

# Brighton and Sussex University Hospitals NHS Trust

# Royal Sussex County Hospital










## Quality Report

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

## Ratings

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

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.

The 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 trust was inspected in April 2016 and rated as inadequate. Royal Sussex County Hospital was rated as inadequate. Following publication of the report and our recommendation, the trust was placed into special measures by NHS Improvement.

The trust has now been subject to performance oversight for eight months and this inspection was made to assess progress against the actions required subsequent to the publication of the 2016 report.

In designing this inspection we took account of those services that performed well at the 2016 inspection and as a consequence the services inspected only included emergency care, medical services, surgery, critical care, maternity and gynaecology and outpatients and diagnostics.

The trust board and executive leadership has been unstable for the last twelve months and immediately prior to the inspection management responsibility for the trust had been passed to the board of Western Sussex Hospitals Foundation Trust. As such, it was not pertinent to complete a full assessment of trust wide leadership. However, during the inspection we have followed up the concerning areas of organisational culture of bullying and harassment and discrimination that were evident in the 2016 report.

Our key findings were as follows:

### Safe

- Incident reporting, process and culture was much improved with enhanced analysis. Feedback to staff via "safety huddles" and other communications had also been improved. However, in some areas learning and sharing had not been maximised and in critical care, a significant backlog of incidents had occurred that impeded the opportunity to learn from incidents.
- Following an improvement initiative, the trust had reduced the number of never events. The root cause analysis of serious incidents was also of a good standard.
- There was not an overarching strategy for the maintenance of a clean environment and the fabric of some areas of the hospital remained in a poor condition. The concerns relating to fire safety expressed in our last report had been addressed by a process of external review and assessment. However, action plans to complete the work identified lacked documentation of completion and had no corporate oversight mechanism.
- At times of intensive activity, the trust was still using the corridor area in the emergency department to hold patients. However, processes for risk assessment and clinical oversight were much improved although policies and training for supporting staff caring for patients with mental health conditions in the emergency department require improvement.
- The trust had ceased using the post-operative recovery area for the inappropriate care of patients transferred from the emergency department or the high dependency unit. This was an observed and reported practice at our last inspection.

# Summary of findings

- Staffing levels and recruitment remain challenging for the trust, however, staff are now more likely to report staffing issues as incidents than previously. The trust had met the challenge of medical staffing levels in the emergency department with a highly successful and novel role for clinical research fellows.
- In both maternity and critical care, required levels of 1:1 care for patients are not consistently maintained. Although the trust has a mitigation plan there remain gaps in the ICU neurosurgical trained nurses' roster.
- As at our last inspection, medicines management, safeguarding and duty of candour were well managed and applied appropriately. Although the trust has improved its compliance with mandatory and safeguarding training many departments remain below a low threshold target of 75%.

## Effective

- Staff generally followed established and evidence based patient pathways. Staff had access to up-to-date protocols and policies. We saw a significant improvement in maternity. Sepsis training, awareness and protocols had also improved. However, pathways for bariatric patients being managed in medicine were not optimum.
- As also reported in 2016 national clinical audits were widely completed. Mortality and morbidity was reviewed in all departments.
- Pain relief was effectively delivered and the trust had developed its trust wide pain team. However, the service remained unavailable at weekends.
- Patients' nutritional needs were generally met and the trust had increased efforts to provide protected mealtimes. Comfort rounds had been introduced in the emergency department to assist in the maintenance of hydration. There remained no dedicated dietician support to the critical wards.
- Appraisal compliance had significantly improved across the trust. However, this was from a low base and many departments still remained below the trust target.

## Caring

- Our last report indicated issues of dignity and privacy within the outpatients department. Staff had clearly striven to deliver improvements and this was recognised in our observations. The environment within the eye clinic still remained problematic in terms of delivering care in a confidential and dignified manner.
- The privacy and dignity of patients cared for in the corridor area in emergency care, had been alleviated by the introduction of privacy screens. However, there were not enough screens to ensure the privacy of all patients at times of high demand.
- Patients reported they were involved in decisions about their treatment and care and this was reflected in the care records we reviewed.
- Throughout the trust patients received compassionate care and we observed this in the interactions between staff and patients. Patients were very positive in their feedback regarding the care they received.

## Responsive

- As we found at our last inspection, referral to treatment time was consistently below the national standard for most specialties. The trust had improved compliance with two week wait and 31 day standard for cancer but was not attaining the 62 day target. Delays were also being incurred in the processing of biopsies for pathology.
- The number of patients whose operation was cancelled and who were then not re-seen within 28 days exceeded the national average.

# Summary of findings

- The trust had implemented revised escalation procedures to manage surge activity in the emergency department. However, the trust was showing a deteriorating position with respect to the four hour emergency care standard and also for patients waiting between four and twelve hours following a decision to admit. A similar trend was seen for the number of patients waiting longer than one hour for transfer from ambulance to the emergency department.
- Provisions for the care of patients living with dementia was well developed with appropriate forms of patient identification and well considered design of clinical environment and signage.
- Complaints responses continue to exceed the trust target time and are of an inconsistent quality.

## Well led

- At our last inspection, staff widely reported a culture of bullying and harassment and a lack of equal opportunity. We discussed the findings in individual interviews and staff focus groups and the findings were largely acknowledged as accurate. However the trust had not clearly communicated its acknowledgment of the issue to the workforce.
- The trust has commissioned and commenced an external consultancy to develop a strategy that addresses 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
- The trust has tried to address bullying and harassment via leadership training and an initiative "Working Together Effectively #stopbullying". This was promoted by a poster campaign using a well-crafted definition of bullying and a supporting intranet web site providing helpful guidance and tools. During our interviews and focus groups very few staff indicated recognition of the initiative.
- Some staff indicated during focus groups and interviews that there had been an improvement in the management of poor behaviour, notably in maternity where a behaviour code of conduct had been introduced. However, representative groups described a lack of corporate acknowledgement of discrimination and inequality issues and little change over the last twelve months.
- The lack of equitable access to promotion was again raised by members of the BME network citing recent changes in the management of soft FM services as an example of bias. This has resulted in a further review of the soft FM management of change process by the trust and a pause in implementation. Concerns on this issue have been raised by staff.
- The role of outdated human resource policies and their inconsistent application in exacerbating inequality was highlighted in our last report. The human resource team have responded with a comprehensive review of policy and revised training of team and managers. Representative groups viewed that there had been a lack of engagement in the development and review of these policies.
- BME staff again indicated the lack of equitable access to training and leadership initiatives. The trust did not maintain data indicating the equality of access to leadership programmes.
- Staff in focus groups indicated that staff themselves had not been suitably trained to manage the diversity of patients they treat leading to an inability to manage difficult situations and support staff who have been abused.
- The latest staff survey results rank among the worst nationally. Overall the organisational culture and the management of equality remains a significant obstacle to the trust improvement plan.
- We observed improvements in local directorate governance arrangements but the complexity of the operational model continues to lead to a lack of clarity in terms of accountability, alignment of strategy and consistent dissemination of information and direction.

# Summary of findings

- Clinical leaders indicated a need for personal development, increased non-clinical time and greater management expertise in order to deliver the required organisational change. This group appeared as highly motivated with an appetite for the challenge ahead. The clinical transformation programme was seen as indicative of the potential this group has for delivery.

There is no doubt that improvements have been made since our last inspection and that the staff involved in the delivery of that change should be congratulated. However, there remains an extensive programme of change to be delivered in order to attain an overall rating of good. The lack of consistent board and executive leadership has hampered the pace of change in the last twelve months and it is anticipated that the incoming management team can provide both stability and clarity of leadership that will lead to sustainable change.

However, I recommend that Brighton and Sussex University Hospitals NHS Trust remains in special measures to provide time for the leadership to become embedded and that the outstanding patient safety, culture and equality issues are addressed.

We saw several areas of outstanding practice including:

- In ED, the new self-rostering approach to medical cover had a significant impact on the department. Medical staff appreciated the autonomy and flexibility this promoted as well as the effective and safe cover for the department. Because of this initiative, the department was able to provide round the clock medical cover without the use of temporary staff.
- The introduction in ED of the clinical fellow programme that had improved junior cover in the department and also the education and development opportunities for juniors.

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

Importantly:

- The trust must ensure that the (WHO) Five Steps to Safer Surgery checks are fully completed for all patients undergoing surgery.
- The trust must ensure that safer sharps are used in all wards and departments.
- The trust must ensure anaesthetic equipment checks are consistently completed.
- National Specification of Cleanliness (NCS) checklists and audits must be in place including a deep cleaning schedule for theatres.
- The trust must ensure that in theatres controlled drug dose given and amount destroyed is consistently recorded.
- The trust must ensure records in ED are held securely and kept confidential.
- The trust must ensure ED patients dignity and privacy is respected by ensuring there is adequate space in holding areas, adequate screening is available and by avoiding the use of mixed sex accommodation.
- The trust must ensure that medications in ED are stored safely, securely and at the appropriate temperatures.
- The trust must ensure that all staff within the medicine directorate have attended mandatory training, and there are sufficient numbers of staff with the right competencies, knowledge and qualifications to meet the needs of patients.
- The trust must ensure all staff within the medicine directorate have an annual appraisal.
- The trust must ensure fire plans and risk assessments ensure patients, staff and visitors can evacuate safely.
- Medical wards must ensure all areas where medicines are stored have their ambient temperature monitored in order to ensure safety and efficacy.

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- The trust must take action to ensure that information in the critical care department is easily available for those patients and visitors that do not speak English as a first language.
- In critical care, measures must be put in place to check that stock levels of controlled drugs in critical care correct and that the list of authorised signatories is also correct and up to date.
- In critical care, the trust must make arrangements so pharmacy provision meets the national guidelines.
- The critical care department must employ a dedicated dietitian to meet national guidance with a critical care pharmacist for every critical care unit.
- The trust must ensure that adequate oversight of laser safety is provided and that laser protection supervisors who are assigned to look at this at a local level are sufficiently trained to oversee and enforce this. All laser machines must be serviced annually and taken out of use if annual service check has expired.
- The trust must ensure that worn protective eyewear in outpatients and diagnostic imaging is replaced.
- The trust must take action to ensure that patient privacy and dignity is maintained, particularly in the Sussex Eye Hospital and CT waiting area.
- In maternity, the trust must ensure that fire safety issues are addressed, monitored and reviewed to ensure that all areas where patients receive care and treatment are safe and well-maintained.
- The trust must ensure appropriate measures are taken to improve the ventilation system in the obstetric theatre on level 13.

In addition:

- The trust should 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 should continue to work on reducing the waiting list for a specific colon surgery.
- In surgery the trust should improve attended mandatory training rates.
- The trust should review patient flow through the surgical assessment unit.
- The trust should review its policy of boarding patients on the ward areas before a bed is available.
- The trust should effectively communicate the clinical strategy to all staff and arrange for the plan to improve staff engagement to be fully implemented.
- The trust should make arrangements for patients in ED with impaired capacity to have these risks identified and managed appropriately.
- The trust should improve ED mandatory training and appraisal rates to meet the trust's own compliance rates.
- The trust should consider how to improve continuity with incident, complaint and risk management processes across both ED sites.
- The trust should improve engagement between the ED's in RSCH and PRH site.
- The trust should improve learning and the sharing of best practice between ED's at the RSCH and PRH site.
- The trust should review any possible data confidentiality issues that may occur from the use of large electronic displays at the nursing hub in ED.
- The trust should review the provision of the medical pain service in order to provide a seven day service including the provision of the management of chronic pain services.

# Summary of findings

- The trust should review the provision of pharmacy services across the seven day week and improve pharmacy support.
- The trust should prioritise patient flow through the hospital as this impacted on length of stay, timely discharge and capacity.
- The trust should devote sufficient time and resources to address the backlog of incident investigations in critical care.
- In critical care, the trust should make arrangements for mandatory training modules to be completed in a timely manner and any outstanding modules to be completed.
- In critical care, level two training in child safeguarding should be completed to meet the trust target.
- In critical care, the trust should take action to improve compliance with the trust policy that says staff should be bare below the elbow.
- The practice of removing used bed pans from side rooms in critical care should be done in accordance with the trust's infection prevention and control policy.
- The trust should introduce a method to monitor the temperature across the unit on level five critical care.
- In critical care, the trust should take action to ensure that patients are clearly identified in their records, that no records are kept loose and care bundles are filled in.
- In critical care, the trust should consider how to improve screening for venous thromboembolism.
- Arrangements should be made so neurology trained nursing staff are available to cover the critical care area where ventilated neurology patients would be cared for.
- The trust should take action to ensure it meets its own standard/KPI of discharging all patients with a rehabilitation prescription.
- The trust should display that any information collected in relation to the friends and family test in critical care is available on the NHS England website.
- In critical care, the trust should introduce a process to follow when they take a patient under the age of 18 and that paediatric input is sought in these circumstances.
- The critical unit should clarify with the site management team what would amount to a mixed sex breach on their unit.
- The critical care unit should replace the neurology fill educator post which was vacant.
- The trust should improve mandatory training completion in the outpatient and diagnostic imaging departments.
- The trust should make arrangements for outpatient and diagnostic imaging staff to receive annual appraisals.
- The trust should share learning from incidents and complaints handling with staff to prevent recurrence within outpatient and diagnostic imaging services.
- The trust should have systems to check fridge temperatures within outpatient and diagnostic imaging. They should be undertaken in line with trust policy and national guidance.
- The trust should monitor that compliance with WHO audits in interventional radiology and improve performance.
- Consent for interventional radiology procedures should be taken in line with best practice.
- The trust should develop a strategy in place for the outpatients and diagnostic imaging department.

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- In maternity, the trust should fully explore recent hypoxic-ischaemic encephalopathy (HIE) numbers and consider an internal investigation into the high numbers to identify any common themes.
- In maternity, the trust should consider how improvement to training targets are met and consider revising the target percentage.
- In maternity the trust should make arrangements to update the risk register to reflect all risks to the service, and check that there are clear reasons documented for any changes to risk ratings.
- In maternity the trust should consider how targets for adult and child safeguarding level three are met.
- The maternity department should consider participation in morbidity and mortality meetings to ensure robust learning and review.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**



# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Requires improvement

### Rating



### Why have we given this rating?

At our previous inspection in April 2016, overall, we rated the ED as inadequate. On this inspection, we have changed this rating to 'requires improvement'. This reflects the improvements to patient safety, risk and quality management, maintaining the dignity and respect of patients, strengthened senior leadership and oversight, and an improved culture.

- The environment was not fit for purpose as it did not have the physical capacity to meet demand. As a result flow through the department was impeded and this was a cause of mixed sex accommodation usage. Additionally, staff were unable to protect patients from the risk of health care acquired infections because the department became very overcrowded.
- Records were not always stored securely, medicines were not always managed in line with national guidance and vulnerable patients did not always have their capacity to consent to treatment assessed.
- Nursing staffing and retention remained a concern.
- Mandatory training and appraisal rates were low but had improved since our last inspection although the department supported staff to develop in their roles. There were new competency based assessment tools to promote personal development and give assurance staff had the right level of training to meet people's individual care needs.

#### However:

- There was a notable culture shift, with a more positive emphasis apparent. Staff worked hard to maintain patients' dignity despite the circumstances. Staff worked cohesively as a team. Staff found the senior leadership team to be effective and visible. Engagement processes with external organisations and care providers had greatly improved.

# Summary of findings

- Patients' feedback was generally positive. "Comfort rounds" were regularly undertaken and these helped ensure patients' needs for food and drink, and their other social care needs were met.
- Care and treatment given reflected best practice and national guidance.
- There were new processes to improve department performance, the patients' journey and the quality of the care delivered such as single clerking and the clinical fellow initiative.
- The department had an electronic tool that estimated and monitored patient attendance and discharge rates. This showed the department was exceeding the set discharge target of 90 patients a day.
- Systems to monitor incidents clinical and departmental risks had significantly improved. Staff used information from trend and theme analysis to improve the service, to prevent recurrence and aid learning. Managers had strengthened governance processes, for example, comprehensive morbidity and mortality meetings and a multi-disciplinary approach to governance.

## Medical care (including older people's care)

### Requires improvement



At our previous inspection we rated medical care as requires improvement. At this inspection we have retained this rating. This is because:

- Fire safety plans and risk assessments and actions were not complete and there was no overarching governance around fire risks. Not all staff had completed mandatory fire safety training.
- Although issues regarding the environment remained, we saw some improvement as risk assessments were completed on a regular basis to ensure the suitability of individual patients within the Barry Building. However, this adversely affected patient flow through the hospital and the number of bed moves experienced by patients.

# Summary of findings

- Incident reporting was variable across directorates in the medical service and there continued to be a lack of learning from these. Silo working had improved within directorates, but we found there was no cross directorate learning from incidents or complaints.
- Each directorate still had its own risk register, which did not feed into an overarching risk register. Therefore, managers did not have an effective method for identifying, monitoring, or managing the risks in all six medical directorates.
- Risks associated with cleanliness, hygiene and infection prevention and control were not always fully recognised, assessed or managed.
- Nursing staff numbers did not always meet planned levels. There was no guarantee that the nurse co-ordinator for each shift was supernumerary and therefore they could not always fulfil their supervisory responsibilities.
- Staff had difficulty accessing learning and development. Mandatory training rates were generally low; the lowest completion rate was in basic life support. Not all staff had received an annual performance review or had opportunities to discuss and identify learning and development needs through this review.
- Care and treatment did not always reflect evidence based guidance. For example, there was no care pathway for bariatric patients. Outcomes from national audits were mixed and were below expectations when compared with similar services. However, staff had access to policies based on national best practice guidance from all professional disciplines, the service had been awarded Joint Advisory Group on GI (JAG) accreditation and had made adjustments to the rehabilitation pathway to ensure it was fully compliant with national guidance.
- Referral to treatment times were worse than the England average. The hospital had a high rate of mixed sex breaches and outliers, which impacted on flow.

# Summary of findings

- The hospital was not yet offering a full seven-day service. Not all patients had access to a consultant and other members of the multi-professional team on a daily basis.
- Staff satisfaction was mixed and staff did not always feel actively engaged or empowered.
- Staff advised us there were still issues with HR processes, stating support depended on who the HR representative was. Although policies and standard practices were in place, not all HR representatives followed them.

## However, we also found:

- Medicines were always supplied, stored and disposed of securely.
- Patients had a comprehensive assessment of their needs, which included clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. Expected outcomes were identified and documented, regularly reviewed and updated.
- Feedback from people who used the service, those who were close to them and stakeholders was positive about the way staff treated people. The hospital continued to deliver a good service for patients living with dementia.
- Assessments carried out to comply with the Mental Capacity Act (2005) and consent forms were completed appropriately.

## Surgery

### Requires improvement



When we inspected the Royal Sussex County Hospital in April 2016 we rated surgery as requires improvement. At this inspection we have retained this rating because:

- Since the last inspection there have been a number of programmes and training events to reinforce the importance of the WHO safe surgery checklist. However, between April 2016 and April 2017 there have been two further Never Events. Following surgery the debriefing of staff was not consistently completed meaning the (WHO) Five Steps to Safer Surgery was not fully completed.

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- The theatre department was not complying with The Health and Safety (Sharp instruments in Healthcare) regulations 2013. Anaesthetic equipment checks were not consistently complete and medicines were not always managed in line with current legislation.
- National Specification of Cleanliness (NSC) checklists and audits were not carried out, including a deep cleaning schedule for theatre.
- Staff had achieved a rate of 75% with statutory and mandatory training; although this met the trust target, the target itself was low. However, Staff reported that appraisals were being carried out annually.
- Whilst improvements had been made to reduce the admitted referral to treatment time (RTT), they still remained below the national standard for all specialities apart from cardiac surgery. Work had been done on identifying patients on the waiting list for a specific colon (bowel) surgery but there was still a backlog of patients waiting for surgery.
- The surgical assessment unit had a high number of inpatients and were not always able to take patients from the emergency department as intended and this impacted on patient flow. This resulted in the practice of 'boarding' patients on the ward which put strain on the ward management and staffing. Boarding meant that patients from the emergency department were put on the ward before a bed was available. However, patients were no longer inappropriately admitted to the recovery area in theatre due to lack of capacity.

## However, we also found:

- Staff continued to report incidents and spoke of an open and transparent reporting culture. Safety meetings (huddles) were established on all wards and departments to discuss any patient or department incidents or concerns to promote a safe culture.

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- There was a sufficient number of staff appropriate to the workload with the necessary skills and qualifications to meet patients' needs.
- Progress had been made on reviewing and ensuring improved consent processes.
- Patient feedback was generally positive. We observed the care to be respectful, patient-centred and delivered with compassion. Patients were treated with dignity and respect.
- The service treated patients in accordance with best practice and recognised national guidelines and demonstrated collaborative working across directorates to deliver joined-up care which ensured the timely management of patients through their care pathway.
- Governance structures across the four directorates were established and developing and staff were able to identify risks within their departments and risk registers were in place and kept under regular review.
- The trust had a plan for redevelopment and a clinical strategy. Each of the four directorates had strategies and business plans in place which could demonstrate progress over the last year.
- Staff reported an improvement in the culture at the hospital but they were still concerned at number of changes in the hospital senior management. They looked forward to a period of stability and increased visibility of the new management team.

## Critical care

Inadequate



When we inspected Royal Sussex County Hospital in April 2016 we rated critical care as inadequate. At this inspection we retained the rating of inadequate. This is because:

- The critical care department had a large incident report backlog dating back to 2015 that still required investigation. However, there had been the appointment of a Clinical Risk Nurse to review and investigate the large backlog of incident reports.

# Summary of findings

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- Although pharmacy staffing had improved, it was still not in line with the Guidelines for the Provision of Intensive Care Services. The hospital still did not have a permanent dietitian working in critical care. Incidents relating to medication errors were high. There were no investigations or analysis undertaken of these incidents which meant themes and lesson learnt could not be identified. However, medicines waste was handled appropriately in line with current legislation and best practice. CCTV had been placed in the room that contained the drug cupboards and fridges on level seven. This mitigated the risk identified during the previous inspection of drug fridges remaining unlocked.
- Dietetic support for the unit did not meet national guidance.
- Patients' records were not always kept secure.
- Not all staff complied with the "bare below the elbows" policy when delivering direct patient care. Some other infection risks were not recognised. For example, a side room on level seven was being used for a patient that was highly infectious. Bedpans were being taken from the side room to the main dirty utility area due to the lack of sluice in the room.
- There was a lack of impetus from the senior management team to drive improvements and develop a plan for improvement and the vision and strategy for the service had yet to be finalised.
- The critical care service at RSCH had failed to meet key performance and quality targets. For example, the unit had failed to meet a number of its own key performance indicators in regard to the rehabilitation of patients. The number of patients with a delayed discharge of more than eight hours was much worse than the national average. Between April 2016 and December 2016, there were 70 incidents of cancelled elective surgery due to a lack of a bed in critical care.

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- There was a lack of information available to patients or relatives in any language other than English despite the hospital seeing patients of different nationalities.
- There were not always appropriately skilled and qualified nurses to care for neurology patients. However, there were systems that allowed staff to gain and maintain the necessary skills to care for neurology patients. There was a divide between the neurology nurses and the general intensive care nurses. This meant there was not a cohesive approach to nursing on the units and this affected staff morale.
- The ITU at Royal Sussex County Hospital (RSCH) and the Princess Royal Hospital (PRH) are part of one department, sharing management and staff. However, the sites did not share a common patient IT system.

## However, we also found:

- All areas we viewed, including clean utility rooms, toilets and showers were visibly clean.
- A simulation room was used in the recruitment process for band five nurses to enable potential recruits to demonstrate their clinical skills. There were systems to identify patients at risk of deterioration. We saw good use of National Early Warning Scores (NEWS) and there was good awareness of this system across the critical care department.
- Nursing staff treated the patients with dignity and respect. Patients and relatives expressed satisfaction with the care received. The commitment to the welfare of the patients was evident from both clinical and non-clinical staff. Staff had been able to accommodate some family members of patients so they could visit outside of normal visiting hours. However, there were frequent occasions when male and female patients were cared for in the same bay whilst awaiting bed placement in the hospital.
- There were some examples of innovative practice. For example, each patient on ICU had a



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‘patient diary’. This was a diary written to record what had happened to the patient and how they had been cared for. The patient could then take this with them when leaving the unit.

## Maternity and gynaecology

Good



On our last inspection we rated the maternity and gynaecology services as requires improvement. At this inspection we have rated the service as good. This is because:

- During this inspection we found incident reporting was much improved and feedback routinely given via a number of methods. We saw noticeboards for governance in every clinical area within maternity and gynaecology. These included information on the risk register, recent serious incident investigations and recent learning from complaints.
- Guidelines had been reviewed and were in date with good monitoring processes in place for further reviews.
- The department had recently employed more consultants and on this inspection consultant numbers were in line with trust expectations. A range of specialist midwives were available ensuring women’s individual needs were met.
- There was now a separate theatre team in obstetric theatres to ensure that the midwives role in theatre was to care for mother and baby only.
- Staff were committed to providing and promoting normal birth. Women were offered a choice of birthing options and the trust had high homebirth rates. Targets for elective caesarean sections were had improved, recent figures showed improvement with the trust target being met from November 2016 through to January 2017. However, the maternity department were not meeting expected targets for some patient outcome indicators. These included vaginal birth after caesarean (VBAC), emergency caesarean section, and meconium aspiration.
- Referral to treatment times had much improved and women were being seen in a timely way,

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in-line with expected targets. All patients received diagnostic tests with six weeks between July 2016 and February 2017, which was better than the national target.

