma, epilepsy and diabetes was much better than the national average.
- Children and young people with allergies were well supported by a weekly allergy clinic where patients could receive skin prick testing for diagnosis. The progress of patients with complex allergies was monitored at monthly joint dermatology and paediatric clinics and the hospital was part of the Safe Food Challenge where food allergies could be safely tested and protocols shared.
- **Competent staff**
 - The ED saw attendances of more than 24,000 children a year, and the hospital had employed consultants with sub-specialty training in paediatric emergency medicine. This was in accordance with Royal College of Paediatrics and Child Health standards, as set out in Standards for Children and Young People in Emergency Care Settings.

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- Staff were supported to develop competencies through the use of study days. For example, the hospital worked with the Barcelona Medical Agency to pioneer non-invasive ventilation practices. Two physiotherapists had been trained to use the Ponseti Method, a method for treating clubfoot, which is nearly 100% effective and is considered the gold standard in clubfoot treatment.
- Staff on medical wards spent their first two weeks as supernumerary, received a competency based teaching programme which required signing off and had a senior member of staff act as a mentor. On the Trevor Mann Baby Unit staff were given a four week orientation on supernumerary working with two supporting staff. After orientation staff received training from a specialist mentorship trainer who focused on developing specific skills. All new staff members we spoke with stated they felt very supported by their teams.
- Health Care Assistants (HCA) in all parts of the hospital advised us they were supported in their development. In the ED three HCA's were working towards their nursing qualifications.
- Staff advised us they were supported to develop their understanding through training initiatives. We were given many examples where staff had undergone or were currently undergoing training that was beyond their band level. Staff advised us they appreciated the opportunity to develop and it provided them with examples of accountability that enabled career progression. For example, in A&E, HCA's received competencies in inserting cannulas (putting a tube into a patient's vein so that infusions can be inserted directly into the patient's bloodstream).
- Appraisal rates for children and young people's services from April 2015 to January 2016 were 100% for administrative and estates staff, 75% for nurses and midwives and 50% for scientific, therapeutic and technical staff. At the time of inspection the Trevor Mann Baby Unit had a 100% appraisal rate for nurses as the department used a system where band 7 nurses were allocated to appraise band 6 nurses, band 6 nurses appraised band 5 nurses and so on.
- **Multidisciplinary working**
- Multidisciplinary working was embedded throughout children and young people's services. We witnessed effective communication between a registrar and a nurse where the registrar asked the nurse's advice about the insertion of a long line (the insertion of a tube into a baby's vein to provide nutrition when a baby's intestine is not yet working). The registrar listened to the nurse's suggestions and together they made a plan to ensure the procedure was completed effectively and as quickly as possible to reduce discomfort to the child. More than one member of staff advised us the relationship between doctors and nurses was very strong and that there was mutual respect for each profession.
- Allied health professionals supported the wards according to demand for their services. Physiotherapists attended wards regularly, occupational therapists were involved with discharges and speech and language therapists and dieticians could be contacted when required via telephone.
- Dieticians worked closely with ward staff, including the gastroenterology nurse and nutrition nurse specialists, parents and the Children and Adolescent Mental Health Services (CAMHS) to support the dietary needs of children and young people. The multidisciplinary team agreed meal plans, which were reviewed daily to check the dietary requirements of patients with eating disorders.
- CAMHS attended all multidisciplinary meetings where a child or young person had an eating disorder and/or repeat admissions. They would also be involved in best interest meetings where there were concerns for the mental health of a child or young person, or where an adult with mental health issues was admitted who had a child.
- Ward rounds took place three to four times a day. This included the night staff on the ward handing over any cases where there were concerns about the condition of a baby in the late evening and any possible admissions. Daily handovers were attended by a wide range of disciplines, including play specialists who planned focused play sessions depending on the needs of the child.
- Nursery nurses on the Trevor Mann Baby Unit supported kangaroo care, a method of caring for a premature baby in which the infant was held in skin-to-skin contact with a parent for as long as possible each day, and other skin-to-skin support to parents of babies.
- The hospital worked closely with charities to provide multidisciplinary care. For example, Crohn's and Colitis UK, Young Epilepsy, Amaze, Early Birth Association and

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Wishing Well. The hospital had close ties to Rockinghorse Children's Charity, which supported the hospital in obtaining equipment, facilities and activities for children.

- The adolescent and transition nurse supported adolescents moving from children's to adult services. The role was patient focused but also available as a resource for families and staff. All adolescents received a Ready, Steady, Go Transition Plan to support transition from children's to adult services. The plan enabled adolescents to check their understanding of health issues such as self-advocacy and managing emotions. It gave them the opportunity to access more information or help if they did not feel confident in a particular area. This supported adolescents and enabled them to be confident in taking control of their own health when moving into adult services.
- Staff worked closely with outside agencies such as the police and social services. Staff described a patient who had been in hospital for a year and was ready to return home but had problems bonding with their family. The hospital worked closely with social services to monitor the progress of the child and ensure both the child and family were ready for the return home.
- **Seven-day services**
 - CAMHS were available on site seven days a week from 9am to 5pm.
 - The high dependency unit outreach team responded to children across Brighton and Sussex University Hospitals Trust and consisted of two nurses available Monday to Friday 9am to 5pm.
 - The ED had access to an out of hours GP.
 - Physiotherapists provided a weekly drop in session for health visitor referrals, as well as weekly hip assessments to children in the community.
 - A play specialist was based in the ED Monday to Friday from 9am to 5pm to support the team. Outside these hours staff could call on The Alex's main play specialist team.
- **Access to information**
 - There was a pager system in place to allow staff to contact senior nursing staff for advice and support. Play specialists were also contactable by pager if they were required to assist in providing distraction techniques, or to calm a patient.
 - We checked over 30 policies at The Alex, all were in date and followed nationally accredited guidelines. Staff knew where to find policies, which were available on the intranet and easily accessible. There were systems in place for ensuring that policies were reviewed following changes to national guidance.
- Electronic recording systems allowed staff to access patient specific data readily. Staff encouraged the use of personal child health record, also known as the Personal Child Health Record (PCHR) or 'red book', which is a national standard health and development record given to parents at a child's birth. The PCHR is the main record of a child's health and development and was updated each time the child was seen in a healthcare setting.
- A computer system was used to plan discharges and transfer patient data to GP's and other tertiary centres. Robust protocols were in place to ensure safe and effective transfer of information.
- **Consent**
 - All staff we spoke with had a good understanding of legislation and procedures around consent. They could describe Gillick competency. We observed staff informing patients of the type of procedure they required and explaining what the procedure entailed prior to gaining consent.
 - An internal audit showed there had been improvements in the number of completed consent forms in patient notes, a reduction in the use of abbreviations on consent forms and an increase in noting the benefits and risks of a procedure. This meant the hospital was implementing learning from its audit results to ensure staff gained consent in accordance with best practice methods.
 - There were detailed policies in place regarding consent to examination or treatment and included a section detailing parental responsibility and the assessment of Gillick competence for staff to reference.
 - There were separate forms for young people aged 16-18 who were consenting to surgical procedures, which adhered to Gillick principals.

Services for children and young people

Are services for children and young people caring?

Outstanding



We rated the children and young people's services at the Brighton and Sussex University Hospital NHS Trust hospital as outstanding for caring.

This was because:

- Staff at all levels were strongly motivated to provide the most reassuring and compassionate care to both patients and their families, including siblings, and demonstrated a passionate commitment to this.
 - Staff used highly innovative ways to ensure that the views of children were always heard and made use of this to develop the service in ways which greatly improved the child's experience. They showed determination and creativity to overcome obstacles to delivering care, particularly for children and young people receiving end of life care. People's individual preferences and needs were always reflected in how care was delivered.
 - Parents were unanimous in their praise of the service and reported that staff went "the extra mile" to support them as well as their child in a manner which exceeded their expectations and previous experience of other services.
 - Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between the children and young people who used the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.
 - Parents told us that staff took the time to ensure that they understood what treatment their child was receiving, and that staff involved the child as far as possible. In every area of the hospital, we saw staff speaking to parents and children with the greatest respect and care.
 - Parents were considered to be active partners in their child's care, and staff took care to ensure that the individual needs of both patient and families were met. This was particularly visible in the end of life care where staff consistently went out of their way to ensure that both patients and families were emotionally supported and their needs met. Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account when planning and providing care.
- **Compassionate care**
 - Throughout our inspection, on the wards, in outpatients, the children's ED and in the neonatal unit (TMBU), we observed patients and families being treated with care, compassion and understanding. The parents we spoke with praised medical and nursing staff for the way they communicated with them and we were repeatedly told that "the doctors and nurses go beyond the call of duty in their caring" for their patients. Parents told us that they felt staff cared for them as well as their children; one commented on "how they encouraged me to eat when I needed to".
 - All the parents we spoke with told us they were very happy with the care their child was receiving, saying they felt "safe" and that the service was "absolutely fabulous". The inspection team observed examples of compassionate caring by staff throughout handover. We found that the 6 C's used by the NHS in Britain were embedded in ward culture: Care, Compassion, Competence, Communication, Courage and Commitment. One parent in the medical ward told us, "It's a shame that every hospital is not like this one."
 - Patient and family feedback was obtained through the Friends and Family Test (FFT), using both hard copy and a text system. To the core FFT question, "How likely are you to recommend our ward to friends or family if they needed similar care or treatment?" 100% of respondents said they were either 'likely' or 'very likely' to do so.
 - In the Children's Survey (2014), the trust scored similar to other trusts for all but one of the 36 caring measures. The results showed The Alex to be better than other trusts for the question related to being told about what would happen during an operation or procedure.
 - The Alex also had its own Children and Young People's Friends and Family Questionnaire using the monkey imagery. The results from February 2016 showed that the parents who responded consistently described the staff as compassionate, kind and helpful. Parents commented on how they were given comprehensive advice on what to do and telephone numbers to call for help if needed when their child was discharged.
 - Patient feedback was obtained through the innovative 'Tops and Pants' scheme where children could write positive feedback on cut out paper tops, and negative

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feedback on cut out paper pants. These comments were then laminated and displayed around the wards on a washing line. The majority of these were praising staff for their kindness and care.

- In the TMBU, a band 6 managed end of life care with chaplaincy support. Staff helped parents to create memory boxes, taking photos and doing hand and foot prints. Parents were allowed to spend as much time as they wanted with their baby.
- The March/April edition of the trust staff newsletter Talkback, described one couple's experience of the TMBU and how the compassion shown by staff helped them to cope. The parents wrote: "TMBU helped us greatly when our babies [...] passed away. They gave us time and space to dress them and the staff were so caring, they still spoke to the children like they were children, which was so human and so touching... We love them dearly; they helped us through the darkest period of our lives".
- Parents were unanimous in describing the care in the neonatal unit as excellent, telling us that nurses explained everything before completing tasks and doctors fully explained progress and changes in their baby's care. Parents described staff as being like "a family" to them, and told us they could trust them and rely on them to look after their baby. Parents told us how they had been encouraged to get involved with care, taught by staff how to hold their babies, wash them and change the nappy. Mothers said they were encouraged to express breast milk and helped with this by staff. We saw good care of a mother by night staff who took the baby for winding and helping to sleep so that she could rest.
- The Child Patient Safety Quality Forum had awarded rosettes to the teams on level 9 and in the HDU to thank them for the end of life care provided to children and their families.
- **Understanding and involvement of patients and those close to them**
- We saw good interactions between consultants and child and parent. We observed a visibly good relationship between a parent and a nurse, with them laughing and joking, and discussing the patient's care. We observed good communication between parents, doctors and nurses, including times when medical staff had to explain uncertainties to parents.
- Parents told us that staff kept them informed of their child's progress in a way that they could understand and that staff supported them throughout, sharing information clearly and discussing their care plans. We saw evidence in patient records that medical staff had discussed the care plan with parents. Parents told us they felt included in the care plan and were able to ask questions if they did not understand something.
- Breastfeeding mothers told us staff ensured they had food and drink and supported them in breastfeeding.
- Parents also told us that staff took the time to ensure that where appropriate, their child also understood the need for treatment and felt included in the care plan.
- In the TMBU, parents told us that they were taken on a tour of the ward when their baby was admitted and that the same nurse was allocated to them for the first few shifts. This enabled staff to build a relationship with the parents and to gain a better understanding of the child's needs.
- Parents told us that the consultant would give them regular updates on their child, especially after they had been away for a few hours to rest. They told us how much they appreciated this.
- Parents told us how the matron had organised accommodation for them, a nurse had explained their baby's medications and offered counselling support, and described it as "a scary time but everyone has been so kind".
- Staff told us that they encouraged siblings to be involved in aspects of basic care on the unit and we observed a nurse encouraging a sibling to draw a picture for a baby which the nurse then put on the outside of incubator facing in towards the baby.
- We saw evidence of staff understanding the importance of parent involvement at handover when a nurse handed over information about parents visiting and said, "Please don't change his nappy before 9pm as mum is coming back and would like to do it."
- On the surgical wards, we saw a leaflet with information for parents about bringing their child in for surgery, what to bring and what to expect. This was given to parents when they attended for a pre-admission visit one week before surgery for assessment so that a nurse could talk through the procedure with both the child and family. The nurse then took them on a tour of the ward so they could see where they were going to be and gave them the brightly illustrated booklet, *Monkey Has An Operation*. The aim of the visit was to make friends with

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the family and give them confidence about the procedure. On the day of operation, if possible, the child would be admitted by the same nurse. Staff made use of this visit to identify any particular needs the child may have so that they could be fully prepared when the child attended for surgery.

- An example given by staff was of a child with a learning disability who was very interested in trains, so nurses prepared his room in advance by putting lots of trains in it for him before he arrived. This meant the child could focus on his interests and not worry about the hospital and surgery.
- On the medical wards, we observed staff going down to the child's level when speaking to them to discuss what the procedure was, what they were going to do before doing it, and asking the child for permission. Conversations were kept at a low level, we noted that staff didn't use medical terminology when explaining procedures to parents, and saw that staff took time to play with patients and interact with parents. All parents told us that they knew which nurse was looking after their child, and all said the consultant had introduced themselves to them.
- We were given several examples of how well staff understood and involved patients and families in end of life care. A female staff nurse took a 19 year old end of life patient to his school ball so he could attend with medical support and have "a glamorous date". An older child wanted to be able to die on the balcony looking out at the sea, and staff arranged it so they could do this. TMBU parents wanted their baby to be allowed out of hospital so they could sit on the beach with the baby as they died. Nursing staff and the chaplain arranged for this to happen with their support. In the HDU, we talked to music therapists and learned how they helped in the end of life care of a child in HDU, both by playing music to the child on the ward and by playing at the funeral.
- In outpatients, parents told us that they felt involved in care, and that information was easily presented by medical staff so they could understand. One parent told us how they had seen how medical and nursing teams communicated well with each other. In the community nurse team, we were told that care plans were signed off by parents and reviewed with them every visit. Our inspectors saw notes that indicated this was the case. All the families we spoke with were positive about the

care their child received, describing staff as "always kind and helpful". The diabetes clinical nurse specialist won the 2015 Trust Exceptional Care Award nominated by families and colleagues.

• **Emotional support**

- Staff demonstrated an understanding of how both parents and children were affected emotionally by the need to spend time in hospital, and they ensured that support was available to reassure parents and calm patients. We saw that the pre-admission assessment included asking if the child had a particular toy or comforter that they would like to bring with them.
- The Health Passport for children and young people which is in use throughout The Alex includes questions on 'what things could make me anxious' and 'things that make me feel safe and comfortable'. We observed staff speaking in a kind and warm manner to patients and observed a nurse walking alongside a patient and reading to them to reassure them as they were going into theatre.
- The play therapy team came to the wards to work with patients around anxiety and distress, and helped to prepare them for procedures. Patients were also able to go to the play centre on level 10. Music therapists visited the wards each week and could work with patients to reduce anxiety and help them cope with the emotional aspects of being in a hospital.
- There was a nominated chaplain dedicated to The Alex who visited once a week and could be called to offer support whenever needed outside this time. The chaplain worked as part of a multi-faith team, which was open to all patients and their family regardless of whether they held a religious belief.
- Staff explained how the team "pulls out all the stops to get it right" when looking after a dying child. The chaplaincy service provided support to patients, family and staff.
- Volunteers also played a part in providing support for patients and their families. A church group made cakes for parents (as on all in-patient floors at the RSCH) and brought them to the ward every week, whilst in the PRH neonatal unit, a volunteer brought tea and cakes twice a week.
- In the TMBU, senior staff acknowledged that caring for a child with a life-limiting condition was particularly stressful for staff. Following the experience, the member of staff was offered support and counselling, as were the

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parents. Emotional support was provided to parents by the whole multi-disciplinary team, with staff taking the time to talk to parents and reassure them about the care their child was receiving.

- There was a counsellor attached to the unit to provide support for parents.

Are services for children and young people responsive?

Good



We rated the children and young people's services at the Brighton and Sussex University Hospital NHS Trust as good for responsive.

This was because:

- The service was tailored to meet the needs of individual people and was delivered in a way to ensure flexibility, choice and continuity of care. There were numerous examples of where the needs and preferences of children and young people were central to the planning and delivery of tailored services. Of particular note were children's facilities including the sensory garden, the adolescent sensory room in the ED and the play centre.
 - The support mothers received to encourage breast-feeding was also an example of outstanding practice. The hospital had an initiation rate of 91%, which was in the top ten in the country and the best in the South East.
 - Services were flexible, provided choice and ensured continuity of care.
 - The involvement of other organisations and the local community was integral to planning and ensured services met the needs of children and young people. The hospital's work with the Wishing Well charity and regular support sessions for patients and families with Crohn's, epilepsy and special educational needs were exceptional examples of the commitment to responding to the needs of children, young people and their families.
 - Integrated person-centred pathways were developed with other providers that ensured the holistic needs of children and young people were met through shared working and information sharing.
 - Patients and families could easily complain or raise a concern and were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with. Complaints and concerns were always taken seriously and responded to in a timely way. We were shown numerous examples of improvements that had been implemented as a direct result of complaints and concerns.
- **Service planning and delivery to meet the needs of local people**
 - Staff actively involved children, young people and families when planning and delivering services. For example, wards had a 'You Said, We Did' board displaying patient comments and showed examples of service changes as a result of the comments. The ED gathered comments on cut outs of clothing, with tops for positive comments and pants for negative ones and displayed them across the department. One comment stated that patients in the waiting area did not know how long they had to wait to be seen. A digital sign behind the reception desk had been installed showing waiting times and providing updates to services. However, the hospital did not differentiate between the views and opinions of children and those of adolescents.
 - We saw evidence the hospital was involved and engaged with local communities in planning services for children and young people. The hospital worked with local schools to promote children's understanding of health and exercise. Sessions helped understanding of medical issues present in classmates, increased knowledge of how to react in a crisis and provided a simulation environment for children to receive hands on experience. The physiotherapy team also provided after school Pilates sessions.
 - The Alex had monthly commissioning meetings where performance was reviewed, and review meetings were held following any serious incident to ensure that learning from the investigation was shared.
 - Staff actively involved children, young people and families when planning and delivering services. Staff worked closely with Chalkhill, a local inpatient unit at Haywards Heath, to develop pathways and treatment for children and young people with anorexia nervosa. Children and young people would be assessed and treated at facilities at Chalkhill and in tertiary and community care, which reduced the number of patients presenting at the ED.
 - The hospital supported families who were likely to spend long periods on site, by providing use of kitchens

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and separate bathroom facilities. Section 2.26 of the 'Department of Health, Health Building Notice 23, Hospital Accommodation for Children and Young People' states hospitals must provide onsite accommodation in order that at least one parent can stay with their child on a 24-hour basis. The hospital provided on ward bedrooms for families and additional fold up beds next to patients so parents could sleep next to their child. The hospital also provided accommodation for families at Ronald McDonald House Charities, which was not only on the trust site, but in the same building as the children's hospital. This meant if parents needed to visit their child at short notice, they would be a maximum of a few floors away. There was further accommodation provided by the charity in a separate house adjacent to the outpatients department.