- There were strict criteria the department followed to ensure patients were not admitted inappropriately to the gynaecology ward as outliers.
- Previous issues with gaining valid consent had been addressed through a variety of means and we saw consent was given the appropriate importance and staff followed trust policy.
- There was now a designated triage team allowing for better continuity of care and improved communication via an online shared drive and an improved system for recording calls. The improvements have led to a reduced number of triage closures and reduced complaints about triage.
- Appraisal rates had improved significantly from 59% at our last inspection to 91%. The trust employed a dedicated preceptorship midwife and a midwifery placement educator who met with midwives throughout their employment.
- Staff treated patients with dignity and respect. We saw compassionate interactions between all staff members and patients.
- Universally staff felt that there had been improvements in the culture of the organisation. They reported that it was a different place to work than a year ago and that positive changes to the consultant body and leadership had been the driving force behind the changes. Staff we spoke with during this inspection were positive about the leadership team.
- There was a clear strategic direction. The women's directorate had three, six and 12 month plans which were drawn up in March 2017. This included short and long term initiatives.
- There were examples of innovation. For example, the trust is one of 44 trusts throughout the country engaged in the Maternal and Neonatal

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Health Safety Collaborative. This is a three-year programme to support improvement in the quality and safety of maternity and neonatal units across England.

## However, we also found:

- There was some improvement in mandatory training figures however; the trust's target for mandatory training was lower than other similar NHS hospitals with completion targets at 75%. Despite having a low target, the department was still falling behind in some areas with worse than expected mandatory training attendance. Safeguarding training targets had improved but still fell below expected targets in level three safeguarding in both adults and children.
- Staff felt they were under pressure despite an increase in staff numbers. We saw an improvement in staff numbers and 1-1 care in labour had improved, but the service was still not achieving the national and hospital target of 100%.
- There were a higher than expected number of hypoxic-ischaemic encephalopathy (HIE) cases within one year. This had not been fully explored by the department and although individual Root Cause Analysis (RCA) reports had been completed there was not an overarching internal investigation into the high numbers to identify any common themes. The directorate did not take part in specific morbidity and mortality meetings.
- The ventilation system in obstetric theatre on L13 is over ten years old and failed the recommended air change frequency level for each hourly period. This has remained on the risk register but had not been addressed and still posed a potential risk to patients.
- There were 13 outstanding fire safety concerns highlighted since June 2016. There had been no trust wide collation of any actions as a result of these concerns being completed.

# Summary of findings

- Despite improvements to the governance structure we still found that some staff were not fully engaged and messages from the board were not routinely heard by all staff groups.

## Services for children and young people

**Outstanding**



We did not inspect this service at this inspection as we rated it outstanding in April 2016.

## End of life care

**Good**



We did not inspect this service at this inspection as we rated it good in April 2016.

## Outpatients and diagnostic imaging

**Requires improvement**



When we inspected the Royal Sussex County Hospital in April 2016 we rated outpatients and diagnostic imaging as inadequate. At this inspection we have changed the rating to requires improvement. This is because:

- Consent for interventional radiology procedures was taken immediately before the procedure, which was not in line with best practice. World Health Organisation (WHO) checklist compliance was worse than the target set in interventional radiology. There was no paediatric cover for diagnostic imaging outside of normal hours.
- Local rules for lasers were not updated and signed, and the policy was overdue review.
- Room cleaning checklists had variable rates of completion across the outpatient department. Mobile equipment in diagnostic imaging had not been cleaned. However, rooms were consistently cleaned and this documented in the diagnostic imaging department.
- Staff understood their responsibilities to report incidents and near misses and "safety huddles" were in use across outpatients and diagnostic imaging. However, incidents were not regularly discussed at team meetings so learning points could be identified and shared. There were two serious incidents that occurred between March 2016 and February 2017, but root cause analysis for these incidents was not made available.

# Summary of findings

- Risk registers were not complete. Some risks that staff told us about in outpatients were not documented on the risk register. The head and neck directorate business continuity plan was incomplete.
- Mandatory training compliance rates and staff appraisal rates were worse than the trust target.
- There was variable compliance with national access targets. The trust was not meeting national targets for patients that should be seen within 18 weeks of their referral, or receive cancer treatment within 62 days or urgent referral. However, the trust was meeting national targets for patients that should receive their urgent appointment within two weeks of referral and receive their cancer treatment within 31 days of a decision to treat being made. The trust could not provide us with data for the turnaround time of biopsies which meant there was no oversight of delays or issues within this department.
- Patients' privacy and dignity was potentially compromised in some areas. The PLACE score for privacy and dignity was worse than the England average.
- There was no formal strategy in place for the outpatient or diagnostic imaging departments. Not all staff were aware of management structure or directorate leads in their area.

## However, we also saw:

- The diagnostic imaging department had policies and procedures which reflected national and best practice guidance. People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. The diagnostic imaging department had been re-accredited by the Imaging Services Accreditation Scheme (ISAS).
- Medicines were managed in line with legislation and national guidance. Prescription forms were

# Summary of findings

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stored safely and securely. We observed good radiation compliance with Ionising Regulations, 1999 and Radiation (Medical Exposure) Regulations (IR(ME)R), 2000.

- Friends and Family test (FFT) results were better than the England average for four out of six months we reviewed. Patients' verbal feedback and that from comment cards was positive. We saw positive interactions between staff and patients. However, signage around the outpatient departments was poor and patients' feedback they had found it hard to navigate.
  - Call abandonment figures had significantly improved since our last inspection. Two-way texting for patient appointments had been introduced and supported to this improvement. The hospital monitored waiting times for patients in clinic which meant they were aware of problem areas or clinics.
  - All complaints were investigated and closed within the trust-wide target for investigating complaints.
  - Local leadership and line management were good and managers were visible across the departments. There was staff engagement at department level with team meetings and forums for staff to attend and discuss best practice.
-

# 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; Outpatients and diagnostic imaging;

# Detailed findings

## Contents

### Detailed findings from this inspection

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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 trust does not have Foundation trust (FT) status.

The trust has a total of 1,069 beds spread across various core services:

- 484 Medical beds (438 Inpatient, 46 day case)
- 360 Surgical beds (338 Inpatient, 22 day case)
- 105 Children's beds (79 Inpatient, 26 day case)
- 79 Maternity beds (79 Inpatient, 0 day case)
- 41 Critical Care beds (41 Inpatient, 0 case)
- 25 A&E beds

The Brighton campus includes the Royal Sussex County Hospital, the Royal Alexandra Hospital and the Sussex Eye Hospital. The whole site is currently undergoing a major redevelopment and major building works were in progress at the time of our inspection.

The trust provides district general hospital services to local populations in and around the 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 primarily serves a population of over 750,000 people.

In 2016 the trust had:

- 166,588 A&E attendances
- 109,782 Inpatient admissions.
- 969,473 Outpatient appointments
- 5,566 births
- 36,482 surgical bed days used

In January, 2017 the trust employed 7,456.2 whole time equivalent (WTE) staff. This included 1,163.4 WTE medical staff, 2,411.6 WTE nursing and midwifery staff and 359.9 WTE allied health professionals. The overall vacancy rate was 2%.

The health of people in Brighton and Hove is varied compared to the England average. Deprivation is similar to the England average and about 17% (7,400) children live in poverty. Life expectancy for both men and women is lower than the England average.

In the latest financial year, April 2015 to March 2016, the trust had an income of £529m and costs of £574m, a deficit of £45m for the year. The trust predicts that it will have a deficit of £59m in 2016/17.

We inspected the trust in April 2016 and rated the trust and the Royal Sussex County Hospital as inadequate. The



# Detailed findings

trust was subsequently placed into special measures by NHS improvement. This inspection was performed to assess progress at the trust following eight months of performance oversight as part of special measures.

After a period of instability at executive level, management arrangements for the trust passed to the board of Western Sussex Hospitals Foundation Trust on 1st April 2017. Therefore it was not appropriate to carry out a assessment of the trust-wide leadership.

We inspected the core services of emergency care, medical services, surgery, critical care, maternity and gynaecology and outpatients and diagnostics. We did not inspect end of life care as this was rated good in 2016, nor did we inspect children and young people's services as these had been rated as outstanding at our previous inspection. We have retained the ratings for these services from the 2016 inspection for the purposes of aggregating ratings.

## Our inspection team

Our inspection team was led by:

Chair: Martin Cooper, Consultant Surgeon and retired Medical Director

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The team included CQC inspectors, including a pharmacy inspector, and a variety of specialists, including: Consultants and Nurses with experience in the core services inspected, a Midwife, a Radiographer, Physiotherapist, and specialists with board level experience including in facilities management. The team also included two experts by experience.

## 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 who wished to share their experiences with us.

We carried out the announced inspection visit on 25 - 27 April 2017 and returned for unannounced inspections on the 4 and 9 May 2017

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, allied health professionals and support staff. We also spoke with staff individually as requested and during our ward and departmental visits.

We visited wards, departments and outpatients where patients received care and observed how people were being cared for. We spoke with patients and carers in these areas. We reviewed patients' records of personal care and treatment. We looked at documents including policies, meeting minutes, action plans, risk assessments and other records relevant to the running of the service.

We analysed a wide range of performance and other data provided by the trust both before and during the inspection.

## Facts and data about Royal Sussex County Hospital

Data was generally provided at trust, not site, level. Therefore the data presented relates to the trust overall rather than the Royal Sussex County Hospital.

Safety

- Between March 2016 and February 2017, the trust reported five incidents which were classified as never

# Detailed findings

events. Three of these were at the Royal Sussex County Hospital. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- There were 5,746 incidents reported to NRLS between 1 April 2016 and 30 September 2016. Seven resulted in death, and three were classified as causing severe harm, 64 as moderate harm and 4,635 were recorded as causing no harm. During this period NRLS incidents were reported at a rate of 8.9 per 100 admissions, similar to the England average of 8.8 per 100 admissions
- Data from the Patient Safety Thermometer showed that the trust reported 28 new pressure ulcers, 28 falls with harm and 76 new catheter urinary tract infections between February 2016 and February 2017. All three areas have shown a mixed performance throughout the reporting period.
- There was one case of MRSA reported between February 2016 and February 2017. Trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within this period. Additionally, the trust reported 51 MSSA infections and 22 C.Difficile infections over the same period.
- The trust failed to meet the safeguarding training completion target of 100% for all staff across four modules. 75% of staff had completed training in safeguarding adults. The module with the highest completion rate was Safeguarding Children Level 1 with 79%. For nursing staff, 80% had completed safeguarding adults training, and the module with the highest completion rate was Safeguarding Children Level 2 with 86%.
- As of February 2017, the trust reported an average vacancy rate of 0.8% for nurses with a turnover rate of 15.7%. The use of bank and agency nursing staff was 8%.
- The vacancy rate for medical staff in February 2017 was 6.4%, with a turnover rate of 41.8%. the bank and locum usage rate was 9.1%. In November 2016, the proportion of consultant staff reported to be working

at the trust was higher than the England average and junior (foundation year 1-2) staff reported to be working at the trust were the same as the England average.

## Effective

- There are no active mortality outlier alerts as at September 2016. This total includes no open alerts currently being considered for follow up by CQC's expert panel.
- Between April 2016 and January 2017, 75% of staff within the trust received an appraisal. This was an improvement of the previous reporting period when 63.8% of staff within the trust had received an appraisal. The staff group with the best performance was nursing and midwifery at 83.8% and the worst was healthcare science staff at 64.9%.
- Between 2016/17, Mental Capacity Act (MCA) training had been completed by 75% of staff and Deprivation of Liberty training had been completed by 75%.

## Caring

- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England Average between February 2016 and January 2017. In latest available period, January 2017 trust performance was the same as the England average of 95.2%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for four of the 34 questions, in the middle 60% for 24 questions and in the bottom 20% for six questions.
- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts in all of the 12 questions examined by the CQC.
- The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Cleanliness and Food. The performance was lower than the England average for both Privacy/dignity and wellbeing and Facilities.

## Responsive

## Detailed findings

- Between Q2 2015/16 and Q1 2016/17 the trust's bed occupancy was generally in line with the England average. Bed occupancy then exceeded the average in Q2 2016/17 and Q3 2016/17.
- The main reasons for delayed transfer of care at the trust were waiting further NHS non-acute care (38.4%), followed by Patient or family choice (15%). This was recorded between February 2016 and January 2017.
- Between February 2016 and February 2017 there were 1,374 complaints about the trust. The trust took an average of 73 days to investigate and close complaints, despite trust policy stating complaints should be responded to within 40 days. The speciality with the highest number of complaints was A&E with 160 (11%).
- In the NHS Staff Survey 2016, the trust performed about the same as other trusts in 27 questions. It performed better than other trusts in one question (Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months) and worse than other trusts in five questions relating to: work related stress, effective team working, satisfaction with resources and support, management interest and action on well-being and good communication between staff and senior management. The engagement score for this trust was 3.62, which is lower than the England average of 3.81.
- In the same survey, 32% of white staff, and 74% of Black and Minority Ethnic (BME) reported experiencing harassment, bullying or abuse in the past 12 months. This was worse than the median average for acute trusts. For white staff, 82% believed the trust provided equal opportunities for career progression or promotion but only 64% of BME staff agreed with this statement while 8% of white staff and 21% of BME staff had personally experienced discrimination at work, worse than average.

### Well led

- The trust's sickness levels between November 2015 and September 2016 were similar to the England average.

## Our ratings for this hospital

Our ratings for this hospital are:







# Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Inadequate	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
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	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

## Notes

The ratings for children and young people's services and end of life care are from our inspection in April 2016. We did not inspect these core services on this occasion.

# Urgent and emergency services

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

## Information about the service

Brighton and Sussex University Hospital Trust (BSUH) is an acute teaching trust and has achieved trauma centre status. It has two sites the Royal Sussex County Hospital in Brighton (centre for emergency and tertiary care) and the Princess Royal Hospital in Haywards Heath. The Brighton site includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital. We did not inspect the emergency services at the Royal Alexandra Children's Hospital on this occasion.

The Emergency Department (ED) at the Royal Sussex County Hospital (RSCH) provides urgent and emergency care services to the local populations of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across the south east of England.

The adult emergency department saw 88,197 attendances at its urgent and emergency care services at the Royal Sussex County Hospital between January 2016 and January 2017, and 14,582 at the Royal Sussex County Hospital (Eye) Hospital.

RSCH ED is located within the "acute floor" directorate, which includes the Urgent Care Centre (UCC), acute medicine, and critical care. Patients who arrived by ambulance are taken to the patient assessment and triage (PAT) area.

In order to undertake this inspection, we gathered the views of patients, staff, external stakeholders, reviewed care records, service feedback and trust performance data. We spoke to 32 patients, 50 staff and reviewed 18 care records.

# Urgent and emergency services

## Summary of findings

We rated this service as Requires Improvement.

- At our previous inspection in August 2016, overall, we rated the ED as inadequate. On this inspection, we have changed this rating to 'requires improvement'. This reflects the improvements to patient safety, risk and quality management, maintaining the dignity and respect of patients, strengthened senior leadership and oversight, and an improved culture we found. This rating also takes into account the need for further improvement.
- We identified several mix sex breaches during the inspection. Staff were acutely aware of these, and did their utmost to segregate patients appropriately and as efficiently as possible. The physical size of the ED and the lack of bed availability (especially in medical and surgical and elderly medicine specialities) had a significant impact on the likelihood of mixed sex breaches. We acknowledged the staff faced challenges to ensure continuity of same sex areas.
- The ED environment was not fit for purpose and unable to meet the capacity needed to manage the large volumes of patients who presented for treatment. Access and flow through the ED continued to be a major concern. The department had reviewed and implemented new processes to improve safety and address the long waits patients experienced. However, the lack of beds elsewhere in the trust had a significant impact on the department's performance and patient experience.
- Vulnerable patients did not always have their capacity to consent to treatment needs assessed.
- Staff were unable to protect patients from the risk of health care acquired infections because, the department became very overcrowded at busy times. Patients were too close to each other. For example, we saw patients sharing cubicles with approximately only 10cm between trolleys in the PAT and corridor areas.
- We identified a large box of clinical records in an unlocked room. This meant that records were not stored securely or kept confidential.

- Staff did not handle or store medications in line with national guidance. This included departmental and patients' own medication, and the storage of medical gasses. Staff did not monitor fridge temperatures continuously, and one was found to be unlocked. Staff did not always double sign the Controlled Drugs (CD) register.
- Mandatory training and appraisal rates fell below the trust's own targets. This meant that staff were not accessing the training and personal development opportunities needed to undertake their roles.
- Nurse staffing and retention continued to be a concern in the department with best practice guidance during busy times.
- Managers identified the culture in terms of cross-site learning and staff engagement as an area for continued improvement.

However:

- There was a notable and positive shift in the culture of the department.
- Staff were observed working tirelessly, to ensure patient dignity and respect was upheld despite the restraints placed upon them. We observed commendable teamwork and a positive staff attitude. "People really care about what they do" was a frequent expression used by staff to describe how they felt about their work.
- The feedback we received from the many patients was consistently positive, very complimentary of the staff, and the service they received.
- The care provided reflected best practice and national guidelines. The department had introduced the use of prompt cards as a support tool for staff. These cards contained information on best practice guidance, care pathways and treatment protocols for staff. These were available in hard copy or online on the newly refurbished department intranet page.
- The systems and processes used to monitor incidents, clinical and departmental risks had significantly improved. Staff used information from trend and theme analysis to improve the service, prevent recurrence and aid learning.

# Urgent and emergency services

- Management had strengthened governance processes and staff found the senior leadership team to be effective and visible. Examples of improvements included comprehensive Morbidity and Mortality (M&M) meetings, linking the incident data with the department risk register, improved governance meetings and multidisciplinary approach to governance. Mortality and Morbidity meeting are a key component of workplace-based learning where clinicians discuss errors and adverse events in an open manner, review care standards, and make changes if required.
- Managers had introduced new processes to improve department performance, the patients' journey and the quality of the care delivered. These included, single clerking, consultant presence at the front door, a new emergency department escalation policy, the clinical fellow initiative, new nursing documentation to improve safety and care and record quality.
- The department supported staff to undertake their roles. The hospital had developed new competency based assessment tools to promote personal development and assurance that staff had the right level of training to meet peoples individual care needs.
- Patients had their nutritional and hydration needs met by a new staff driven incentive that ensured regular reviews several times per shift.
- The hospital had introduced comfort rounds that were undertaken regularly. This meant that patients were regularly asked if they needed something to drink, or if they'd like to be repositioned or use the bathroom
- The department had an electronic tool that estimated and monitored patient attendance and discharge rates. Data demonstrated the department was exceeding the set discharge target of 90 patients a day which demonstrated good levels of efficiency.
- Engagement processes with external organisations and care providers had greatly improved in a bid to manage capacity, access and flow within the department.

## Are urgent and emergency services safe?

Requires improvement



At our previous inspection in 2016, we rated safety at the Royal Sussex County Hospital (RSCH) as inadequate 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
- Nursing leadership was poorly organised with no single individual providing strategic nursing direction.
- 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 below planned hours nearly 61% of the time.
- Staff compliance in mandatory training, statutory training and appraisals fell well below the trust target for statutory and mandatory training for both nurses and doctors.



# Urgent and emergency services

- 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.

On this inspection, we have changed the rating to requires improvement. This reflects the significant improvements made to ensure patient safety, appropriate management of patient risk, medical staffing and nurse staffing levels.

- Staff protected patients from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated and learned from to prevent recurrence.
- Systems and processes for the assessment and management of individual patient risk, as well as departmental safety, were much improved. For example, the introduction of single clerking and safety check lists, comfort rounds and the new escalation policy.
- Medical staffing reflected the Royal College of Emergency Medicine guidelines for twenty-four hour cover. There was also robust middle grade doctor cover in the department because of the new medical fellows programme.
- There were sufficient plans to ensure an appropriate response to a major incident, and business continuity plans, which had been tested and deemed effective.
- When appropriate, staff applied the duty of candour.

However,

- Patients were not protected from the risk of acquiring a health related infection because at busy times, the department was unable to support safe distances between trolleys.
- Whilst we recognised there was an improvement to mandatory training and appraisal complaints rates, they continued to fall short of the trust target.
- Staff did not handle or store medications appropriately in line with trust policy and national guidance. Departmental and patients own medications and medical gas cylinders were not

stored in line with national guidance. We also identified gaps in the Controlled Drug registers that indicated staff did not consistently handle CD's in line with national and local policy.

- Staff did not keep medical records confidential and stored securely.
- Patient records were generally accurate, contemporaneous and comprehensive. However, we found that busy times in the department had an impact on the levels of record completeness.

## Incidents

- The department had strengthened its systems and processes to ensure staff reported, investigated and learned from incidents.
- The introduction of a dedicated quality and risk post was of benefit to the department. Whilst the post was still relatively new, a significant piece of work had been undertaken to review the 1,000 un-reviewed incident reports identified in November 2016. On the day of the inspection, staff had reduced the total number of incidents waiting review at the RSCH to 173, which indicated an improvement to the management of, and oversight of incident processes.
- Management monitored data from incident reporting regarding trends and themes, which were shared with all members of the team. We found investigations were undertaken when necessary. These promoted staff involvement as well as departmental learning.
- We reviewed a sample of root cause analysis investigations. We found they contained an appropriate level of detail and sufficient learning actions. However, we noted a lack of staff with Root Cause Analysis (RCA) training. RCA training is defined as a problem solving and quality improvement approach used to identify, understand, and resolve any root causes of problems or incidents.
- There was a new incident information board in the staff corridor that provided staff with easy access to incident trends, themes and departmental learning.
- Nursing handover was used as an opportunity to hand over important messages from incidents to the team. Nurse letters and emails were used to communicate learning to staff.



# Urgent and emergency services

- The staff we talked with told us that they received better quality and consistent feedback since our last inspection.
  - Examples of improvements from incident reporting included a neutropenic sepsis training update for all staff. Neutropenic sepsis is a life threatening complication of anticancer treatment, the term is used to describe a significant inflammatory response to a presumed bacterial infection in a person with or without fever. However, whilst management shared learning successfully within the department, it was noted that this could be improved across the RSCH site.
  - During the inspection, we found staff reported nine incidents in a twenty-four hour period, which was indicative of a healthy reporting culture amongst staff. Medical staff we talked with also told us they reported incidents and had confidence in the systems and processes to review and learn from these.
  - In addition to incident reporting, the department had introduced an 'Issues of the day' briefing which was formally recorded. This allowed staff to raise concerns as they were identified and in some instances, prevent possible incidents.
  - Between March 2016 and February 2017, the trust did not report any incidents that were classified as Never Events for Urgent and Emergency Care. Never Events are serious incidents that are wholly preventable, where 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.
  - In accordance with the Serious Incident Framework 2015, the trust reported 29 serious incidents (SIs) in Urgent and Emergency Care that met the reporting criteria set by NHS England between March 2016 and February 2017. Of these, the most common type of incident reported was Commissioning Incidents meeting the SI Criteria (18), (4) Adverse media coverage or public concern about the organisation or the wider NHS, (3) Diagnostic incident including delay meeting SI criteria (including failure to act on test results) (2) Treatment delay meeting SI criteria, (1) Environmental Incident meeting SI criteria (1) Slips/trips/falls. Staff told us they perceived the number of incident reports had reduced in the department.
  - Staff used the Safety Thermometer to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.
  - Staff told us Mortality and Morbidity (M&M) meetings were held regularly, and we reviewed minutes of these. The aim of an M&M meeting is to improve patient care by developing a culture of awareness of quality and encouraging front line staff to identify harm, report problems and share lessons to prevent recurrence.
  - All the staff we talked with were aware of the duty of candour (DoC) regulations. 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 were able to provide examples of DoC being applied in practice within the department. We reviewed written evidence that demonstrated appropriate responses from the trust.
  - Staff had displayed information about safety improvements since our last inspection in the corridor area of the department.
- ## Cleanliness, infection control and hygiene
- Patients were not protected from the risk of contracting a health related infections whilst in the care of the ED department. This was because when the department was severely overcrowded and it was impossible to maintain a safe distance between patients trolleys in line with national and best practice guidelines.
  - We saw patients sharing the same treatment cubicle with approximately a 10cm gap between trolleys. We noted a similar gap between trolleys in the corridor area.