• Access and flow

- Layout was effective in terms of use of space and efficiency. In the resuscitation area of the ED, staff had organised, compiled and stored emergency boxes containing all the equipment required for specific procedures, for example central line and arterial lines, therefore enabling staff to respond quickly to an emergency. On the Trevor Mann Baby Unit (TMBU), there was a neonatal intensive care unit tech room by the entrance to the ward. This enabled equipment to be quickly accessed when patients came onto the ward. There were also plans to open up a unit to make space for cots for a special care nursery. This allowed staff to monitor patients more easily and provided less cramped accommodation. Surgical theatres, the ED, medical wards and labour wards were located in the same building, enabling children to receive rapid access to all paediatric services.
- The TMBU was proactive rather than reactive regarding utilizing available space. Babies were triaged into three separate nurseries with the most unwell being located closest to the nurses' station and tech room. A fourth nursery was used when babies needed separation from other nurseries, for example during the swine flu epidemic.
- Wards had a mixture of communal bed bay areas and individual rooms with en-suite. All sleeping accommodation was separated into male and female only areas, and each communal area had its own bathroom facilities. This meant patients did not need to pass through an area used by the opposite sex. Parents

told us they were grateful that there were toilet facilities in the bay as it meant they did not have to leave their child to use facilities at the other side of the ward. Staff used Patient Led Assessments of the Care Environment assessments to monitor accommodation standards; we saw assessments and audit results.

- Adolescent beds were separated from the rest of the ward and patients stayed in single sex rooms from the age of 13 upwards. This met National Service Framework standards.
- In the outpatients department, paper referrals were received at the central appointment centre. Staff scanned them onto a computer system. Consultants accessed this system to triage referrals.
- The median length of stay for both elective and non-elective patients was in line with the England average. This meant patients did not stay unnecessarily long on wards.
- **Meeting people's individual needs**
- A patient access manager monitored referral to treatment times (RTT). At the time of inspection, all children and young people's outpatient clinics were meeting the 18 week RTT. Respiratory and allergy clinics had the longest RTT and in response to this, staff made the clinic available weekday evenings and weekends and an extra Paediatric Medical Consultant had been hired, allowing other consultants to support other clinics.
- Wards provided expressing rooms to enable mothers to breast feed in private. If these were in use, privacy screens were available for mothers to express by the bedside.
- Section 2.9 of the Department of Health Health Building Notice 23, Hospital Accommodation for Children and Young People states "Interior decor, artwork, furnishings and fittings should be carefully selected to reflect their needs. Many healthcare trusts now encourage young people to actively assist in the design of their own environments." At The Alex, adolescent patients had designed the graffiti mural wallcoverings in the adolescent rooms. Local art students were also involved in the design and creation of murals along hospital corridors and wards.
- The separate playrooms for children and adolescents were light and airy with a good selection of toys in the children's playrooms and a sofa, tv, dvd player and games consoles in the adolescent rooms. The play

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centre had an under the sea themed room with treasure chests full of toys and a bubble tank. There was also an interactive floor where fish swam around your feet and changed direction according to your footsteps. The sensory garden provided children and young people with a relaxing environment away from clinical areas. It was particularly beneficial for children spending long periods of time at the hospital, as it could be their only opportunity to be outdoors. Staff were proud of the adolescent sensory room in the ED, which was used to support children with behavioural issues. Coloured lights, a bubble tank, mirrors and a 3D tv were effectively used as distraction techniques and to calm agitated patients.

- On the medical ward, the adolescent room contained age appropriate information and advice leaflets for issues such as self-confidence, relationships and eating disorders. Storing information in an adolescent only room enabled young people to research accurate information in an environment that was safe, private and where they would not be disturbed.
- Information was provided in age appropriate formats, for example, there was a picture leaflet available called 'Monkey has a blood test' showing pictures and simple explanations of the entire process of having bloods taken. ED staff provided children with activity packs that included games, puzzles, colouring in pencils and facts about being in an ED that were age appropriate.
- All areas of the hospital provided information leaflets from recognised sources such as UNICEF and the Foundation for the Study of Infant Deaths and were relevant to the department.
- Staff responded to the needs of grieving families by creating bereavement boxes that included memento's such as a lock of hair and handprints and supported families to complete day-to-day tasks away from the hospital environment, such as supermarket shopping.
- Staff could describe the ethnic and religious diversity of the people who used their services and explained how they could make modifications to ensure they were culturally sensitive. Information leaflets were available in languages other than English in accordance with the local demographic. There was a private multi faith prayer room called the Oasis Room, which provided prayer books in 31 different faiths/denominations, as well as prayer mats and nearby washing facilities.
- Staff supported children and young people undergoing surgical procedures by giving them a tour of the theatre

beforehand. Parents were allowed to accompany their child to the anaesthetic room and children were encouraged to attend theatre by driving themselves to the surgical department in ride on electronic cars.

- There was disabled access to all on site facilities, staff were trained to use Makaton (a language programme using signs and symbols to help people to communicate) and there were posters around wards showing deaf patients/families how to get assistance quickly.
- Staff supported patients with learning disabilities and their families to be involved in the creation of their own unique 'passports', which included their full health history and background and followed the patient through the hospital system. The information was tailored to meet the patient's individual needs and improved staff understanding of patient needs.
- The outpatients booking system notified staff if a patient had a learning disability. This enabled staff to contact the play centre to arrange support for the patient whilst in the waiting area. Staff also contacted the medical library to book any required equipment and ensure availability for the appointment.
- Staff we spoke with recognised and understood how families could feel overwhelmed in a hospital setting where they may not have the same support network as at home, particularly those who had children with complex needs. Staff supported families by watching over children when parents needed a rest, and provided 1:1 cover when required.
- Nursing staff on the TMBU were allocated to support the same baby for as many shifts in a row as was possible. This enabled staff to build strong, supportive relationships with families. Staff also worked on all three nurseries meaning when the severity of a baby's condition decreased and they were moved to another nursery, parents still had access to staff they knew and trusted.
- We observed how the TMBU made use of previous patients' experiences with their families to support parents with a child in the unit now. We saw a wall of photos of former patients by the entrance to the unit with updates from their parents on how they were doing now, some even years later, encouraging parents of babies who were currently in the unit to see how things would get better.
- Staff met the needs of children and young people and worked with outside agencies to support holistic care.

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We viewed the work of the Wishing Well charity that visited the hospital, played instruments to sooth patients and provided pleasant hospital experiences and memories. We witnessed the charity play to a baby who was crying and saw the calming effect the music had on the baby's heart rate. Staff welcomed the sessions and said the music comforted not only patients but also parents and siblings and was particularly useful in communicating with patients with sensory impairment.

- Fish tanks were located in many waiting areas and pets as therapy dogs and donkeys made regular visits to the hospital. As patients' own family pets were not permitted in the hospital environment, the visits gave patients an opportunity to interact with animals. Evidence shows interacting with pets can be beneficial to physical, social and emotional wellbeing.
- The paediatric gastroenterology team held a family event at the trust in partnership with Crohn's and Colitis UK as an opportunity for families to meet each other, meet members of the team, gain information and ask questions. Feedback from the event included, "Lovely to meet the Crohn's and Colitis UK team and to speak to the doctors and nurses in a more informal setting" and "The Royal Alex has been fantastic in its support and care of our daughter."
- The hospital organised parental support and counselling sessions with local charity Amaze. Amaze provides information, advice and support to parents and carers of children and young people with special educational needs and disabilities. Session topics included support with completing disability allowance forms and Personal Independence Payment applications as well as individual support in preparing for adulthood.
- Young Epilepsy is the national charity for children and young people with epilepsy and associated conditions. The trust held regular parent learning sessions with the charity to discuss clinical understanding of epilepsy and ways schools and families can support the child. All parents who attended the sessions rated them as 5/5 stating, "I understand so much more about epilepsy now that I didn't before. I know so much about the effect on education and have arranged a meeting with school to discuss it" and "I have learnt so much from her over the past four sessions, and it certainly will be life changing for our family. Thank you very much".
- Parents with children on the TMBU were encouraged to contact The Early Birth Association, a support group set up by parents who themselves have had premature or sick babies in special care units. Members of the association regularly came to the unit to support parents on site, rather than parents attending an outside location.
- Staff supported children and young people affected by substance misuse by encouraging them to contact local services where they could receive specialised support, such as the CRI alcohol brief intervention service, an open access support and treatment for people with alcohol problems and the Brighton Oasis Project, a substance misuse service for women and families. Staff repeatedly told us of the close working ties the hospital had with RU-OK?, a local organisation specialising in supporting under 18 year olds with substance misuse.
- Every year the hospital organised a Christmas party at a location outside the trust where children and families met and enjoyed the festive season away from the hospital environment. Feedback from these events was overwhelmingly positive including, "So nice to see the children meeting up in happier circumstances," "I thought the whole party was fantastic, the effort was amazing" and "Thank you, lovely to spend time with no stress and worry."
- **Learning from complaints and concerns**
 - The hospital had a complaints policy and staff we spoke with knew how to access it. Staff felt the process was open and honest. Staff showed awareness of actions to take when concerns were raised. This included trying to resolve any problems at the time they were raised. Staff worked in partnership with children, young people and their families, which minimised the need for people to make formal complaints. If there were complaints, staff knew what to do and how to signpost people to the complaints procedure.
 - Staff in all departments could provide examples of learning and changes in practices and procedures due to a complaint. For example, in outpatients the parent of an autistic child who was having a blood test complained that staff had not prepared the child fully for the procedure. This led to staff introducing colouring books with pictures of equipment such as tourniquets to support learning and prepare children.

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- We reviewed complaints made between February 2015 and February 2016. Eight complaints had been made during this time. There were no discernible themes or trends.
- Parents advised us they knew how to make a complaint and information about how to make a complaint and how to contact the Patient Advice and Liaison Service was clearly displayed in all wards, outpatient waiting areas and in the children's emergency department.

Are services for children and young people well-led?

Good



We rated the hospital as good for well led.

This was because:

- teams had positive supportive managers and staff told us they felt respected and valued within their teams.
- There was clear evidence of dynamic and innovative leadership within the nursing teams.
- We saw numerous examples of innovative developments to improve the patient experience and patient care.

However, we also found:

- The vision and strategy of the hospital as a whole were not well communicated within the hospital and there was some evidence of teams working in silos.
- Links with the trust were limited with no non-executive director lead on the board and no formal mechanism for ensuring that the voice of children was represented at board level.
- The lack of robust data on mandatory training levels did not support the delivery of high quality safe care.
- Nursing vacancies meant that nurses in management roles were at times unable to fully complete the management side of their roles because of pressures to provide clinical cover.
- The 2015 staff survey showed that a large proportion of staff did not feel that senior managers tried to involve them in important decisions and that their feedback was not acted upon.

Vision and strategy for this service

- The Children and Young Person's service had been a separate directorate since September 2014. Before this, it was a specialist division within the women and children's directorate. The clinical director was keen to protect this and wanted the hospital to have more autonomy within the trust as a 'hospital within a hospital'. Staff had worked hard on creating a brand for the hospital and it was clear during the inspection that staff felt very proud to work "for The Alex".
- The Alex was aiming to be a district cardiology centre supported by the Evelina London Children's Hospital. It had developed trauma pathways and was a key part of the Sussex trauma network for children's ED. Staff in ED were aware of the vision for the service and had regular updates from the nurse consultant on developments and strategy.
- We saw a good strategic view of the day surgery service in future, with planning ahead for the next five to 10 years from consultants. Theatre staff and anaesthetists were involved in planning the introduction of a children's orthopaedic service. There were monthly management meetings and clear leadership with staff on the ward demonstrating an awareness of the service's vision.
- The lead consultant and acting matron in the neonatal unit described a forward looking strategy for the service. They organised an annual day out with the matron, obstetricians and others as needed to ensure that staff were involved and engaged with the development of the service. We saw the TMBU values displayed on the noticeboard at the entrance to the unit and the departmental strategy 2015/16 on the staff noticeboard.
- The Oncology unit was currently working as a region level 2 service and aspired to be level 3. It submitted a business case for additional resources to achieve this.
- The head of nursing described a clear strategy of developing nursing roles to build an Advanced Nurse Practitioner team to support the whole service, including an ANP neonatal led service at PRH.
- The hospital was working with primary care to help GPs to improve their skills in assessing and managing children and ensure that parents are aware of where to take their child if unwell.

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- Staff told us they felt that all staff were working to the same goal of caring for children identified with the values. However, staff were unsure how the strategy and vision for The Alex came to be written and described it as a very medically dominated service.
- We noted that all staff could explain the vision and strategy for their unit, but few could describe the overall strategy for The Alex with almost none of the junior staff able to describe the values, vision and strategy for the trust as a whole. We saw little evidence of engagement with the wider trust apart from email bulletins sent to all staff. Staff told us that they felt “very separate” from the trust.
- Although there was a draft policy on transition, we saw no overall embedded vision or strategy for transition from children’s to adult’s services.
- **Governance, risk management and quality measurement**
- Each area had a systematic programme of clinical and internal audit, participated in national audits and made effective use of audit results to improve performance and service quality. Specific metrics were used in each area to measure performance and identify areas for improvement, which were then shared with staff.
- There were monthly meetings on clinical governance throughout the hospital. Meetings for each of the four areas (paediatric surgery, neonatology paediatrics and orthopaedics and dentistry) were minuted and mostly well attended.
- The neonatal service risk panel reviewed risks within the TMBU and reported updates in the quarterly bulletin to all staff. This included alerts circulated by the regional sector.
- Paediatric risks were documented on the trust wide risk register and we saw evidence that these were being reviewed and updated regularly.
- However, there was no non-executive director children’s champion on the trust board and no annual report to the board on children’s services. There was no formal mechanism to enable the service to influence the board or to allow the board to know about The Alex’s performance. Senior managers were unable to explain how the voice of children’s services could be heard at board level.
- Although there were directorate meetings attended by the whole of the management team, including clinical leads, we saw no evidence of regular meetings between the triumvirate where strategy and performance could be reviewed. It was not clear how the strategy and vision for The Alex had been set.
- There was a lack of reliable up-to-date information from the trust on mandatory training figures which made it very difficult to monitor compliance on an individual level. The standards for key mandatory training courses were not being met and there was no evidence of an effective way of rectifying this. This meant that a large proportion of staff had not received up-to-date training on key areas which could affect the quality of patient care
- **Leadership of service**
- There was a clear management structure described as a triumvirate consisting of a clinical director, a head of paediatric and neonatal nursing and an operations manager. The operations manager was on leave at the time of the inspection. There were also clinical leads for each of the four areas within the hospital (paediatric medicine, neonatology, paediatric surgery, orthodontics and dentistry).
- The clinical director managed the operations manager and lead nurse. He had a nominal 1.5 programmed activities per week to carry out his management role, but this time was not ring fenced. The lead nurse managed the nurse consultant, the perioperative care manager and the neonatal matron. The operations manager managed the newly appointed deputy operations manager.
- The management structure of The Alex had changed with the removal of the overall matron post and the downgrading of another matron post. Whilst the clinical director told us that the removal of the matron post had not created a gap in nursing management, the views of nurses were very different. Nursing staff told us that this created a strain on other senior nurses and meant there was no nurse at an appropriate level with an overview of the whole service.
- There was a band 7 vacancy at the time of the inspection which was proving hard to fill because of a national gap in the workforce. This was impacting on other senior nurses who had to cover this post as well as providing leadership for their own service area.

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- We saw effective and supportive leadership in each separate area of the children's hospital, with staff able to describe their local leadership structure and speaking positively about the support they received from their manager.
- Staff in the TMBU described how they felt well supported by their leadership team and said team morale was high because of this.
- Staff in the ED spoke enthusiastically of their leadership team and said they were accessible and supportive. The managers promoted supportive relationships between different staff groups and staff explained that there was "no them and us" culture in ED with nurses and consultants.
- However, the senior management team, with the exception of the lead nurse, was not widely known throughout the service. Staff told us that they regularly saw the lead nurse on the ward and found her approachable.
- Nursing shortages meant that the band 7 nurses had to cover clinical rotas which stopped them from being able to fulfil their management role. One described their role as "having all the responsibility and no empowerment to make changes".
- Nurse meetings were held on a ward basis with no band 6 or band 7 meetings for The Alex as a whole. Multi-disciplinary team meetings were also held by service area and there was no structured opportunity for all staff across The Alex to meet together to share learning and improve practice.
- Junior staff we spoke with throughout the hospital were able to describe their own service with enthusiasm and knowledge but were not aware of developments or challenges elsewhere within The Alex.
- **Culture within the service**
- Staff pointed out that that The Alex was historically on a separate site, and it still maintained a separate identity from the main trust. Staff consistently described feeling as though they worked for The Alex, not BSUH, and told us they were proud to work for The Alex.
- Staff were passionate about providing excellent, holistic, patient and family centred care. The atmosphere in the wards was friendly and purposeful, with all staff working collaboratively to meet the needs of children and young people. Groups of nurses could be heard singing and chatting before handover.
- Staff told us they felt valued and appreciated within their local teams. Health Care Assistants in particular described the support and training they were given to develop their role and progress in a way they would not be able to in other trusts. We saw evidence that other staff had been supported in further study to improve patient care.
- We saw good working relationships between different staff groups with evidence of respect for each other's views at handovers. Staff were encouraged to delegate and ask for help with extra support available if needed. We saw a very strong nurse/doctor working relationship of mutual respect and cooperation regarding the insertion of a long line, with staff working together to achieve the best result for the patient.
- Staff described the support they received from their manager and their teams both in terms of their professional practice and their wellbeing, and said how this helped them return to work and cope with challenging patients. Staff were informed of secondments and other opportunities to develop.
- Some staff reported a culture of bullying in the wider trust and pointed out that this also included The Alex. In the staff survey 2015, 32% reported harassment, bullying or abuse from other colleagues compared to 21% for the trust average. Staff told us they felt under pressure to cover vacant shifts in different departments and we were told "I don't think you can raise a concern without repercussions".
- Commitment to the service and the care of children could be experienced as a pressure. In the staff survey, 58% felt pressure from colleagues to come to work despite not feeling well enough (compared to 29% for the trust average) and 100% reported that they "put myself under pressure to come to work despite not feeling well enough". Both these scores were the worst of all localities in the trust.

Public engagement

- We saw several examples of effective public engagement across the service.

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- There was a parents' group in the diabetes service which worked around fundraising and education. Diabetes nurses worked with children's services across schools in Brighton and Hove to educate and inform.
- The epilepsy Clinical Nurse Specialist was setting up a programme for school nurses with e-learning and follow up sessions.
- The neonatal service ran a parents' forum to obtain their views and ensure that the service best met their needs.
- The respiratory team had a stall and ran a discussion at the Brighton Fringe Festival last year on the theme "Every child is different".
- The hospital commissioned 'Right Here', an innovative mental health and wellbeing project in Brighton led by volunteers aged 16 to 25, to review their service. The project used the Department of Health's 15 Steps Challenge tool (a tool developed from a parent saying, "I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward"). As a result of this, they changed posters on display and colours used on the wards.
- Parents of patients in oncology and epilepsy had social media pages and assisted the teams in recruitment by sitting on interview panels
- The Alex works closely with the Rocking Horse Charity which is the official fundraising arm of the Alex. The charity supports the Alex, the Trevor Mann Baby Unit and the Special Care Baby Unit at the Princess Royal Hospital in Haywards Heath. The charity has raised thousands of pounds for the services and has recently helped to fund cardiac monitors for the children's ED, the sensory garden and the new trauma room in the ED.
- **Staff engagement**
 - We saw communication boards and post boxes in staff areas which invited staff to comment on departmental plans either openly or anonymously.
 - There was evidence of some staff groups (for example, the weekly day surgery updates) having regular meetings and getting information on service developments, but it was not always clear what mechanisms existed for staff to feedback to managers and have an input. In the staff survey 2015, 21% reported that they were not involved in deciding changes that affected their work and 53% said that senior managers do not act on staff feedback.
- Whilst most staff were confident about raising concerns, others expressed doubts about the openness of the service, with one telling us, "I don't think you can raise a concern without repercussions."
- In the staff survey, medical engagement scored less well than expected; we were told that staff do not identify with the whole trust and so responded negatively on the engagement questions.
- In the 2015 staff survey of children's services, the results on two measures were significantly better than the average for the trust: only 5% said they had not had an appraisal in the last 12 months (compared to 17%), and only 16% said their team did not often meet to discuss their effectiveness (compared to 33%).
- The staff survey also produced results which were worse than the trust average: 47% said that communication between senior management and staff is not effective, and 63% said that senior managers do not try to involve staff in important decisions.
- **Innovation, improvement and sustainability**
- The TMBU demonstrated good innovation in training and using advanced neonatal nurse practitioners in response to dwindling numbers of middle grade doctors.
- In response to increasing stress around the trust, the TMBU developed a 'Mind clinic' to provide mental health support funded by Early Birth Association in worktime.
- A business case had been approved by commissioners for an integrated community based CNS/ED nurse to work with GP clusters, to have nurses rotating through ED and supporting education for GPs around acute care pathways for children. This would help to ensure the most appropriate and effective management of children attending a GP practice.
- New sedation guidelines had been developed in the ED with the installation of piped nitrous oxide for the management of serious injuries that do not require surgery. A nurse could give a patient with a musculoskeletal injury or a specific wound nitrous oxide at 70% (instead of usual lower dose of 50:50). They could then complete the procedure under sedation and

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wake the patient up. Feedback so far had been wholly positive but it was too soon (three months) for a full evaluation to have taken place. Patients said they found it “brilliant” because they could recover immediately and leave very shortly after instead of having to go into recovery room and wait. Initial findings showed that it was less distressing for parents and patients, meant the child did not require an overnight stay and reduced strain on theatres by reducing number of procedures required. There were very clear exclusion criteria and a comprehensive risk assessment before use, with resus facilities on site if needed to ensure safe practice.