# Urgent and emergency services

- There was ample Personal Protective Equipment (PPE). PPE is equipment that protects the user against health or safety risks at work, for example gloves and aprons. We observed staff using PPE when delivering care, using hand sanitiser and washing their hands in between patient contact.
- Hand hygiene data for the department showed compliance between 90% and 97% between December and April 2017, this was an improvement on our previous inspection.
- We also observed all staff adhering to the bare below the elbow policy whilst in the department. This was a significant improvement on our last inspection.
- As a result of our previous infection control concerns, a new sink was made available in the corridor area which promoted staff handwashing and prevented the spread of infection.
- There were side rooms available in the department to ensure that patients with suspected infections could be isolated to prevent the spread of infection. We saw staff use these rooms appropriately during the inspection.
- We found commodes had been labelled with an 'I'm clean' sticker to indicate to staff they had been cleaned appropriately. The sluice area and commodes we viewed appeared visibly clean.
- The waste management policy was in place and waste was stored securely.
- Staff ensured that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- There was a colour-coded approach to cleaning in line with best practice guidance. We saw cleaning rotas that showed cleaning was regularly undertaken. All areas in the department appeared visibly clean.
- We noted the bins in the staff changing room were overflowing onto the floor. This area did not appear clean or tidy. We made staff aware of this during the inspection and they took the necessary steps to address our concerns.
- Our last inspection identified concerns relating to fire safety in the corridor area. The department had responded by placing tape on the floor of this area to make staff aware of how many trolleys could be safely placed in the corridor area.
- Medication cupboards and security had been improved as staff could only access the cupboards via an electronic swipe card access system.
- Resuscitation equipment was readily available and staff sealed all crash trolleys with a red tag. However, we noted that staff had not checked the trolleys in line with trust policy. We discussed this at the time of the inspection with the matron. We were told that this had been the responsibility of the support staff who had recently left the department and had not yet been replaced. We were told that the nursing staff had been reminded to carry out the checks as part of the department safety checks. However, this was not happening continuously as records demonstrated. We had assurances from the unit matron that this would be addressed as a matter of urgency.
- We returned to carry out an unannounced inspection and reviewed the emergency trolley check logs. These demonstrated that the appropriate checks had been undertaken since raising this as a concern. This meant the safety concern we raised had been appropriately addressed.
- The resuscitation area was very cramped, and an unsuitable and challenging environment for staff to deliver care.
- At busy times, staff used the plaster room to clerk patients. However, there was no piped oxygen, or call bell in this room. Therefore, it was an unsuitable environment for clerking patients.
- The mental health assessment room had undergone a recent renovation. The room was not ligature free, therefore patients could not be left unsupervised.
- The emergency department at the eye hospital did not have a dedicated paediatric area as outlined in best practice guidelines.
- A department reconfiguration meant that space was available for a simulation suite. This was to improve training quality and the opportunities available to staff.

## Environment and equipment

# Urgent and emergency services

- Patient Led Assessment of the Care Environment (PLACE) Scores for the ED were 99% for cleanliness, 82% for appearance of environment. (PLACE) is a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of teams to assess how the environment supports the patient's privacy and dignity, food, cleanliness and general building maintenance.
- Staff regularly serviced all equipment in accordance with manufacturer guidance and electrical equipment was tested. Records we viewed demonstrated routine electrical testing, calibration and maintenance of medical equipment was completed as per hospital policy.

## Medicines

- Staff did not always handle or store medicines in line with current regulations.
- We reviewed the Controlled Drug (CD) register and found gaps in the register signatures. There should be two signatures to show admiration and witnessing of the use of CDs as outlined in the Safe and Secure Handling of Medicines: A Team Approach (the revised Duthie report) March 2005.
- We found a box with one ampule of gentamycin left out on the workbench near the department hub. The inspector gave this ampule to the nurse in charge who promptly locked it up. This meant that drugs were not stored in line with trust policy or national guidance.
- On the morning of the 26 April 2017, an inspector became aware of a patient who was on a trolley in the corridor area who had two boxes of medication lying on top of a blanket. The patient told us that staff took their morphine away and locked it up but did not take the remaining medication. We returned to talk with the patient and found a member of the day staff had removed the medication and stored it accordingly. However, we noted this patient had been in the department a considerable length of time before the oral medication had been stored appropriately.
- We were aware of a patient who had taken an overdose was also in the department. This was a potential risk if patients own medication was not handled in line with trust policy.

- We looked at temperature records and found an inconsistent approach to medicine fridge temperature checks and found one fridge unlocked. This meant that medications were not stored securely and there were no assurances that medicines were stored at the required temperature range to maintain their efficacy and safety.
- We found three cylinders of oxygen on the floor of the side room in CDU. This meant they were not stored safely and in line with national guidance.

## Records

- Records were not stored securely or kept confidential. For example, we found a large box of medical records in an unlocked room. We pointed this out to staff who dealt with our concerns appropriately and the records were removed
- We noticed during our inspection a relative who was standing at the department hub/desk reading confidential patient information from one of the electronic screen display. This meant there was a risk of confidential patient information was easily accessible to members of the public.
- The trust was in the process of reviewing and standardising nursing documentation across both hospital sites. We found improved care pathway documentation that promoted safety, risks assessments which aided safe care and continuity
- The majority of patient records we viewed demonstrated improved risk management and audit trails. Since our last inspection, assessment tools were reviewed and improved to reflect best practice guidance. The completeness of the assessment undertaken had also improved.

## Safeguarding

- The department had systems to safeguard adult patients identified as at risk of abuse.
- Safeguarding policies and procedures were available and reflected best practice guidance.
- The chief nurse was the designated executive lead for safeguarding. The trust employed a team of nurses to support staff with safeguarding issues upon request, who were available 24 hours a day, seven days a week.

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- The staff we talked with were able to tell us about how they recognised actual or potential abuse issues and how to report it. This included the identification and reporting of patients subjected to female genital mutilation (FGM). This meant staff had the knowledge necessary to safeguard adult patients in vulnerable circumstances.
- Safeguarding training rates for the department varied and showed 63% of HCA's, 82% of nursing staff and 100% of medical staff had received level two safeguarding training. Level three training had been completed by 28% of nursing staff and 72% of medical staff and 36% of HCA's. The trust target for compliance with safeguarding training 75%.
- The Sussex Eye Hospital ED had robust safeguarding processes. This included safeguarding children who used the service. The department had a nominated child protection nurse who reviewed all paediatric attendances. When necessary, this nurse ensured that information was shared effectively with social workers.

## Mandatory training

- Whilst we recognised the improvements made to training compliance since our last inspection, the compliance continued to be low in some areas. The training data provided to CQC was at trust level, which meant that we were unable to provide data at site level.
- Data showed low training rates in the department. The overall compliance rate reported for the healthcare assistant group was 69%. Detailed data demonstrated the following compliance rates: 64% for basic life support, 70% conflict resolution, 72% health and safety, 89% information governance, 67% manual handling, 82% management of sharps and splashes.
- The overall compliance rate for the nursing staff group was 76%. Detailed data demonstrated the following compliance rates: 61% for the administration of blood products, 65% basic life support, 76% conflict resolution, 82% health and safety, 88% infection prevention, 92% information governance, 65% manual handling, 90% management of sharps and splashes and 76% venous thrombosis prevention training.
- The overall compliance rates for medical staff was reported as 84%. Detailed data demonstrated the

following compliance rates: 85% basic life support, 59% conflict resolution, 90% health and safety, 92% infection prevention, 97% information governance, 72% manual handling, 72% of paediatric life support, 87% management of sharps and splashes and 72% venous thrombosis prevention training.

- Ninety-two percent of band seven and eight nurses had completed the Advanced Trauma Nursing course this was an improvement since our last inspection and was better than the trust target of 75%.

## Assessing and responding to patient risk

- Since our last inspection, staff had reviewed and strengthened the systems and processes relating to the management of deteriorating patients. Changes included new documentation that provided guidance and a comprehensive checklist laid out hour by hour. This documentation also took account of the various risk assessments that were needed to manage individual needs. Examples included, safeguarding management tool, mouth care tool, NEWS scoring chart and fluid management.
- The Royal Sussex County Hospital met the fundamental standard of having an Early Warning Score documented, 95% of patients had their score recorded.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met this standard for the entire 12-month period when to when. Performance against this standard showed a trend of improvement. In December 2016, the average time to treatment was 49 minutes, which was better than the England average of 60 minutes.
- Since our last inspection, the department had changed its processes in carrying out patient initial assessments. The introduction of single clerking had a positive effect on the patient journey and medical staff resources. Clerking is a comprehensive history and full examination of a patient taken when a patient was admitted to hospital. Single clerking means bringing together all the specialty on-call doctors with ED

# Urgent and emergency services

doctors as one acute floor team. The main aim of this process was to ensure the care delivered was efficient and provided access to a senior decision maker at the earliest opportunity.

- This change significantly reduced the time taken for a senior medical review and thus the Decision to Admit (DTA) was also responsible for an immense change in the culture of treating patients.
- The department used a NEWS scoring system to monitor deteriorating patients. NEWS is a guide used by medical services to quickly determine the degree of illness of a patient. The escalation pathway was readily available on the observation records for staff to easily refer to. There were processes to ensure that staff reported elevated NEWS scores to a medical practitioner and patients had access to necessary medical reviews. We saw NEWS being performed and concerns escalated through appropriate channels. 95% of patients treated at BSUH had an Early Warning Score (EWS) documented score recorded. This meant that patient risk was being continually recorded and assessed.
- Staff used a wristband system to alert staff of any patient risks. For example, a red wristband meant the patient had an allergy and prompted staff to check notes before prescribing any medication or offering food. A green wristband meant the patient was a falls risk, therefore staff knew to accompany them to the bathroom etcetera. The wristband system meant staff could keep patients safe without advertising that there was a concern to other patients or the public.
- Since our last inspection, staff had also reviewed and strengthened escalation procedures. We observed staff used the procedures during the inspection and found they worked well. The policy followed the Red, Amber, Green, Black, (BRAG) system of risk. The policy clearly described what actions needed to be taken at each stage and the individual tasks and responsibilities of staff, by grade. This meant that staff had a clear pathway to escalate safety concerns.
- We saw falls risk assessments, venous thromboembolism (VTE) assessments, sepsis screening tools and safeguarding and managing patient risk assessments tool for patients with a mental health needs.
- The new approach to managing patient risk promoted care continuity and consistency. Whilst the majority of the documents we reviewed were contemporaneous and complete, we noted a lack of continuity in undertaking risk assessments during very busy periods. This predominantly related to vulnerable patients who lacked capacity and where DoLs may be applicable. This meant that at busy times, vulnerable patients might not have their risks identified and addressed in a timely way.
- Staff referred patients who were considered as a mental health risk to the in-house mental health team for review and support.
- The department held a daily safety huddle. We observed this meeting during the inspection and found it to be effective.
- Our last inspection identified serious concerns with patient safety when the corridor area was in use. At this inspection, we found the area was still in use at busy times. However, there was a significant improvement in how the department managed safety in this inappropriate area.
- There was improved clinical oversight and accountability. This was because staff were formally allocated to this area and had their names displayed on a wall to indicate to patients who was responsible for their care. This change to practice provided care continuity, improved clinical oversight and patient safety.
- Patients had to achieve a set criteria before being placed in this area due to the risk. This included having an early warning score of less than four, and have no signs of altered mental capacity.
- Screens were purchased to maintain dignity and confidentiality, to a point.
- A safety check list which featured a wide range of checks expected to be undertaken within the four hour wait time which included: wrist band, pain assessment and analgesia, communication, early warning score, bloods, cannula, electrocardiogram (ECG) etc. We saw this in use and found the checks fully completed for all patients in the area during the inspection.



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- High visibility tape had been placed on the floor to indicate the safe space required to move emergency equipment and ensure patients could be evacuated in the event of a fire.
- The use of this area was incorporated into the new escalation policy. This meant that senior trust managers were made aware that this area was in use, and were obliged to provide immediate support to the department.
- A list of all the patients who were accommodated in this area was retained for audit purposes.
- The quality and completeness of the risk assessments undertaken had significantly improved.
- Between February 2016 and January 2017, there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In January 2017, 72% of ambulance journeys had turnaround times over 30 minutes. The trend over time has shown a gradual increase from May 2016 onwards.
- A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they were handed over to the emergency department staff. Between July 2016 and January 2017, the trust reported 1,062 'black breaches'. The trust reported 326 'black breaches' in January 2017 this was nearly twice as many as previous months. There was an upward trend in the monthly number of 'black breaches' reported over the period.
- Staff we talked with felt that with the use of temporary workers, there were sufficient staff available to be able to meet patients' needs.
- We were told that the nurse team were flexible and multi skilled and worked where a need was identified. We saw staff rotate between areas during the inspection to meet individual care needs.
- Overall, the trust employed 3.3 fewer nursing staff than what was determined by the trust to provide safe high quality care. RSCH reported 99.3 as the desired Whole Time Equivalent staff numbers (WTE) staffing numbers, however, there were 96.3 in post in December 2016.
- The department was on the whole, ensuring there was sufficient staff to meet the needs of the service.
- Temporary staff were used to backfill outstanding staffing vacancies. Senior nursing staff told us that the temporary staff used in the department had worked there for a prolonged period and were very familiar with trust policies, procedures and they were familiar with the team they worked with.
- Senior staff told us that temporary staff went through a formal induction process, and we saw documentation which supported this.
- The department had recently completed a successful recruitment campaign and new nursing staff were about to join the team.
- However, ten nurses were preparing to leave. This may indicate concerns regarding staff retention in the department. Staff told us they were concerned about staff retention in the department.

## Nursing staffing

- The department used a staffing acuity tool to measure staffing levels in the department.
- Senior staff told us that a formal staffing review was underway at the time of the inspection. The staffing review was evidenced in meeting minutes we viewed.
- Nursing leadership had been strengthened by recruiting a new matron for the department. The hospital had recruited a new nurse consultant since our last inspection. This post was to ensure the development of Emergency Nurse Practitioners. (ENP).
- Handover processes had improved since our last inspection. Improvements included a structured approach to communicating the demands of the service, patient risks, team achievements and other important departmental messages.
- Management had developed health care assistant posts since our last inspection to undertake particular tasks to support the nursing team and improve the efficiency of the department.

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- There was a new electronic screen in the acute floor hub. This had been introduced to display the names of all the staff on duty and the clinical areas they were clinically responsible for during their shifts.

## Medical staffing

- Medical staffing and consultant cover in the department had improved since our last inspection deserved significant recognition. There was twenty four hour consultant cover, which meant the department was meeting the Royal College of Emergency Medicine guidelines.
- We reviewed the medical rotas and noted there were no gaps in the rota for consultant or middle grade cover. This meant that the department was providing quality, medical cover, twenty-four hours a day.
- The department did not use any locum cover as the limited outstanding cover required each month was covered in-house. Twenty-four hour consultant cover and no locum cover is an uncommon inspection finding and was the result of a new and very successful approach to self-rostering and a flexible approach to PA (programme activities) allocation.
- A successful business case was developed to support a new workforce of educational, management and research fellows with flexibility in working practice and rostering had improved junior doctor staffing. The RCEM recognised these initiatives as a 'beacon of good practice'.
- Since our last inspection, the department had recruited three new consultants.
- We attended a medical handover during the inspection and found it to be structured, effective and fit for purpose.
- The trust approach to planning medical staffing relied on quantifying the volume of medical care to be provided on the basis of the size of population, mix of patients, and type of service and relating it to the activities undertaken by different members of the team. Overall, the trust employed 9.6 fewer medical staff than what was determined by the trust to provide safe high quality care using this methodology. The trust reported their staffing numbers for medical staff in December 2016 as 32.5 desired WTE with an actual WTE of 25.5.

## Major incident awareness and training

- The department had an up to date major incident policy which was easily accessible for staff to reference. Department responses to major incidents were included in the staff induction pack
- There was a dedicated consultant and senior nurse with oversight and responsibility for the major incident equipment and plans.
- Staff were able to tell inspectors what was expected of them should a major incident occur and their role in ensuing business continuity.
- The department had appropriate security cover twenty-four hours a day. We saw an incident in the department when a patient's behaviour became aggressive and threatening. Staff called for security back up and we noted a fast response from the security team.
- Appropriate hazardous material (HAZMAT) arrangements were in place and the equipment was kept in a dedicated, but easily accessible storeroom in the department.
- We requested data to show major incident training in the ED. We reviewed a document labelled DR90 which showed compliance rates for staff in receipt of major incident training was; 64% of band 7's, 80% of band 6's, 29% of band 5's and 36% of band 2's.
- Compliance rates for training in the use of chemical, biological, radiological and nuclear suits (CBRN) was 64% for band 7's, 80% for band 6's, 29% for band 5's and 36% for band 2's. (CBRN is protective suit that gives staff 24-hour protection against a chemical, biological, radiological or nuclear incident).
- Training compliance rates for the use of a decontamination tent were; 35% of band 7's, 57% of band 6's, 29% of band 5's and 33% of band 2's.
- This data came with additional comments to explain the low training rates for example "Major Incident /CBRN Training was delivered in June 2016 for ED, however there has been a large turnover of staff since the training so data may be skewed". The trust

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provided details of the planned training dates for July and August 2017. Whilst we recognise the department had recruited new staff, the data may suggest barriers to training exist in the department.

- Records we viewed demonstrated fire training was provided to staff. Data was presented by staff group, at trust level. The compliance rates were reported as: 77% for healthcare assistants, 81% for nurses and 95% of medical staff.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



At our previous inspection in 2016, we rated effectiveness at the Royal Sussex County Hospital (RSCH) as requires improvement because:

- Patient pathways and national guidance for care and treatment were generally followed as 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).
- 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.

On this inspection, we have rated the service as good. This reflects the improvements made in relating to monitoring and recording of patients' pain scores, the implementation of nutrition and hydration rounds, and the improved and dynamic multidisciplinary approach to care.

- The policies and procedures used within the ED department reflected evidence based practice.
- Patient outcomes were predominately in line with England averages.
- There was good use of a standard pain-scoring tool and improved documentation of assessments. Patients told us they had their pain needs added in an appropriate manner.

- Staff were supported to ensure they were competent to do their jobs and meet people's individual needs. There was a multidisciplinary and inclusive approach to training. A much more cohesive and multidisciplinary approach to care was noted and observed at this inspection.
- We found a positive audit culture, formal audit cycle and clinical audit lead in the department. Audits were regularly presented to staff and there were good processes to ensure re-audit was taking place.
- There were suitable arrangements in place to access support and specialist services seven days a week.
- Staff had sufficient access to necessary information to undertake their roles.

However:

- Managers had not reinstated a Patient Group Direction (PGD) for the administration of analgesia since our last inspection. This was about to be put back into practice after the inspection, however, the departmental response to address this was considered very slow.
- Mental Capacity Act (MCA and DoLS) training compliance rates were below the trust targets. During the inspection we identified some patients who did not have their mental capacity assessed.
- In the 2014/15 RCEM audit for mental health in the ED, the site was in the lower 25% of departments compared to other hospitals for four of the eight comparable measures.

## Evidence-based care and treatment

- Policies and procedures used within the ED department reflected evidence based practice.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines.
- Staff used a standardised checklist adapted from Royal College of Emergency Medicine (RCEM) guidelines, when assessing patients.
- Medical records reviewed during the inspection demonstrated that staff delivered care in line with national and best practice guidance.
- Staff showed us the department's new prompt cards that were introduced to ensure best practice



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guidelines and treatment protocols were readily available for staff to follow. Staff told us the prompt cards were a useful resource. All of this information was available on the newly designed landing page on ED intranet.

- The service used a sepsis screening tool and sepsis care pathway based on the 'sepsis six', which is a national screening tool for sepsis. The department followed the Sepsis 6 Pathway. Sepsis is a potentially life-threatening condition, triggered by an infection or injury. Data for April 2017 showed the department was achieving a compliance rate of 90% with the sepsis pathway.
- The trust had a fractured neck of femur pathway in place. Data demonstrated that this pathway was meeting national performance targets. This meant that any patient who had a fractured neck of femur was transferred via ambulance to the Princess Royal Hospital for surgery.
- There was a clinical audit lead with oversight of the local and national audit programme. Audit results were shared with the department as part of the governance meetings.

## Pain relief

- The department used a recognised pain assessment tool to measure patients' pain levels. Staff appropriately documented pain scores and acted promptly. Inspectors saw patients' pain being addressed in a very prompt manner and we saw staff using the pain tool to measure and record pain levels.
- The majority of the patients we talked to told us they had their pain relief adequately met. However, a small number of patients told inspectors they experienced a delay in having pain medication dispensed but they did not wish to raise a complaint because there were acutely aware of how busy the department was.
- In the CQC A&E Survey 2016, the trust scored 5.32 out of 10 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts.
- The trust scored 7.58 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

- However, at our last inspection in August 2016, staff told us that band five nurses were not allowed to administer analgesia via a Patient Group Direction (PGD) due to a previous error. This meant staff had to call a senior nurse to approve pain relief, which may lead to delayed administration. We found this was still the case at this inspection. We were told the PGD's had been rewritten and were awaiting final approval before they were reintroduced to the department.

## Facilities

- The department had two new rooms made available since our last inspection. One was being used as a training and simulation room to promote staff learning and development opportunities.
- The other was not finished at the time of the inspection, but was to be used as the 'ED hub room'. This was going to provide space to facilitate clinical staff to be able to work electronically to reduce ineffectiveness, for example waiting for specific investigation results and using that time to do administration or other electronic records reviews. Staff told us that this room was going to have display equipment to show department activity via a live data dashboard.

## Nutrition and hydration

- Staff ensured patients had appropriate access to food and fluids, and therefore protected them from risk of poor nutrition and dehydration.
- Staff had implemented a new nutrition and hydration round. This meant that one member of staff regularly carried out checks to ensure patients in the department were provided with food and fluids. We saw this in practice during our inspection.
- Patients we talked with told inspectors they had adequate food and drink whilst in the department.
- We observed staff prescribed and recorded intravenous fluids appropriately. All the fluid balance charts we viewed were complete.
- The CQC A&E Survey demonstrated the trust scored 7.16 for the question "Were you able to get suitable food or drinks when you were in the A&E"

# Urgent and emergency services

Department?” This was about the same as than other trusts. This meant that people had access to appropriate nutrition and hydration whilst using the department.

## Patient outcomes

- In the 2013 RCEM audit for paracetamol overdose, the trust was in the upper quartile compared to other hospitals for three of the four measures, and was between the upper and lower quartiles for one of the four measures. The measures for which the trust performed in the upper quartile were: Consultant/associate specialist saw the patient (22%), consultant/associate specialist discussed the patient was (25%) and the ST4 or more senior doctor discussed the patient was reported as (72%). The measures for which the trust performed between the upper and lower quartiles was: ST4 or more senior doctor: Saw the patient (55%)
- In the 2013/14 RCEM audit for severe sepsis and septic shock, the trust was in the upper quartile compared to other hospitals for two of the 12 measures and was in the lower quartile for four of the 12 measures. The trust was between the upper and lower quartiles for seven measures. The measures for which the trust performed in the upper quartile were: was capillary blood glucose measured and recorded on arrival: Yes (100%) and Is there evidence that serum lactate measurement was obtained in ED: At any time (97%).
- The measures for which the trust performed in the lower quartile was for capillary blood glucose measured and recorded on arrival: Within 15/20 minutes of arrival was reported as 22%, 56% of patients had a first intravenous crystalloid fluid bolus given in the ED, 28% of patients had evidence in their notes that blood cultures had been obtained, 72% of patients had antibiotics administered in the ED.
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the trust was in the upper quartile compared to other hospitals for one of the six measures and was between the upper and lower quartiles for four of the six measures.
- Between December 2015 and November 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average. In latest period, trust performance was 8% compared to an England average of 7.5%. The trust met the England average of 7.5% in June 2016, although the trust remained worse than average, the trend appeared to be reducing over time.
- The department had a clinical audit lead and a formal audit plan. This included Participation and in local audit. We reviewed the department audit matrix which demonstrated a wide range of audit activity was underway in the department.
- In the 2014/15 RCEM audit for mental health in the ED, the site was in the lower 25% of departments compared to other hospitals for four of the eight comparable measures and in the middle 50% for the remaining two measures. Of the two fundamental standards included in the audit, the site did not meet either the standard of having a documented risk assessment taken but did meet the fundamental standard of having a dedicated assessment room for mental health patients. The measures for which the site performed in the lower 25% were having mental state examination taken and recorded, having a patient assessed for their level of alcohol and/or illicit substance dependency, having a provisional diagnosis recorded and having details of follow-up arrangements documented. The measures for which the site performed in the lower 25% were having a mental state examination taken and recorded and having a provisional diagnosis documented.
- In the 2015/16 RCEM audit for procedural sedation in adults, the site was in the lower 25% of departments compared to other hospitals for one of the seven measures and in the middle 50% for the remaining six. The RSC site did not meet any of the five fundamental standards.
- In the 2015/16 RCEM audit for VTE risk in lower limb immobilisation in plaster cast, showed the trust was in the upper 25% of departments compared to other hospitals for one of the two measures and in the lower 25% for the other.

## Competent staff

- The appraisal rate for the acute floor was reported as 79%. Whilst the appraisal rates remained low, we acknowledge that there had been an improvement in compliance since our last inspection.