- A missed fracture policy had been introduced to reduce the risk of staff missing a fracture on an x-ray. The staff member who ordered an x-ray (nurse practitioner or doctor) received the report electronically and had to enter what they viewed. The next day their comments

were reviewed by the radiographer who compared documentation with their own findings. If a fracture had been missed, they contacted the consultant and the patient was recalled immediately. This had been in practice for two months and would be audited.

- There was a concern about the relationship with the Rocking Horse charity which had provided funding for several innovations in The Alex. The Alex had to follow trust procurement procedures even though the planned purchases which would be paid for by the charity. This was causing prolonged delays in the actual purchasing of equipment and causing difficulties for the charity. Because of this, it had been raised as an issue of concern in the quarterly report for directorates in January 2016. According to the report, there was a fear that the need to follow trust processes could affect future funding.

End of life care

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

Information about the service

Brighton and Sussex University Hospitals NHS Trust end of life care was trust wide and led by two members of the executive team, the director of nursing and the medical director. Teams across a variety of directorates were involved in the provision of end of life care. These included the specialist palliative care team, ward staff, a non-clinical end of life care facilitator, bereavement office, mortuary, porters, chaplaincy, discharge team, critical care outreach team, resuscitation team, medical examiner and organ donation team.

The specialist palliative care team was made up of a multi professional team of health care professionals, supported by patient pathway coordinators and administrative staff. They operated a service Monday to Friday 9am to 5pm. Out of hours consultant telephone advice was available from the local hospices. The palliative team delivered palliative services to all clinical areas across the hospital and worked cohesively with all areas of the hospital involved in the care of patients who were on the end of life care plan.

At the Royal Sussex County Hospital location we visited a variety of wards across the hospital including wards: Vallance, Chichester, Jowers, Trafford, Intensive Care Unit, Egremont, Level 9a, Solomon, A&E, Howard 1 and Overton. We also visited the Patient Advice and Liaison (PALS) office, bereavement office, and the mortuary and hospital chapel and prayer room. We reviewed the medical records and drug charts of 10 patients at the end of life and 30 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records.

We spoke with and observed the care provided by medical and nursing staff on the wards. We spoke with two patients receiving end of life care and one of their relatives. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital and trust.

End of life care

Summary of findings

Overall we rated the end of life care service at the Royal Sussex County Hospital good for safe, caring, responsive and well-led and requires improvement for effective.

The duty of the inspection was to determine if the hospital had policies, guidelines and training in place to ensure that all staff delivered suitable care and treatment for a patient in the last year of their life. The hospital provided end of life care training at induction for staff and an ongoing education programme which was attended by staff. A current end of life care policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.

The specialist palliative care team were a dedicated team who worked with ward staff and other departments in the hospital to provide holistic care for patients with palliative and end of life care needs in line with national guidance.

The Royal Sussex County Hospital and its staff recognised that provision of high quality, compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team, end of life care guidelines and an education programme.

The palliative care team was highly thought of throughout the hospital and provided support to clinical staff. The team worked closely with the end of life care facilitator to provide education to nurses and health care assistants. Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals.

The majority of end of life care was provided by clinical staff on the wards. The palliative care service worked as an advisory service seeing patients with specialist palliative care needs, including those at the end of life.

Staff at the hospital provided focused care for dying and deceased patients and their relatives. Most of the

clinical areas in the hospital had an end of life care link person. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.

Staff in the mortuary, bereavement office, PALS and chaplaincy supported the palliative care teams and ward staff to provide dignified and compassionate care to end of life care patients and their relatives.

Medical records and care plans were completed and contained individualised end of life care plans. Most contained discussions with families and recorded cultural assessments. The DNACPR forms were all completed as per national guidance.

There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. These referrals were seen and acted upon promptly.

The trust had an advance care plan which supported a patient to develop their wishes and preferences. The plan could be located in the patient's health record on admission and was accessible to the out of hour's community service.

The trust had a Rapid Discharge Pathway (RDP) and the documentation for this process was available on the end of life care intranet site which staff could access. The discharge team worked closely with the specialist palliative care team and coordinated the discharge of end of life care patients across the trust. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.

The trust had a multi professional end of life steering group that oversaw the improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also meeting the National Institute of Health and Care Excellence's (NICE) end of life guidance.

The end of life care service had board representation and was well led locally. This had resulted in a well led trust wide service that had a clear vision and strategy to provide a streamlined service for end of life care patients.

However:

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- We found there was not a specific cleaning schedule and procedure for cleaning of the mortuary as per national guidelines.
- Portering staff did not receive a specific training programme with appropriate updates for transfer of the deceased to the mortuary, as per national guidelines.
- The trust was not meeting the requirements of three key performance indicators of the National Care of the Dying Audit 2014. In their response to the audit in the End of Life Audit- Dying in Hospital 2016 the trust was worse than the national average for two areas.
- There were inconsistencies in the documentation in the recording of spiritual assessments, Mental Capacity Act assessments and recording of ceilings of care (best practice to guide staff, who do not know the patient, to know the patients previously expressed wishes and/or limitations to their treatment) for patients with a DNACPR.
- Patients did not have access to a specialist palliative support, for care in the last days of life in all cases, as they did not have a service seven days a week.

Are end of life care services safe?

Good



We rated the end of life care service at Royal Sussex County Hospital good for Safe.

The trust provided us with the incidents relating to end of life care at the hospital with evidence of learning achieved and the resulting changes in practice that took place. The trust used an electronic incident reporting system. Staff gave us examples of how they reported incidents and the feedback they received. Staff informed us that they were encouraged to report incidents to enable learning as an organisation. Incidents relevant to end of life care were not addressed at the end of life care steering group.

There were robust systems and processes to ensure that a high standard of infection prevention and control were maintained on the wards. Staff in all departments could show appropriate hand hygiene and complied with the trust's policies and guidance on the use of personal protective equipment. Syringe pumps (a device which helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin) were readily available across the trust to support end of life care patients. Staff reported they did not have any problems with obtaining them when required.

We reviewed 10 medical records and care plans of end of life care patients. We observed the appropriate prescribing of medication for patients who were end of life. The palliative care team documented changes in patient care needs and the management of their medications in the records.

We saw the documentation used in the mortuary for recording patients details and the bereavement officers explained the systems to process death, burial and cremation certificates.

The trust had a programme of end of life care training at induction for all staff in line with recommendations by the National Care of the Dying Audit 2014.

However:

- Portering staff did not receive training for transfer of the deceased to the mortuary as per national guidelines.

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- The mortuary was visibly clean but cleaning schedules and procedures were not being adhered to as per national specifications for cleanliness and environmental standards.
- **Incidents**
- The trust had an incident report writing policy and used an electronic incident reporting system. Permanent nursing and medical staff, porters, mortuary and administrative staff gave us examples of how they reported incidents and they received feedback. There is an area on the trust website for lessons learnt which staff can access individually or for discussion at team meetings. Staff told us the trust encouraged them to report incidents to help the whole organisation learn.
- There were no 'never events' reported by the trust about end of life care from December 2014 to January 2016. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Trust wide, 52 serious incidents (SI) were reported from January 2015 to January 2016. There were four incidents with the words death, dying or died within them or were categorised as relating to patient death. Two of these were at the Royal Sussex County Hospital. One related to a child death in critical care and was an infection control incident. The other was in medicine regarding the delay of treatment. Both the incidents showed key findings and lessons learnt.
- Trust wide, 38 incidents had been reported related to end of life care from February 2015 to January 2016. Fifteen incidents were recorded as 'low impact' and 23 incidents 'no harm, impact not prevented'. Sixteen incidents recorded action taken and nine incidents recorded 'lessons learnt'.
- Twenty incidents were reported by the mortuary. Nineteen were about incorrect or missing patient information on the body when transferred to the mortuary.
- Thirteen incidents were reported by the wards. Five were medication errors and four were about staffing levels for end of life care patients.
- Minutes seen of the end of life care steering group did not show that clinical incidents were discussed and actions identified.
- Staff told us monthly Trust Mortality Review Group meetings were in place. These were attended by members of the multidisciplinary team, including pharmacy, medical and nursing. Action points were recorded at the end of each meeting and learning points discussed.
- Staff were able to describe the rationale and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The trust apologised and informed people of the actions they had taken.
- **Cleanliness, infection control and hygiene**
- We saw ward and departmental staff caring for patients on the end of life care plan complying with the trust's policies and guidance on the use of personal protective equipment (PPE). We observed staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.
- The trust had a policy for the management of a patient's body following their death with a suspected or confirmed infection. This had clear guidelines about the potential risk from body fluids and specific advice for portering staff when transporting a body.
- We observed there was PPE for use by staff handling deceased patients in the mortuary.
- We observed that all areas of the mortuary, including the viewing area were visibly clean. However staff told us that housekeeping services do not clean the mortuary and this was done by the mortuary staff on an 'as required' basis. They did not document when they did this. This meant the mortuary was not cleaned as per national legislation.
- The National Specifications for Cleanliness in the NHS by the National Patients Safety Agency and the Human Tissue Authority (HTA) standards of practice relevant to mortuaries define the cleaning regimes required by mortuaries. The HTA premises, facilities and equipment standards PFE2 state: 'environmental controls are to be in place to avoid contamination with documented cleaning and decontamination procedures and documented cleaning schedules and records of cleaning and decontamination'.

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- The hospital provided us with the results of two housekeeping audits of the mortuary. The audit in October 2015 audited three areas. The results showed that estates responsibility was 100% and housekeeping responsibility 87.5% with a total achievement of 88.6%. The audit in February 2016 audited seven areas. Estates and nursing responsibility was 100% and housekeeping 94.3% with total achievement of 94.3%. However the audits were not robust as they had been completed by an unaccompanied member of housekeeping staff and were not countersigned by a clinical auditor.
- **Environment and equipment**
 - We saw and were provided with the up to date servicing and maintenance records for all the equipment used in the mortuary.
 - Syringe pumps were maintained and regulated by the equipment services and stored in the equipment library. Staff told us these were easily available.
- **Medicines**
 - The trust had a policy for the safe and secure handling of medicines. The policy ensured that medicines were prescribed, stored, administered and managed safely according to current best practice.
 - There was trust wide guidance for the administration of medicine using the appropriate syringe pump which fulfilled the safety guidance by the National Patient Safety Agency Rapid Response Report (2010). The syringe pump is a portable battery operated device to help reduce symptoms by delivering a steady flow of injected medication continuously under the skin. It is useful way of delivering medication for an end of life care patient when they are unable to take medication orally.
 - All registered nurses and medical staff received training about the safe use of medication for an end of life care patient and prescribing anticipatory medication. The prescribing of anticipatory medication is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. A patient discharged with 'Just In Case' medication would allow qualified staff to attend and administer medication which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital. All patients on an end of life care plan were discharged from hospital with 'Just In Case' medication which ensured that streamlined care was maintained.
- Across the wards, we reviewed 10 medication charts for patients who were receiving end of life care. The charts we observed showed that appropriate medications had been prescribed as stated by NICE Quality Standards guidelines for anticipatory medication. This ensured that end of life care patients received timely and appropriate care.
- The trusts 'Care of the Dying Person' and 'symptom observation chart for the dying patient' contained clear guidelines for symptom management for patients at the end of their life. The guidelines were comprehensively set out and presented in an easy to follow manner. Practical guidance was provided for the use of syringe pumps including set up and drug advice. We spoke with medical and nursing staff who were able to show us the guidance which was available on the intranet and in all ward areas.
- **Records**
 - All palliative care records were hand written and managed in line with trust policy.
 - Patients receiving care from the specialist palliative care team had their documentation updated when reviewed. This gave information around changes in patient care needs and medicines management. Staff on the wards then implemented the changes required, such as applying a syringe pump or changing medication. We observed that the palliative care team provided a holistic assessment on their first visit to a patient and subsequent visits were documented in the patient's medical notes.
 - The trust had a 'symptom observation chart for the dying patient'. This assisted healthcare professionals in assessing and managing physical symptoms in dying patients. Its aim was to support the provision of consistently high quality care tailored to dying patient's individual needs in the last few days or hours of their life. The chart gave clear guidelines for nursing staff to assess the patient every four hours and escalation prompts as required. Staff told us the chart was user friendly with helpful prompts.
 - Across the wards we visited we reviewed 10 medical records and nursing notes. Eight records contained evidence of discussion with patient or family. Three records contained evidence of advance care planning. None of the records contained evidence of the patient being assessed for their psycho-spiritual care.

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- We saw that Egremont ward audited 10 sets of patient records every month. This was part of the action plan for the End of Life Care Audit – Dying in Hospital. However we did not see lessons learnt from this audit.
- Following the withdrawal of the Liverpool Care Pathway and the release of ‘One Chance to Get it Right’ 2014 by the National Leadership Alliance for the Care of the Dying Person, the trust generated the ‘Priorities for Care of the Dying Person’ in 2015. This ensured that patients who were identified as dying experienced transparent and open communication and compassionate care from all health care professionals.
- The ‘Priorities for Care of the Dying Person’ care plan had recently been introduced by the trust and had not been widely initiated across the wards. Staff on Vallance ward told us they had used the care plan and symptom checklist. However, Chichester ward told us they had used the symptom chart which was useful but had not used the care plan yet.
- The mortuary staff told us that effective systems were in place to log patients into the mortuary. They explained the process and showed us the ledger record book that contained the required information. We observed that the book was appropriately completed.
- On visiting the bereavement office we saw there were systems to process death, burial and cremation certificates. An officer showed us the process and explained what the role involved.
- **Safeguarding**
 - Trust wide the chief nurse was executive lead for safeguarding. Adult safeguarding was managed by the deputy chief nurse and had 1.6 whole time equivalent (WTE) band seven nurses for safeguarding, learning disability and Mental Capacity Act and Deprivation of Liberty Safeguarding. Children’s safeguarding had a consultant nurse and two band sevens.
 - The trust had a safeguarding adult’s policy. Safeguarding was part of mandatory training for all staff and this was monitored by managers. Trust wide data provided for safeguarding adults was 50% with a target of 100%.
 - The specialist palliative care team was trust wide and their training rates for safeguarding adults was 100%. Safeguarding children level two was 85%.
- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults. The relevant local authority and social services numbers were available for staff.
- **Mandatory training**
 - The trust had a programme of mandatory training for all staff and we saw evidence and records of this training. The National Care of the Dying Audit 2014 recommended that staff received mandatory training in the care of the dying. All staff who had direct contact with patients received training for caring for patients and their relatives at the end of life. This specifically identified the need for staff to communicate well and practice care in line with national and local best practice. This training was received at induction.
 - The trust had a trust wide induction programme for permanent and temporary staff with the required mandatory and statutory training plan which involved classroom and E-learning. Education in end of life care was provided by the specialist palliative care team and the end of life care facilitator. Significant contributions were also made by the chaplaincy team about spirituality/religion/faith and the bereavement team taught about care after death.
 - Trust wide mandatory training for all staff had achieved 49% with a target of 100%. Trust wide statutory training for all staff had achieved 52% with a target of 95%.
 - The specialist palliative care team was trust wide and had achieved 58% statutory training with a target of 100%. Mandatory training for the team was 50% with a target of 95%. This figure applied to seven members of staff. Subjects included infection control, information governance, fire safety, Mental Capacity Act and Deprivation of Liberty Safeguards.
 - Training for the use of syringe pumps was mandatory for permanent nursing staff and was part of the intravenous study day. The trust provided us with lists of names of staff who had attended the course. However, the trust was unable to provide specific numbers of attendance and told us this would be collated on the central computer system in the future.
 - The chaplaincy, patient affairs and bereavement officers provided evidence that they were up to date with their mandatory training.
 - Guidance from Hospice United Kingdom for staff responsible for care after death clearly states education and training on all aspects of care after death should be

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included in induction and mandatory training programmes. For porters this should include safe handling and transfer and preparation for transferring of the body. However, portering staff at the hospital did not receive this training.

- Since they had changed from being employed by private company to being employed by the trust in 2015 the porters told us they did not receive an induction or specific training for transfer of the deceased to the mortuary. We were told by the mortuary staff that a training system had been devised but was not in practice at present.

- **Assessing and responding to patient risk**

- The clinical needs of patients were monitored through regular nursing, medical and therapy reviews.
- The officers in the bereavement office supported all bereaved families with the paperwork and processes for care after death. All doctors were supported and guided by the Medical Examiner (ME) in the completion of the medical certificate of cause of death certificate where appropriate. This enabled the certificate to be completed in a timely manner.
- Staff on the wards told us they moved end of life care patients to side rooms if appropriate and available.

- **End Of Life Care staffing**

- The trust wide palliative care team was made up of four consultants which was equal 1.8 whole time equivalent (WTE) consultants. Five clinical nurse specialists (CNS) were employed which were equal to 4.6 WTE. The team had two (1.34 WTE) patient pathway coordinators/administrators.
- The specialist palliative care team was based at the Royal Sussex County Hospital. A two week rota enabled one CNS from the team to be based at Princess Royal Hospital. This was to ensure staff were not lone working on a regular basis.
- The trust wide chaplaincy team had 3.5 WTE Christian staff plus Roman Catholic representation. There was an on call Jewish Orthodox Rabbi and Sunni Muslim Imam. Three sessional on call chaplains provided cover for absences. There was a large team of ward based volunteers from a variety of faith traditions and on call representatives of a variety of faith and belief groups from the immediate area. The service had a vacancy for a two day a week Church of England chaplain and this was advertised.

- A trust wide full time end of life care facilitator, who was not part of the specialist palliative care team, provided information and education for end of life care. The facilitator worked with the specialist palliative care team to provide the end of life care education programme.
- The Patient Advice and Liaison (PALS) office was staffed by two WTE officers, one WTE PALS and complaints coordinator and an administrator. The PALS team were an extension of the complaints team which had six WTE complaints managers. One PALS officer worked at Princess Royal Hospital on a Wednesday and also covered sickness and leave.
- The bereavement office was staffed by four (3 WTE) officers and one member of staff covered the Princess Royal Hospital every Wednesday and for sickness and annual leave.
- The hospital had five medical examiners (three full time and two part time) who worked Monday to Friday 9am to 5pm.
- There were two WTE members of staff employed in the mortuary. There were no arrangements for covering annual leave or sickness. This was organised and covered by the mortuary staff.
- During our inspection we asked ward managers about their staffing levels and whether they felt adequate staff were on the wards when caring for patients on an end of life care plan. Staff on Chichester and Trafford wards confirmed that retaining and recruiting staff was a main concern but they were aware of the trust's efforts to manage the situation. Ward managers we spoke with told us that sometimes staff were unable to provide adequate specific end of life care to patients due to availability of staff and workload. Staff on Trafford ward told us there was not a facility to request additional staff as they were able to for patients who are at risk of falls.
- **Major incident awareness and training**
- There was a trust wide Major Incident Plan (2015) which set out a framework for ensuring that the trust had appropriate emergency arrangements which were in line with the Civil Contingencies Act 2004 statutory duties.
- Emergency planning was a mandatory training subject for all staff. Staff told us there was a major incident exercise planned for July 2016.