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- The department had introduced new ED band 6 competency based development programme. This included key department documents, critical incident reflection, co-ordinating competency, nurse in charge leadership role, trust policies and procedures, and a Continued Professional Development (CPD) log. These booklets had only recently been introduced to the department, we did not see evidence of completed booklets.
- A new local induction had also been introduced for staff. This provided information relating to working in the department, the nursing structure, rostering, education, documenting, Manchester triage, trauma at BSUH, stroke calls, major incident handling, mental health, human resources (HR) support and an induction checklist. We saw examples of these.
- Senior staff checked Nursing and Midwifery Council (NMC) registrations appropriately to ensure they were valid. We received documentary evidence of one referral that had been made to the NMC.
- There was a dedicated practice educator in the department whose role included delivering training as well as training oversight. Staff had access to a training programme and opportunities for professional development.
- We saw evidence of a new approach to training delivery in the department, which was more inclusive and had a multidisciplinary approach. The new approach meant that health care assistants, a nurse, a junior doctor and a consultant provided training. Each took a different perspective on the training topic and shared their experience and skills. This ensured a holistic and team based approach to the training. The feedback we received from staff about this approach was overwhelmingly positive.
- Staff used a new simulation training room for simulation-based learning as a way to develop health professionals' knowledge, skills, and attitudes, whilst protecting patients from unnecessary risks.
- The introduction of single clerking meant that junior doctors could avail of more educational opportunities. Clerking juniors assess undifferentiated patients and review their patients with senior decision maker.

- There were appropriate processes in place to ensure that staff had the relevant experience and qualifications before being offered a post. Background checks were carried out prior to commencing work to ensure they were of good character.

## Multidisciplinary working

- There was a significant and notable improvement to ensuring a multidisciplinary team approach to the care delivered, since our last inspection.
- There was a newly implemented ED charter, which teams for other specialities adhered to. This had helped improve working relationships between the specialities and in effect, make 'the front door' everyone's concern.
- Data provided demonstrated that patients were getting specialist reviews in a timely manner. For example, we saw medical, surgical, trauma, outreach, mental health, radiology, radiography, pathology and the ED rapid discharge team working together to deliver the service.
- We also noted a positive working relationship with the local ambulance service. This provided much needed support during busy times when managing capacity became a challenge.
- A local mental health trust provided mental health support for the department. There was also a mental health liaison team in the department five days a week, with telephone support out of hours.
- There was a dedicated ED Rapid Discharge Team (HRDT) that were able to provide support to patients and staff and promote safe and timely discharges.
- We observed staff interact with each other in a very positive and professional manner. Their interactions demonstrated strong and positive working relationships.

## Seven-day services

- The department provided a twenty-four hour, service seven days a week.
- There was support provided from other services to ensure that patients had access to the specialist care they needed.

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- Pharmacy services were available seven days a week. Monday to Friday 9.30am to 5.30pm, Saturday, Sunday and bank holidays 11.00am to 1.30pm. An emergency duty pharmacist was available via switchboard outside of opening hours.
- The diagnostic imaging department provided a seven day, on call service. This was in line with; NHS services, seven days a week, priority clinical standard 5, 2016. This requires hospital inpatients to have seven-day access to diagnostic services such as x-ray, ultrasound, CT and MRI and radiology consultants to be available, seven days a week
- Mental health support services were available twenty-four hours a day seven days a week.
- The outreach service was available 08.00am to 20.00hrs seven days a week. The outreach service provides support to the ward and department teams when a patient's condition changes and more complex support is required for example when a patient's condition deteriorates. This meant that after 20:00hrs there was no outreach services provision.
- The chief nurse was the designated executive lead for safeguarding. The trust employed a team of nurses to support staff with safeguarding issues upon request, who were available 24 hours a day, seven days a week.
- We identified a number of vulnerable patients who did not have their capacity assessed during busy times. Examples of this included frail elderly patients who clearly lack capacity and did not have the appropriate MCA and DoLs documentation in place.
- The trust wide data we reviewed showed 67% of healthcare assistants, 84% of nurses and 85% of medical staff had received MCA and DoLs training.

## Are urgent and emergency services caring?

Good



At our previous inspection in 2016, we rated caring as requires improvement because:

- Most of patients and relatives we spoke with told us that they were satisfied with the care they received but we also received negative feedback from patients.
- 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.

However:

- 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.

## Access to information

- Staff had access to the information they needed to be able to undertake their roles.
- Examples included the use of prompt cards and a new and easy to use department webpage, which contained a wealth of information for staff like referral pathways and forms, national and best practice guidance reference guides, trust policies and procedures.
- There was a combination of paper and electronic records used in the department.
- An electronic system was in place to monitor the patients journey, admission times, length of time in the department and bed status.

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

- Staff we talked with were aware of their roles in terms of obtaining consent, the mental capacity act and deprivation of liberty safeguards.

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- 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.

On this inspection, we have changed the rating to good. This reflects significant improvements in how staff managed and provided care for patients in the department.

- Since our last inspection, a specific member of staff was allocated to patients in the corridor and had clinical oversight of their treatment plan, and provided emotional support to these patients.
- The interactions we saw between staff and patients during the inspection were positive, kind, caring, and respectful. The patients we talked with were very complimentary about the way staff treated them and of the care they received. All the patients we talked with commented on how busy the department was, but wanted to highlight and commend the way the team worked to ensure they got the care they needed. Relatives we talked with were also positive about their experience of the department.
- Patients and relatives told us they felt involved in their care and the patients we spoke to were aware of their treatment plans.
- Friend and family data for the department was generally better than the England average and The results of the CQC A&E survey 2014 showed the trust scored about the same as other trusts in all of the 24 questions relevant to caring.

However:

- In busy times, it appeared an impossible task for staff to prevent mixed sex breaches due to the layout and lack of capacity in the department. Whilst there were screens available to promote dignity, when the corridor was full, there were not enough screens available.

- We saw trolleys with patients around the nurses station, and patients 'two abreast' in the triage area when the corridor area was full. In these circumstances, staff were unable to maintain patients dignity or confidentiality.

## Compassionate care

- The patients we talked with during the inspection were very complimentary about the care they received. They told us staff were "kind and attentive". Comments received included "The nurses were amazing".
- Patients felt the care they received reflected their personal beliefs and said staff respected their wishes.
- The interactions we observed between staff and patients were professional and compassionate.
- The department had embraced the 'hello my names is' campaign. This encouraged and reminded healthcare staff about the importance of introductions in healthcare. We saw staff greeting patients in this way.
- All staff wore name badges and introduced themselves by name. Staff routinely asked patients how they would like to be addressed.
- The trust's Urgent and Emergency Care Friends and Family Test performance (% recommended) was generally better than the England average between February 2016 and January 2017. In January 2017, performance was 89%, compared to an England average of 87%. The percentage recommending the emergency department varied between 87% and 91% over the 12 month period. The overall trend was mixed; recommendation rates reached a high point of 91% in June 2016 and met the England average in August and October 2016.
- Our last inspection identified concerns with the lack of dignity, confidentiality, and respect for patients treated in the corridor area. The department responded by introducing a new patient assessment area to reduce the need for using the corridor areas. New screens ensured that patients treated in the corridor area during busy times had their dignity

# Urgent and emergency services

respected. However, when the corridor was full, there were not enough screens available, and there was a lack of space available to erect additional screens had they been.

- The department had introduced patient dignity audits, also known as comfort rounds. We saw this in practice during the inspection. Patients' records demonstrated staff completed this in line with the new department policy. Patients told us that staff regularly checked them to ensure their needs were being met.
- The department achieved a PLACE score of 75% for privacy.

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

- There was a named nurse system in place for each clinical area. The 'named nurse' was a designated individual who was responsible for a patient's nursing care during their hospital stay.
- There was a nurse in charge for each shift, who wore a large red badge to indicate their position. This meant patients could easily identify who had nursing responsibility for the department during their stay.
- The corridor area had a new system where staff were identified at the beginning of each shift as having responsibility for this area. These staff had their names displayed on an information board for patients and their relatives to see. This meant the staff in charge of this area was easily identifiable.
- Staff wore different coloured uniforms, which made identifying different disciplines easier. There were posters in the department that indicated what the different colours meant.
- The patients we talked with knew who their allocated named nurse was.
- Patients told us they felt involved in planning their care and we observed this in practice.
- Relatives we talked with were very happy with the way their needs were met during their loved ones hospital stay.

- The patients we talked with told us they were provided with enough information and access to clinicians to ensure they were able to make informed choices about their care and treatment.
- The results of the CQC A&E survey 2014, showed the trust scored about the same as other trusts in all of the 24 questions relevant to caring.

## Emotional support

- We observed clinical staff provided immediate emotional support to patients and their loved ones. This included reassurance from nursing, ancillary, and medical staff.
- Staff told us they could access various clinical nurse specialists and teams in the hospital who were able to provide additional emotional support for patients and their relatives. This included but was not limited to cancer nurse specialist, end of life care team and mental health team.
- There was contact information on display in the department for a range of support groups which included, but were not limited to domestic abuse, alcohol and drug abuse and mental health support.
- A chaplaincy and bereavement service was available seven days a week.

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

Inadequate



At our previous inspection in 2016, we rated responsive at the Royal Sussex County Hospital (RSCH) as inadequate because:

- There were 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.



# Urgent and emergency services

- 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 appeared to have become normalised.
- Many of these were longstanding issues brought to the trust's attention previously and while there had been some improvements, the trust needed to demonstrate sustained progress.

However:

- There was a program of building works underway, new senior medical and nursing leaders and innovations such as single medical clerking.

On this inspection, the rating of inadequate remains unchanged. Whilst we recognise significant improvements have been made to service to ensure it meets patients individual needs, we remain concerned about departmental access and flow, and the impact of this on the quality of care, and patient experience.

- We saw several patients sharing mix sex accommodation during the inspection, which was identified as a breach of the regulations.
- The department continued to struggle to meet the demand of the service. Whilst it is an important observation to report, it is equally as important to report that these findings were very much outside of the control of the staff. The departmental environment was simply unable, nor suited to providing care for large volumes of patients.
- Whilst we found the department had worked extremely hard to improve access and flow it continued to be a significant concern. We recognised that patients who were triaged, had access to a review from the most senior specialist, and received a decision to admit (DTA) within a responsible timeframe, patients continued to be exposed to long waits for a bed elsewhere in the hospital due to a lack of capacity.
- The departmental environment did not support the volume of patients that required treatment which meant that inappropriate areas were being used at busy times

- During busy times, we identified some patients who did not have their individual needs identified or addressed. We also identified patients who presented as 'confused' who were in the corridor area overnight, which was against the newly implemented corridor areas user guidelines.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between February 2016 and January 2017

However:

- The department had strengthened its engagement with the local Clinical Commissioning Groups (CCGs) and external providers and services, to ensure a more robust approach to managing service demands. This included local CCG's and secondary care providers as well as the police service.
- There were appropriate processes to ensure that complaints were handled and learned from. We found good clinical oversight of departmental complaints and noted there was a clinical lead who took responsibility for these processes.
- Patients had their individual needs met by the service.

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

- The department was subject to building works at the time of our inspection. Staff told us that funding had been made available to secure the building of a new acute floor, which was expected to provide additional capacity to cope with the increased volume of patients who attend the department.
- There was also major building works being carried out elsewhere in the hospital, which would improve capacity in other specialist areas and in turn have a direct impact on the ED effectiveness.
- Senior staff had an improved approach to regular engagement with local CCGs and secondary care providers. For example, this included a formal monthly meeting to assess bed availability in the community, and trust, to aid the management, access and flow of the department.

## Meeting people's individual needs

# Urgent and emergency services

- At busy times, patients did not always have their individual needs identified or managed effectively. Examples included not upholding confidentiality and dignity, mental capacity and Deprivation of liberty (DoLs) concerns.
- Staff were unable to tell us if, or who their various specialist champions were. For example, learning difficulties (LD), dementia, sepsis. A clinical champion is someone with excellent knowledge and skills in a particular area. They advocate for patients and a source of information and support for co-workers.
- Staff were also unable to tell us if the department used a recognised dementia awareness symbol to help identify patients with this condition.
- Records we viewed contained assessment of the patients' individual needs. We found the majority were contemporaneous; however, we did identify some patients whose assessments were either inaccurate or incomplete. This predominantly related to patients who lacked capacity.
- Patients with a learning disability had their individual needs identified. Carers were encouraged to stay in the department with the patient to act as an advocate. We saw this in practice during the unannounced inspection.
- Translation services were available at the department. Staff were able to describe the booking process to request translational support. In emergencies, staff who were able to speak another language were used to translate.
- ED referred older people with complex needs to the elderly care team for review before discharge.
- There was close links with the mental health services to ensure the service met the needs of patients with mental health related conditions. A mental health liaison services was provided to the department between eight am and six pm. There was a guaranteed, one hour response time to referrals once the patient was medically fit. Out of hours, urgent support to a mental health consultant was available via telephone service.
- Between December 2015 and November 2016, the monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was similar to the England average. Throughout the period, the performance in this metric showed no real trend of improvement or decline and remained between 3-4%, as did the England average. Between August and November 2016, the trust performance was slightly better than the England average.
- Staff provided patients suspected as suffering or been exposed to domestic abuse with the necessary support and information.
- A frailty geriatrician provided support to the department eleven hours a day.
- During our inspection, we observed staff answer call bells immediately and staff were attentive to patients' needs.
- A range of food was available to patients so their individual dietary and religious needs or preferences could be met.
- Whilst we identified several mixed sex breaches during the inspection. It is important to note staff were acutely aware of these, and did their utmost to ensure patients were relocated to same sex areas, as soon as reasonably possible, when it was safe to do so.
- The provider was taking the necessary steps to address the environmental restraints and building works were in progress to improve the department.
- The hospital had secured finances to build a new acute floor, which would provide appropriate patient accommodation that assured dignity, privacy and confidentiality for patients.
- The department achieved a PLACE scores of 57% for dementia, 65% for disability friendliness.

## Access and flow

- Our last inspection identified concerns with patient access and flow in the department. At this inspection, we found the hospital had made significant improvements to address our concerns. Examples included several new Standard Operating Procedures (SOP) that improved ambulance handovers, trust escalation, department escalation, corridor area management. A new Patient Assessment Triage (PAT) area was developed to reduce the need for placing patients in the corridor areas.



# Urgent and emergency services

- However, despite these improvements, the department continued to struggle to meet the demands placed upon it, because of the lack of capacity elsewhere in the hospital. This meant that during busy times inappropriate areas were being used. This included the corridor and PAT area where patients had less than 10 cm of space between trolleys. The plaster room was being used for clerking purposes, and the quiet room was also used for patients. Using these inappropriate areas for patients was identified as a potential risk to patient safety.
- The department had used tape on the floor to ensure that some areas were left clear to uphold the fire regulations. However, during extremely busy times, all the space available in the department was being used as staff had no other alternative.
- We saw the single clerking process was working well. This meant that patients received one medical clerking from the most senior decision maker: reducing the time and the duplication associated with the old clerking process.
- There was an acute floor ethos which promoted working together as one team rather than in individual silos, to encourage collaborative decision-making. Doctors, nurses, outreach and site managers met as one acute floor on a daily basis.
- The department had also introduced a new telephone system that made escalating concerns to the senior leadership team more effective.
- Between March 2015 and March 2016, the RSCH reported 85,437 attendances (over 17's).
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between February 2016 and January 2017.
- Between February 2016 and January 2017, performance against this metric showed a trend of decline, although the trend mirrored the England average throughout the time period. The trust performance remained below the average ranging from 85-77%. May 2016 showed the highest rate of 85% of patients seen within four hours however January 2017 saw a decrease to 77%.
- Data presented for the Eye hospital suggested 1,088 (under 16's) and 13,558 (over 17's) attendances within the reporting timeframe.
- Between February 2016 and January 2017, the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. Between February 2016 and January 2017 performance against this metric showed a trend of decline, there was a slight improvement between May and July 2016 where performance ranged between 16-18% against an England average of 10-12%. In the following months, the trust showed a more rapid decline against the England average with performance in January 2017 reaching 40% against the average of 22%.
- Between December 2015 and November 2016, the trust's monthly average total time in A&E for all patients was consistently higher than the England average. Performance against this metric showed a trend of decline; although the trust performance slightly mirrored the England average the overall time spent in A&E was approximately 10 minutes longer at the trust between December 2015 and July 2016. From August 2016 the trust's performance against this metric continued to decline and in November 2016 the total time in A&E at the trust was 171 minutes compared to the England average of 151 minutes.
- Over a recent bank holiday weekend the hospital had improved bed capacity, (which was achieved by a lack of routine surgery, reduced ED attendance and successful discharge planning from ward areas). This had a positive impact on the ED as it provided an opportunity to test the new and improved processes, introduced to improve flow and patient experience in the department. It demonstrated to the team, when there was sufficient bed capacity elsewhere in hospital the department could achieve the national set targets. Staff told us how "good it felt" having tested the new processes and found them to work effectively.
- The percentage of A&E attendances at this trust that resulted in an admission was higher than the England average from 2014/15 to 2015/16. Compared to 2014/15, the percentage of attendances resulting in an admission at this trust showed a slight increase in 2015/16.

# Urgent and emergency services

- Data April 16 to March 17 demonstrated the time to initial assessment for 95% of patients to be within 60 minutes with the exception of February 17 and March 17 in which it increased to 78 and 65 minutes respectively.

## Learning from complaints and concerns

- There were effective systems and processes to manage and learn from complaints.
- A&E accounted for the majority of the complaints raised in the trust.
- A consultant and the quality risk lead that had overall responsibility to review and respond to complaints. This was a new incentive since our last inspection and staff told us that it was working well.
- Staff monitored complaints for trends and themes to aid learning and make improvements in the department. For example, it was identified that patients did not have sufficient access to drinks whilst in the department. This was addressed by a staff incentive to do nutrition and hydration rounds to ensure patients had their needs regularly reviewed and met.
- There was a new staff notice board, which contained information about the complaints received.
- Staff reviewed feedback from complaints at the daily handovers, email, in person and via the staff notice board.
- We found the formal complaints responses contained an apology when appropriate, were detailed and fair. There was evidence the Duty of Candour regulation was being applied where necessary.
- The trust website provided relevant information on how to raise a complaint with the trust. This included encouraging raising concerns directly with staff, making a complaint in writing and the contact details for the Patient Advice Liaison Services department.
- The PALS department provided patients with support and appropriate signposting when they wished to raise a concern.

## Are urgent and emergency services well-led?

Requires improvement



At our previous inspection in 2016, we rated well led in the Emergency Department at the Royal Sussex County Hospital (RSCH) as inadequate because:

- There were unresolved long standing capacity issues which frequently impacted on the ability to move patients through the emergency care pathway. National targets were consistently not 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 and the risks and issues were not understood by leaders.
- 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.
- 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.

However:

- 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.

On this inspection, we have changed the rating to requires improvement. This reflects the significant improvements made to the vision and strategy of the service as well as the governance and risk management processes, and the improvements to culture.

# Urgent and emergency services

- We recognise significant improvements have been made but we are mindful that improvements need time to become embedded.
- This was also true of the staff who were new to post within the leadership team.
- The feedback we reviewed about the culture in the department was largely positive, however some staff remained sceptical about the changes.
- The department used the mandatory route to engagement with members of the public but there was no additional strategy that inspired a public engagement agenda.
- The trust had developed separate behaviour and values and we were told that staff were involved in their development. However, the trust values were not widely known or recognised and staff told us they did not feel involved in their development.
- Engagement with the ED at the PRH site and at trust level, was challenged and may require significant input to improve.

However:

- We saw effective processes to assess, monitor, and improve the quality and safety of the service. Governance, risk management and quality measurements systems were found to be much improved at this inspection.
  - We found evidence of improved staff engagement strategies and staff told us they felt more involved in the change process. They also told us the culture had undergone positive changes, which meant an open, inclusive, and no blame culture was developing.
  - There was an appropriate vision and strategy in place. Staff felt very much involved in its design and were committed to its successful implementation.
- The senior management team demonstrated a cohesive and effective approach to managing the department during our many interactions and interviews. They told us they were very proud of the team they led. They also recognised and praised the team's ability to embrace and effectively manage constant change that was being driven by a patient safety and quality agenda.
  - We asked the leadership team what would make the biggest difference to their ability to deliver the changes needed to improve the service. They told us they would like stable leadership and support at board level, improved capacity on the RSCH site, and a new acute floor, which would provide a larger and more appropriate care environment.
  - Comments we received from staff included "from an ED perspective the one thing that has made the changes possible is the staff have respect for each other and the support and drive to help patients. They have worked hard to hold the department together".
  - Staff also told us about what they perceived to be "problematic hierarchical structure" that contributed to an "us and them" culture.
  - Other comments we received included "people are supportive but we are pulled in different directions" and uncertainty about the plan and vision means that things get delayed.
  - Directorate management teams were based in the department to ensure they were more visible and accessible for staff.
  - The department had agreed and implemented the 'emergency department internal professional standards'. This was designed to allow management of speciality reviews and Decisions to Admit (DTA) within the ED.
  - The Rapid Processes Improvement Workshop methodology was introduced to the department to aid the design of the proposed urgent care centre new build.
  - The matron had implemented a new initiative called matrons surgery. This provided two hours open access to the senior leadership team and an opportunity to talk about experiences or concerns.

## Leadership of service

- The leadership of the service had changed since our last inspection. There was evidence that these changes had a positive impact on the staff and department efficiently and effectiveness.
- Staff told us the senior management team were more visible, accessible and approachable.

# Urgent and emergency services

- Compliance rates for mandatory and additional training continued to low at this inspection. This demonstrated a lack of senior drive to ensure staff received the necessary training.

## Vision and strategy for this service

- There was a vision and strategy for the service which was much supported and understood by staff. Senior leadership told us recent meetings with the new hospital board demonstrated confident and a commitment to the local strategy. This included the building of a new acute floor that would provide a much larger and safer improved care environment for patients.

## Governance, risk management and quality measurement

- There was effective processes to assess, monitor, and improve the quality and safety of the service. Governance, risk management and quality measurements systems was found to be much improved at this inspection. It is important to note these processes needed further time to mature and become embedded in practice.
- The various governance processes consisted of appropriate Red/Amber/Green (RAG) rated risk register. The RAG system is a widely used method of rating for issues or status reports, based on colours used in a traffic light rating system.
- The risk register was directly linked to the incident reporting system. This provided evidence of an improved and strengthened process to help identify trends, themes and service risks. There was documentary evidence of an enhanced complaints review processes, contemporaneous M&M meetings and an improved incident reporting culture. Data collected and collated from these systems and process were reviewed at a departmental level through the quality and safety improvement board. There was also an additional meeting the trust governance lead to review the department risks regularly. These adaptations had strengthened data quality, and oversight of quality and safety monitoring, which in turn, improved the strength of the overall governance processes.
- The department held a weekly clinical governance meeting with staff representatives. The meeting was chaired by the clinical lead for ED and was attended by a range of staff who held senior management positions and lead roles in the department, for example, medical director, matron, nurse consultant, practice educator, infection control lead, quality and risk lead nurse, rapid discharge team and clinical manager. The aim of the meeting was to ensure robust review of departmental performance, which included trend and theme analysis from incidents and complaints, risk register oversight and care quality reviews. This provided a formal an opportunity to review performance as a MDT team, and escalate concerns through the trusts governance mechanisms and report to the trust board as necessary.
- The senior leadership told us staff had a better understanding of the risks in the service and were more proactive in reporting and raising concerns. They told us they were very confident they had a good understanding, oversight and much improved processes to manage and escalate the risks in the department. We asked the leadership team if they had the same level of confidence in the governance and risk management meant structures outside of the department and were unable to get that assurance. This may suggest that the senior leadership team would benefit from improved feedback processes to ensure that governance processes at board level were effective and efficient.
- It was currently mandatory that band seven level nurses attended the department governance meeting. At the time of the inspection, staff from other designations and roles did not attend these meetings. We were told that the leadership team wanted to make these meetings accessible to all staff at all levels, and intended to extend an 'open invite' and advocate an MDT approach to future meetings.
- They also told us that the department planned to develop a governance lead role for band 6 nurses.
- Managers had developed performance dashboards for unscheduled care and shared both internally in the department and with the executive and operational teams.

# Urgent and emergency services

- The use of the corridor area was a standing agenda item at the acute floor directorate performance review meeting with the executive team and at the daily bed meeting.
- Data management and report in the department required further improvement to provide robust assurance and oversight of both ED sites.

## Culture within the service

- Our last inspection identified serious concerns with the culture in the department.
- Staff morale at the last inspection was found to be extremely low. However, staff told us that morale had improved and was continuing to improve. Comments we reviewed included “people care about what they do”, “the change is not coming from the leadership, its coming from the floor” and having a positive impact on delivery because we are using staff involvement to drive improvement”.
- Other comments included “change is scary but staff are now supported through it and the department feels better because we have a can do attitude” and “because of culture change, changes are getting easier”.
- We also asked staff why they chose to work in the ED at BSUH and receive the following feedback: “I keep coming to work because I love my team” and “I feel supported by my department” and “We are an amazing team of people who really care about what we do”.
- The majority of the staff we talked with told us that the culture in the department was changing and was now one that reflected positivity and progression. Comments we received suggested an open and blame free culture was being developed. Staff felt more empowered to report their own errors as incidents and raise a concerns or complaint about the service they worked in.
- However, it is important to note that we spoke to some staff who did not feel as confident the culture was as positive as it was being portrayed.