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- The mortuary had arrangements to use overflow spaces at Princess Royal Hospital mortuary and an arrangement with the council mortuary in the event of a major incident.

Are end of life care services effective?

Requires improvement



We rated the end of life care service at the Royal Sussex County Hospital Requires Improvement for Effective.

- The trust did not meet the requirements of the key performance indicators of the National Care of the Dying Audit 2014. They did not have access to specialist palliative support, for care in last days and hours of life, as they did not have a service seven days a week. They did not have a non-executive director for end of life care services. Also they did not have a formal feedback process regarding capturing bereaved relative's views of delivery of care.
- The trust was worse than the national average in End of Life Audit- Dying in Hospital 2016 for multidisciplinary recognition of a patient dying and documented evidence in the last 24 hours of life of a holistic assessment.
- The service did not have a programme of regular audits for end of life care.
- There were inconsistencies in the documentation in the recording of Mental Capacity Act (MCA) assessments and recording ceilings of care for DNACPR.
- Trust wide only 68% of staff had received an annual appraisal. Staff we spoke with confirmed that some had and others had not received an appraisal in the last year.

However:

- The trust was in the process of correcting the organisational and clinical indicators highlighted in the National Care of the Dying Audit 2014. The trust had an action plan with defined implementation dates.
- The hospital had implemented standards as set by the National End of Life Care Strategy 2008 published by the Department of Health, NICE End of Life Quality Standard for Adults (QS13) and 'One chance to Get it Right' 2014 by the National Leadership Alliance for the Care of the Dying Person.

- Alternative end of life care guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway. The 'Priorities for Care of the Dying Person' and 'symptom observation chart for the dying patient' had been generated. Patients on the care plan were prescribed appropriate medication by medical staff.
- Patients' pain, nutrition and hydration needs were monitored in accordance with national guidelines. The palliative care team supported and provided evidence-based advice to health and social care professionals from other wards and departments.
- End of life care education consisted of study days, induction programme, and workshops for clinical staff, sessions and lectures for medical staff. Most clinical areas had an end of life care champion who was central to disseminating end of life care education and support to their local multidisciplinary team.
- The chapel and prayer room were accessible 24 hours 365 days of the year. The chaplaincy team provided a 24 hour on call service for all faiths via the switchboard. The palliative care team were available Monday to Friday between 9am and 5pm, with out of hours telephone support for palliative medicine provided by a consultant.
- The 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were completed for appropriate patients.
- **Evidence-based care and treatment**
- The National End of Life Care Strategy 2008 published by the Department of Health, sets out the key stages for end of life care, applicable to adults diagnosed with a life limiting condition. NICE End of Life Care Quality Standard for Adults (QS13) sets out what end of life care should look like for adults diagnosed with a life limiting condition. The 16 quality standards define best practice within this topic area.
- Two of the standards had been achieved with the provision of a specialist palliative care team and had an operational policy. The trust was working towards being compliant with the remaining standards and had an action plan with defined implementation dates. The action plan was in draft form and started in March 2016. The specific actions compared Brighton and Sussex University Hospitals NHS Trust with national results.
- The trust had responded to the withdrawal of the Liverpool Care Pathway (LCP) and the publication of 'One Chance to Get it Right'. The specialist palliative care

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team worked with the end of life care facilitator to introduce the 'Priorities for Care of the Dying Person' and 'symptom observation chart for the dying patient'. Training sessions were provided trust wide in 2015 for staff or for individual groups of staff and were attended by approximately 380 members. The sessions were completed over a two week period and lasted one hour each. The care plan was available on the intranet. However the trust did not record the number of patients within the hospital who were on the care plan. It had recently been introduced and had not been widely initiated across the wards.

- The trust told us that they were committed to continuing to embed best practice in care of the dying patient. This was to be achieved with a comprehensive education programme, modelling of a gold standard of care by senior clinicians, monitoring performance with an internal audit programme and benchmarking themselves against national standards by participating in the bi-annual National Care of the Dying Audit for Hospitals (NCDAH).
- The results of the NCDAH (2015) were published March 2016 and the trust had incorporated the findings into a draft action plan to ensure the lessons from the audit process were shared. The overarching actions were allocated to teams with specified timescales. The hospital told us they would disseminate the findings of the audit within the trust end of life care newsletter and local governance meetings.
- We did not see a programme of regular audits for the end of life care service. However we saw that some audits were being performed.
- The rapid discharge pathway (RDP) for the dying patient was audited for patients who were on the pathway at Royal Sussex County Hospital from June 2011 to July 2012. Results of the audit showed 84% patients achieved their preferred place of care and 14% had died in hospital before discharge. Data on the remaining patients was not recorded. The audit recommended that RDP should be used for all discharges and the audit repeated after three years, and this was due in 2016.
- We saw DNACPR records were audited March 2016. The result of the audit showed that generally the standard of completion of the forms was high and there were no concerning patterns or trends. The audit was suspended until after the inspection. We were not provided with a reason for this.
- We saw evidence across the wards we visited that the specialist palliative care team supported and provided evidence based advice when caring for patients reaching the end of life. Guidance and instruction was given regarding complex symptom control and individualised care of the patient.
- During our visits to the wards staff demonstrated how they were able to access end of life care information on the intranet and knew how to refer to the palliative care team.
- Most of the clinical areas in the hospital had at least one end of life care champion known as 'link persons'. These were mainly nurses and some health care assistants (HCA). The end of life care links were central to disseminating end of life care education and support to their local multidisciplinary team. We spoke with the link persons on Valance, Chichester and Jowers wards who were knowledgeable and proud of their role. They told us they received monthly updates. The link persons on Chichester and Jowers wards showed us the resource folders they had assembled.

• **Pain relief**

- Effective pain control was an integral part of the delivery of effective end of life care and was supported by the specialist palliative care team and the acute pain team.
- The trust had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). There were guidelines for prescribing using NICE guidance on opioids (a strong pain killer) for palliative care.
- The 'Priorities for Care of the Dying Person' and 'symptom observation chart for the dying patient' supported the effective management of pain in the dying patient. Guidelines included prescribing anticipatory pain relief alongside guidance for other common symptoms.
- We reviewed 10 patients' medical records and drug charts and saw that patients had regular assessments for pain and appropriate medication was given frequently and as required.
- We saw in Valance and Chichester wards a pain relief score chart was used for assessment and acted upon. Staff told us that doctors were good at increasing medication for pain if required and anticipatory medication always available.

• **Nutrition and hydration**

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- Risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a nutritional screen assessment tool which identified patients who were at risk of poor nutrition, dehydration and or those who experienced swallowing difficulties. It included actions to be taken following the nutrition assessment scoring and weight recording. The 10 care plans we observed across the wards contained the nutritional screening assessment and showed where patients had been referred to the dietician.
- The 'Priorities for Care of the Dying Person' and 'symptom observation chart for the dying patient' had clear guidelines for the assessment of mouth care, hydration and nutrition. The end of life care records we observed showed that these were being completed and updated by staff.
- The personalised care plan included prompts to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- Staff on Valance ward told us they assess each end of life care patient separately and administer subcutaneous fluids, which provide additional fluids into the space under the skin from where it can be slowly absorbed into the blood and body, if required. They talk to patients and their relatives about hydration.
- We saw an end of life care patient on Jowers ward was receiving good mouth care and this was actioned in a timely manner and was documented.
- **Patient outcomes**
 - The Hospital Standardised Mortality Ratio (HSMR) for the trust was 97.3 for 2013/14 and 90.5 for 2014/15. HSMR is a calculation used to monitor death rates in a trust and is based on a subset of diagnoses which give rise to around 80% of in hospital deaths. The ratio is worked out by the total number of observed in hospital deaths compared to expected deaths (multiplied conventionally by 100). If mortality levels are higher than would be expected, the HSMR will be greater than 100. Therefore, the trust's ratio for HSMR was better than the national average.
 - Trust wide there were 1085 deaths in 2013/14 and 1251 referrals to the palliative care team. Cancer referrals were 78%, non-cancer 19% and unknown 3%.
 - Trust wide there were 1711 deaths in 2014/15 and 1085 referrals to the palliative care team. Cancer referrals were 73.5%, non-cancer 26% and unknown 0.5%.
- The trust was unable to provide data for the number of patients who die who had been seen or referred to the specialist palliative care team for each hospital. The data was requested from the trust and at the time of writing the report this had not been provided.
- March 2015 to February 2016 the specialist palliative care team had received 1302 new referrals and 984 were for Royal Sussex County Hospital.
- Results of the NCDHAH 2014 showed the trust achieved four of the seven organisational indicators and was worse than the England average for three of the ten clinical indicators. The trust was worse than the England average for access to specialist support for care in the last hours and days of life, trust board representation for care of the dying, formal feedback processes regarding capturing bereaved relatives views of delivery of care, multidisciplinary recognition that the patient was dying, review of assessments in 24 hours of life and review of care after death.
- The trust had responded to the results of the NCDHAH 2014. There was multidisciplinary recognition that the patient was dying and documented evidence in the last 24 hours of life of a holistic assessment. Staff received end of life care education at induction and there was an ongoing education programme for all staff. End of life care champions known as 'link persons' were on most wards and information was easily accessible for all staff on the intranet.
- The trust did not meet the requirements for three key performance indicators of the NCDHAH 2014. They did not have access to specialist support for care in the last hours and days of life as they did not have a service seven days a week. The trust had executive members representing end of life care but did not have a non-executive director. A formal feedback process was not in use. We were shown a draft of a bereavement survey which had been designed. However at the time of the inspection this had not been piloted.
- The End of Life Audit- Dying in Hospital 2016 national achievement against end of life care quality indicators showed the trust had not achieved and was worse than the national result for communication skills training for care in the last hours of life for all staff.
- The trust had responded to the withdrawal of the Liverpool Care Pathway (LCP) and the publication of

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'One Chance to Get it Right'. The specialist palliative care team worked with the end of life care facilitator to introduce the 'Priorities for Care of the Dying Person' and 'symptom observation chart for the dying patient'.

- The trust had an advance care planning policy which explained staff's role and the importance of healthcare professionals involving patients and their families in decisions about care and respecting decisions that had been made and documented earlier. The policy related to the information leaflet given to patients who were recognised to be end of life and gave guidance on the reason and process of advance care planning.
- Data provided by the chaplaincy team showed that in 2014/15, 16599 visits were made to patients across the trust. Data was not recorded for each hospital. Approximately 1750 visits were to patients in other trusts which the chaplaincy team had a service level agreement. The department recorded visits made for Christian, Muslim and Jewish visits. However the trust did not record the number of visits specific to end of life care patients. They were unable to provide data of how many people known to the specialist palliative care team were referred to and seen by the chaplaincy team.

• **Competent staff**

- In line with the NICE end of life care quality standards (2011) and Ambitions for Palliative and End of Life Care (2015) the trust recognised the need for a workforce skilled to provide end of life care, care after death and for staff to have the ability to have honest and sensitive conversations with patients and their families.
- The end of life care facilitator was not a member of the specialist palliative care team. However they worked with the team to provide trust wide end of life care education.
- Training of end of life care was given to non-specialists in many aspects of palliative care on a one to one basis on prescribing and symptom management. Sessions were organised at ward level on a variety of topics including the RDP for the patient who wanted to die at home. The specialist palliative care team delivered sessions for medical students and doctors. The team contributed to sessions on the end of life care education series.
- The specialist palliative care team organised a conference in 2015 which was attended by 60 members of staff. The conference celebrated five years of the specialist palliative service, its development and

innovation. A range of experts in the field of hospital specialist palliative care were key speakers and topics included rapid discharge, advance care planning, revising the boundaries and the future of palliative care. The conference was well received and comments received in feedback included: "an excellent day so insightful and informative", "good variety of topics" and "pain control presentation gave a thorough update."

- End of life care education consisted of study days, induction programme, workshops for clinical staff, sessions and lectures for medical staff. In 2015 there were three conferences which were well attended by trust staff and the local health and social care services.
- End of life care education was provided for all staff and learning opportunities were available on the end of life care intranet site and newsletters. We were given a demonstration by the end of life care facilitator of the intranet site, which can be accessed by all staff at any time. The site included information, such as trust policies and procedures relating to end of life care, referral to the specialist palliative care team, multi professional training days and online booking system for end of life care study days. Staff showed us they could access the education and training easily. Staff on Jowers ward told us they had partaken in end of life care training including post graduate modules.
- Trust wide the appraisal rate for all staff was 68% April 2015 to January 2016 with a target of 75%. The trust did not provide completion rates specific to end of life care. Staff we spoke with confirmed that some had and others had not received an appraisal in the last year.
- **Multidisciplinary working**
- The close working relationship between the specialist palliative care team, end of life care facilitator, link nurses, ward staff and chaplaincy ensured that end of life care was embedded in trust structures, for example induction. The specialist palliative care team had formed close and mutually helpful working relationships with other clinical teams in the hospital. For example, the acute pain team, trust lead cancer nurse, pharmacy, psychological therapies team, bereavement officers and the discharge team.
- The specialist palliative care team had a close working relationship with the local Palliative Care Partnership and several local hospices. They also worked closely with hospital palliative care teams in the region and the Macmillan site specific cancer team.

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- The specialist palliative care team had a six monthly meeting with the Macmillan community and hospital teams.
- The specialist palliative care team held weekly multidisciplinary meetings at the hospital on Tuesday afternoons with doctors, nurses and members of the extended team. There was video conferencing to link both hospital sites of the trust. The meeting covered all aspects of patient's medical and palliative care needs. The outcomes of the meeting were recorded and shared with the extended team. We saw that the team administrator coordinated the meetings ensuring an accurate list was kept of patients discussed and a record of attendance.
- The weekly multidisciplinary meeting had a dedicated time each week to discuss a 'case of the week'. This was for all clinical members of the team to attend and discuss a complex clinical situation and identify learning points from this. Written records of these meetings were shared amongst the team.
- Staff told us the hospital worked as an effective multidisciplinary team recognising an end of life care patient. Medical staff told us that the specialist palliative care team were very supportive in assisting medical staff to have sensitive conversations with patients and their families regarding end of life care. We saw there was good support provided for junior staff.
- Every morning, Monday to Friday, the specialist palliative care team had case-load discussions which were chaired by the triage nurse. Every Monday meeting was used to highlight any outstanding issues for patients who were discharged over the weekend. The Friday meeting included a review of deaths and discharges from the previous week.
- When a specialist palliative care team consultant was present at the hospital they attended the acute medicine handover in the acute medical unit (AMU) to collate referrals.
- The medical examiners (ME) worked closely with the coroner's office and specialist palliative care team. They were involved in the education of junior doctors. The ME attended the trusts mortality meetings and reviewed all hospital deaths.
- **Seven-day services**
- The specialist palliative care team was not staffed or funded to provide a seven day week visiting service.
- The specialist palliative care team was available Monday to Friday 9am to 5pm, except bank holidays. Consultant presence was provided from 8am to enable them to attend the AMU handover. Out of hours consultant telephone advice was available from the local hospices.
- The mortuary was staffed 9am to 5pm Monday to Friday. Within these hours collections were possible from 10am until 4pm and viewing appointments were available to families between 11am and 3pm. Post mortems were not performed at the hospital and the mortuary provided body storage and release only. There were no out of hour's arrangements for collections and viewings.
- The chapel and Muslim prayer room were accessible 24 hours a day every day of the year. The chaplaincy team provided 24 hour on call service and were contactable via the switchboard.
- The Patient Advice and Liaison (PALS) office was open Monday to Friday 9am to 5pm.
- The bereavement office was open Monday to Friday 9am to 5pm.
- The medical examiners worked Monday to Friday 9am to 5pm.
- **Access to information**
- The trust's clinical intranet site, 'info-net', was available for all staff. This intranet resource provided easily accessible and easy to read information for all aspects of end of life care. It contained information for care of the dying patient, guidelines and prescribing advice for palliative patients.
- The trust acknowledged that patients who were dying and those at the end of life may require rapid discharge home. A RDP was developed and the documentation for this process was available on the end of life care intranet site which staff could access. The guidelines were for use by all clinical staff. Part of the resources that supported this process was example prescription sheets for the junior doctors to refer to when prescribing anticipatory medications.
- The trust had developed a Notification Form for Advance Care Planning which was completed to support a patient to develop their wishes and preferences as an advance care plan or if a patient already had one. Therefore the existence of an advance care plan, any advance decisions to refuse treatment or last power

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attorney for health and welfare was documented and could be located in the patient's health record on admission. We did not see examples of the advance care plan in records at the time of inspection.

- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
- The trust had a consent policy which was based on the model developed by the Department of Health. The policy included the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits. The policy also included consent for advanced decisions, guidance for lasting power of attorneys and mental capacity.
- We saw staff always introducing themselves and seek consent before treatment.
- The trust had a Mental Capacity policy which incorporated Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance that included the Mental Capacity Act (MCA) 2005 legislation and set out procedures that staff should follow if a person lacked capacity.
- Staff on Chichester and Howard wards told us they considered the MCA for all patients and described the process.
- Four of the DNACPR forms we observed had recorded that the patient did not have mental capacity. However we did not see documentation of the MCA assessment in their medical notes. Therefore the hospital was not consistent with assessing and recording of MCA.
- Medical staff we spoke with understood the 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decision making process and described decisions with patients and families. They told us they provided clear explanations to ensure that the decision making was understood. There was a trust wide guideline for DNACPR.
- Staff on Chichester ward told us the consultants were excellent at recognising end of life care patients and write DNACPR in a timely manner. They told us they were "really hot on ceilings of care." This guides staff, who did not know the patient, to know the patient's previously expressed wishes and/or limitations to their treatment. This is best practice in hospitals to provide continuity of care and good communication.
- While visiting ward areas we checked medical records and we viewed 30 DNACPR forms. All the forms, except

one, were kept in the front of the patients' notes. We saw that all decisions were recorded on a standard form and signed by a senior clinician on all forms. The rationale for DNACPR was documented with evidence of discussion with the patient and or their relative if appropriate. However, the forms were inconsistent with recording the patients ceiling of treatment

- We were told that DNACPR remains a high priority in teaching. Focus remains on the documentation of the communication of the decisions with the patient and their relatives.

Are end of life care services caring?

Good



We rated the end of life care service at the Royal Sussex County Hospital good for Caring.

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life. We were told about and shown evidence of collaborative working across the teams to provide exceptional care for end of life care patients.
- On the wards we visited we observed compassionate and caring staff that provided dignified care to patients who were at the end of their lives. We spoke with patients and relatives who were complimentary about the care they had received.
- Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support and patience from staff.
- Emotional support was provided by the hospital. Staff knew who to signpost relatives to for bereavement care. There was an on call service with access to chaplaincy staff and other multi faith leaders who supported families in times of loss and grief.

Compassionate care

- Staff on all wards we visited said end of life care was a vital part of their role and they enjoyed the relationships they formed with patients and their relatives. During our inspection we observed end of life care that was sensitive, dignified and caring by all staff.