- The department had promoted the ED values and asked all staff who entered the department to uphold these. The values were displayed on posters around the department and other specialities had formally signed to say they would adhere to these values.
- The trust had developed separate behaviour and values and we were told that staff were involved in their development. However, the trust values were not widely known or recognised and staff told us they did not feel involved in their development.

## Equalities and Diversity

- The trust had a current equality, diversity and human rights policy and an annual report. Staff were provided with equality, diversity and human rights training. Data we reviewed showed 77% of healthcare assistants, 86% of nurses and 82% of medical staff had received this training.
- The trust had a current Lesbian, Gay, Bisexual and transgender (LGBT) forum equality and diversity action plan. This showed actions such as involving the LGBT forum in the development of HR policies. We saw the trust were committed to support the Trans pride and the LGB pride events.

## Public engagement

- The department had various ways to connect with and capture the voice of the public. This included using social media, friends and family surveys, NHS choices website.

## Staff engagement

- Staff engagement had improved since our last inspection. There was evidence that staff views were sought more than they were previously. Staff told us they felt more involved and empowered to raise a concern about the service.
- We saw minutes from staff meetings, showed regular engagement.
- Staff also used a closed social media platforms as a method of engagement.
- Whilst the majority of the feedback we received about engagement at a department level was positive, it was less so at trust level. It was clear these areas required further consideration and development.

# Urgent and emergency services

- There was a 40% response rate to staff survey from the RSC site. The results highlighted some areas of improvement since our last inspection, but also, many areas that require further development.

## Innovation

- The new MDT approach to training was beginning to have a positive impact on staff and the department culture.
- MDT approach to 'guarding the front door' which demonstrated a significant change in culture and patient oversight and ownership.

## Improvement







- The department had introduced various new roles that had a positive impact on the department. Examples included a quality and risk lead, HCA lead for nutrition and hydration rounds, joint Hospital

Ambulance Liaison Officer (HALO) appointment and the practice nurse educator. The role of the HALO is to work with ambulance crews and hospital staff in order to reduce the time that an ambulance spends at A&E.

- The staff led introduction of protected nutrition and hydration rounds.
- There was improved communication between the department staff, senior leadership, operational team. This was supported by several new processes for example,
- Effective MDT working in the department had been significantly strengthened and had improved the effectiveness of the department and the quality of care patients received.
- Improved communication through regular meetings with external providers e.g. CCG's, ambulance trust.



# 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. It is a teaching hospital that provides general, specialist and tertiary services. The medical service within the trust is divided into six different directorates: acute; abdominal surgery and medicine, which includes endoscopy; cancer services; cardiovascular, neuroscience and stroke services; and the specialty medicine directorate, which includes care of the elderly.

Royal Sussex County Hospital (RSCH) has 257 medical inpatient beds and 12-day care beds located within 21 wards. Trust wide there were 46,448 medical admissions between November 2015 and October 2016. Of these emergency admissions accounted for 20,225 (43%), 2,302 (5%) were elective and the remaining 23,921 (52%) were day cases. Admissions for the top three medical specialties were general medicine 7,783, gastroenterology 7,064 and geriatric medicine 6,647. We were not provided site specific information.

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 wards and departments in all six of the directorate areas, as well as the pharmacy and discharge lounge in order that we understood the flow of patients through the hospital. CQC held focus groups as well as a stall where staff and patients could speak with inspectors and share their experiences of working and receiving care at the hospital. We spoke with

50 members of staff including; divisional directors, medical staff, the chief nurse, matrons, ward managers, nurses, health care assistants, administrative staff, allied health professionals, porters and domestic staff. We also spoke with 14 patients and relatives and reviewed 27 sets of patient records.

At our previous inspection we identified the following concerns:

- The wards in the older buildings were no longer fit for purpose. The trust had a strategy for managing this but staff did not carry this out in practice. Risk assessments were poorly completed or out of date and did not provide assurances. Although the trust had plans to replace the older buildings, the project was planned to take a minimum of nine years.
- There was no system to ensure trust wide learning from incidents or take action where poor infection prevention and control practices were identified. The management of incident reporting was variable across the service with limited feedback or learning identified.
- Within the medical service, the medical directorates operated in isolation with little cross directorate learning or sharing of information.
- There was a culture of silo working and an acceptance of poor behaviour amongst staff, which was not supported by effective human resources (HR) practices.

# Medical care (including older people's care)

At this inspection, we focused on the above areas of concern as well as the requirements from the previous inspection report in order to review the extent to which the service had showed improvements in the areas of most concern.

## Summary of findings

We rated this service as requires improvement because:

- Although issues regarding the environment remained, we saw some improvement as risk assessments were completed on a regular basis to ensure the suitability of individual patients within the Barry Building. However, this adversely affected patient flow through the hospital and the number of bed moves experienced by patients.
- Incident reporting was variable across directorates in the medical service and there continued to be a lack of learning from these. This meant that the service was missing an important opportunity to learn from, and prevent incident recurrence. Silo working had improved within directorates, however we found no evidence that there was cross directorate learning from incidents or complaints.
- Each directorate had its own risk register. Although there was a trust risk register, it did not contain any information specific to medicine. Directorate leads were unaware of how they could find out issues occurring in other directorates. Therefore, senior managers did not have an effective method for identifying, monitoring, or managing the risks in all medical directorates.
- Staff advised us there were still issues with HR processes, stating support depended on who the HR representative was. Although policies and standard practices were in place, not all HR representatives followed them. Managers often found themselves following practice as best they could.

Out of eleven “must do” and “should do” actions identified at our previous inspection, the hospital was now meeting three of these as it had; made adjustments to the rehabilitation pathway to ensure it is fully compliant with NICE CG83; ensured medicines were always supplied, stored and disposed of securely, and ensured Mental Capacity Act assessments and consent forms are completed appropriately.



# Medical care (including older people's care)

## Are medical care services safe?

Inadequate



When we inspected the Royal Sussex County Hospital in April 2016, we rated safe as inadequate. This was because:

- The hospital did not manage the risk of fire 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, staff could not safely evacuate vulnerable patients 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, staff did not carry this 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.
- The majority of medical wards reported there continued to be 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 because of reported incidents. The response to incidents, safeguarding concerns and complaints also lacked a consistent approach, was different across the directorates including medical services, and relied on individual managers to be proactive and disseminate information rather than having acknowledged systems.

However:

- 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.
- 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.

At this inspection we have maintained a rating of inadequate because:

- Fire safety plans and risk assessments and actions were not complete and although there was a Fire Risk Group which fed into the Health and Safety Committee to review governance around fire risks, ward staff were unable to input into this. Not all staff had completed mandatory fire safety training.
- Risks associated with cleanliness, hygiene and infection prevention and control were not always fully recognised, assessed or managed. Requirements for cleaning, cleaning schedules, and checklists set out in the 'Health and Social Care Act 2008: code of practice for health and adult social care on the prevention and control of infections and associated guidance' were not always adhered to.
- There were high numbers of catheter related urinary tract infections in the medical service.
- There was less whole time equivalent nursing staff than was determined by the trust to provide safe care.
- There was no guarantee that the nurse co-ordinator for each shift was supernumerary and therefore they could not always fulfil their supervisory responsibilities.
- Mandatory training rates remained low and the lowest completion rate was in basic life support. However, there had been an improvement in completion of a range of topics since our previous inspection and we saw plans were in place for all staff to complete the training.
- There were effective systems in place to ensure the safe supply and administration of medicines. Trained nurses underwent training in medicines management on induction and were supervised until this was

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completed. However, staff told us that medicines management training for staff was not compulsory for staff who handle medicines. Therefore there were discrepancies between staff knowledge and hospital policy. There was no monitoring of ambient temperatures in medicines storage areas except for refrigerated items.

However:

- Since our inspection in April 2016, the trust had appointed a sepsis clinical lead and clinical nurse specialist, which enabled the introduction of a sepsis care pathway, sepsis audit programme and improvements in availability of information for staff.
- The service was awarded Joint Advisory Group on GI Endoscopy accreditation and carried out decontamination of endoscopes in accordance with 'Health Technical Memorandum HTOM 01-06: Decontamination of flexible endoscopes' and Health and Safety Executive (HSE) standards and recommended processes.

## Incidents

- Arrangements for internal and external incident reporting were set out in up to date standard operating procedures. Staff we spoke with were able to access these and correctly recalled the main principle of rapid escalation.
- The trust had trained staff to use the system. We saw examples where staff reported incidents on-line using the trust electronic reporting system.
- At our inspection in April 2016, we identified that incident reporting was inconsistent. Staff we spoke with told us that this was still the case. Pharmacy staff told us they noticed a variation in reporting medicine related incidents, depending on the culture of the ward or department.
- Managers told us of an incident that took place four days prior to our visit where the medical emergency team were called to the acute medical unit to respond to a patient's attempted suicide. We saw the incident was being investigated in accordance with the trust standard operating procedure, and that staff involved were provided with a formal debrief and counselling.

Managers had shared some initial learning points with staff. There was an ongoing review in progress, after which staff would be informed of any learning points and further corrective action required.

- We saw staff discussed feedback from incidents at staff handovers and staff meetings. Staff filed paper copies of feedback in a 'lessons learned' folder in clinical areas to enable staff who had not attended the handover or meeting were informed.
- From March 2016 to February 2017, the trust reported one incident, which was classified as a Never Event for Medicine. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event. The incident occurred at Royal Sussex County Hospital on 18 September 2016. It involved a patient with reduced sensation in their feet, soaking her feet in hot water and sustaining burns. Staff referred the patient for specialist care and arranged transfer to the Burns Unit. A root cause analysis had been undertaken, however at the time of inspection it had not yet been completed. Staff we spoke with knew the incident and could describe learning, for example, a review of staff training and understanding of checking water temperatures, was shared via the trust patient safety podcasts and newsletters, which we saw.
- In accordance with the Serious Incident Framework 2015, the trust reported eight Serious Incidents (SIs) in Medicine at Royal Sussex Hospital, which met the reporting criteria set by NHS England between March 2016 and February 2017. Of these, the most common type of incident reported was slips/trips/falls.
- 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 set out the requirements relating to duty of candour in a local standard operating procedure and letter templates. We saw copies of a leaflet on the duty of candour was available for patients in waiting areas

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and in ward corridors. All leaflets were in date and explained the principles of openness and transparency and where to find support within the trust and from external organisations. We asked for examples of when the duty of candour had been applied. However, staff and managers we spoke with were unable to recall when duty of candour had been used in practice. Therefore, there was limited assurance that staff would know in what situations duty of candour practices would need to be followed.

## Safety thermometer

- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enabled measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism (VTE).
- Data collection took place one day each month and was reported on a quarterly basis by the medical service across the trust: it was not site specific. We found that although staff collected safety thermometer information, it was not visibly displayed in patient areas.
- The patient safety thermometer data showed that the medical service across the trust reported 13 new pressure ulcers, 15 falls with harm and 48 new catheter urinary tract infections between February 2016 and February 2017. On average, one new pressure ulcer was reported per month. No pressure ulcers were reported in March, and from May to July 2016. The highest numbers of pressure ulcers were reported in April 2016 (3) October 2016 (2) and February 2017 (2). For the remaining six months, one pressure ulcer per month was reported. For the remaining seven months, one fall per month was reported. We were not provided with site specific information.
- Trust wide figures for medical service reported no falls with harm in February 2016, May 2016 and January 2017. From September to November 2016, the number of falls increased with two falls in September and three falls each in October and November 2016.
- A high number of catheter related urinary tract infections (UTIs) (48) was reported trust wide by the medical service from February 2016 to February 2017,

we were not provided site specific data. On average, four infections were reported per month. High numbers were reported in February 2016 (4), April (6) May (5), June 2016 (8) and February 2017 (10). From August to October 2016, three infections were reported per month. In December 2016, no infections were reported, although numbers increased from zero in December 2016 to ten in February 2017. Staff we spoke with could not provide us with any further information about the reasons for the high rate of infections or whether these were in any particular patient area or group, nor could staff tell us of any actions that were taken as a result of this data. This showed staff were not analysing and using this data to drive improvements in the safety of care.

## Cleanliness, infection control and hygiene

- From 1 April 2016 to 31 March 2017, there were three incidences of hospital acquired Meticillin-Resistant Staphylococcus Aureus (MRSA). However specific data regarding whether these occurred in medical services was not available.
- There were 32 reported cases of Clostridium Difficile (C.Diff) at the Royal Sussex County Hospital, of which eight were reported in the medical service.
- At our inspection in April 2016, we identified requirements for cleaning, cleaning schedules, and checklists set out in the 'Health and Social Care Act 2008: Code of practice for health and adult social care on the prevention and control of infections' and associated guidance were not adhered to. The trust told us they had taken corrective action and that daily ward safety checklists including cleaning instructions and checklists were being standardised. At this inspection, we found staff still did not always adhere to national specifications for infection prevention and control and cleanliness. In particular, the trust did not have a strategic and operational cleaning plan as required by the National Specification of Cleanliness (NSC) in the NHS, 2007.
- 'Health Building Notice (HBN) 00-09: Infection control in the built environment' requires elbow operated taps where staff wash their hands. These were not provided in all areas, for example in Vallance Ward.
- During our inspection, we saw dusty and stained floors in patient bays, dirty utility areas, corridors

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and bathrooms on Vallance Ward. We saw the nurses' station on Vallance Ward was cluttered and there were boxes containing stationery stored on the floor. We moved the boxes to one side and were not assured that the floor had been cleaned recently as it was very dusty underneath the boxes and there was waste paper on the floor. One bathroom we looked at was cluttered with moving and handling equipment and did not appear to have been recently cleaned. Skirting boards were dusty and the toilet pan was heavily soiled.

- We asked to see evidence that staff used cleaning instructions and checklists. Staff told us they were not available. We were not assured that staff cleaned the ward on a daily basis. We brought our concerns to the attention of the matron who told us corrective action would be taken. Staff told us there were staff shortages in the housekeeping team and that there had been some gaps in the cleaning service provided. Staff told us a recent change of cleaning service provider had just been introduced and they anticipated an improvement.
- At our unannounced inspection, we returned to Vallance Ward and saw there had been some improvement in the cleanliness. Staff we spoke with told us that cleaning staff were not always available and that nursing staff would clean clinical areas in their absence. We repeated the request we had made at the announced inspection to see the cleaning instructions and checklists and were told they were not available. This meant there was no assurance that staff were provided with cleaning instructions or that there was assurance of when the cleaning had last taken place.
- We saw a patient with a suspected infection nursed in an isolation room on Vallance Ward. Isolation procedures are required to be based on a local risk assessment and evidence based practice. Staff did not follow the trust policy on keeping the door closed. We asked to see the risk assessment attached to this decision and were told that none was available. Keeping the door open meant the privacy curtains around the neighbouring patient's bed could be contaminated. We brought this to the attention of the matron in charge of the ward who told us corrective

action would be taken. We returned to the ward and saw that the door remained open. There was no evidence on the ward of when the curtains had last been changed or cleaned.

- There was no ensuite toilet facility in the isolation room on Vallance Ward, which meant that the patient used a commode, which was emptied, in the ward dirty utility room. This meant that there was a risk of cross contamination, as staff had to walk through other patient areas and a corridor to dispose of the contents of the commode.
- We also saw staff nurse a patient with a suspected infection in an isolation room on AMU, where we observed the same arrangements were in place for disposal of the contents of the commode. We asked to see the risk assessment attached to this decision and were told that none was available.
- NICE QS61 requires that people receive healthcare from health care workers who decontaminate their hands immediately before and after every episode of direct contact or care. We saw that staff consistently used hand sanitisers, were bare below the elbow and washed their hands in accordance with national and local policy. We also saw visitors to the departments we visited consistently used hand sanitisers.
- We observed staff appropriately segregated clinical and domestic waste and there were arrangements for the separation and handling of high-risk used linen. We observed staff complied with these arrangements.
- We saw sharps management complied with 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013'. Staff dated and signed sharps containers when brought into use.
- We observed staff working in the endoscopy suite. Staff carried out decontamination of endoscopes in accordance with 'Health Technical Memorandum HTOM 01-06: Decontamination of flexible endoscopes' and Health and Safety Executive (HSE) Standards and recommended processes for endoscope reprocessing units.
- Endoscopes were leak tested and flushed through before guidewire cleansing immediately after each procedure. Instruments were then packed and transported in a closed trolley from the procedure

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room to the washer disinfectant (EWD) located in the decontamination area within the central sterile services department (CSSD) in the operating theatre department.

- We visited the decontamination area in the CSSD and saw staff processed endoscopes before autoclaving (equipment used for sterilizing). We saw evidence of the instrument tracking system, autoclave equipment checks and performance testing used to assure the instruments were cleaned effectively, decontaminated and packaged ready for use.
- Staff returned decontaminated endoscopes to the endoscopy suite where they were stored in a clean environment in a drying cabinet.
- Staff used personal protective equipment, including disposable aprons, visors, gloves, theatre hats and masks, when decontaminating endoscopes. We also saw staff washing their hands appropriately after cleaning to reduce the risk of contamination to staff and patients.

## Environment and equipment

- Staff told us they were satisfied they had sufficient and proper equipment to carry out their responsibilities and deliver effective patient care. Equipment was regularly serviced in accordance with manufacturer guidance and electrical equipment was tested. All staff we spoke with told us they were satisfied they had the equipment they needed to carry out their responsibilities and deliver effective patient care. Staff told us that requests for equipment were responded to promptly, with same day delivery.
- Our inspection in April 2016 identified that the fabric of the buildings in some areas at the Royal Sussex County Hospital was poor and posed a risk to patients, with regard to the management of fire safety and infection prevention and control. We identified a lack of fire safety risk assessment, equipment and evacuation plans. As a result, we requested the trust to take immediate action to address the concerns.
- The leadership team acknowledged that the patient experience in some parts of the Barry Building was impaired by the condition of the estate. They told us they used environmental and individual risk assessments to ensure that patients were safe. Since

the 2016 inspection, bed numbers were reduced by closing the balcony beds and removing two beds on Vallance Ward (now converted to a dining area), and removing one bed on Chichester, and one bed on Jowers Ward. This helped to mitigate the impact of crowding on some of the Barry Building wards. The wards currently located in the Barry Building were all due to be moved out into modern, purpose built premises by the end of 2020.

- The fire officers told us the balcony beds were closed, however we were told by the matron that occasionally these beds had been opened and used. The patients were risk assessed before being admitted to these beds. Criteria (such as being fully mobile) had to be met to ensure the risk was minimised and the beds had appropriate patients in them, who effectively could evacuate themselves in the event of a fire. We revisited the balcony area as part of this announced and unannounced inspection and saw that beds were not placed in this area.
- An outsourced company completed fire risk assessments over a 6-month period from June to December 2016. These were then stored on a shared drive to which all wards had access. The wards were given a hard copy of the assessment by one of the in house fire officers and the fire officers took senior staff through the assessment. The actions were agreed and some assessments had dates of completion on but not all. However, some staff told us that they had only looked at the assessment the week before because of the CQC inspection, so had not taken timely action. The hard copies remained on the ward and the electronic copy on the shared drive. We therefore found that staff managing departments were not all fully engaged in the process, which may have an impact on fire safety compliance in their clinical areas. There was a Fire Risk Group which fed into the Health and Safety Committee, however we found there was no trust wide collation of the actions being completed, as staff in departments were unable to update any actions on the central document. Therefore, no one in the trust was able to inform us of how they ensured compliance with its fire risk assessments.
- Resuscitation trolleys were located at appropriate intervals throughout the medical service. Staff knew how to locate all emergency equipment and



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maintained a register of checks, which showed emergency equipment was checked on at least a daily basis and the required equipment was in place and in date.

- There was clear segregation and correct storage of clean and dirty equipment and clinical waste.
- The Discharge Lounge at the hospital consisted of 12 chairs, two that were reclining and two beds. However, the space within the discharge lounge was limited and cramped, there was no space between chairs and we found some were one in front of the other. The environment was not suitable for staff, as they had to use a cubbyhole at the side of the room as a staff area to keep bags and belongings. However, staff also used this area for storage. There was no door to this area and when we arrived, there was a member of staff having their lunch in the cubbyhole in full view of patients. Therefore, there was no place for staff to have a 'proper' break away from patients. There was a printer and two filing cabinets in the middle of the patient waiting area as there was not enough space to locate these anywhere else.
- On Jowers Ward, two side rooms were very hot. It was difficult to control the temperature in these rooms, as they had originally been one room that had been divided in half where the radiator was. Therefore half the radiator heated one room and the other half the other. Staff used these rooms to look after patients who required isolation nursing for prevention and control of infection and those who were end of life. Although staff agreed the rooms were unsuitable, we saw staff had completed risk assessments at every shift to see if the room was still suitable. However if it was not suitable, this meant moving an end of life patient to another area of the hospital which would be distressing for both the patient and their family.
- We saw the trust had bought two new radiotherapy machines for the cancer directorate and that one of the old machines was due to be closed a few weeks after inspection. Whilst the new building that housed cancer services was state of the art, it was situated next to the largest rebuild area, which posed a risk to patients with lowered immune systems. We saw risk assessments that showed staff routinely checked air quality and patients who were most at risk were treated in areas furthest away from the building work.

The building work had meant the iodine room within the Jubilee Building had been knocked down and had not yet been replaced. Therefore, at the time of inspection, patients requiring iodine treatment had to travel to London.

## Medicines

- There were systems to ensure the safe supply, administration, and disposal of medicines in accordance with 'NICE NG5 Medicines optimisation: the safe and effective use of medicines'.
- At our inspection in April 2016, we identified that not all medicines were stored appropriately.
- During this inspection, we saw all medicines, including emergency medicines, were within the expiry date and were stored securely and appropriately in tamper proof containers or locked cupboards or, where applicable, in a refrigerator. Staff monitored and recorded fridge temperatures at least daily to ensure medicines were kept in optimal conditions.
- Staff did not monitor the ambient room temperature of medicines storage areas in any of the clinical areas we visited. We brought this to the immediate attention of managers who told us corrective action would be taken. The trust has since provided information on work in progress to address this including the introduction of remote monitoring of temperatures across the trust from June 2017.
- Controlled drugs (CDs) are medicines, which require additional security. In all of the patient areas we visited, we saw CDs were stored in locked cupboards with restricted access, which were bolted to the wall. We saw two appropriately qualified staff checked CDs and at the time of our inspection all stock levels we looked at were correct.
- Access to the pharmacy during opening hours was by designated pharmacy staff only. In addition, there were specific procedures for other named staff to gain emergency access out of hours, meaning that unauthorized access was not possible.
- Staff we spoke with told us pharmacy staff supported nursing staff by providing training to enable proficiency in medicines management. Medicine management training was part of staff induction, staff performed drug tests in the clinical area with a

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practice educator, there was a competency document which included assessment of a drug round and also further support given during the perceptorship programme.

- All the individual patient medicines administration records we reviewed were documented in accordance with local and national guidance, and we saw all medicines were given as prescribed.
- We saw staff supplied and administered all medicines against an individual prescription by a doctor or a patient group direction (PGD). PGDs provide a legal framework, which allows some registered health professionals to supply and administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. All of the PGDs we reviewed were in date and reviewed in accordance with local and national guidance.
- In all patient records we looked at, staff had recorded allergies in medicine administration records.
- There was a regular medicine stock top up service provided by pharmacy staff. Staff we spoke with were positive about the service and told us it was very rare to run out of any medicines stock. Measures were in place to arrange for emergency supplies where needed. This included restricted access to pharmacy and emergency medicines storage cupboards by site managers.

## Records

- Staff managed individual care records in a way that kept people safe. The hospital had a clear policy, which described how records should be completed and stored. There was clear guidance on how information should be recorded and which areas of the records had to be filled in, for example, hospital numbers and discharge details.
- During our inspection, we reviewed 27 sets of patient notes. These included records of the patient's journey in the emergency, outpatients and inpatient areas. In all of the notes we looked at we found that staff had completed records in full, were concise, legible and signed. We saw that care plans focused on the individual needs of patients and their families, and included clear instructions and review dates.

- At our inspection in April 2016, we required the trust must ensure safe and secure storage of records. During this inspection, all records we saw were safely and securely stored in accordance with trust policies.

## Safeguarding

- Staff were not completing safeguarding training in sufficient numbers to ensure patients were protected from abuse.
- From April 2016 to February 2017, medical staff and nursing and midwifery staff had a Safeguarding Adults training completion rate of 100% meeting the trust target and in line with the overall trust average.
- However, the trust target was not met for Safeguarding Children Level 2 training. For medical staff the trust wide medicine completion rate was 77% and was lower than the trust overall average of 82%. For nursing and midwifery staff there was a trust wide medicine completion rate of 71% for Safeguarding Children Level 2, which was lower than the trust target and overall trust completion rate of 86%.
- The trust target for Safeguarding Children Level 3 (88 %) was not met. However, the training completion rate was higher than the overall trust average of percentage for medical staff across both sites.
- There were no reported safeguarding concerns at the time of our inspection, in the six months prior to our inspection, and between January 2016 and December 2016.
- The chief nurse was the designated executive lead for safeguarding. The trust employed a team of nurses to support staff with safeguarding issues upon request, who were available 24 hours a day, seven days a week.
- The trust had up to date safeguarding policies for children and young people and for adults. Staff we spoke with knew where to locate the policies and were able to describe what to do if they had any safeguarding concerns. We saw noticeboards in all patient areas we visited displayed information about safeguarding, which could be viewed by staff and members of the public. These boards contained contact details for the safeguarding teams, where to find them and the service they provided.

## Mandatory training

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- Our inspection in April 2016 identified staff compliance with mandatory training fell below the trust target for both nurses and doctors across medical services. We required that all staff in medical services completed mandatory training, including conflict resolution and safeguarding training. Mandatory training completion rates were lower than the trust target.
- As part of this inspection, we asked to look at records to demonstrate the extent of progress with completion rates. The trust told us there had been a discrepancy in training record data, which made their position unclear and they had recently extended the human resources information technology system to include all aspects of mandatory training. They supplied us with data from April 2016 to February 2017, which showed that trust wide compliance with mandatory training for medical and nursing and midwifery staff within the medical service continued to fall below the trust target.
- Within medical services at both sites, the lowest completion rate for mandatory training was reported in Adult Basic Life Support training. Completion rates ranged from 44% in speciality medicine to 70% abdominal surgery and medicine. There was a 56% completion rate in the cardiovascular department, and 53% in the cancer directorate. We were not provided with site specific information. This meant there was a risk that staff would not be able to respond appropriately in the event of a cardiac arrest.
- Staff we spoke with told us that it was difficult to access the Adult Basic Life Support course as there were only 12 places allocated per month. Staff also felt that completion rates could be low as it had been difficult for some staff to get released to attend training.
- We brought this to the attention of the leadership team, who told us that three new members of staff had started in the trust resuscitation team in April 2017. They told us that as a result, it was anticipated that capacity on training courses would increase significantly in the next few months, enabling all relevant staff to undertake their training.
- Staff received Conflict Resolution training in the medical service, the lowest completion rate was 59%

in the cardiovascular service, and the highest completion rate was 79% in the neurosciences and stroke service. We were not provided with site specific information.

- Fire Safety training had generally improved, however it was still below the trust target. The highest reported completion rate was 88% in the neurosciences and stroke unit. The lowest reported completion rate was 68% in specialty medicine.
- Staff we spoke with told us that the majority of mandatory training was on-line. Staff at RSCH had been able to access this without difficulty.

## Assessing and responding to patient risk

- Patient records showed a consultant assessed patients who were urgent or unplanned medical admissions and were seen within 12 hours of admission or within 14 hours of the time of arrival at hospital.
- Staff used the National Early Warning Scores (NEWS) system to identify and monitor patients who were deteriorating. In all of the records we looked at, we saw staff had assessed and documented the NEWS score in accordance with the trust policy. We saw staff had referred a patient to the cardiology service because of their NEWS score, which showed that they were aware of and used appropriate escalation procedures.
- The medical service had on-site access to level two and three critical care (high dependency and intensive care) units.
- Patients on Courtyard 8 Ward were given a red sepsis card to inform them of the signs and symptoms of sepsis and as well as information as to what the patient should do if they suspected they had any symptoms.
- Staff conducted safety huddles twice daily, using the safety, background, assessment and recommendations (SBAR) tool. This enabled them to share information and act on risks in a timely way. We saw safety huddles took place in all of the areas we visited and observed that there was discussion of staffing levels, safety incidents and infection prevention and control issues.



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- Staff used a colour coded wristband system to alert other staff of any patient risks. For example, if the patient had an allergy or was at risk of falls. The wristband system meant staff could keep patients safe without advertising that there was a concern to other patients or the public. We saw this in use on Courtyard 8 Ward.

## Nursing staffing

- The trust monitored staffing levels, sickness and vacancy rates and use of bank and agency staff. The trust did not use a patient acuity tool to determine levels of staffing. The leadership team used an algorithm to quantify the extent of nursing care to be provided based on the size of population, mix of patients, and type of service and relating it to the activities undertaken by different members of the team.
- At our inspection in April 2016, we identified nurse staffing on medical wards as a significant concern across the trust. We found on this inspection, that staffing in medicine on the Royal Sussex site continued to be below the rest of the trust.
- For example, Royal Sussex County Hospital had 5% (18.83) WTE staff less than what was determined by the trust to provide safe care.
- As of February 2017, the trust reported a nursing vacancy rate of 8% in medicine across both sites. There were vacancies in all parts of the medical service with the exception of the neurosciences and stroke department.
- In February 2017, the trust reported a turnover rate of 17% in medicine on both sites, which was worse than an overall trust turnover rate of 15.7% for nursing staff.
- Between April 2015 and March 2016, the trust wide sickness rate in medicine was 4%, which was worse than the overall trust sickness rate of 3.6%.
- Between February 2016 and January 2017, trust wide figures for medicine showed bank and agency usage rate of 9%, which was worse than the trust overall rate of 7%.
- 'Royal College of Nursing Breaking down Barriers, Driving Up Standards 2009' and 'Safer Staffing Levels 2012', state that the nurse coordinator remain

supervisory and is not allocated their own patients on each shift for the purpose of maintaining and improving the quality and consistency of health care experienced by patients and service users. However, nurses with management responsibility advised us they regularly lost supervisory time in order to make up numbers on the ward. They also stated they were included in rota figures when they should have been supervisory, therefore trust figures were not a true reflection of staffing on the wards.

- Although the trust was not monitoring whether nurses leaving the trust were British or overseas. Staff advised us that the number of overseas nurses leaving the trust had increased since our last inspection, and that although this took pressure off mentors to support foreign staff to acclimatise to the UK, it meant staffing levels at the trust were decreasing further.
- We viewed staff rotas from April to July 2016 and found that average fill rates were variable across medical services at the hospital. No ward within the medical directorate was fully staffed during this period.
- Rotas showed that Vallance Ward had an average fill rate of registered night staff of 69.9% during July 2016 and 78% during May and April 2016. Therefore, registered staff levels during the night on Vallance Ward may have been unsafe during these months. This was identified at our previous inspection. We were not shown any actions plans to improve these figures.

## Medical staffing

- At our inspection in April 2016, we identified medical staffing was below the required standards as there was no medical consultant present in the AMU from 9am to 5pm Monday to Friday and no cover out of hours. However, on this inspection we saw there was a consultant trained in either general internal medicine or acute internal medicine on call at all times for the AMU who was able to reach the unit within 30 minutes both during the day and out of hours.
- As of February 2017, the trust reported a vacancy rate of 6% in medicine across both sites. This was worse than the national average.

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- From April 2015 to March 2016, the trust reported a sickness rate of 1% in medicine across both sites, which was better than the national average.
- From February 2016 to January 2017, the trust reported a bank and locum usage rate of 10% in medicine, which was worse than the national average and may be linked to the vacancy rate.
- From November 2016, the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year one to two) staff was about the same.
- Although consultant numbers were below the national average, we saw rotas were fully covered to keep wards safe, however low staff numbers affected consultants ability to attend training. We were not shown a plan to increase consultant numbers.
- Once transferred from the acute area of the hospital to a medical ward, patients should be reviewed during a consultant delivered ward round at least every 24 hours, seven days a week, unless it was determined that this would not affect the patient's care pathway. However, staff we spoke with told us the consultant led ward round normally took place twice a week in most areas, and on other days the ward round would be led by a specialist registrar. Although staff had telephone access to the consultant for advice in the meantime, the hospital was not meeting this standard.

## Major incident awareness and training

- Staff we spoke with understood the arrangements in place for managing major incidents and enabling business continuity, and correctly described their responsibilities.
- Managers provided us with records relating to a recent business continuity incident in respect of patient flow and demand and available capacity. At the time of the incident, a meeting was held in the operational control rooms at both sites and was shared by a video link to ensure all staff could access information regarding the incident and the trusts plan for improving patient flow, for example, building work due to be completed in 2020.
- With the exception of fire safety training, major incident training was not part of the mandatory training programme.

## Are medical care services effective?

Requires improvement



When we inspected the Royal Sussex County Hospital in April 2016, we rated effective as requires improvement. This was because:

- The hospital was not yet offering a full seven-day service. 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 no formal arrangements for access to the acute pain team out of hours and there was no pain team for chronic pain management.
- 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 through this review.
- Staff had difficulty accessing learning and development, including mandatory training.

However:

- 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.
- Throughout 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.

At this inspection we have retained this rating because:

# Medical care (including older people's care)

- Care and treatment did not always reflect evidence based guidance. For example, there was no care pathway for bariatric patients and there were limited facilities or access to specialist trained staff for patients in that group.
- Outcomes from national audits were mixed and were below expectations when compared with similar services. The service scored a higher than expected risk of readmission for two of the top three specialties for all elective admissions.
- There were no formal arrangements for access to the acute pain team out of hours. There was no pain team for chronic pain management, which CQC identified as a “must do” action at our previous inspection.

However:

- Staff had access to policies based on national best practice guidance from all professional disciplines.
- Patients had a comprehensive assessment of their needs, which included clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. Expected outcomes were identified and documented, regularly reviewed and updated.

## Evidence-based care and treatment

- Staff we spoke with told us they had access via the trust information technology system to policies based on national best practice guidance from all professional disciplines. For example policies based on National Institute for Health and Health Care Excellence (NICE), Royal College guidelines, UK Resuscitation Council, and British Dietetic Association.
- We saw evidence that staff planned care in accordance with NICE CG83 rehabilitation pathway critical care. CQC identified this as a “must do” action from our previous inspection in 2016. Therefore, there was evidence of improvement in this area.
- There was no evidence of any evidence based care pathway for bariatric patients. Staff told us there was no commissioned bariatric service or formal arrangement for specialist advice or information.
- The service used a sepsis screening tool and sepsis care pathway based on the ‘sepsis six’, which is a national screening tool for sepsis. Staff showed us this was easily accessed on the trust intranet.

- A stay in hospital is associated with deterioration in oral health of patients. This in turn has been linked to hospitalised-acquired infections; poor nutritional intake; longer hospital stays and increased costs. The specialty medicine directorate had therefore introduced the ‘Mouth Care Matters’ initiative to support awareness of good oral hygiene amongst staff and how this impacted patient’s general health and therefore longevity in hospital. However, the directorate had only recently introduced this initiative; therefore, it was too early to measure any benefits.
- The medical service had been awarded the Joint Advisory Group on GI Endoscopy (JAG) accreditation. This showed the service was using evidence based practice.

## Pain relief

- At our inspection in April 2016, we identified that the service must review the provision of the pain service in order to provide a seven day service that included the provision of chronic pain services.
- On this inspection, there was a trust wide acute pain team that supported clinical services from Monday to Friday during core hours. However, there were still no formal arrangements for access to the acute pain team out of hours. The trust reported that plans remained in progress to expand the pain service, and that in the meantime clinicians would continue to review patients with pain on an individual basis, however there was still no pain team for chronic pain management. This meant the hospital was still not providing a seven day service with regards to pain.
- We saw staff ask patients about their pain on a regular basis as part of clinical observations using a formal patient reported pain scoring system. Staff asked patients to score their pain on a scale of one to 10. We saw in Donald Hall Ward that staff scored 98% in the most recent audit of documentation of pain scores, which was higher than the trust target of 92%.
- All patients we spoke with were satisfied with their access to pain relief medicines and said their pain was managed well. All patient records we looked at confirmed this as they showed staff checked patients after a period of time to ensure that pain relief had been effective.

# Medical care (including older people's care)

## Nutrition and hydration

- A dietetic service was available across the medical service from 9am to 5pm Monday to Friday. Staff could contact an out of hours dieticians by telephone for advice, for example where total parental nutrition or enteral nutrition was in place. Parenteral nutrition is the feeding of a person intravenously, bypassing the usual process of eating and digestion. Enteral feeding is when feeding is administered directly through a tube into the stomach. Staff and patients we spoke with told us they were satisfied with the service they received from the dietetic service.
- However, there was no dietetic service commissioned or provided for bariatric patients. Staff we spoke with told us there was no formal arrangement for accessing any specialist advice for bariatric patients, and that they were not aware of any particular training provided in this area.
- Where possible, a dietitian attended the MDT ward round to assess and manage the nutritional needs of patients. Staff told us this was on average once a week. We saw that dietitians contributed to the patient's care plan and recorded instructions for other members of the multi-disciplinary team.
- All patient records we looked at showed that staff used a nationally recognised tool to assess nutrition and record patients' weight, both on admission and regularly throughout the patients hospital stay.
- We saw on all wards that patients had comprehensive food and fluid balance monitoring on the daily care charts, and staff showed us records where patients had been referred to the dietician if food supplements were required and a speech and language therapist to support patients with swallowing difficulties.
- Staff we spoke with knew when and who to report concerns regarding decreased input and output and we saw records that showed this was happening in practice.
- We observed staff supported patients to eat independently and drinks were placed within their reach. When required, nurses or family members assisted patients with eating and drinking.
- From October 2015 to September 2016, medical patients at Royal Sussex County Hospital had a higher than expected risk of readmission for two of the top three specialties for all elective admissions. Cardiology and general medicine were higher than, and clinical haematology was similar to, expected risk of elective re-admissions. For all non-elective admissions, the risk of readmission was mostly higher than expected risk, with cardiology having the highest risk of re-admission.
- The trust took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A to E, where A is best, the trust achieved a score of B in the most recently reported audit from August to November 2016. For patient centered performance, speech and language therapy improved from D to C. The score for discharged processes decreased from B to C from April to July 2016 and in August to November 2016. Team centred performance improved for occupational therapy from D to C from April to July 2016 and August to November 2016, while speech and language decreased from C to D and discharge processes from B to C.
- At our inspection in April 2016, we identified a need to implement a sepsis audit programme. Since then a sepsis clinical lead and a clinical nurse specialist had been appointed to enable audit and education activities. We saw that sepsis audits had been carried out in some areas. However, this was early work in progress and therefore we were unable to fully assess its impact.
- Royal Sussex County Hospital took part in the 2016 National Diabetes Inpatient Audit. They scored better than the England average in three metrics and worse than the England average in 15 metrics. The hospital had a 66% overall satisfaction rate, worse than the England average of 84%.
- The trust participated in the 2016 Lung Cancer Audit and this showed improvements in performance. The proportion of patients seen by a cancer nurse specialist was 87%, which was better than the audit minimum standard of 80%. This was an improvement since 2015 when the figure was 73%. Trust performance overall improved between 2016 and 2017 and met the audit standards and was not significantly different from the national level.

## Patient outcomes

# Medical care (including older people's care)

## Competent staff

- In-house learning and development for staff in the medical service was planned so that staff from across the trust could attend face to face sessions together, or complete training on line.
- A nurse practice educator supported nurses' education. However, staff told us this post had been vacant for one year. They felt this had a negative impact on access to, and monitoring of, learning and development, in particular non-interventional ventilation and tracheostomy training.
- Staff had raised this as an area of concern and told us they understood a new practice educator had been recruited and would be taking up the appointment in May 2017.
- Staff described how some in-house training sessions had been cancelled due to difficulties in staff being released to attend.
- There were established processes for induction of permanent and temporary (agency and locum) staff. We saw examples of these being applied in all areas we visited. Staff showed us completed induction records and told us they felt the induction processes met the needs of the service.
- Junior doctors we spoke with told us they felt there were some missed learning opportunities as they were not always able to attend outpatient clinics. Medical staff told us that in-house training sessions had been cancelled due to difficulties in staff being released to attend. For example, a training session on venous thromboembolism.
- However, they also told us they had been provided with "Excellent education opportunities" in the cardiology and renal departments, and that teaching by the cardiology medical team took place at least once a week. They told us the medical training director was helpful and supportive. They also gave examples of learning through monthly mortality and morbidity meetings and discussion of clinical audit outcomes at clinical governance meetings.
- At our inspection in April 2016, we identified that the trust target of a 100% appraisal completion rate was not reached for any of the staff groups shown. We required that all staff have an annual appraisal. Trust

wide figures for medical services for April 2016 – January 2017 had improved from 64% to 75%. The highest completion rate within the medical service was 88% within the abdominal surgery and medicine division, 88% in the neurology and stroke service, 84% in specialist medicine, 79% in cancer services and 79% in cardiovascular. Medical staff told us that appraisal rates for consultants were 80%, and that the gaps were partly due to a lack of trained appraisers. Therefore, the trust was still not meeting this standard. We were not provided with site or grade specific data.

- Staff involved in the decontamination of endoscopes demonstrated competencies and training. During our inspection, we saw examples of the use of competency frameworks for health care support workers trained in decontamination processes.
- Staff on Jowers and Vallance Ward were unable to provide evidence of staff competency frameworks as staff on these wards took their certificates home. The ward managers advised us they knew who was up to date with their training, but had no record of this. We were advised this was common practice throughout the hospital. Therefore, there was limited assurance that staff were up to date with maintaining their competencies.

## Multidisciplinary working

- We saw daily multi-disciplinary ward rounds and a safety huddle took place in medical wards and departments, however there was no meeting room available on the acute medical unit for private and confidential staff discussion.
- We saw staff worked within a multi-disciplinary specialty team and alongside the hospital rapid discharge team to enable as early a discharge as possible. The team were available from 8am to 6pm seven days a week.
- Staff we spoke with told us that if patients needed help with mental health needs a referral was made to the mental health services. Specialist nursing care in this area would normally be provided by agency nurses on an as needed basis. We saw this happen during our inspection.



# Medical care (including older people's care)

- Patients also had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and long-term conditions.
- Where possible, a dietitian attended the MDT ward round to assess and manage the nutritional needs of patients. Staff told us this was on average once a week. We saw that dietitians contributed to the patient's care plan and recorded instructions for other members of the multi-disciplinary team.
- Staff accessed most of their information via the hospital's intranet and shared drive. This included up to date policies and procedures, mandatory training, safety alerts and emails from colleagues.
- Staff sent discharge summaries to General Practitioners (GPs) when patients were discharged from the service. All patient notes we looked at contained discharge summaries, which were detailed and contained all key information. Staff gave a copy of the discharge summary to the patient as well as the GP, and one copy kept on file.

## Seven-day services

- During our inspection in April 2016, we found consultants and support services offered an on-call system over the weekend and out of hours, and that there was no seven day service provided by pharmacy.
- The hospital pharmacy was open from 8am to 6pm from Monday to Friday, with a reduced dispensing service (50%) between 8am and 2pm on Saturdays and Sundays. Staff told us that pharmacy was not able to provide a full seven day service because of limited resources. Managers told us that there was "A lot of pressure for pharmacy staff at weekends". They told us additional staffing had been raised with the executive team through business cases over the past 18 months and remained unresolved.
- Staff told us there should be daily consultant led ward rounds and board rounds. However, staff we spoke with consistently told us this did not always happen and that consultant rounds normally took place two or three times a week and that specialist registrars were conducting ward rounds at least once a week. It was not usual to have an evening or weekend consultant ward round.
- We were shown a business plan and advised by staff that as of 1 July 2017, there would be a seven day physiotherapy service provided at the hospital. However, we saw no plans to ensure other therapy services such as the dietetic service, and speech and language therapy provided a seven day service. At the time of inspection, these services were provided 9am to 5pm Monday to Friday, however there was an out of hours telephone advice line to support staff.

## Access to information

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

- At our inspection in April 2016, we identified a need to ensure staff confirmed consent and that mental capacity assessments were completed and clearly documented in accordance with guidelines.
- At this inspection, we found the trust had since reviewed the consent policy and appointed consent champions. There were plans in place to complete an audit of the consent policy by the end of July 2017.
- All staff we spoke with understood the need to obtain consent from patients before performing care, investigations and giving medicines. Where staff could not obtain consent, for example unconscious patients or patients lacking mental capacity, staff explained they would provide care in the patients best interests.
- Staff completed mental capacity assessments for people who they believed may lack the capacity to consent. Key information about mental capacity protocols and Deprivation of Liberty Safeguards (DoLS) was available on the trust intranet.
- Staff were aware when a patient might need to use independent mental capacity advocates (IMCAs) and told us they would seek support from the matrons and safeguarding team.
- Therefore, the trust was now meeting the requirements described in our previous report.

# Medical care (including older people's care)

## Are medical care services caring?

Good



When we inspected the Royal Sussex County Hospital in April 2016, we rated caring as good. This was because:

- We observed staff treated patients with compassion and saw evidence that patients' needs were 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. 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.

At this inspection we have retained this rating because:

- Feedback from people who used the service, those who were close to them and stakeholders was positive about the way staff treated people. Patients were treated with dignity, respect and kindness.
- Patients were involved and encouraged to be partners in their care and in making decisions, with any support they need. Staff spent time talking to patients and patients were communicated with in a way they understood.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

However:

- The Friends and Family Test response rate between February 2016 and January 2017 was worse than the England average. In addition, the cardiac day case unit had an average recommendation rate of 40%.

## Compassionate care

- The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used. The FFT response rate for medical wards at Royal Sussex County Hospital was 18%, which was worse than the England average of 25% between February 2016 and January 2017. The Cardiac Day Case Unit (CDCU) and Endoscopy had the lowest response rates of 5%; therefore, these units were not receiving a true reflection of patient experiences within the wards. In addition, the CDCU had the lowest average recommendation rate of 40%, therefore more than half of all patients receiving treatment in this department would not recommend it. However, the Acute Medical Unit (AMU) had the highest average recommendation rate of 98% though a low response rate of 10%. Albion and Lewis Ward had the second highest average recommendation rate of 95% and the highest on site response rate of 21%.
- On the lead up to our inspection, CQC left comment card boxes on wards around the hospital. On the day of inspection, we received 12 comment cards related to medicine. Comments included "Good service, very caring nurses and staff, no complaints at all", "I have nothing but respect for all the staff" and "I found all the staff very caring and I was treated with dignity and respect."
- On Jowers Ward we saw a patient become distressed because all other patients in the room except for her had visitors. A HCA sat with the patient who was in the middle of knitting and asked her to show them how to knit. The HCA spoke to the patient in a kind and friendly manner and did not rush the patient in order to get on with another task.
- In the Discharge Lounge, we saw a patient become very distressed, as they had been waiting a long time for family to pick them up. Staff handled the situation

# Medical care (including older people's care)

well. One member of staff sat with the patient and did not apportion any blame. They asked if they could get the patient something to eat or drink and stayed with them until they had calmed down.

- On all wards we visited, we saw staff knock on doors before entering, staff closed curtains during examinations and conversations were quiet in order that other patients and visitors could not overhear.
- On Courtyard 8 Ward, we saw patients looked after in a very calm environment. Patients spoke of "Their nurse" looking after them and "Going the extra mile". For example, staff spent time washing and blow drying patients' hair. Patients advised us they appreciated this as it made them feel normal again after "A life changing experience". All patients we spoke with praised the ward manager; one patient said, "The ward manager is amazing. She is very sensitive to my needs but in a discreet way. I'm grateful for the support but she gives you space as well."
- Staff on Jowers Ward completed regular comfort checks on patients to make sure they had enough to drink, were comfortably positioned and asked whether they needed to use the bathroom. However, staff advised us there was no system of checking patients at regular intervals, it was just when staff were available; patient notes and records confirmed this.

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

- On all wards we visited, patients had a named nurse and/or consultants name written on or near their bed. All patients and relatives we spoke with knew who was looking after them. When we asked who patients would speak to if they had a query, most knew who was in charge. The trust had recently introduced bright red armbands for nurses to wear when they were the nurse in charge. Patients we spoke with said this was useful when they needed to speak to a senior member of staff.
- On the Emerald Unit, we saw patients encouraged to use the REACH programme, a patient and family activated rapid response program. The programme introduces a formal process for patients and families

to escalate concerns and empowers patients/family to act. Patients, family and carers we spoke with said they felt valued as partners in improving safety and quality.

- On the Haematology Day Unit, patients we spoke with said they felt listened to as well as involved in decision making regarding their care.
- On wards where there were people living with dementia, we saw staff encouraged family and friends to support patients during meal times. Staff advised us patients were more receptive to receiving support from family members than they were from staff and that this had improved patient's dietary intake. Families advised us they appreciated feeling involved and enjoyed "Being able to help in a small way".
- On all wards we visited, we saw staff speak to patients using plain english. Staff ensured patients understood what was going to happen next and kept them informed of when they would likely be discharged. Staff also gave patients the opportunity to ask any questions.
- Staff in oncology supported patients who wished to go home during treatment. We were told of an example where a long term patient with a naso-gastric feed (a tube that is passed through the nose, nasopharynx and oesophagus into the stomach) wanted to go home for a few days. Staff trained the patient in how to use and monitor their feed in order to enable the patient to go home.