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- We saw staff on Valance and Chichester wards were passionate and committed to caring for end of life care patients. We observed they cared deeply about their team and the standard of care that was given.
- Staff on Valance ward told us consultants were good at talking to end of life care patients and their relatives. They were honest and work well with the ward team.
- A patient on Jowers ward told us “staff were excellent, their pain was well controlled, staff had good communication and there was open visiting for relatives.”
- A patient on Howard 1 ward told us they were very happy with their care “even the food.”
- A relative of an end of life care patient on Overton ward sought out the inspection team to inform them of the high quality of care they have received. They told us nursing staff go “above and beyond” and staff had facilitated all the family’s needs.
- Staff on Chichester ward told us the specialist palliative care team were “brilliant and very responsive.”
- The 2014/15 carer’s survey by the specialist palliative care team had written feedback which included: “the team was very kind, supportive and helpful.”
- The PALS officers told us of an example where an end of life care patient was concerned that their pet was not being looked after. The PALS team contacted a neighbour and arranged this.
- The chaplaincy team gave us examples of compassionate care provided for end of life care patients. In the event that a patient wished to marry their partner the chaplaincy team contacted the local registrar to conduct the ceremony and the chaplaincy team performed a blessing if required. We were told of two examples where this happened in the previous two weeks. The ceremony had taken place on the same day that the dying patient had decided they wished the ceremony to take place.
- The chaplaincy told us of the ‘music project’. This was devised after an end of life care patient wished to listen to music as they were dying and this was arranged by the chaplaincy team. At the patient’s funeral, money was collected instead of giving flowers. The chaplaincy team were presented with £700 and they bought portable equipment to enable other end of life care patients to listen to music.
- The bereavement officers and medical examiners (ME) told us of an occasion when a young patient with a fear of the mortuary had expressed a wish they not be moved to the mortuary when they died. The team worked closely with the coroner and funeral directors to arrange for the patient to be transferred directly to the offices of the funeral directors.
- The bereavement officers told us that if a patient who had died did not have any next of kin they had access to companies who would trace families in the United Kingdom. Failing this the hospital would arrange the funeral with the assistance of the chaplaincy team.
- **Understanding and involvement of patients and those close to them**
 - We spoke with two patients and one of their relatives. They told us staff providing end of life care were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and that their questions were answered in a way they could understand.
 - We observed staff introducing themselves to patients and their relatives.
 - Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with mouth care and personal care.
- **Emotional support**
 - Staff provided emotional support for end of life care patients. We observed on the wards occasions when this occurred.
 - Bereavement support was not specifically provided by the hospital. Relatives were signposted to the relevant agencies that could support them. A relative told us they had been provided with information on who to contact if they required emotional support. However, we were told a member of the bereavement team was a trained counsellor and could provide support if required.
 - All GPs were informed within one working day of a patient’s death so they could provide appropriate community centred bereavement support if required.
 - The chaplaincy service offered access to multi faith worship 24 hours a day. There was an on call service with access to chaplaincy staff and other multi faith leaders. The chapel was a space for patients and families to have a quiet time.
 - The hospital ensured that the faith needs of the community were met. The chaplaincy team offered spiritual, religious or pastoral support to people of all

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faiths and beliefs, religious and non-religious. The chaplaincy team was assisted by a group of volunteer visitors. They were able to contact community faith leaders who represented the major world religions.

- The chaplaincy team were involved in supporting families in times of loss and grief. Relatives of end of life care patients told us that they had been offered chaplaincy support and a member of the team had visited them promptly.

Are end of life care services responsive?

Good



We rated the end of life care service at the Royal Sussex County Hospital good for Responsive.

- The specialist palliative care team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive to patients, relatives and other members of the multidisciplinary team. This was demonstrated with their specialised advice and knowledge.
- The specialist palliative care team responded promptly to referrals to assess the patient and plan care. Online referrals to the team were triaged throughout the working day and they were contactable via bleeps. The team told us everyone received telephone advice on the same working day and most patients were seen within 24 hours.
- Although the hospital had limited facilities for relatives owing to its environment we found that staff supported relatives to stay with end of life care patients. Some wards did not have side rooms and others only had one side room and limited space. However staff were resourceful to ensure relatives were accommodated.
- The wards provided an information pack for bereaved relatives which advised them about collecting the death certificate from the bereavement office. The pack contained the contact details for contacting the mortuary for a viewing if required.
- The mortuary viewing area was visibly clean and welcoming for relatives.
- The chapel accommodated all faiths as well as no faith. Staff respected the cultural, religious and spiritual needs of patients.
- The trust had an advance care plan which supported a patient to develop their wishes and preferences. The plan could be located in the patient's health record on admission and was accessible to the out of hour's community service.
- The trust had a RDP and the documentation for this process was available on the end of life care intranet site which staff could access. The discharge team was involved with all discharges for end of life care patients. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.
- The trust had processes in place to acknowledge and investigate complaints appropriately. Complaints were handled in a timely manner and lessons were learnt.
- **Service planning and delivery to meet the needs of local people**
- During the inspection we observed that the specialist palliative care team was embedded in all clinical areas of the hospital. Staff on the wards told us that the team was professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals, for example, therapists. Staff on the wards confirmed that the referral criteria was clear and patients were seen within 24 hours if not sooner.
- We observed across the wards we visited that staff supported relatives to stay with end of life care patients. A relative on Jowers ward told us they had been encouraged to stay overnight by the ward staff. We were told and observed that when a patient was recognised as in the dying phase all wards would offer patients and their families side rooms dependant on availability and suitability.
- The mortuary had a viewing suite where families could visit their relatives. They were escorted by the mortuary attendant who would stay with the relatives in the waiting area during the viewing for as long as they required.
- Guidance and support was offered after death from the bereavement office. Contact numbers were provided to relatives within a trust wide information wallet. The staff in the bereavement office told us they were aware of whom to signpost relatives to if they required additional support.
- The bereavement office advised relatives on the process around the death of a patient. The office issued death,

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burial and cremation certificates. The information leaflet provided for relatives by the wards advised that the certificate would not be available for five working days. Bereavement officers told us that the certificate was usually issued within two to three working days. However, they were unable to provide any data to confirm this.

- The PALS office was a spacious office located off the main corridor and contained a separate seating area to accommodate confidential and private conversations. The PALS officers told us they would visit patients on the wards if required.

• Meeting people's individual needs

- There were limited facilities for relatives of end of life care patients within the current hospital environment. Some wards only had one side room and the environment on the wards was cramped.
- Solomon ward had made use of the limited space and the staff had provided a relatives room.
- The accident and emergency department had two side rooms for use by dying patients. Vallance ward had a side room which could be used for end of life care patients. The ward staff told us that not all relatives wanted to use the side room. The ward had open visiting and relatives were encouraged to stay by the bed overnight.
- Chichester ward did not have any side rooms but staff told us this was not a problem. Staff let relatives use the staff room to sleep and staff went elsewhere.
- The hospital ensured that the faith needs of the community were met. The chaplaincy team offered spiritual, religious or pastoral support to people of all faiths and beliefs, religious and non-religious. The chaplaincy team was assisted by a group of volunteer visitors. They had 28 volunteer on call representatives of a variety of faith and belief groups from the immediate area. The chaplaincy team had a large team of ward based volunteers from a variety of faith traditions who made weekly visits to the hospital.
- The hospital chapel was multi faith. The Muslim prayer room had separate washing facilities which met the needs of the local community.
- The mortuary had a viewing room. The room was visibly clean and provided facilities for relatives such as seating, tissues and access to drinking water. The room was neutral without religious symbols which allowed the suite to accommodate all religions.

- The mortuary was able to facilitate the transportation of obese and bariatric (severely obese) patients. They could facilitate the storage of three obese patients at any one time. However, they did not have fridges specific for a bariatric patient who had to remain on a bariatric bed in the fridge space with the shelves removed.
- The hospital had access to translation services for face to face and telephone interpreting. This could be booked through a centralised booking system.
- Patients living with learning disabilities or dementia were supported by the hospital. A blue butterfly flagging system on the notes identified the patients who required extra assistance.
- The chaplaincy team provided leaflets which explained its services, contact details and special events. Details were advertised on the chaplaincy centre notice boards and available on the hospital's web page. The team provided specific leaflets and information for supporting different religions while an inpatient and advice for going into hospital.
- A patient information leaflet for continuous subcutaneous infusions using a syringe pump was available on the hospital's web page.
- Relatives of a person who had died were provided with a trust wide information wallet by the wards. This contained information on collecting the medical certificate of cause of death, Department for Work and Pensions: what to do after death and a funeral choice information leaflet.
- The trust's clinical intranet site, 'info-net', was available for all staff. This intranet resource provided easily accessible and easy to read information for all aspects of end of life care. It contained information for care of the dying patient, guidelines and prescribing advice for palliative patients.
- Ergemont ward had a specific information board with end of life care information for staff and patients.
- **Access and flow**
- Online referrals to the specialist palliative care team were triaged (the process of determining the priority of a patient's treatment based on the severity of their condition) throughout the working day. The specialist palliative care team carried bleeps and there was a triage bleep at the Royal Sussex County Hospital. Every morning the patient list was updated and referred patients were graded on level of care 1-4 (4 the highest).

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The team told us everyone received telephone advice on the same working day and most patients were seen within 24 hours. Data provided by the trust showed that in 2015 the team saw 67% of patients within 24 hours of referral and 87% by the next working day.

- The trust did not record data specific to preferred place of death. Data was recorded specific to preferred place of care (PPC) and rapid discharge pathway (RDP). The information did not split into hospital site specific. The 2014/15 specialist palliative care team annual report showed for 83% of patients the PPC was achieved when known and 84% from March 2015 to February 2016.
- The 2014/15 annual report showed 75% of RDP was successful and from March 2015 to February 2016, 82% of patients achieved rapid discharge. The average length of time (including weekends) to arrange RDP, when successfully achieved, was two days. Failures to achieve rapid discharge were due to delays in arranging necessary equipment and/or care or family were unable to support an individual's expressed preference.
- The discharge team worked closely with the specialist palliative care team and coordinated the discharge of patients trust wide. The coordinators attended ward rounds and handovers to highlight them of end of life care patients who wished to be discharged home or to a nursing home. This enabled them to start the process of arranging funding and the availability of packages of care.
- Fast track continuing healthcare applications were completed by the discharge coordinators. They told us that a patient who lived in the Brighton area, a discharge could usually be arranged within one working day. This took longer for patients who lived in east and west Sussex owing to the availability of nursing home places and packages of care. Brighton patients had access to a 'Rapid Home Care Service' who provided care for the patient until their funded package of care could start.
- The trust told us they used the Supportive and Palliative Care Indicators Tool (SPICT) to identify patients in last year of life. The SPICT supported clinical judgement by multidisciplinary teams when identifying patients at risk of deteriorating and dying. It can help identify patients with multiple unmet needs who would benefit from earlier, holistic needs assessment, a review of care goals and anticipatory care planning. This was available to all but not widely used at present. The training of its use was in the education programme for staff.
- The respiratory team told us they had audited the SPICT to determine the discharge time of end of life care patients pre and post use of the tool. They told us that the patient's length of stay in hospital had decreased after using the tool. We requested information about the audit but the hospital was unable to provide us with it.
- The trust's policy for the administration of medication using a syringe pump had clear guidelines for discharge planning for a patient being discharged home with a syringe pump. The patient and/or the carer were provided with a pre stamped and addressed padded envelope. This system ensured the safe return of the syringe pump once community services had replaced it with their own.
- **Learning from complaints and concerns**
 - The chief nurse was the executive lead for patient experience and complaints. The chief of safety and quality and deputy chief nurse shared the responsibility for the line management of the head of patient experience, PALS and complaints who were responsible for the operational management of the services and line management of the complaints and PALS teams.
 - The patient experience PALS and complaints team comprised of six complaint investigation managers, two complaints/PALS coordinators and three PALS advisors who worked closely with the complaints team.
 - There was a monthly serious complaints and safeguarding meeting held by the head of patient experience, PALS and complaints, deputy chief nurse, patient experience, safeguarding lead nurse and chief of safety and quality.
 - A patient experience report was produced quarterly for submission to the quality and risk committee and the board. An annual report was produced and shared at both meetings.
 - The chief executive officer received copies of all complaints relating to clinical treatment and care. These were discussed at monthly meetings with the head of patient experience, PALS and complaints to discuss actions arising, themes and learning.
 - Patient information that advised patients how to make a complaint or raise a concern with PALS was available on the trust website. There was an easy to read leaflet 'comments, concerns and complaints' which was

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available throughout the trust and was available in other languages upon request. A poster 'Have you got a concern or complaint and don't know where to turn' was displayed throughout the hospital.

- Trust wide between February 2015 and January 2016 there were eight complaints relevant to end of life care. Seven of them were about Royal Sussex County Hospital. Most of them referred to failures in communication by staff. All complaints were formally logged and had either been resolved or action was ongoing.
- Formal complaints relevant to the specialist palliative care team were dealt with by the team leader and lead clinician in accordance with trust policy. Outcomes, learning and improvement were discussed at the monthly team meetings. The eight complaints received trust wide relevant to end of life care were not applicable to the specialist palliative care team.

Are end of life care services well-led?

Good



We rated the end of life care service at the Royal Sussex County Hospital good for Well-led.

- The specialist palliative care team working with the end of life care facilitator and ward staff had a vision to ensure that end of life care was consistent with a trust wide approach. This was to be delivered in a timely, sensitively, spiritually and culturally aware manner, with appropriate patient and relatives focused care of the dying and deceased patients. We saw that the trust wide end of life care strategy was underpinned by a clear action plan. The vision, values and strategy were being developed in line with all who were involved in the end of life care steering group.
- The trust had two executive members representing end of life care but did not have a non-executive director. There was good leadership of the specialist palliative care team led by a consultant and a nurse team leader. All staff we spoke with thought their line managers and senior managers were approachable and supportive. However they did not feel supported by the trust board.
- The end of life care team service had an action plan, governance meetings and a strategy and steering group. The hospital and trust were committed to delivering

excellent end of life care for all patients. The end of life care leadership, team working within the palliative care team and ward staff delivered care of a high standard and were proud of the service they provided.

- The trust culture encouraged candour, openness and honesty. The specialist palliative care team had an annual carer's survey and had designed, but not yet instigated a bereavement survey.
- The end of life care service worked with other teams in the hospital and trust to provide innovative and award winning systems that were to the benefit of the end of life care patient and their relatives.
- **Vision and strategy for this service**
- The trust told us that it strived to promote a culture where end of life care was seen as 'everyone's business' both personally and professionally.
- The trust aimed to continue to build the specialist palliative care team which provided excellent clinical care as well as being a learning team that provided and encouraged training to non-palliative care colleagues. It contributed robustly to research and policy development and was innovative in palliative and end of life care.
- The specialist palliative care service was not funded to provide a seven day visiting service. National guidelines and recommendations from the Neuberger Report 'More care - less pathway' 2013 and public Health England 2013 request seven day availability of face to face assessments for end of life care patients in acute hospitals. This had been recognised by the Cancer Services Strategy but was not allocated urgent priority by the trust board. The specialist palliative care team continued to forward a business case as one of the three cancer service development priorities for the directorate. A decision was pending at the time of reporting.
- The trust wide palliative care service and end of life care facilitator told us that they aimed to expand the education programme, particularly the training of senior clinical and education staff who would roll out training to other staff. They aimed to work with colleagues to embed training in palliative and end of life care throughout undergraduate and post graduate training as well as continuous professional development.
- The vision of the service was to streamline the discharge process by educating ward staff and ensuring adequate support services in the community. This would enable patients to return home in a timely manner.




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- The leadership of the end of life care service recognised that they needed to identify the dying patient earlier and keep end of life care as the focus. The specialist palliative care team acknowledged in the 2014/15 annual report a high number of referrals were received for patients who were actively dying and had not been recognised as end of life earlier. Therefore they were unable to engage in conversations about the patient's wishes and preferences or have the opportunity to achieve these. Additionally these had not been previously explored by the referring team.
- **Governance, risk management and quality measurement**
 - The specialist palliative care team had regular team meetings in which performance issues, concerns, complaints and general communication were discussed. The annual work programme was discussed quarterly, with the progress and outstanding projects updated.
 - The specialist palliative care team and relevant members of the extended team met annually in April to discuss, review, agree and record operational policies. At the meeting the team also reviewed other relevant activities including a formal review of the team's clinical activities, audits and other projects. The teams work plan from the preceding business year was reviewed and a work plan for the current business year agreed.
 - There was a trust wide specialist palliative care team Annual Report for 2014/15 that described the staffing, role and training provided by the team. The annual report was approved by the specialist palliative care team. The report was sent to the Chief Executive, end of life care executive leads (director of nursing and medical director), directorate lead team, Macmillan, and Clinical Commissioning Group. We were told the information for the 2015/16 report had not yet been collated.
 - The specialist palliative care team had an operational policy that set out the aims and objectives of the team and was reviewed every year.
 - The trust had an end of life steering group that met monthly and was chaired by the end of life care facilitator. The director of nursing attended these meetings as the board representative. This group was overseeing the various improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also meeting the NICE end of life guidance. This was a multi professional group and included members from chaplaincy, specialist palliative care team, bereavement, pharmacy and organ and tissue donation teams.
- We saw minutes of the steering group meetings, for January 2016 and February 2016 which were well attended by representatives across the hospital who were involved in the care of an end of life care patient. The previous five months were not available due to poor attendance. The notes from the steering group were shared with all members. However, following a governance review, the steering group were to report to the new clinical effectiveness committee in the future.
- A specialist palliative care team consultant attended the trust mortality review group. Action points were recorded at the end of each meeting and learning points discussed.
- **Leadership of service**
 - The trust had two executive members representing end of life care service: the director of nursing and the medical director. The trust did not have a non-executive director for end of life care. Teams across a variety of directorates were involved in the provision of end of life care and all reported to the executive leads.
 - There was good leadership of the specialist palliative care team led by the palliative care consultant and the specialist palliative care nurse team leader.
 - All staff we spoke with thought their line managers and senior managers were approachable and supportive but not supported by the trust board. Staff on Jowers ward told us they had complained to the board about the hospital general infrastructure and had not received a response. For example, the pressure to move patients and the accident and emergency department, lack of appropriate number of qualified staff and lack of required equipment.
 - Ward staff told us the specialist palliative care team were visible and provided good levels of education and support.
- **Culture within the service**
 - We were told by staff and the senior team that the trust culture encouraged candour, openness and honesty.
 - Staff on Jowers and Egremont wards told us there was an open culture on the wards.

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- All staff we spoke with demonstrated a positive attitude toward caring for the dying person. They described how important end of life care was and how their work had an impact on the overall service.
- 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.
- We found staff had a 'can do' attitude. Staff were patient-centred and wanted to deliver good care though good training and support.
- The end of life care facilitator had a proactive approach to developing the workforce and ensuring the training of staff fitted the changing needs of the patients.
- **Public engagement**
 - The carer's survey by the specialist palliative care team obtained feedback from carers about the service in 2012/13 and received a 19% response. In 2014/15, 55 surveys were distributed trust wide and 23 completed surveys were returned giving a response rate of 42%. Overall responses were satisfied with the support they were provided with. Written feedback included: 'be available at the weekend' and 'more information i.e. booklets and financial support'. The survey was due to be repeated in 2016/17.
 - The palliative care team acknowledged that although overall the survey achieved some positive feedback it was too small a sample from which to draw conclusions. They told us that consideration was needed to be given to future audits on the best way to capture patients' experiences of their service.
 - At the time of inspection the trust did not have a bereavement survey which would enable the trust to capture feedback from bereaved relatives. We saw that this had been designed but not yet piloted. The results of this survey would be fed back to wards and services.
- **Staff engagement**
 - Staff told us that they were actively encouraged to express their views which could help to develop services.
 - The specialist palliative care team told us they were actively encouraged to report any concerns regarding wards that may affect the care of an end of life care patient. For example, staff shortages that could affect the care of end of life care patients and identified training issues.
- **Innovation, improvement and sustainability**
 - The 'symptom observation chart for a dying person' won an award for a doctor involved in its development. The idea was taken to the innovation forum and developed with the support of the members of the end of life care work stream which measured effectiveness.
 - The critical care outreach team was engaged with the end of life care service and were members of the end of life care work stream. The team ensured that inappropriate interventions were not undertaken by the team if it was agreed that it was not in the patient's best interest including recognising that the patient was dying.
 - In 2014 a palliative consultant won Doctor of the Year for Brighton and Sussex University Hospitals NHS Trust.
 - The end of life care facilitator had developed a regular end of life care newsletter. In March 2016 newsletter subjects covered included 'Key messages from teams supporting the end of life care work'; 'The doctors involved with the End of Life Care Audit: Dying in Hospital' and 'Invitation to the 8th Brighton and Sussex University Hospitals NHS Trust End of Life Care Issues' to all staff across the trust.
 - The end of life care computerised resource was an innovative system. This intranet resource provided easy to read information for all aspects of end of life care. It was easily accessible and was available for all staff.

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Safe	Inadequate	
Effective	Not sufficient evidence to rate	
Caring	Requires improvement	
Responsive	Inadequate	
Well-led	Inadequate	
Overall	Inadequate	

Information about the service

The Royal Sussex County Hospital offered outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required. The hospital had medical and surgical specialty clinics, as well as paediatric and obstetric clinics. There were 476,350 outpatient attendances at the hospital in the last calendar year.

The diagnostic imaging department carries out routine x-rays, magnetic-resonance imaging (MRI), computerised tomography (CT), mammography and ultrasound. In the last year, 172,959 patients used this service.

During the inspection, we spoke with 60 members of staff, which included managers, nurses, administrative staff and allied health professionals. We spoke with 13 patients and their relatives. We visited outpatient areas, the booking centre and all areas of diagnostic imaging.

Summary of findings

Overall we found the outpatient and diagnostic imaging departments to be inadequate. This was because;

- We identified areas of significant concern with regard to infection control. The outpatient areas did not consistently comply with hospital building notes in relation to infection control. Compliance with infection control training was poor. The most recent infection control audit score for the outpatient department was below the target score. There appeared to be no action plan following it. Not all clinic rooms had cleaning checklists.
- Not all staff were confident to report incidents, incidents were not always discussed at staff meetings and there appeared to be no learning from incidents. Compliance with mandatory training was poor.
- We identified concerns about the storage and security of hospital prescription forms. Resuscitation trollies were not tamper proof and, although drugs were kept in sealed boxes, they were not stored securely.
- Confidential medical information was not always stored securely and around 4,500 medical records had gone missing each month.
- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. We saw that staff on the whole had a good awareness of National Institute for health and Clinical Excellence

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(NICE), although some staff in outpatients were unaware what a NICE guideline was. We saw competency documents, which indicated staff were competent to perform their roles.

- Patients were not always treated with dignity and respect. We saw staff did not always consider the privacy of patients. Staff did not always introduce themselves to their patients. We witnessed breaches of confidentiality in patient waiting areas.
- The trust had failed to meet the England standard for referral to treatment (RTT) times since September 2014. The trust had failed to meet cancer waiting and treatment times.
- The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.
- Call centre data indicated almost half of all calls had been being abandoned and unanswered.
- Of all appointments cancelled by the hospital, 60% were cancelled with less than six weeks' notice. There was no monitoring of overrunning clinics by managers. Staff recorded clinic delays on an ad hoc basis.
- There was no formal strategy or vision in place in the outpatient department. Not all staff felt they could approach their managers for support. Senior managers and the executive team were not always visible to staff in the department.

However;

- The trust had won an NHS innovation award for the implementation of a virtual fracture clinic which cut the number of times patients had to go to the hospital.
- The diagnostic imaging services were safe, effective, caring and well-led.

Are outpatient and diagnostic imaging services safe?

Inadequate



We rated safe as inadequate. This was because;

- Staff did not consistently report incidents and some staff were unsure of what to report. Outpatient services reported only 137 incidents across the whole trust last year. There was no regular discussion about incidents at team meetings and did not appear to be any learning from incidents.
- The outpatient department had scored poorly in a recent infection control audit and staff were not compliant with infection control training.
- Cleaning checklists of treatment areas were not regularly completed, we saw dirty clinical areas and patients were measured in dirty utility areas. Urine samples were stored in an area open to and accessed by patients.
- Soft furnishings did not comply with hospital building note standards and could not be adequately cleaned.
- Medicines management was good on the whole but there was no system of monitoring how many prescriptions had been issued. Prescription pads were not securely stored. Temperatures of drug fridges were not always monitored.
- There was no process of alerting the booking team when a patient category had been changed from routine to urgent. Assurance could not be given they were receiving an appointment in a timely manner. There was no clinic oversight of patients waiting longer than 18 weeks. Patients waiting longer than 52 weeks were reviewed. This meant patients waiting longer than 18 but not more than 51 weeks for an appointment had no review to establish whether any harm had come to them as a result of the delay.
- Staff were not compliant with mandatory training.
- **Incidents**
- Staff in the outpatient and diagnostic imaging departments used an electronic commercial software system that enabled incident reports to be submitted. In the last year, 137 incidents were reported using this system across the trust.
- Some staff told us they felt confident in knowing what to report as an incident, others did not. They did not

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regularly receive feedback following incidents. Minutes of staff meetings indicated incidents were not a regular agenda item. Clinical governance meeting minutes did not demonstrate incidents or lessons learned were discussed regularly. This indicated incidents, themes or learning from incidents was not discussed regularly amongst outpatient staff.

- In the last calendar year, the radiology department reported four incidents to the Care Quality Commission in line with ionising radiation (medical exposure) regulations (IR (ME) R, 2000). Staff dealt with the incidents in an appropriate manner and the incidents were investigated. These incidents were also discussed at the trust radiation safety committee meetings, we saw minutes of these meetings.

• **Cleanliness, infection control and hygiene**

- To maintain registration with the CQC, healthcare establishments must demonstrate compliance with Infection Prevention criterion as detailed in The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health 2015).
- An email sent on the 5th April 2016 indicated the most recent infection, prevention and control audit indicated the outpatient department was 53% compliant. The main issue identified was cleanliness and it had been identified that housekeeping standards were not being met.
- Data provided indicated 47% of clinical staff had attended infection control training in the past year, which was below the trust target of 95%.
- We saw workman's footprints and dirt on the carpet of the Sussex eye hospital waiting area. The Lead nurse raised this as the workmen should have been wearing overshoes and the area was cleaned.
- In 8 treatment rooms we visited, there were no cleaning checklists visible. Staff told us they were not sure who was responsible to ensure they were complete.
- In the retinal screening room, there were two fabric chairs, one of which the fabric was torn. This is not in line with Hospital Building Note (HBN) 00-09, 3.133 which states: Soft furnishings (for example, seating) used within all patient areas should be chosen for ease of cleaning and compatibility with detergents and disinfectants. They should be covered in a material that is impermeable, preferably seam-free or heat-sealed.

- Chairs in some waiting areas were covered in fabric and soiled. This is not in line with HBN 00-09, 3.134 which states: Fabric that becomes soiled and stained cannot be adequately cleaned and will require replacement.
- Staff took patient measurements in a dirty utility room, and the door was wedged open. Patients walked through the dirty utility to have blood pressure measurements taken in a room which stored equipment and medical records.
- Urine samples were kept unlabelled on a work surface and we saw they remained there for more than one hour. We were told samples were left in case further testing was required.
- We did not see any equipment cleaning checklists in the outpatient department. We did not see equipment with 'I am clean' stickers on, which would indicate it was clean.
- Hand hygiene audit scores from April 2015 to Jan 2016 were on average 97.5%. This was below the Trust expectation of 100% and indicated the required standard was not consistently being achieved. We did not see staff using hand sanitiser.
- We were shown a schedule of when curtains were to be changed with varying frequencies according to the risk factor within the area. There was however no documentation of the curtain changing having actually been carried out at the hospital. We were told that the curtains in the outpatient department at the hospital had never been changed in 3 years and saw visible signs of staining on these curtains. If Trusts do not have a robust system in place for changing of curtains, microorganisms could be passed from curtains to hands when staff open and close them. This was not in line with HBN 00-09,3.138, which states: there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known/or suspected infection.
- The definitions as laid down in the national specifications for cleanliness (NSC) state that areas where invasive procedures are carried out should be rated as very high risk achieving 98%. We visited the sexual health clinic, where invasive procedures were carried out. The trust had rated this area as high risk, rather than very high and was not achieving the standard of cleanliness required.
- As the Trust has rated this functional area as high risk the standard expected for auditing purposes is 95% and

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the standard to be achieved according to the NSC is as follows; High-risk functional area the required service level outcomes should be maintained by regular and frequent cleaning with 'spot cleaning' in-between.

- This was not the case on the day of inspection. Out of the areas available we inspected 13. They were; CN001, CN006, CN007, CN0011, CN0012, corridor CN010 to CN011, corridor to CN0012, CN0013, CN0014, CN0015, toilet, disabled toilet, pharmacy consulting room.
- Throughout the unit there was deep seated grim on the flooring, dark dust and debris at the floor wall joint, grey dust on high and low surfaces in particular bay curtain rails. In CN006 the floor was torn with evidence of debris under the flooring. CN012 had a gap in the seal of the floor. There was dried faeces on the toilet brush in both toilets. The housekeeping manager was contacted directly to replace these brushes, which was done within 20 minutes. This shows that insufficient cleaning is taking place and potentially puts patients receiving treatment in these rooms at risk of hospital acquired infection (HAI).
- HTM 00-09, 3.108 for flooring states; the quality of finishes in all clinical areas should be readily cleaned and resilient. 3.109 states; flooring should be seamless and smooth, slip-resistant, easily cleaned. The standard of finish in these areas means that suitable and sufficient cleaning cannot take place. The holes in the flooring when mopped will potentially leave moisture which could become an ideal area for bacteria to multiply. Therefore potentially increasing the risk of a HAI.
- The most recent audit results that were available on the day of inspection were November 2015. No results of 2016 audits were available for inspection. The Trusts own audits of the out patients department which includes Lawson unit, Claude Nicole unit and ground floor outpatient department showed that out of the 12 audits that were undertaken in November 2015, five failed to achieve the standard as defined in the NSC for high risk areas 95%. If the area was rated according to what we were advised regarding invasive procedures and rated as very high risk 10 of the 12 audits would have failed to achieve the standard 98% required. Out of the 10 that failed to achieve the standard three scored 97.6% and can be rounded up making the figure seven of the 12 audits failed to achieve the required standard. These percentages were not consistent with the standard of cleanliness that was found on the day we inspected. Neither was the standard of cleanliness consistent with the patient led assessment of the clinical environment (PLACE) score of 100% for cleanliness.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations.
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed and by whom.
- The endoscopes used in the ear, nose and throat (ENT) clinics were cleaned between each use with a triple cleaning system. At each of the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff used. The records we saw showed each time an endoscope was clean with the three stages completed.
- Complete, daily, cleaning checklists were visible in diagnostic imaging examination rooms. We saw staff clean equipment between patient use and they wore suitable personal, protective equipment.
- In the diagnostic imaging department, an infectious patient would have an investigation at the end of the list, so the room could be deep cleaned after.
- **Environment and equipment**
- A store cupboard in the eye hospital contained medical records, a fridge, a toaster, a microwave and a kettle. We asked staff if a fire risk assessment had been carried out. They indicated senior staff were aware of the cupboard. We escalated our findings to a senior manager who indicated they were not aware. They gave us assurance the cupboard would be looked into as a matter of urgency.
- In the Sussex Eye Hospital a shutter which divided the reception area from the office where medical records were kept was broken and could not be closed. Staff told us they had reported this in August 2015, but was yet to be repaired.
- In one treatment room a window had been broken six weeks prior to inspection and was still awaiting repair.

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- The resuscitation trolley in outpatient areas had equipment for adults and children. The trollies were non-tamper proof and there was easy access to drawer contents. Medications were stored in sealed units, but were not secured to the trolley.
- We saw copies of service records which indicated equipment is serviced annually. We saw stickers on equipment which indicated it had been serviced recently.
- Waiting areas on the whole were open, with enough seating for waiting patients.
- An environmental audit of the diagnostic imaging department completed in March 2016 scored 100%.
- All equipment was regularly serviced. We saw records of regular quality assurance tests of diagnostic imaging equipment. In addition to this a radiation protection committee reported annually on the quality of radiology equipment. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations IR (ME) R 2000).
- Lead aprons were available in all areas of radiology for children and adults. Regular checks occurred of the effectiveness of their protection. We saw spreadsheets which showed checks occurred regularly and equipment provided adequate protection.
- **Medicines**
 - Doctors' hand wrote prescriptions that could only be dispensed in the hospital pharmacy.
 - The pads were stored in unlocked clinic rooms. We saw three pads in examination room four in the diabetic outpatient area. The pads did not have serial numbers on. No record was kept of how many prescriptions were issued each day. This was not in line with NHS Protect security of prescription forms guidance (2013).
 - Some medicines need to be stored within a limited temperature range. They should be stored in a dedicated fridge. Regular temperature checks should occur to ensure the limited temperature range is maintained. We saw that on the whole temperatures of drug fridges were recorded. However, we saw that one fridge had a temperature of 10 degrees, which was greater than the required range. Staff explained the reason for the elevated temperature was as the fridge has just been cleaned. It was not clear where the medicines had been stored during the cleaning process.
 - The drug fridge located in the kitchen of the diabetic outpatient area did not have its temperature checked or recorded regularly.
- Drug cupboards we saw in outpatients were locked. Only registered nursing staff held keys to the drug cupboards. This was in line with NICE guidelines MPG2.
- Records held by the Patient Group Directions (PGD) Group indicated PGDs were in use that were past their review dates. PGDs provide a legal framework that allows the supply and/or administration of a specified medicine, by a named, authorised, registered health professional. Provider data suggested PGDs were in use past their review dates in Ophthalmology, Radiology and Dermatology.
- **Records**
 - On average, in 2015, 8% of patients were seen in outpatients without the full medical record being available.
 - Data indicated between January 2015 and January 2016, on average 4,524 records could be not located when initially looked, for every month. On average 93% of these were found. Staff told us the tracking system was not taken seriously. They told us they could spend up to 40 minutes looking for records.
 - We saw records in outpatients kept in unlocked trollies and not constantly attended by staff. We found patient identifiable data which included clinical diagnoses, in an unlocked, unattended area, which related to 203 patients. This indicated records were not consistently being kept securely.
 - Between January 2015 and 2016 on average 296 temporary records were made each month. The percentage number of temporary records being made each month had reduced from 14% to three percent of all records each month.
- **Safeguarding**
 - Nursing and diagnostic imaging staff demonstrated a good awareness of what to do if they had safeguarding concerns. They could explain what to do if they had concerns and who to contact. Staff told us, once an alert had been raised, they did not receive an outcome, which they would have liked. There was no record of the number of safeguarding alerts raised in the last year as the trust did not record this information.
 - Staff demonstrated where and how they could flag safeguarding issues on their computer patient booking system.
- **Mandatory training**

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- Data provided to us indicated that outpatient staff were 54% compliant in mandatory training which was below the trust target of 100%. Statutory training compliance was 61% which was below the trust target of 95%. Staff told us the new computer based training system was not user friendly. They told us there were delays in the availability of training, so they missed their target date.
- **Assessing and responding to patient risk**
- Some eye treatments can be carried out using light amplification by stimulated emission of radiation (LASER) therapy. We saw a LASER stored in a treatment room with the door open and the key in the machine. This is not in line with LASER safety guidelines (BS EN 60825-1: 2007. Safety of laser products: Part 1. Equipment classification and requirements). There was a warning sign on the door and a key pad entry to the door. The local rules were not located with the machine. We asked the LASER protection supervisor where the rules were and were given a recently written system of work. Which stated; the key should never be left in the LASER.
- Turnaround times for diagnostic biopsies for breast, prostate and bowel cancers were monitored regularly. There was no system in place to identify biopsies for other potential cancers, so they were not fast tracked or monitored. This indicated some patients may not have been receiving a cancer diagnosis in a timely manner.
- Booking centre processes, on the whole, ensured patients did not get lost in the system. On receipt, referrals were put onto a patient administration system, for booking appointments. In addition to this, they were put onto a referral management system. The staff who inputted this data made a decision based on clinical details, which specialist team the referral was sent to. These staff were not clinically trained. A serious incident occurred last year as a result of this. A two week wait referral resulted in an appointment with an inappropriate clinician.
- Staff and managers told us the computer systems were not compatible. If a consultant re-graded a referral as urgent, this would appear on the referral management system, but not on the patient administration system. This indicated not all urgent patients would receive an urgent appointment.
- We received an email statement which read: There is no clinical review of patients that go over 18 weeks. We prioritise those triaged or expedited as clinically urgent. This indicated patients waiting greater than 18, but less than 52 weeks were not reviewed for any potential harm.
- A clinical review group was established to review all clinical records of patients who have waited over 52 weeks and whether the patient has been harmed by the delay to treatment. This review would take place once treatment has been given. Progress and outputs of the Clinical Review Panel and any patients where significant harm had resulted because of a delay were reported to the Quality Review Meeting.
- A tracking system was maintained which listed all patients treated over 52 weeks, date of review and actions. This was to be maintained and updated during the clinical review process. We saw this list. Of the 309 reviewed so far 114 were patients under the digestive diseases specialties (37% of all reviewed).
- Patients on a two week pathway had a dedicated booking team in the booking centre. Most referrals were received electronically. A paper referral would be taken to the two week wait team on the same day. The booking team could escalate concerns about appointment to service managers. Weekly cancer patient tracking list meetings provided clinical oversight of patients on two week pathways.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in areas we visited. Diagnostic imaging staff had a clear understanding of protocols and policies. Protocols and policies were stored on a shared computer file which staff had access to. Staff demonstrated their knowledge of where policies were kept.
- We observed good radiation compliance as per policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. There was key card entry to examination rooms and only authorised staff held a key card.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with ionising regulations 1999 and regulations IR (ME) R 2000).
- Departmental staff also carried out regular Quality Assurance checks. This indicated equipment was

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working as it should. These mandatory checks are in line with ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R 2000). We saw records of these checks.

- Lead aprons were available in all areas of diagnostic imaging where necessary for children and adults.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging departments in line with best practice.
- **Staffing**
 - At the time of inspection although the nursing staff were one Band 6 understaffed, they had over recruited the numbers of Band 5 nurses and planned to develop them further.
 - Additionally the diagnostic imaging department had a vacancy rate of 11%. If agency staff were used, there was a comprehensive induction checklist completed, which we saw.
 - A radiologist was available through the day every day to provide reports and assistance to radiographers and medical staff if required.
- **Major incident awareness and training**
 - Outpatient staff we spoke with had varied understanding of what a major incident was and what would happen during one. They told us there was no training for major incidents.
 - Staff in diagnostic imaging were able to describe clearly the process if a major incident occurred. An example was given of a recent incident and how the department responded.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effectiveness as we do not currently collect sufficient evidence to rate this.

- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. We saw that staff on the whole had a good awareness of National Institute for Health and Clinical Excellence (NICE) guidelines and this was demonstrated in their practice.
- We saw staff were competent to perform their roles.

- The diagnostic imaging department had policies and procedures in place in line with national guidance.
- **Evidence-based care and treatment**
 - Diagnostic imaging services participated in the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focussed assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. A requirement of the programme was to audit services regularly. We saw that a variety of audits were ongoing in the imaging departments which could demonstrate that best practice was being achieved. We noted that these audits were ongoing.
 - The diagnostic imaging department were following a variety of National Institute for Health and Care Excellence (NICE) guidelines. They followed NICE clinical guideline (CG), 176 for early assessment and management of head injury. Local implementation of a suspected lung cancer pathway in March 2016 met NICE guideline (NG), 12 for suspected cancer: recognition and referral. They were also working in line with NG, 39 for major trauma: assessment and initial management, with the CT traumagram protocol for polytrauma.
 - The imaging department had policies and procedures in place. They were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000) and in accordance with the Royal College of Radiologists standards.
 - In outpatients some staff we spoke with were unclear about what a NICE guideline was.
- **Nutrition and Hydration**
 - Staff told us that if a patient experienced a delay in diagnostic imaging, they would be offered a snack box.
- **Pain relief**
 - If pain relief was required in outpatients, a patient would be given a prescription which they could take to the pharmacy department within the hospital.
 - In diagnostic imaging, staff would contact the ward if an inpatient was in significant discomfort. This was in order to return them to the ward as soon as possible and inform ward staff pain relieving medication was required.
 - We saw a variety of pillows and pads were available to make patients as comfortable as possible whilst undergoing an examination.

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• Patient outcomes

- Patient outcomes recorded on the computer system indicated if a patient, had another appointment, or had been discharged. Staff could not close a clinic without inputting an outcome. This indicated all patients had an outcome.