## Emotional support

- There was a hospital chaplaincy service that 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.
- Patients received support from staff on the wards as well as clinical nurse specialists, such as the diabetes nurses, renal counsellor and dementia specialist nurses.
- Staff in Courtyard 8 Ward provided discharged patients with the ward number and encouraged them to



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contact the ward if they had any worries or concerns. Patients we spoke with appreciated the service and said it made them feel more confident about going home.

- A cancer nurse specialist ran workshops with end of life patients to provide support and information regarding next steps and gave patients an opportunity to discuss any worries and concerns. The nurse specialist trained staff within cancer services where they reviewed how to best support patients emotionally.
- Most wards had 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. For example, the call bell system was stored in the AMU quiet room. Therefore, every time a call bell went off it caused difficulty in hearing a conversation. Therefore, this was not a suitable area to have difficult conversations.

## Are medical care services responsive?

Requires improvement



When we inspected the Royal Sussex County Hospital in April 2016, we rated responsive as requires improvement. This was because:

- The trust faced significant capacity pressures. Although patients felt well looked after, staff did not always place patients 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, multiple bed moves 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 because 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.

At this inspection we have retained this rating because issues identified at our previous inspection had not been addressed:

- Referral to treatment times were worse than the England average.
- Facilities within the hospital did not support the needs of bariatric patients.
- The hospital had a high rate of mixed sex breaches and outliers, which impacted on flow.
- The facilities in the discharge lounge were still unsuitable for patients and staff.
- And flow through the medical directorate had deteriorated since our last inspection.

However:

- The hospital continued to deliver a good service for patients living with dementia.

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

- At our last inspection, we found the average length of stay for medical elective patients at Brighton and Sussex University Hospitals NHS Trust was better than the England average for medical non-elective patients, the average length of stay was similar to England average. At this inspection, we found between November 2015 and October 2016, the average length of stay for medical elective patients at Royal Sussex County Hospital was 3.2 days, which was better than the England average of 4.1 days. For medical non-elective patients, the average length of stay at

# Medical care (including older people's care)

RSCH was 7.3 days, which was similar to the England average of 6.7 days. Elective patients in nephrology had a much shorter length of stay in comparison to the England average, 3.1 compared to 8.6 days.

- The cardiology team provided a call service to patients to answer questions, queries and concerns in order to support patients and prevent unnecessary readmission. This service had supported a measurable impact in the reduced number of groin related emergency readmissions.
- Staff in endoscopy used a telephone pre-assessment service to support admissions and ensure patients had taken all required bowel preparations before arriving at the hospital. This reduced the likelihood of staff cancelling procedures due to medicines not being taken and reminded patients of their appointment.
- On the Emerald Unit we saw open visiting hours were advertised, which patients and relatives advised us they appreciated as it meant family could come whenever it was convenient for them. This meant relatives of patients who were end of life could stay on site over a 24-hour period.
- The AMU was cramped, with little bed space between each patient. This issue had been raised out our previous inspection; therefore, there was limited assurance of learning from CQC's previous findings.
- Donald Hall Ward and Solomon Ward had a male bay that was only suitable for seven rather than eight patients. CQC commented on this in our previous report. Since then staff had removed the eighth bed but due to lack of beds, it had recently been set up again on the ward. Staff advised us that managers had not considered the extra bed when reviewing staffing figures.
- On the day of inspection, we found mixed sex breaches on several wards in three directorates including; stroke, cardiology and the AMU. Mixed sex breaches are when patients from the opposite sex are looked after in the same bay as each other. Wards must ensure a bay is single sex only and that different sexes have direct access to toileting and washing facilities without the need to walk past an area occupied by the opposite sex. We saw trust wide data for mixed sex breaches that showed the trust was

worse than the England average. The trust did not provide site specific information. We could not find any action plans to improve the situation apart from the new building work, which was not due for completion until 2020. CQC highlighted the issue in our previous report. Therefore, the trust was not taking adequate steps to meet the requirements set out by NHS England.

## Access and flow

- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for medicine across the trust, showed 78% of this group of patients were treated within 18 weeks, which was significantly worse than the England average of 93%. Trust performance was below the England average from February to October 2016. During November and December 2016, trust performance was similar to the England average and again lower than the England average in January 2017. Cardiology had the lowest percentage of patients receiving treatment within 18 weeks with 65%, and Dermatology had a referral to treatment of 74%, both lower than the England average. Rheumatology and General Medicine had the highest referral to treatment rates better than the England average. The trust did not provide site specific information.
- The following specialties were above the England average for admitted RTT (percentage within 18 weeks); thoracic medicine (respiratory) was 99% against an England average of 95%, rheumatology (arthritis and other disorders of joints and ligaments) was 100% against an England average of 95% and general medicine was 100% against an average of 96%. However, the following specialties were below the England average for admitted RTT (percentage within 18 weeks), gastroenterology (disorders of the stomach and intestines) was 90% against an England average of 94%, dermatology (skin, nails and hair) was 74% against an England average of 87% and cardiology (heart) was significantly worse than the England average at 65%. This data was trust wide as we were not provided site specific information.
- Between January 2016 and December 2016, at Royal Sussex County Hospital, 67% of individuals did not move wards during their admission, 25% moved once and 8.6% moved twice or more. Between January

# Medical care (including older people's care)

2016 and December 2016, at Royal Sussex County Eye Hospital, 5% of individuals did not move wards during their admission, 45% moved once and 50% moved twice or more.

- We requested data from the trust regarding the number of times medical patients moved wards between 10pm and 6am. Between 1 October 2016 and 31 March 2017 there were 3,541 bed moves and of this number 812, or 23% occurred between 10pm and 6am. This is worse than the England averages, therefore, bed capacity at the time of the inspection was unable to ensure patients were placed in the most appropriate bed to meet their needs from admission. The trust did not provide site specific information.
- We saw the management and performance report from February and March 2017 for Albion and Lewes Ward, part of the cardiology directorate. The report showed reviewed discharge planning was at 45% compared to a trust target of 80%. Within a patients discharge plan there was a purple planner document that staff were required to complete daily. The report showed staff only completed 30% of these planners against a target of 71%. In response to this, the ward was introducing a discharge administrator to support the process; however, at the time of inspection, they had not yet been appointed.
- The cardiology directorate leads advised us that on the day of inspection there were six medical outliers in the Day Case Unit. Due to the lack of beds in medical wards, many patients are placed in other departments' wards (usually in surgical wards). These patients are called medical outliers. We asked about outliers on the ward and found the area was routinely used for outliers rather than as a Day Case Unit, which resulted in the cardiology team making cancellations as there was nowhere for day case patients to go. The area was an unsuitable ward environment. The Day Case Unit was housed in an area off another ward, we saw the bays were only big enough for trolleys rather than beds, there was not enough on ward food facilities for overnight patients and the nurses station was around a corner, therefore vulnerable patients were not in line of sight. As the area was only supposed to be used during the day, staff advised us it was very cold at night as the heating did not come on in the area of an evening. Therefore, patients were

sleeping in inappropriate temperatures. In addition, the Day Case Unit was situated within cardiology and therefore the staff were only cardiac trained.

Therefore, there was a risk that staff may not notice deterioration in an outlier, as staff were not trained in all specialisms found in the unit. When we spoke to the ward manager, they advised us that medical staff from relevant specialisms monitored outliers, however this was usually out of hours, which affected timely discharge and meant patients were bed blocking the unit for longer than necessary. The directorate leads had raised the issue repeatedly, however the only response they had received from the trust was that it was hoped the improvements in the Emergency Department (ED) would improve hospital flow and allow the area to be used as a Day Case Unit again. The inspection team found this response showed poor insight into the issues around access and flow at the trust, as the site did not have enough beds to meet capacity and was not just related to a lack of space in ED. The number of patients requiring admission was unlikely to fall because they were rebuilding ED.

- One of the "should do" actions from our previous report was the trust must "Prioritise patient flow as this impacted on length of stay, timely discharge and capacity". The above statistics and the issues we identified showed the trust had not met this since our last inspection.
- On Jowers Ward, we found daily handover sheets had a column dedicated to social information about a patient that staff used to support discharge planning. For example, it stated whether the patient lived alone, therefore physiotherapists were to ensure the patient was independent before discharge. It also described any environmental challenges in the home, for example, one patient lived in a fifth floor flat. Therefore, discharge goals included demanding stair climbing.
- The trust had approved for the cardiology team to complete waiting lists on a Saturday to help in bringing numbers down and improve flow through the hospital. However, at the time of inspection this had not yet started. Therefore, there was no data to show how the lists had helped reduce waiting times and improve flow through the hospital.

## Meeting people's individual needs

# Medical care (including older people's care)

- We found the hospital did not meet the needs of bariatric patients (the branch of medicine that deals with the study and treatment of obesity). The Barry Building did not have suitable accommodation for bariatric patients and therefore staff in the Acute Medical Unit (AMU) looked after all bariatric patients. Staff in the unit advised us that since November 2016, there had been at least one bariatric patient on the ward every month. The environment within the AMU was inappropriate because the unit needed to close a bed in order to fit a bariatric bed into the cubicle space, which was obvious to see, not dignified and meant the unit could not support as many patients.
- The AMU did not have a bariatric toilet or shower; therefore, whenever a bariatric patient required the toilet they used a commode by the side of their bed that only had a curtain between themselves and adjacent patients. Bariatric patients were unable to have a shower, as there were no suitable facilities. Staff advised us that one bariatric patient had been on the ward for 36 days. Therefore, they had gone without a shower for over a month. We also found the trust did not have any bariatric specialists to work in conjunction with medical consultants to reduce comorbidities often seen in this patient group.
- Bariatric patients also put extra strain on staffing numbers as three staff members were needed to support mobilisation and an extra HCA was required at night to help with toileting. Therefore, the situation at the time of inspection was not suitable or sustainable and did not meet patient's individual needs. We did not see this issue on the acute directorate risk register and when we spoke with staff they advised us everyone was "Just waiting for the building work to be completed", however this would not be completed for another three years and there was no action plans to improve the situation in the meantime. This meant the risk associated with bariatric care provision was not managed effectively.
- In the Discharge Lounge, we found numerous information leaflets for patients and relatives to take away. Many leaflets provided contact details for outside support agencies such as a local community alarm service that also provided support for medication reminding, falls and memory loss and a free helpline for the over 60's that also provided a telephone and correspondence 'friendship service'.
- We saw dementia friendly signs used on all wards we visited where people were living with dementia. These supported patients as they used pictures as well as large writing to prevent patients wandering into inappropriate areas.
- The Emerald Unit had adopted The Butterfly Scheme. The Butterfly Scheme provides a system of hospital care for people living with dementia or who find their memory is not reliable. The hospital used symbols next to a patients bed that identified to staff the patient had memory issues such as dementia, whilst promoting the patients dignity by not showing the information in a format that families and other patients would understand.
- Jowers Ward had implemented a system where patients chose their own distinctly patterned blanket. Staff advised us this helped patients to recognise their own bed and therefore patients were not walking round the ward for longer periods than necessary. Although comfort rounds did not occur at regular times, when they did happen staff asked patients if they needed the bathroom. Therefore, staff escorted all patients to and from bathrooms. The two initiatives had meant that at the time of inspection the ward had 125 days without a fall, which was the third best ward in the trust.
- The Macmillan Horizon Centre was located opposite cancer services. Staff advised us they encouraged patients who had a lengthy wait for treatment or an appointment to use the facilities over the road, as they were more comfortable as there was a café and refreshment area. Staff used a pager system to notify patients when they were ready to be seen.
- The hospital worked with the nearby Macmillan Horizon Centre to support cancer patients using holistic therapies such as relaxation techniques, massage, aromatherapy and providing a hair and wig service.

# Medical care (including older people's care)

- Staff had access to an interpreter service that was available 24 hours a day, seven days a week. Staff we spoke with knew that it was inappropriate to use family and friends to translate.
- Staff advised us they could access a learning disability and a mental health link nurse if they needed support or information regarding a patient with these needs. Staff we spoke with advised us they would utilize family, friends and carers to communicate with patients and support their understanding of procedures and next steps. In a patient's record we saw MDT notes with the Children and Adolescent Mental Health Services (CAMHS) when an adult patient with mental health issues who had children, was admitted to AMU.
- Staff ensured patients could access food and drink that met social and cultural requirements. For example, we saw a menu that showed patients had vegetarian and vegan options as well as access to halal and kosher products. Menus also detailed soft food options and we saw staff advise patients that food could be pureed for those with swallowing difficulties. Patient opinion regarding food was variable. Patients in oncology advised us they appreciated food could be ordered in smaller portions as they did not always want a large meal after treatment. However, a patient in cardiology advised us they considered the food was "Awful".

## Learning from complaints and concerns

- The complaints process was outlined in information leaflets that were available on the ward areas. We saw information on how to raise a complaint readily available on all the wards and departments we inspected with access to the Patient Advice and Liaison Service (PALS).
- Between January 2017 and February 2017 there were 374 complaints about medical care across all sites. Medicine responded to 82% of complaints within 38 working days; this is not in line with their complaints policy, which states that 90% of complaints should be responded to within 40 days. There were 66 complaints about medicine that were not responded to and closed yet. Of these 37 were received from February 2016 to December 2016, indicating that response and closure of these complaints will take

longer than 40 days. Medicine received 29 complaints in January and February 2017 that were not responded to. The most complained about subject was waiting times and treatment delays, followed by medical care and treatment and communication with patients or relatives. We were not provided with site specific data.

- Changes were made as a result of complaints. In cancer services, we were advised of changes to practice as a result of a complaint. For example, a patient had cancelled an appointment which had delayed the process of identifying they had cancer. As a result of the complaint, all patients were set on a diagnostic pathway before going on to the various cancer pathways if that was appropriate. There were also reminders within the pathway to ensure patients are told at the earliest possible stage that they had cancer. This triggered pathways to provide emotional support for the patient and also showed an improvement in appointment attendances as patients knew at an earlier stage, how important the appointment was.
- In the AMU we were advised that noise was an issue at night time and that due to a complaint the ward had introduced soft closing bins.
- We saw minutes that showed complaints were reviewed at management meetings as well as escalated to governance meetings.

## Are medical care services well-led?

**Requires improvement**



When we inspected the Royal Sussex County Hospital in April 2016, we rated well led as requires improvement. This was because:

- The trust had a complex vision and strategy which staff did not feel engaged with.
- 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.



# Medical care (including older people's care)

- 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:

- 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.

At this inspection we have retained this rating because:

- The vision and values were not well developed and the strategy was not aligned in all directorates within medicine.
- Staff satisfaction was mixed and staff did not always feel actively engaged or empowered, especially in endoscopy.
- Directorates were still working in silos and not cohesively. This had been highlighted during our previous inspection.

However:

- We saw trust plans to improve staff survey results.

## Leadership of service

- Each directorate management team consisted of a directorate manager, a clinical director and a directorate lead nurse, who worked across all specialties within the directorate. This team managed the different leads within each specialty, however the cardiovascular directorate only had four specialties and neurosciences had seven. Therefore, there was no balanced support across directorates.
- There was no neurophysiology lead, therefore there was no one to directly represent this team at the monthly clinical governance meetings. Therefore, there was limited assurance that issues within the department would be fed up into the executive safety and quality meetings.

- We were advised by band seven staff in neurology and cardiology wards that whilst they were allocated management time, they very rarely got to use the time for its intended purpose due to staff shortages on the wards.
- Leadership within cancer services was praised at all levels. We were advised that the directorate leads had an open door policy and were visible on the ward floor. We were also advised that staff felt supported emotionally as they had to work with patients with life changing experiences every day and that management at ward level understood the emotional toll this took on staff. For example, regular meetings were held with staff after head and neck clinics to support staff who had provided treatment for patients with severe disfigurement. The MDT took turns to run the sessions in order to provide discussion and support from different points of view.
- Staff at management level felt that the new executive team was visible, however, this had not yet cascaded to lower bands.
- All staff we spoke with praised their ward managers and felt that their work was valued.

## Vision and strategy for this service

- CQC conducted interviews with directorate leads. We found that adherence to the strategy varied between directorates. For example, in cardiology we were advised the strategy had been lost and “Not articulated well” due to the changes within the board and therefore needs and requirements changed as well.
- When we asked directorate leads about the trust values all said that adherence to a trust idea of values was difficult, again due to the changing board. However, we were advised the current board with the support of another trust, was looking to implement a trust wide set of values.
- Staff on the wards were not aware of the strategy for medicine. A common response was that it changed every time new management came into post.
- We found some wards had their own internal value system, however, these were not related to trust wide values. For example, the Emerald Unit had its own

# Medical care (including older people's care)

manifesto that was developed with all staff within the unit, this was reflected by the fact that staff we spoke with knew the manifesto and their responsibilities to help make it happen in practice.

- Some wards did not have their own set of values, we were advised by senior staff on Jowers Ward that they thought it made more sense for staff to be open and honest with each other. When we spoke with the ward manager they said they were confident that staff would come to them with any issues, that there was an open door policy within the ward and they had good relationships with staff. Staff on the ward reflected this opinion, however none of the staff we spoke with understood the position set out by the Royal College of Psychologists that staff morale is an important issue within the healthcare system and "One of the keys to raising morale in healthcare today is to re-emphasise the importance of values in guiding practice at all levels. There are some excellent values statements produced by health care bodies in the field, but for values to be meaningful, they must be owned at a personal level, and then integrated into the workplace."
- However, in the cancer centre we saw the trusts values promoted on posters throughout the unit, staff we spoke with knew the values and how those values related to their job.

## Governance, risk management and quality measurement

- The cardiovascular directorate had four specialties; renal, vascular, cardiac surgery and cardiology. Each specialty had a monthly clinical governance meeting as well as a bi-monthly clinical governance and morbidity and mortality meeting. These fed into the quarterly meetings with the management team. We saw minutes of these meetings where they reviewed serious clinical incidents and updated action plans, updated the risk register and reviewed any incidents that required duty of candour. These quarterly meetings were fed back to the executive safety and quality meetings which were held quarterly. We were advised the monthly specialty clinical governance meetings were shared within all three specialties within the directorate. However, we found no evidence to suggest that good practice was being shared across directorates.
- The neurosciences directorate had seven specialties; neurosurgery, neurology, spinal surgery, neuroradiology, neurophysiology, stroke and rehab. Each specialty had monthly clinical governance meetings that had input from two clinical governance leads. Neurosurgery, spinal surgery, stroke and rehab had monthly morbidity and mortality meetings and neurology had morbidity and mortality meetings every quarter. There was also a governance lead meeting held quarterly, we saw from minutes that they discussed any infection control updates, new NICE guidance and any safeguarding incidents. Again, these were fed back to the executive safety and quality meetings, which were held quarterly. We found no evidence to suggest that good practice and learning from incidents was shared outside the directorate.
- During interviews with the directorate leads we found that cancer services shared learning across their own directorate, however, cardiology found this difficult to implement due to differences between the core areas within cardiology.
- When we spoke with the neurology team we advised them of the issue of silo working described in our previous report and asked whether this was still an issue. We were advised joined up working had improved within the neurology team. However, there was no working together outside of directorates. For example, each of the directorates within medicine did not meet regularly to discuss governance issues and look at any trends across medicine.
- On our previous inspection, we rated children and young people's services as outstanding. Whilst the directorate leads congratulated the team for their achievement, we could not find any examples of where directorate leads had requested support from the children and young people's team to help medicine learn or improve the service. Therefore, there was limited evidence of learning from best practice.
- All directorates had their own risk register. During interviews with directorate leads, we asked how directorates knew what was going on in other directorates within medicine and whether there was an overarching risk register. None of the directorate leads knew about the trust risk register and we could not find any evidence that themes from individual risk



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registers were cascaded up into an overarching medicine risk register that the trust leads had access to. We were sent a copy of the trust risk register, however there were no issues specific to medicine contained within it.

- Because of the above, we found there was still evidence of medical directorates working in silos within the trust.
- At our previous inspection, we identified issues regarding the environment within the Barry Building. Whilst the trust was undergoing extensive building work to improve the environment, this was not due for completion until 2020. Whilst we found that patients were no longer cared for in balcony areas, the layout of the building meant that to get to Vallance Ward you had to walk through Jowers Ward. Jowers Ward was a care of the elderly ward and therefore looked after a group of very vulnerable patients. Staff on Jowers Ward complained not only of the security issue but also stated that visitors left corridor doors open which was another risk to patients subject to Deprivation of Liberty Safeguards (DOLS) and those who wandered with a purpose. This issue was on the ward risk register, however there was no plan beyond the fact that the ward would be rehoused in the new building and there was no plan of action regarding how to reduce risks in the meantime.
- The leads of the cancer directorate advised us two of their biggest risks were old equipment and the ongoing building work. They advised us that the cancer department had the oldest working radiotherapy machines in the country. It was on their risk register that it needed replacing.
- As part of the inspection process, CQC requested data from the trust. However, the majority of data we received was not site specific and/or was not broken down further, for example by ward or staff banding. Therefore, there was limited evidence that the leadership team understood the specific risks and issues found at each of the trust sites.

## Culture within the service

- The culture within each medicine directorate was diverse. When we interviewed the directorate leads for each specialty, each one said the issues identified in our previous inspection around bullying and tolerance

of poor behaviour, were not an issue within their directorate and that they were “Shocked by the bad behaviour found in the previous report.” However, we found opinion varied greatly when we spoke to staff on the wards.

- We found specific individuals within middle management were the most criticised for lack of support and inappropriate behaviour within the specialty directorate. Staff also advised us of tensions within the senior management team in the cardiology directorate. However, all staff we spoke with in the cancer team had positive responses to middle and senior management. At the time of inspection, the number of on-going trust wide staff grievances that related to bullying and harassment was eight, however there were another six grievances related to bullying and harassment within the previous 12 months that had since been closed. The average response time for the issue to be investigated and resolved was 17.5 weeks. These figures are worse than the England average for a trust this size. Therefore, bullying was still a cultural issue within the trust. However, we found there was limited acceptance by directorate leads that it was an issue within their teams. These figures were not service specific.
- The endoscopy and associated staff trust wide survey 2016 showed a third of staff did not believe management and co-workers treated them with respect. Comments included “Never a positive word!” and “Totally unapproachable”. We saw comments that showed management expected staff to work on good will, which was a regular occurrence and was unsustainable. Comments included “Every session overruns” and “Every list overruns by 30 minutes to 1 hour”. When asked ‘Do you feel pressured into staying beyond the end of your shift?’ staff wrote “[We have] no choice, either we stay or patients are cancelled” and “[There is] no-one to cover me”. However, we saw plans to improve staff survey results through the implementation of improved staff engagement.
- On our previous inspection, we found issues with HR processes in that policies were not always followed, and support varied enormously between HR teams. All staff we spoke with during the inspection stated there were still issues with HR to a varying degree. In cancer services, directorate leads and ward staff said that

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their HR assistant was supportive but “Stretched.” However, managers within the specialist directorate stated they felt “Alone” especially when the staff sickness policy was triggered. Staff told us there was “No support on how to take the issue forward”. Management informed us of cases where staff returning from sickness supported their own return to work processes. Other senior staff within the specialist directorate did not know who their HR contact was.

- We heard issues from all directorates regarding employment processes. For example, on Jowers Ward, HR had offered a nurse a position in October 2016; however, at the time of our inspection in April 2017, they had still not been cleared to start due to visa issues. HR had not provided the manager with any updates or support on how to cover the ward if the nurses' application was not successful. We saw details of a business case to introduce five new occupational therapists and physiotherapists in order to support a seven-day therapy service. All finances were in place, however managers advised us of issues within HR regarding the advertisement of the jobs. The roles were due to start in July; however HR had not published any advertisements at the time of inspection. We saw no plans for taking the issue forward and management advised us that they could not get a response from their HR team.
- We saw the patient access team within cancer services had created a team dignity tree where every quarter colleagues wrote something positive about another colleague. Staff advised us they were “Very close knit” and had a “Good culture of working together”.
- All staff carried a BSUH prompt card that provided on hand reference regarding patient care. However, it also promoted the nursing 6 Cs; care, compassion, competence, commitment, communication and courage. All nurses and HCAs we spoke with knew the 6 Cs. One nurse said she thought compassion and courage were the most important to her role, the compassion she showed to patients and the courage needed to ensure she did the right thing, as the culture did not always support this.

## 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 hospital 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.
- The cancer directorate held patient groups every Saturday and the hyper acute stroke unit held monthly meetings. These provided patients the opportunity to meet consultants and senior nurses to discuss any issues or concerns.
- Patients from oncology could take part in a patient peer review. This was where staff interviewed local patients who had gone through pathways about their experiences in order that improvements could be made. The directorate was looking to extend the review to include the local clinical commissioning group and Macmillan in order that they could get a more holistic view of local oncology services.
- Cancer services also took part in the National Cancer Patient Experience Survey. Whilst the results from the survey were national and therefore not site or trust specific, we saw meeting minutes that showed management discussed overall results at managerial meetings.