• Competent staff

- Staff told us that additional staff were available during the induction process so that sufficient time was allocated to get to know the area they were working in. Staff were moved through different clinical areas regularly to maintain their competency in a variety of skills. There was a system for assessing the competency of staff in several skills. We saw copies of competency certificates.
- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the nursing and midwifery council (NMC).
- One member of staff had additional duties on their main role as a health and safety representative. Training for this extra role has been self-funded. There was no time within main job role to carry out these additional duties.
- Some staff said they were able to access funding for external training and that this was positively supported. However, one member of staff was told at interview that there was no budget available for formal training.
- We saw that all employed radiology staff were registered with the Health Care Professions Council (HCPC). Managers checked the registration of their staff regularly. Radiology staff who administered medicines were required to be certified to do so and we saw certificates for those staff which were in date.
- Agency staff completed an induction prior to starting work in the diagnostic imaging departments. We saw copies of these checklists.
- Eighty two percent of all diagnostic imaging staff had an appraisal in the last year, which was above the trust target of 75%.
- Some staff working in diagnostic imaging can give medicine to patients for certain diagnostic tests. We saw certificates which confirmed staff were competent to do so.

• Multidisciplinary working

- In the sexual health clinic, staff attended team meetings regularly from the clinic, community pharmacy and ward.
- One stop clinics involved several different staff groups working together and occurred in urology and head and neck specialities. A variety of staff from different staff groups and hospitals attended.
- **Seven-day services**
- Radiology consultants worked seven days a week, on a rota basis. The radiology department provided a seven day, on call service.
- **Access to information**
- The computerised radiology information system (CRIS) stored patient data and was used for booking appointments.
- A patient archiving computer system (PACS) was used for the storage of diagnostic imaging tests. Staff throughout the trust could access the results of diagnostic tests through PACS. They required a passcode to log in.
- Policies, procedures, service records and meetings of minutes were stored in a shared folder on the trust intranet. We saw staff could access this information with ease.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
- We saw posters around the hospital which gave a brief description of the mental capacity act.
- Staff were able to describe the process of dealing with a patient who may not have the capacity to consent to treatment. They were aware of who to contact if they required further advice.

Are outpatient and diagnostic imaging services caring?

Requires improvement 

We rated caring as requires improvement. This was because;

- We saw inconsistent levels of caring and compassionate care delivered by staff working at the Royal Sussex County Hospital. Patients were not always treated with dignity and respect.

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- We saw staff did not always consider the privacy of patients. Staff did not always introduce themselves to their patients. There was a poor response rate (less than 1% of patients) to the Friends and Family Test (FFT). The responses that were received were largely positive.

However;

- In the diagnostic imaging department staff dealt with patients in a kind and considerate manner.
- We saw staff consistently introduce themselves to patients and treat them with dignity and respect.
- **Compassionate care**
- A friends and family test (FFT) completed in January 2016 indicated 96% of patients would recommend the outpatients department and 2% would not. This was greater than the average of 92% who would recommend and three percent who would not recommend a service. Four hundred and eighty four of an eligible 51,556 patients completed the survey which is less than 1% of all patients who attended the outpatient department. Patients we spoke with told us the care they received from staff at this hospital was good.
- The outpatient department completed an FFT of 154 people from April to October 2015, which indicated 86% were likely to recommend the department to friends and family.
- We observed poor levels of privacy and dignity for patients throughout the department. We saw a non-clinical member of staff knock and enter a clinic room without waiting, despite being told there was a patient in the room. Clinic doors were left open when patients were having their consultation, with waiting patients observing. Confidential patient information was clearly heard at reception desks. We heard a staff member discuss a patient's condition in a waiting room, whilst other patients were waiting in that area.
- In the Sussex Eye Hospital, we saw clinic doors were left open, whilst patients had examination. Patients waiting in corridors outside the rooms could see patients being examined. We observed eye examinations being carried out and overheard patient-doctor conversations. Some eye tests performed in corridors due to a refurbishment programme.
- We did not see knock and wait signs on any examination room doors.
- There were no posters offering a chaperone service in clinic rooms or waiting areas. Staff told us that some services ask this question at the patient assessment.
- The majority of staff we saw did not introduce themselves to patients. We heard staff referring to patients as he or him, rather than using their name.
- In the Claude Nichol Unit there were privacy screens at reception so patients could talk to the receptionists without being seen or overheard
- **Understanding and involvement of patients and those close to them**
- Patients were not always told in advance if their service was moving to receive their care in a different area. A staff member told us they were informing patients in clinic of the diabetic service's planned move from the hospital to community teams. Patients, however, continued to receive appointment letters telling them that their future appointments would be in the hospital.
- We saw a variety of health-education literature and leaflets produced by national bodies. Some of this information was general in nature while some was specific to certain conditions. This literature was available in all waiting areas of the outpatient departments.
- The Lawson Unit offered an opt-in follow-up clinic conducted via email. This meant patients could choose to have their follow-up consultation by email rather than attending the clinic in person.
- The Lawson Unit were developing an application for use on smart phones to be able to connect with more patients.
- There were no toys available in the main OPD waiting area, but we did see a member of staff guide a parent in the waiting room to a different department where there were toys available for her child to play with whilst they waited.
- At the entrance of the main outpatients, we saw a 'you said we did' poster. This stated that patients had asked for a radio in the diabetic waiting room and that this had been actioned by the trust. During the inspection we did not see or hear a radio in the diabetic waiting area.
- A patient experience panel met every other month. Staff and patient representatives attended. Patient representatives were encouraged to give feedback on their experiences in the hospital. Action points were made as a result of this feedback. We saw minutes of these meetings and updates on actions which had arisen.
- **Emotional support**

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- We saw Macmillan cancer support information was available for patients, carers and their families. Literature on bereavement services was available in waiting areas.
- A charity provided a friend service to support patients living with cancer. The friends were trained Macmillan volunteers who had undergone treatment for cancer themselves. They provided help and support to patients, their families and carers.
- The ultrasound department had a system in place so that, if a patient received bad news in the baby scanning department, staff could take them to a separate quiet room and an additional staff member could be called for counselling and emotional support.
- Staff told us they received no emotional support following difficult or challenging situations. Some staff, due to their distance from the nearest security office, had to wait up to five minutes after raising the alarm to get help from the security team.

Are outpatient and diagnostic imaging services responsive?

Inadequate 

We rated responsive as inadequate. This was because;

- The trust had failed to meet the England standard for referral to treatment (RTT) times since September 2014. An action plan to recover the RTT was being implemented, but was in the early stages and yet to have an impact on waiting times.
 - The trust had failed to meet cancer waiting and treatment times.
 - The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.
 - Call centre data indicated almost half of all calls had been being abandoned and unanswered.
 - From April 2015 to March 2016 the hospital cancelled 17% of its clinics. Of those cancelled, 60% were cancelled with less than six weeks' notice. No reasons were given for the cancellation of clinics.
- Overrunning or delayed clinics were not monitored, so managers could not be aware if this was a problem or not.
- However;
- We saw there were systems and processes in place to deal with patient's individual needs.
 - Patients accessed examinations in the diagnostic imaging department in a timely manner.
 - **Service planning and delivery to meet the needs of local people**
 - In the last year the hospital ran 855 clinics during the weekend, offering patients a variety of days to attend.
 - In the eye hospital, staff monitored patients to identify any with a potential delay in their treatment. Additional clinics ran at weekends to ensure patients had their treatment in a timely manner.
 - We saw adequate numbers of chairs in waiting areas we visited. Staff displayed clinic delays and waiting times on white boards.
 - The sexual health clinic ran a walk in service. This meant patients could attend the department at a suitable time for them.
 - An email contact and a phone line had recently been set up for patients with a tracheostomy. This enabled patients to contact a member of staff at the weekend if they had concerns.
 - The trust established a virtual fracture clinic in 2013. The clinic meant patients who were treated in A&E with a broken bone no longer had to come to hospital for face-to-face assessment. They could receive advice and exercises from a specialist physiotherapist. Patients could continue their management at home.
 - **Access and flow**
 - Since January 2009, every citizen of this country has the binding NHS constitutional right to be treated within 18 weeks. Where a hospital is unable to offer patients treatment within 18 weeks, the patient has the right to be treated elsewhere. Operational standards are that 95 % of non-admitted pathways should start consultant-led treatment within 18 weeks of referral.
 - The non-admitted referral to treatment times (RTT) for this hospital from September 2014 was consistently worse than the England average and the standard of

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95%. At the end of February 2016, one out of 18 specialities had met the standard. Overall 85 % of patients were seen within 18 weeks which remains below the standard.

- A referral to treatment time (RTT) action plan had been established to deal with the RTT's. We saw the action plan had 104 actions, of which three had been completed. One of the actions was to have a weekly access meeting. Access meetings looked at the numbers of patients waiting longer than 18 weeks. Staff discussed capacity and patients waiting longer than 52 weeks were identified. We saw minutes of these meetings.
- The percentage of cancer patients seen by specialist within 2 weeks of an urgent referral varied between from April 2015 to December 2015 and in four out of the seven quarters was below the national average. The most recent data indicated 92% of patients were seen in two weeks. This was below the England average of 95% and the standard of 93%.
- The last reported data indicated ten out of four specialities had met the standard. The percentage of patients within two weeks with suspected lower gastrointestinal cancer was 67%. The most recent cancer meeting minutes indicated this had reduced further to 38%. The percentage of patients seen within two weeks with suspected upper gastrointestinal cancer was 87%. The most recent cancer meeting minutes indicated this had reduced to 76%. This indicated the performance in these two areas was worsening.
- The percentage of patients waiting less than 31 days for treatment for cancer was below the England average from April to December 2015. The most recent data indicated 95% of patients were seen within 31 days, which was below the England standard of 96% and England average of 98%.
- The percentage of patients waiting less than 62 days for their first treatment for cancer was below the England average from April to December 2015. The most recent data indicated 82% waited less than 62 days which was below the standard of 85% and England average of 84%.
- The pathology department tested specimens where a piece of tissue had been removed to provide a diagnosis. Turnaround time (TAT) is a measure of how quickly a diagnosis can be provided. The most recent TAT for suspected breast cancer was 90% of results were available in seven days, this was better than the target of 80%. One hundred percent of results were available 14 days which was better than the target of 90%. For suspected prostate cancer, the TAT was 15% of results available in seven days, which was below the target. Seventy percent of results were available in 14 days, which was below the target score. The TAT's for suspected bowel cancer were; 55% of results available in seven days, which was below the target of 80%. Eighty five percent of results were available within the 14 days, which was below the target of 90%. Any suspected cancer samples which did not fit into the above category were labelled as 'other'. TAT' for these samples were; 30% of results available in seven days and 60% of results were available in 14 days. This indicated only samples for patients with suspected breast cancer were receiving a result within the target time.
- Data indicated 82,873 patient appointments were cancelled by the hospital in the last year, which equated to 17% of all appointments. Sixty percent of appointment cancellations were done with less than 6 weeks' notice. This was not in line with the patient access policy which states; a minimum of 6 weeks' notice is required if a Consultant or Clinician needs an outpatient clinic or inpatient theatre list cancelled or reduced. We requested the reasons for short notice cancellations but did not receive this information. This was not consistent with the outpatient service delivery and improvement plan which planned to monitor reasons for cancellations in order to set targets. We saw booking centre staff cancelling appointments with less than 24 hours' notice during the inspection.
- Paper referrals were received into the outpatient appointment centre. Staff scanned them onto a computer system. Consultants accessed this system to triage referrals. The target time for this process was 48 hours. We requested data to indicate how long it took to triage referrals. We received data about referral to appointment booking time. This suggested the time taken from referral to appointment booking indicated the length of time taken to triage the referral. The data provided indicated 68% of referrals had an appointment booked within 5 days, 15% had an appointment booked between 6 and 10 days and 17% waited more than 11 days to have an appointment booked. It was not clear what percentage of patients were triaged within the target time. Patients we spoke with told us they had been 'fobbed off' by the hospital and had waited more than a year to receive an appointment.
- The number of calls received at the call centre had increased from 18,097 to 26,916 from July 2015 to

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January 2016. During this period, the number of calls abandoned by the caller had increased from 8% to 41%. During our inspection we saw 48% of calls were abandoned. Staff told us patients come to the outpatient department with queries about appointments as they cannot get through on the phone.

- The trust did not record or monitor waiting times in clinic. There was no policy or protocol in place for overrunning clinics. This indicated the trust was unaware if and how many clinics ran late.
- We saw data which indicated in March 2015, 15% of clinic letters were completed in 2 days. Thirty percent of all clinic letters were completed in 14 days. This meant 39% took more than two weeks, which equated to 12,129 patient letters. Performance was variable between specialities. This was not in line with the target of all clinic letters to be sent in five working days. The number sent in five days was not measured.
- The most recently published data indicated that overall, 98% of patients received a diagnostic test within six weeks. Ninety nine percent of patients had an MRI in six weeks, 99.5% of patients had a CT in six weeks. Ninety nine percent of patients had an ultrasound scan in six weeks.
- Patients on a two week pathway were booked an appointment straight away. This was in line with the patient access policy. There were designated slots for diagnostic tests. If they were full, staff would be able to create another available appointment. Staff told us they never had issues finding appointments for patients on a two week pathway.
- A troubleshooting radiologist was available through the day to provide urgent reports on diagnostic tests. They also provided staff with advice.
- **Meeting people's individual needs**
 - Staff told us patients living with dementia were fast tracked when attending outpatient appointments. They told us patients would attend with a carer and carry a hospital passport. Passports outlined a patients care needs, preferences and any other information the staff would find useful to assist with their care.
 - Staff gave patients with learning disabilities longer appointments. Patients would be seen at the next available appointment on attending the department.
 - In the sexual health clinic, clinics for transgender patients were available, run by specialist nursing staff.

- A patient receiving a new diagnosis of HIV would have a nurse allocated to them providing support and specialist advice.
- Staff could indicate on the electronic patient information system if a patient had an individual need. We saw how this could be done.
- We saw wheelchair accessible reception desks in some areas. They had been installed following a disability access audit in 2008. Further work was to be done to make the hospital more accessible in the planning of the new build.
- We saw waiting areas had seats of varying height, bariatric seating and space available for wheelchair or push chairs.
- Hearing loops were not consistently available in outpatient waiting areas. Staff told us they could book a sign language interpreter if required.
- We saw posters advertising a telephone interpretation service. Staff told us if a referral indicated an interpreter was required, they could book one at the time of booking an appointment.
- Information was not available in other languages.
- There was no separate waiting area for children and adults in the ear nose and throat department. Clinics ran for children and adults at the same time, on the same day.
- We saw toys and books were available for children in some areas , but not others.
- **Learning from complaints and concerns**
 - Leaflets informing patients how to make complaints were available in waiting areas. Staff felt able to handle complaints and preferred to do so at a local level to diffuse the situation.
 - There was no regular feedback documented regarding complaints at team meetings.
 - We received information which indicated 30% of all complaints to the trust were about outpatients last year. The three most common cause for complaint across the trust were; administrative error/failings, communication and waiting for an outpatient appointment. Complaints did not appear to be a regular agenda item on any of the meeting minutes we saw.

Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Inadequate



We rated Well led as inadequate. This was because;

- There was no formal strategy or vision in place in the outpatient department.
- Senior managers and the executive team had variable levels of visibility across the department.
- There were variable levels of access to training across specialities.
- There was no evidence of innovation, improvement or sustainability.
- Managers did not monitor clinic waiting times.

However;

- The diagnostic imaging department management had a clear structure in place, managers were visible.
- Managers monitored the department's performance and staff took pride in their work.

Vision and strategy for this service

- Staff told us there was no agreed vision or strategy for the outpatient department. When we asked managers about their vision, they told us about the vision for departments they were moving to.
- An interim manager told us about the referral to treatment (RTT) recovery plan and we saw this. The plan was extensive and had timescales which were Red, Amber, and Green (RAG) rated. A number of actions on the plan had passed their due date and some actions did not have a due date allocated.
- A manager told us that the trust had requested a pause in patient referrals for digestive diseases speciality from the Clinical Commissioning Group (CCG). The CCG has implemented a strategy to ensure that patients are re-directed to other providers during this period, to ensure they are receiving appropriate care. This was because waiting times had increased for this speciality. The manager explained waiting times for patients on an 18 week pathway had increased and this was because appointments had been given to patients on a two week pathway, which enabled the two week targets to be met in some specialities.
- The outpatient department had a values and behaviours champion. Senior staff told us the majority of staff complied with the trust values.

Governance, risk management and quality measurement

- The Lead Directorate Nurse for the outpatients department told us that monthly outpatient manager meetings were held and was a good forum for sharing ideas across the directorate. We saw minutes of these meetings, however, quality issues such as complaints, incidents, risks and audits, were not regular agenda items.
 - The outpatient department carried out a variety of local audits. We did not see any improvement or action plan because of these audits. For example, over a ten month period, the hand hygiene audit scores for the outpatient department across the trust varied for 90% to 100%. The scores varied from month to month. This indicated standards were not consistently met and improvement was not occurring as a result of these audits.
 - Minutes of outpatient staff meetings indicated incidents were not a regular agenda item. Clinical governance meeting minutes did not demonstrate incidents or lessons learned were discussed regularly. Staff were not always confident in reporting incidents. When they did report incidents they did not always receive feedback.
 - Access meetings occurred monthly for cancer, diagnostic and referral to treatments times. We saw the minutes of these meetings. Regular agenda items were outcomes, learning from specific queries and reviewing the departmental dashboard. These meetings reported to the planned care programme board, which in turn reported to the finance, performance and people committee. This committee reported to the trust board.
 - The diagnostic imaging department had a dashboard which provided managers with monthly performance data. It included waiting times, reporting times and friends and family test results, which we saw. They provided feedback to the board on their performance via the access meetings.
 - The diagnostic imaging department took part in a number of audits which were on-going. They demonstrated NICE guidelines were being followed in a number of areas.
- ## **Leadership of service**
- Nurse Managers reported to the directorate lead nurse. The directorate lead nurse with the directorate manager and lead clinicians for head and neck specialities all

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reported to the clinical director, who was on leave at the time of our inspection. The directorate lead and lead nurse were due to move to different roles the month in May 2016.

- However, not all outpatient staff were in the same directorate. This was dependent on which speciality team they were in. We asked to see the structure of outpatient nursing staff and received a list of the numbers of staff at different pay bands at the eye hospital, main outpatients and the ENT outpatients. It indicated one of the band 7 nurses was an outpatient manager. The outpatient manager was on leave at the time of our inspection. Staff told us this happened at the last inspection and demonstrated the lack of support.
- During our inspection, the nurse in charge of main outpatients was running a clinic and not readily available to assist other members of staff.
- When asked about visibility of the executive team in the outpatient department, staff felt managers visited wards more than the outpatient department.
- One member of staff told us there was no ownership of issues higher up in the trust. They gave the example of patient transport issues that have been recurring and the knock on effect this has on patients and staff. The issue had been raised with managers on several occasions, but had never been acted upon.
- A member of staff who had worked at the trust for many years said that the communication “from above” was poor. They described how their job had been displaced with the arrival of the booking hub and although was well supported by their line manager, found this time very difficult.
- Some senior members of staff felt that the Chief Nurse was approachable and accessible.
- The majority of the staff we spoke with felt well supported by their immediate line managers.
- In the diagnostic imaging service, staff told us their managers were visible and approachable. They felt well supported by local and more senior managers. Managers formed a well organised team.
- **Culture within the service**
 - New members of staff told the induction process was comprehensive and lasted two days.
 - Staff told us that the medical model that the trust had adopted could be a barrier to further development. An example was given where a job role was advertised but was only available to nursing staff and not to other healthcare professionals.
 - Staff felt happy in their individual teams. There was no overall outpatient team.
 - The diagnostic imaging departments clearly took pride in their work and worked well together as a team. They supported one another and told us there was an open and honest culture.
- **Public engagement**
 - A manager told us that the trust published waiting times to the website per speciality. The trust had included on their website a ‘guide to waiting times’. The page on the website showed a high level overview of the 18 week pathway and the areas or departments where patients may experience delays.
 - We were not able to see specific waiting times data for specialities on the trust website.
 - A patient experience panel met every other month. Attendance was by patient representatives, staff members and other stakeholders from the local health economy. Patients and their representatives had the opportunity to raise issues which the trust team could action. We saw minutes of these meetings, actions that were carried forward and completed.
- **Staff engagement**
 - Staff told us about an innovation forum that was available for staff to attend, but other staff did not know about the forum. They told us they did not know how to access it.
 - A review of the booking hub had been undertaken and changes recommended because of this. Staff told us no one had discussed these changes, but they were happening anyway.
 - Managers had invited staff to patient tracking list meetings in order for them to feel part of the wider team. It allowed staff to escalate concerns and feel part of the wider team.
 - Staff told us the executive team were taking an interest in the management and development of the booking hub centre. The Board had approved the purchase of an additional module of the booking system which should allow more efficient working.

Outstanding practice and areas for improvement

Outstanding practice

- The play centre in The Alex children's hospital had an under the sea themed room with treasure chests full of toys and a bubble tank. There was also an interactive floor where fish swam around your feet and changed direction according to your footsteps.
- The virtual fracture clinic had won an NHS award for innovation. It enabled patients with straightforward breaks in their bones to receive advice from a specialist physiotherapist by telephone. It reduced the number of hospital attendances and patients could start their treatment at home.
- We found that an outstanding service was being delivered by dedicated staff on the Stroke Unit (Donald Hall and Solomon wards). The service was being delivered in a very challenging ward environment in the Barry building. Staff spoke with passion and enthusiasm about the service they delivered and were focused on improving the care for stroke patients. The results of audits confirmed that stroke care at the hospital had improved over the past year.
- The children's ED was innovative and well led, ensuring that children were seen promptly and given effective care. Careful attention had been paid to the needs of children attending with significant efforts taken to reassure them and provide the best possible age appropriate care.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times.
- The trust must ensure that all staff have attended mandatory training and that all staff have an annual appraisal.
- The trust must ensure that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.
- The trust must undertake an urgent review of staff skill mix in the mixed/neuro ICU unit and this must include an analysis of competencies against patient acuity.
- The trust must establish clear working guidelines and protocols, fully risk assessed, that identify why it is appropriate and safe for general ICU nurses to care for neurosurgery ICU patients. This should include input from neurosurgery specialists.
- The trust must take steps to ensure the 18 week Referral to Treatment Time is addressed so patients are treated in a timely manner and their outcomes are improved. The trust must also monitor the turnaround time for biopsies for suspected cancer of all tumour sites.
- The trust must ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines and intravenous fluids. Additionally the trust must ensure patient group directives are reviewed regularly and up to date.
- The trust must implement urgent plans to stop patients, other than by exception being cared for in the cohort area in ED.
- The trust must adhere to the 4 hour standard for decision to admit patients from ED, ie patients should not wait longer than 4 hours for a bed.
- The trust must ensure that there are clear procedures, followed in practice, monitored and reviewed to ensure that all areas where patients

Outstanding practice and areas for improvement

receive care and treatment are safe, well-maintained and suitable for the activity being carried out. In particular the risks of caring for patients in the Barry and Jubilee buildings should be closely monitored to ensure patient, staff and visitor safety.

- The trust must ensure that patient's dignity, respect and confidentiality are maintained at all times in all areas and wards.
- The trust must stop the transfer of patients into the recovery area from ED /HDU to ensure patients are managed in a safe and effective manner and ensure senior leaders take the responsibility for supporting junior staff in making decisions about admissions, and address the bullying tactics of some senior staff.
- The trust must review the results of the most recent infection control audit undertaken in outpatients and produce action plans to monitor the improvements required.
- The trust must ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates.
- The trust must urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board.
- The trust must undertake a review of the HR functions in the organisations, including but not exclusively recruitment processes and grievance management.
- The trust must develop and implement a people strategy that leads to cultural change. This must address the current persistence of bullying and harassment, inequality of opportunity afforded all staff, but notably those who have protected characteristics, and the acceptance of poor behaviour whilst also providing the board clear oversight of delivery.
- Review fire plans and risk assessments ensuring that patients, staff and visitors to the hospital can be evacuated safely in the event of a fire. This plan should include the robust management of safety equipment and access such as fire doors, patient evacuation equipment and provide clear escape routes for people with limited mobility.

Action the hospital SHOULD take to improve

- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.
- Review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- Consider improving the environment for children in the Outpatients department as it is not consistently child-friendly.
- Ensure security of hospital prescription forms is in line with NHS Protect guidance.
- Ensure that there are systems in place to ensure learning from incidents, safeguarding and complaints across the directorates.
- Ensure all staff are included in communications relating to the outcomes of incident investigations.
- Implement a sepsis audit programme.
- Provide mandatory training for portering staff for the transfer of the deceased to the mortuary as per national guidelines.
- Ensure there is a robust cleaning schedule and procedure with regular audits for the mortuary as per national specifications for cleanliness and environmental standards.
- Review aspects of end of life care including, having a non-executive director for the service, a defined regular audit programme, providing a seven day service from the palliative care team as per national guidelines and recording evidence of discussion of patient's spiritual needs.
- The trust should ensure all DNACPR, ceilings of care and Mental Capacity assessments are completed and documented appropriately as per guidelines.
- The trust should implement a formal feedback process to capture bereaved relatives views of delivery of care.

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

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
10.—(1) Service users must be treated with dignity and respect. (a) Ensuring the privacy of the service user.and staff must respect people’s personal preferences, lifestyle and care choices.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Staffing 18-(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.(a) receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Medicines management 12(2)(g) Appropriate arrangements must be in place for the safe keeping, dispensing, administration and disposal of Medicines
Safe Care and treatment 12-(1) Care and treatment must be provided in a safe way for service users (b) doing all that is reasonably practicable to mitigate any such risks.

This section is primarily information for the provider

Requirement notices

Safe Care and treatment 12-(1) Care and treatment must be provided in a safe way for service users (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

Safety and Suitability of premises 15 The provider must ensure that service users and others having access to the premises where regulated activities are carried on are protected against the risks associated with unsafe or unsuitable premises. In particular address the risks from infection and the risk of fire from poor environmental maintenance, design and layout in the Barry and Jubilee buildings.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Good governance 17-(1) Systems or process must be established and operated effectively to ensure compliance with requirements of this Part.

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided

This section is primarily information for the provider

Enforcement actions

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.

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

1. Your systems to assess, monitor, and mitigate risks to people receiving the care as inpatients and outpatients are not operated effectively.
2. Your systems to assess, monitor, and improve the care and, privacy and dignity of people attending your hospitals as inpatients and outpatients are not operated effectively.
3. Your systems to ensure patients are seen in line within national timescales for treatment are not operating effectively.

Where these improvements need to happen

1. Your trust board of directors receives conflicting and inaccurate evidence of assurance about the risks to patients using your services; we saw little or no evidence of robust discussions and challenges at board level to the risks posed to patients using services. We reviewed Trust board minutes from April 2015 – April 2016. There were frequent occasions during our inspection (April 4th- 8th 2016) when the number of patients requiring treatment exceeded the number of cubicles available in the emergency department (ED) at RSCH. This meant that patients spent long periods of time waiting in the 'cohort' area at RSCH, a corridor immediately adjacent to the ambulance entrance and handover bay. There was a lack of assessment of patients' conditions before they were placed in the 'cohort' area in the emergency department at RSCH and a lack of clinical ownership of patients in the 'cohort' area. We raised concerns following a focussed inspection in June 2015; however the actions taken by the trust since our last inspection remain insufficient to mitigate the risk. Between 1st January 2016 – 31st March 2016, 6623 patients waited in the 'cohort' area and, from information provided by the trust, the most time a patient spent in the corridor was 12 hours 53 minutes. We found that the risk assessments used for placing people in the 'cohort' area were not sufficient and patients sometimes received nursing care from a combination of ambulance paramedics and ED staff without appropriate monitoring. The responsibility for ongoing care was arbitrarily allocated and confusingly signposted, as described to us, by an informal system of either leaving or taking gloves off the bottom of the respective trolley, to identify wither ED staff or ambulance staff were responsible for the care.

Enforcement actions (s.29A Warning notice)

There were no systems in place for the management of overcrowding in the 'cohort' area. Staff were not able to provide satisfactory details of "full capacity" protocols or triggers used to highlight demand exceeding resources to unacceptable levels of patients in the area. ? There was an incident where a patient who had suffered a cardiac arrest whilst in the 'cohort', area reported in February 2016. The nurse in the cohort area had escalated her concerns regarding the patient to the coordinator but there was no space available elsewhere for the patient. The patient then suffered a cardiac arrest and had to undergo cardiopulmonary resuscitation (CPR).

? Patients presenting with a mental health illness were not adequately risk assessed prior to being placed in the 'cohort' area, one patient in May 2015 tried to self-harm whilst in the 'cohort' area. One patient in the September 2015 absconded from the hospital and was found collapsed and unresponsive on the road outside the hospital. Three other patients absconded from the department in August 2015, July 2015 and 10 May 2015, one patient was found safe and well the other two patients had no outcome recorded.

? At PRH there was only an emergency medical consultant (EMC) present in the department from 9am until 5pm Monday to Friday and no cover during evenings or weekends. We were unable to determine the status on Bank Holidays. This breached the Royal College of Emergency Medicine recommendations of having an emergency medicine consultant (EMC) presence from 8.00am until midnight seven days a week.

? There was a governance framework in place in ED with responsibilities defined that monitored the outcome of audits, complaints, incidents however it was unclear how this fed into the wider governance structure within the trust.

? The recovery area at RSCH in the operating theatres was being used for emergency medical patients due to having to reduce the pressure on an overcrowded ED and to help meet the emergency department's targets such as 12 hour waits. Some patients were transferred from the HDU to recovery to allow admission to HDU and some patients were remaining in recovery when there was no post-operative bed available. We were told and saw evidence in records that some patients were discharged home directly from the recovery area.

Enforcement actions (s.29A Warning notice)

? Some patients at were kept in the recovery area for anything between four hours and up to three days with some patients being discharged home directly from the recovery area.

? Whilst staff working in the recovery area were highly trained in looking after patients recovering from an anaesthetic they were not trained to look after emergency high dependency medical patients and ventilated patients when they were transferred directly to the recovery area.

? In out-patients (OPD) at RSCH we found a store cupboard in the eye hospital that contained medical records, a fridge, a toaster, a microwave and a kettle. We asked staff if a fire risk assessment had been carried out but none had.

? In the Sussex Eye Hospital a shutter which divided the reception area from the office where medical records were kept was broken and could not be closed. Staff told us they had reported this in August 2015, but was yet to be repaired.

? The wards in the older buildings at RSCH were extremely difficult environments for staff to provide safe and effective care. Some of the most challenging and vulnerable patients were being cared for in premises that were no longer fit for purpose. Although the trust had a strategy for managing this, this was not carried out in practice. Risk assessments were poorly completed or out of date and did not provide assurance that risks to patients, staff and visitors were identified and managed appropriately.

? Patients were not always protected from avoidable harm because there was no system to ensure trust wide learning from incidents or take action where poor infection control practices were identified.

? We were told and saw that all the environmental issues for the older buildings were on the risk register and had been "fed up the line." Staff were told by senior managers and the executive team that all the issues would be resolved during the rebuilding of the hospital. In the meantime staff and patients remained at risk from care and treatment being undertaken in an inappropriate environment.

? Managers told us that the acuity of patients in the Barry Building at RSCH was closely monitored as it was acknowledged the environment was inappropriate. However staff told us that due to pressures on beds their guidelines for admitting patients to these beds were

Enforcement actions (s.29A Warning notice)

frequently overridden by the bed managers. We saw examples where staff had completed incident reports due to inappropriate patients being admitted to these beds without any additional resources being put in place.

? We had particular concerns that the risk of fire was not being managed appropriately. We found that the Barry and Jubilee buildings were particular fire safety risks as they were not constructed to modern safety standards and had been altered and redesigned many times during their long history. They were overpopulated, overcrowded and cluttered with narrow corridors and inaccessible fire exits. We found flammable oxygen cylinders were stored in the fire exit corridors. We found fire doors with damaged intumescent strips which would not provide half an hour fire barrier in the event of horizontal evacuation. We found fire exits which had not been tested to ensure they provided safe, easy and immediate evacuation for the number and acuity of patients accommodated. We raised this with the executive team and requested action to be taken. It was unclear that the executive were aware of this risk to patient and staff safety.

? In the OPD at RSCH a doctors' hand written prescriptions could only be dispensed in the hospital pharmacy. The pads were stored in unlocked clinic rooms. We saw three pads in examination room four in the diabetic outpatient area. The pads did not have serial numbers on. No record was kept of how many prescriptions were issued each day. This was not in line with NHS Protect security of prescription forms guidance (2013).

? We saw records in outpatients at RSCH kept in unlocked trolleys and not constantly attended by staff. We found patient identifiable data which included clinical diagnoses, in an unlocked, unattended area, which related to 203 patients. This indicated records were consistently being kept securely.

? Staffing levels on the mixed intensive care unit (ICU) and cardiac ICU units were frequently and significantly short of enough nurses to provide safe care. This unit also frequently breached the minimum staff to patient standards set by the Intensive Care Society and the Royal College of Nursing.

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The skill mix of nurses on the mixed ICU unit was often insufficient to provide specialised care to neurosurgery patients. The trust had systematically failed to respond to staff concerns about this and mitigating strategies had failed.

? There was a lack of team working and skills competence in the mixed ICU unit that meant patient risks were not adequately assessed. This situation occurred when the nurse in charge overruled more junior neurological ICU nurses about specific treatment for high acuity neurosurgical patients. Several neurological ICU nurses raised this with us and told us they felt it was a dangerous precedent to set. For example, one individual said a nurse in charge, who was not trained in neurosurgery, disagreed with them about the ventilator settings used for a ventilated neurological patient. When the bedside nurse was not present, the nurse in charge changed the settings without a discussion. The patient's condition deteriorated and the bedside nurse then returned the settings to their original level. Staff told us this was a common occurrence but the department did not monitor such events we found no evidence on the risk register.

2.

Your trust board of directors receives conflicting and inaccurate evidence of assurance about the care and needs of patients, and we saw little or no evidence of robust discussions and challenges at board level of the care given or the responsiveness to people's needs. We reviewed Trust board minutes from April 2015- April 2016.

? We saw that people attending both RSCH and PRH did not always receive care in line with best practice, nor care that always met individual needs and protected their privacy and dignity.

For example :

During the inspection we saw a patient with a fractured ankle who was using a pain relieving gas arrive on a trolley, however because the 'cohort' area was already busy, a nurse wanted to re direct the patient to the unscheduled care centre (UCC). We witnessed the patient experiencing severe pain when trying to transfer to a wheelchair as patients on trolleys are not accepted in UCC. The patient was crying and obviously unable to transfer to a wheelchair, at this point a member of the inspection team voiced their concerns that this was subjecting the patient to unnecessary pain. The patient

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was then kept on the trolley in the 'cohort' area. We considered this interaction uncaring even though the action was taken because of the activity in the department but did not take into account the needs of the patient.

We observed an elderly patient who was left on a urine saturated sheet on a trolley for over an hour in the 'cohort' area.

We observed frail elderly vulnerable patients left in the 'cohort' area without call bells for extended periods of time and without any interaction with staff.

Some of the patients we spoke to in the 'cohort' area felt they were "on a conveyer belt" waiting to be placed in a cubicle.

We saw that there was constant moving of patients within the 'cohort' area and the inspection team felt this could disorientate and confuse patients.

We heard staff make assumptions and judgements about patients depending on their presenting condition; this indicated that they did not consider patients' individual needs.

We did not see interactions where staff apologised to those waiting in the 'cohort' area.

We observed poor levels of privacy and dignity for patients throughout the outpatient department. We saw a non-clinical member of staff knock and enter a clinic room without waiting, despite being told there was a patient in the room. Clinic doors were left open when patients were having their consultation, with waiting patients observing. Confidential patient information was clearly heard at reception desks. We heard a staff member discuss a patient's condition in a waiting room, whilst other patients were waiting in that area.

In the Sussex Eye Hospital, we saw clinic doors were left open, whilst patients had examination. Patients waiting in corridors outside the rooms could see patients being examined. We observed eye examinations being carried out and overheard patient-doctor conversations. Some eye tests performed in corridors due to a refurbishment programme.

AT RSCH patients were being kept in the recovery area of operating theatres for significant periods of time due to the trust attempting to reduce its target of moving a patient within 12 hours out of the emergency department (ED), lack of beds on the high dependency unit (HDU) and lack of beds in other areas of the trust.,

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Some patients could be kept in the recovery area for over four hours and up to three days with some patients being discharged home directly from the recovery area. Patients did not have their privacy when they needed it and did not have free access to washing and toilet facilities, could not move freely around the recovery area and could not see their relatives whilst in this area.

3.

Your trust board of directors receives conflicting and inaccurate evidence of assurance about the Referral to Treatment Time (RTT) target of 18 weeks and the 12 hour breach target (decision to admit) in ED across the Trust services. We saw little or no evidence of robust discussions and challenges at board level of the need to meet these targets and strategies to achieve this. We reviewed Trust board minutes from April 2015- April 2016.

The trust had failed to meet the England standard of 95% for referral to treatment (RTT) times since September 2014. At the end of February 2016, one out of 18 specialities had met the standard. Overall 85 % of patients were seen within 18 weeks which remains below the standard.

The trust had failed to meet cancer waiting and treatment times. The percentage of cancer patients seen by specialist within 2 weeks of an urgent referral varied between from April 2015 to December 2015 and in four out of the seven quarters was below the national average. The most recent data indicated 92% of patients were seen in two weeks. This was below the England average of 95% and the standard of 93%.

The percentage of patients within two weeks with suspected lower gastrointestinal cancer was 67%. The most recent cancer meeting minutes indicated this had reduced further to 38%. The percentage of patients seen within two weeks with suspected upper gastrointestinal cancer was 87%. The most recent cancer meeting minutes indicated this had reduced to 76%. This indicated the performance in these two areas was worsening.

The percentage of patients waiting less than 31 days for treatment for cancer was below the England average from April to December 2015. The most recent data indicated 95% of patients were seen within 31 days, which was below the England standard of 96% and England average of 98%.

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? The percentage of patients waiting less than 62 days for their first treatment for cancer was below the England average from April to December 2015. The most recent data indicated 82% waited less than 62 days which was below the standard of 85% and England average of 84%.

? The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.

? Data indicated 82,873 patient appointments were cancelled by the hospital in the last year 2015/16. Sixty percent of appointment cancellations were done with less than 6 weeks' notice. This was not in line with the patient access policy which states; a minimum of 6 weeks' notice is required if a Consultant or Clinician needs an outpatient clinic or inpatient theatre list cancelled or reduced. We requested the reasons for short notice cancellations but did not receive this information. We saw booking centre staff cancelling appointments with less than 24 hours' notice during the inspection.

The percentage of patients whose operations were cancelled and not treated within 28 days was 20% which was consistently higher than the England average of 5% from quarter four 2013/2014 to the first quarter 2015/2016. In the most recent data quarter 2015/2016 the service was three times higher than the national average at around 15% and had been as high as six times above the average at one point during the whole time period. Cancelled operations as a percentage of elective admissions had been variable over the time period, and been above the England average for four quarters between quarter four 2014/15 to quarter three 2015/16. Average theatre utilisation rate was 81% which was below the trust standard of 85%.

Between March 2015 and February 2016 24% of operations were cancelled with an average of 32 patients cancelled every month. Of these cancellations 40% were due to the patients cancelling themselves. The percentage of patients waiting four hours from "decision to admit" to being admitted through the ED were consistently worse than the England average for the period January 2015 - to December 2015. During this period 3,926 people waited between 4 to 12 hours from the time of "decision to admit" to hospital admission.

This section is primarily information for the provider

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52 breaches for exceeding the 12-hour target were reported on the incident computer system between October 2015 - January 2016, however post inspection we have received incident reports for at least 15 breaches between 8th April 2016 and 31st May 2016. The percentage of patients seen within four hours in ED were consistently lower than the England average and lower than the 95% target set by the trust throughout the period from September 2013 - to December 2015.