## Staff engagement

- The trust staff survey for 2016 showed the trust was in the bottom 20% of all NHS trusts in the country. Staff carried around prompt cards, which promoted “The best of BSUH” however, nowhere in the prompt cards was there any information regarding the culture of the trust.
- Staff told us they felt able to raise concerns with their immediate line managers but very little ever changed.
- Staff also told us that there was no cross communication between the different directorates and that directorates continued to work in silos.

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- We were advised by staff on Vallance Ward that they had not had a staff meeting for 6 months due to lack of staff. However, they were trying to organise one at the time of inspection to support staff morale. CQC identified this issue in our previous report, therefore there was limited assurance that ward managers were learning from previous findings.







## **Innovation, improvement and sustainability**

- The cardiac rehabilitation team was one of 14 out of 300 trusts to be awarded the gold standard by the

British Association of Cardiovascular Prevention and Rehabilitation. The reason the team received the award was due to MDT working involving assessment, prescribed exercise, education and counselling.

- Since our previous inspection in April 2016, there had been building work improvements. This had the greatest benefit to the cancer team who had previously been housed in the Jubilee Building that had since been demolished. As a result, there were no mixed sex breaches in cancer services and patients had access to piped oxygen, whereas previously oxygen tanks had been stored along corridors and were a trip hazard and fire risk.

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

## Information about the service

Brighton and Sussex University Hospitals Trust surgical services (the service) delivers services to the local population in and around the city of Brighton and Hove and the South East of England.

The service provides surgical services across two sites, the Royal Sussex County Hospital (RSCH) in Brighton and the Princess Royal Hospital (PRH) in Haywards Heath, this report will focus on RSCH. The service is made up of four directorates: head & neck, abdominal surgery and medicine, musculoskeletal and perioperative directorates. The head & neck directorate manage audiology, ear, nose and throat (ENT), oral and maxillofacial, clinical media centre, ophthalmology (eyes) and out patients department (OPD). The abdominal surgery and medicine directorate provide urology, gastro-intestinal (GI), neurosurgery (brain surgery), cardiac surgery and medicine services. The musculoskeletal directorate provide trauma, major trauma, orthopaedics, pain management and rheumatology services and the perioperative directorate provided operating theatres, anaesthetics and general surgery.

The trust had 36,960 surgical admissions between February 2016 and January 2017. Emergency admissions accounted for 21.4% (7,925), 59.6% (22,030) were day cases and 19% (7,005) were elective admissions. Site specific information was not available from the trust.

There is a pre assessment clinic which is based at the PRH and assesses 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 the two principle sites, enabling surgery provision in all major specialities. Both centres undertake emergency, elective inpatient and day case surgery. At RSCH there are 151 surgical beds across four wards. On Level 8 there are 37 beds for urology/vascular surgery, Level 8a East 24 beds for trauma and orthopaedics, Level 8a West 32 beds for neuro/head and neck surgery and Level 9a, 58 beds for abdominal surgery and medicine. We also visited Trafford Ward which has 26 beds. In addition there is a Surgical Assessment Unit which has two clinic rooms and the facilities to take trolleys and seated patients.

We visited all surgical services as part of this inspection, and spoke with 63 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 23 patients, four relatives and examined 17 patient records, including medical and nursing notes and medication charts.

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## Summary of findings

When we inspected the Royal Sussex County Hospital in April 2016 we rated surgery as requires improvement. This was because:

- The surgical service 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 medication administration. These had been investigated and changes had been made to prevent reoccurrence.
- The service was not always responsive to people's needs. Patients were being kept in the recovery area of the operating theatre for significant periods of time as a result of pressures from the Emergency Department (ED) and a lack of beds in High Dependency Unit (HDU). In some cases patients were kept in recovery for over four hours and up to two days with some patients being discharged directly from the recovery area.
- Adherence with the National Emergency Laparotomy Audit (NELA) 2014 standards was poor with 14 of the 32 standards not being met. However systems were being put in place to address this.
- The service was not meeting its Referral To Treatment (RTT) targets of being seen by the service within 18 weeks, the only specialty to meet this target was cardiac surgery.
- 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 recovery did not have the skills to look after emergency medical patients transferred directly from ED or HDU.
- 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.
- There was a high number of nursing vacancies, agency and bank staff were used and sometimes staff worked additional hours to cover shifts.

At this inspection we have kept the rating as required improvement. This was because:

- Since the last inspection there have been a number of programmes and training events to reinforce the importance of the WHO Safe Surgery Checklist but between the period April 2016 and April 2017 there have been two further Never Events. Following surgery the debriefing of staff was not consistently completed meaning the (WHO) Five Steps to Safer Surgery was not fully completed.
- National Specification of Cleanliness (NSC) checklists and audits were not in place including a deep cleaning schedule for theatre.
- Staff had not completed mandatory training and in some areas compliance remained low.
- Whilst improvements had been made to reduce the admitted Referral To Treatment (RTT) target, it still remained below the England average for all specialities apart from cardiac surgery.
- Work had been done on identifying patients on the waiting list for a specific colon (bowel) surgery but there was still a backlog of patients waiting for surgery.

However:

- Staff continued to report incidents and spoke of an open and transparent reporting culture. Examples were given where changes had occurred due to an incident. Safety meetings (huddles) were established on all wards and departments.
- There was a sufficient number of staff appropriate to workload with the necessary skills and qualifications to meet patient's needs.
- Staff reported that appraisals were being carried annually and where compliance was low there were plans in place to correct this and there was improved support for training.
- Progress had been made on reviewing and ensuring improved consent processes.
- Patient feedback was generally positive.

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- Whilst bed occupancy across the service remained high, patients were no longer inappropriately admitted to the recovery area in theatre.
- Governance structures across the four directorates were established and developing and staff were able to identify risks within their departments and risk registers were in place and kept under regular review.

## Are surgery services safe?

**Requires improvement**



When we inspected the Royal Sussex County Hospital (RSCH) in April 2016 we rated safe as good. This was because:

- Staff knew how to report incidents and felt confident that when incidents were reported, they were listened to and acted upon.
- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool, the Safer Nursing Care Tool, the planned and actual staffing numbers were displayed on the wards visited.
- The safety and security of medicines was regularly audited which included areas such as 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 all aspects of the patients care was reviewed to check what had been agreed and a plan of action was put in place.

However:

- The service had experienced five Never Events over a seven month period in 2015 and involved three wrong side nerve blocks, wrong tooth extraction and wrong route administration of medicine.
- 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 did result in patient's needs not always being met.
- The majority of mandatory training compliance was less than 50%.

At this inspection we have changed the rating to requires improvement. This was because:

- Despite a focus on training and learning from previous Never Events there have been two Never Events



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between our inspection in April 2016 and April 2017. This meant that the actions taken after the previous Never Events were not sufficiently effective to protect patients.

- We observed that following surgery debriefing of staff was not consistently done meaning the Five Steps to Safer Surgery was not always fully completed.
- The theatre department was not complying with The Health and Safety (Sharp instruments in Healthcare) Regulations 2013, which states that healthcare providers must use safer sharps.
- National Specification of Cleanliness (NSC) checklists and audits were not in place including a deep cleaning schedule for theatre.
- In theatres we saw that anaesthetic equipment checks were not consistently completed.
- In theatres controlled drugs were not consistently recorded and the amount destroyed was not always recorded.
- Mandatory training figures had improved but in some areas remained low.

However:

- Staff continued to report incidents and spoke of an open and transparent reporting culture. Examples were given where changes had occurred due to an incident.
- There were a sufficient number of staff appropriate to workload with the necessary skills and qualifications to meet patient's needs.
- Safety meetings (huddles) were established on all wards and departments to discuss any patient or department incidents or concerns to promote a safe culture.

## Incidents

- Following the last inspection we told the trust it must make improvements in ensuring lessons learnt taken from Never Events and incidents were shared across all staff groups. At this inspection we saw that the trust had made some progress.
- Between March 2016 and February 2017, the trust reported three incidents which were classified as Never Events for Surgery. 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.

- Two of the Never Events occurred at The Royal Sussex County Hospital, both related to a retained foreign object, the first in August 2016 following cardiac surgery the other incident took place in September 2016 following hernia repair surgery.
- We saw the Root Cause Analysis (RCA) had been completed for both incidents which followed a standard format and included lessons learnt. For the incident in August we saw a completed action plan. The RCA of the September incident included an internal safety alert that was circulated trust wide. We observed that duty of candour had been applied in both incidents.
- These incidents had been discussed at the Perioperative Standards Forum and learning and action plans had been agreed. The learning was shared with staff through training sessions that all medical and nursing staff attended.
- There had been a number of changes made as a result of learning from the Never Event investigations which occurred. The department had undertaken a review of National Safety Standards for Invasive Procedures (NatSIPPs). NatSSIPs bring together national and local learning from the analysis of Never Events, Serious Incidents and near misses through a set of recommendations that help provide safer care for patients undergoing invasive procedures.
- One of the recommendations of NatSIPPs was that organisations produce Local Safety Standards for Invasive Procedures (LatSIPPs). We saw that the department had developed LatSIPPs for prosthesis (an artificial body part) verification and 'stop before you block' (injection local anaesthetic to an area to provide pain relief). The LatSIPPs were based on national guidance and best practice and they provided a standardised approach to undertaking a procedure. We saw the LatSIPPs were displayed within theatres; this ensured staff were informed of the correct procedure to follow. There was a monthly NatSIPPs/patient safety day



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when staff took it in turns to be released from clinical duties to attend the day. The focus of the day was discussing initiatives which could improve patient safety and undertaking mandatory training.

- The trust updated the swab, needle and instrumentation policy to reflect lessons learnt from one of the Never Events. For example, there was a clear process to follow should a member of theatre staff need to take a break or come to the end of their shift before the operation was finished. This minimised the risk of error when there were changes to staff who were performing swab, needle and instrument counts. New theatre boards were ordered for each theatre that showed information about swab and instrument counts and who was responsible was clearly recorded.
- The department had formed a patient safety steering group, which was a multidisciplinary group who met monthly and focussed on ways to improve patient safety. For example, the group had initiated a formal debrief at the end of the operating list, this meant throughout the day staff could document on the theatre noticeboard anything they felt affected patient safety. At the end of the day the list was discussed with the whole team and ideas for reducing patient risk was fed back into the patient safety steering group.
- In accordance with the Serious Incident Framework 2015, the trust reported nine Serious Incidents (SIs) in surgery which met the reporting criteria set by NHS England between March 2016 and February 2017. Of these, the most common type of incidents reported were surgical/invasive procedure incident meeting SI criteria (67%). Seven of these incidents occurred at Royal Sussex County Hospital. These were reported through the Strategic Executive Information System (STEIS). Evidence was seen of RCA of these incidents, the investigations were seen to be robust and learnings were discussed at Safety and Quality Meetings and team meetings and circulated on safety alerts across sites.
- Between November 2016 and February 2017 there was a total of 326 incidents for surgery at RSCH. Nine resulting in moderate harm, 68 low harm and 249 no harm.
- Of the incidents reported the highest number of incidents were experienced in Ward Level 9a (73) followed by Theatres (48) and Ward Level 8 Tower (43).
- The highest category of incident was due to falls (42) and medication errors (39).
- A system for reporting incidents was in place. Staff understood the mechanism of reporting incidents both at junior and senior level. Staff told us that incident reporting training was part of the trust induction programme; this ensured all staff received training prior to starting working in the hospital. The form was accessible for all staff via an electronic online system.
- Staff told us learning was shared at the morning theatre huddle, at the weekly safety meeting and we observed a recent clinical governance agenda that showed learning from incidents and Never Events was a standing agenda item.
- We saw that any new information or learnings were emailed to staff on a monthly basis.
- Safe and Quality Meetings were held every three months to review incidents and see if there were any trends that needed action to be taken. For example, currently theatres were monitoring sharps injuries as they had three in the last two months.
- Mortality and Morbidity Meetings took place within all four directorates and were undertaken to improve and monitor patient care.
- For example, the trauma and orthopaedics directorate discussed their mortality and morbidity issues at the start of the monthly Clinical Governance Meetings. The perioperative directorate used its perioperative Quality, Safety and Patient Experience Meetings to discuss their cases. Minutes showed individual case discussion and review of poor outcomes with recommended change of practice where necessary.
- We found patient safety podcasts (a digital audio file made available on the intranet) and newsletters were being published monthly and staff were aware of these. These podcasts told the stories about incidents and how they could be avoided in the future.
- Staff described an open and transparent culture of reporting incidents enabling 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

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persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw that duty of candour was exercised in letters sent by senior managers following incidents that had been investigated.

- All surgical departments and wards reported that safety huddles were undertaken every morning and that any issues, concerns or learnings were discussed at this meeting. On Ward Level 8A East we saw these meetings were documented, this meant that if staff could not attend they were able to update themselves.
- On Level 8 Wards, monthly team newsletters were seen to containing information about incidents and learning. For example, following one incident it was requested that all information about next of kin was completed within the patient record. We saw there had been a recent audit of patient records and results were communicated to the nursing staff. On Ward Level 9, team meeting minutes from 15 March were seen on the staff board, in the communication folder and on the shared drive for all staff to access.
- On Trafford Ward, staff confirmed they got feedback from incidents and we observed learning from the last incident which was a patient fall. Staff had access to the RCA which included learnings. The most recent patient complaint was shared on the staff notice board. When asked, staff told us these incidents were discussed at team meetings.

## Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harm and their elimination.
- Data collection takes place one day each month – a suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of suggested data collection date.
- Data from the Patient Safety Thermometer showed that the trust reported 13 new pressure ulcers, nine falls with harm and 13 new catheter urinary tract infections between February 2016 and February 2017.

- The falls rate fluctuated for the first six months of the year reaching its highest in July 2016. The number of falls then fell to zero until one incident occurred in January 2017. The rate for catheter urinary tract infections varied throughout the reporting period; performance was at zero between June and August 2016 however the trend showed the number of infections rose in November and December 2016.
- All surgical ward areas displayed the safety thermometer information. For example on Ward Level 9 we observed that information on patient falls, pressure damage and catheter infections and number of complaints showed a better trend than the trust overall. Further analysis was done by breaking down the falls data to acuity, location, time and suggested actions to be taken to mitigate the risk. For example, staff were reminded about ensuring patient assessments were completed and the importance of locating the patient in an appropriate position on the ward depending on their risk.
- On Ward Level 8 Tower we saw that there had been no new pressure ulcers since October 2016 when there were two. We saw how this was communicated to the staff with actions to be taken.
- Venous Thromboembolism (VTE) assessments were recorded on the drug charts and appropriate prescribing of anticoagulation (medication to prevent blood clots) was on prescription charts. This ensured best practice in assessment and prevention of VTEs.
- VTE audit results from October 2016 to December 2016 showed 92% of patients admitted to the trust were risk assessed for VTE, which was not in line with National Institute for Health and Care Excellence (NICE) Guidance 2010 which states all patients should be assessed. Actions had been taken to address this with a new VTE prevention flowchart and VTE compliance was discussed at the ward managers meeting.

## Cleanliness, infection control and hygiene

- The trust participated in Surgical Site Infection (SSI) surveillance data collection that was submitted to Public Health England (PHE). Data collected and submitted included every patient who had undergone

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knee prosthetic (an artificial body part) surgery. The current surveillance 2016/2017 was completed March 2017. At the time of inspection this data was not available.

- The Royal Sussex County Hospital reported no cases of Meticillin Resistant Staphylococcus Aureus (MRSA) between February 2016 and February 2017. Trusts have a target of preventing all MRSA infections, so the hospital met this target within this period.
- Additionally, the trust reported 20 Meticillin Sensitive Staphylococcus Aureus (MSSA) infections as trust acquired with no reduction target. The trust reported 47 Clostridium Difficile (C. Diff) infections over the same period. The year to date trajectory for C.Diff was just above the trust target of 46.
- The trust infection prevention team monitored all patients who were suspected to have or who gave a history of C.Diff. The trust undertook an audit in January 2017 which examined the management of C.Diff, overall compliance was 94%. The completed audit contained discussion and recommendations; this was part of regular surveillance.
- On the ward areas we saw signs on side room doors indicating when a patient had an infection, there was equipment to support barrier nursing. This meant staff could take precautions to prevent the risk of cross infection. Training records showed that cleaning staff had training on how to manage a patient being barrier nursed, and we saw them wearing appropriate Personal Protective Equipment (PPE), such as gloves and aprons and these were available in sufficient quantities.
- We saw minutes of monthly meetings of the Infection Prevention Operational Meeting which included discussion regarding the isolated case of MRSA, suspected source and actions. We saw there were standing agenda items of hand hygiene and surveillance monitoring. RCA was a standing agenda item and showed discussion of outcomes and actions. Meetings were chaired by the Deputy Director of Infection Control (DIPC) and attended by a microbiologist.
- Whilst there was good management of sharps within the wards, we saw that theatres did not adopt the safer sharps initiative. However as a trust they have a legal obligation in introducing it into every area. 'EU directive 2010/32/EU Prevention from sharps injuries in the hospital and healthcare setting 2010' In line with 'The Health and Safety (Sharp instruments in Healthcare) Regulations 2013' healthcare providers must use safer sharps.
- Between October 2016 and March 2017, the trust carried out monthly hand hygiene audits which demonstrated compliance across the surgical wards and departments to be 97%. Across the four ward areas, theatre department and surgical assessment unit only Ward Level 9A scored less than the trust target of 95%. These results were reviewed at the Infection Prevention Operational Meeting.
- We saw staff complying with infection prevention and control policies. All members of staff we saw in clinical areas were bare below the elbows to prevent the spread of infections in accordance with national guidance.
- We observed staff washing their hands and using alcoholic hand gel between treating patients. We observed all staff using gel when entering and exiting wards and theatres in accordance with the World Health Organisation (WHO) 'Five moments for hand hygiene'.
- 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.
- In theatres we observed all staff wore the appropriate theatre attire, such as theatre scrubs, hats and masks, all staff were bare below the elbow with good use of hand gel.
- Staff in theatre had taken part in a trust initiative 'Five Actions or a Safer Hospital', which they had won with their poster and efforts to improve hand hygiene. Within the department we observed good scrub practice.
- Senior theatre staff were involved in carrying out an observational hand hygiene audit and we saw there was an initiative to teach medical students about hand hygiene and how to 'scrub up' using the game of frustration with the use of florescent powder on each piece of the game.
- On all surgical ward areas we saw hand hygiene audit results and signed cleaning schedules were displayed.
- In the Surgical Assessment Area, patients commented on the cleanliness of the unit and one patient said,

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“Hygiene is excellent, they use gel between each patient and wear gloves and aprons for treatment, the ward is very clean and I have read the cleaning schedules on the wall, they clean in all the high places”.

- On Ward Level 8 Tower the environment was clean and dust free. However, there was no assurance of staff using 'I am clean tape' on equipment. In the sluice area we found that five commodes all had I am clean stickers but three were found to be soiled. This meant there was not an effective process in place which ensured the cleanliness of commodes.
- On Level 8A East, in bay one we saw a tear in the vinyl flooring that had been partly repaired using tape, that was not compliant with 'HBN 00/10 part A flooring'.
- Cleaning schedules were correctly signed and dated however we noted that one hand wash sink was obstructed by equipment and therefore a potential risk for incomplete flushing processes. All sinks should be flushed twice weekly to prevent pseudomonas and legionella (bacteria's).
- We saw effective processes in place for the separation and disposal of waste compliant with 'HTM 07/01 Management and Disposal of Healthcare Waste DH 20'. We followed the waste journey to the waste holding room and saw that waste was appropriately managed.
- Theatre staff followed NICE 'Guideline CG74, Surgical Site Infection' (2008) this included skin preparation and management of the post-operative wound.
- Cleaning schedules were in place to guide cleaning staff and the manager was able to explain how they would deal with any issues. We saw that quality checks were done both on a regular and ad hoc basis by the theatre manager and cleaning supervisor. Current compliance checks were seen to be 98%. We could see evidence that when cleaning concerns were observed there was an email trail to show what action had been taken. We were shown a standard operating procedure for the cleaner in recovery.
- Theatre equipment appeared clean and we saw use of 'I'm clean' stickers and we are ready to go. This meant staff knew that equipment was clean and safe to use.
- Cleaning schedules for the clinical staff were colour coded in weeks and was presented on the information board with signing sheets for each week, we saw that this rolling programme of cleaning schedules were signed and dated by staff.
- In theatres we were told that there was improved manual handling and infection prevention and control management by introducing a single use slide sheet that went with the patient to the ward. Theatre trolleys were covered with plastic to keep them dust free.
- Decontamination did not take place in theatre as all instruments were managed by the sterile stores department based next door to the department.
- Theatre department had a champion for sustainability who has worked with staff on how they managed their waste stream and the department recycled as much waste as possible.
- Patient Led Assessment of the Care Environment (PLACE) is a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of the teams to assess how the environment supports the patient's care. The trust performed about the same as the England average in (PLACE) 2016 for assessment in relation to cleanliness.
- However we asked facilities if there was a strategic and operational cleaning plan as required by the National Specification of Cleanliness (NSC), the trust did not have these documents. The strategic document outlines the Boards commitment to cleaning and supplying sufficient funding. The operational document shows how the complete cleaning operation actually works in practice.
- We asked for the cleaning checklists as required by the NSC we were told these had been worked on and trialled but had been difficult to get the staff fully engaged with the process and the managers were in the process of re writing more appropriate cleaning checklists. Without the checklists it would be difficult for staff to know which areas had been cleaned, and for manager or supervisors to know if the areas had been cleaned. This could lead to areas being missed. The checklists can also be used when auditing to determine if the level of cleaning and timings of cleaning is appropriate.

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- We asked for the deep cleaning schedule for theatres and were told this task has not been completed since the third party left as the cleaning provider in September 2015.

## Environment and equipment

- At the last inspection we told the trust to ensure that resuscitation/emergency equipment was checked according to trust policy and we found this had improved.
- We checked resuscitation trolleys on wards Level 8A East, 8A West, Level 9A and in the theatre department. We found tamper proof seals on emergency trolleys and that all checks were correct and complete. Log books for recording checks were easy to understand and contained relevant information and emergency algorithms.
- There were eight theatres in the main department and a recovery area with 10 bays. The department also included anaesthetic rooms, scrub facilities, clean preparation rooms and dirty utility.
- The department was seen to be visibly clean and tidy. Flooring throughout was fully compliant with 'Health Building note (HBN) 00/10 part A'. We saw that stock was stored in containers with glass doors to keep dust free, a new initiative since the last inspection. All couches and theatre tables checked were in good condition.
- Theatre department ventilation maintenance was part of an ongoing maintenance programme.
- In theatres we saw that electrical safety checking labels were attached to electrical items showing that they had been tested and were safe to use. We checked 22 pieces of electrical equipment and all had been tested within the last 12 months.
- The theatre Assessment Unit was situated on level five, the reception and waiting room were on level 8 shared with the Renal Outpatients and notes were kept on level 9. The unit comprised of up to six spaces, the area was noted to have separate male and female toilets. The area was clean and tidy with appropriate storage of equipment.
- The Surgical Assessment Unit had two clinic rooms, seven trolley spaces and a waiting area with room for 14 chairs. Male and females were not segregated in the ward area although there were separate toilet facilities.
- On ward areas we carried out spot checks on equipment in use and found that electrical safety checking labels were attached to electrical items showing that it had been tested and were safe for use.
- The PLACE audit carried out in 2016 showed the trust performance for facilities was 85% which was worse than the England average of 93% for facilities.
- We were shown evidence of environmental ward reviews being done for example, for Ward Level 8 Tower we saw an audit completed in November 2016 with actions completed.
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) was not consistently adhered to. This guideline states that records must be kept of each safety check of all anaesthetic machines in a logbook, which is kept with the machine.
- In five log books we examined not all were complete with daily signatures to confirm the safety checks had been undertaken. For example, in the anaesthetic room in theatre one between 20 March 2017 and 15 April 2017 there was six occasions when the safety checks were not recorded or marked as the theatre was closed. This meant there was not an effective process in place, which ensured these safety checks had always been undertaken and documented.
- We raised this issue with a senior member of theatre staff who said they would take immediate action. Since the inspection the trust has provided evidence that staff in the department have been briefed to complete all checks, all log books have been audited and staff who have omitted to sign were emailed to be reminded of correct practice.

## Medicines

- The trust had a medicine policy, which was in date and referenced relevant legislation and national guidance for example the Nursing and Midwifery Council (NMC) 'Standards for Medicines Management' (2010).



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- We looked at controlled drugs (CD's) (medicines liable to be mis-used and requiring special management) in wards. We checked order records, and CD registers and found these to be in order. We saw ward staff checked stock balances of CD's daily. We randomly checked a sample of stock in each department all were in date and stock balances were correct.
- However, we examined three controlled drug registers within theatres and recovery they demonstrated instances of block signing of controlled drugs at the three stages, supply, administered and discarded. In addition, we saw occasions when the amount administered of a controlled drug was not consistently recorded and the amount destroyed was not always recorded. This was against the Misuse of Drugs Regulations 2001 and 'Safer Management of Controlled Drugs: A Guide to Good Practice in Secondary Care (England)'. We raised this issue with a senior member of theatre staff who said they would take immediate action to address the issue.
- In theatres we saw there was a process which ensured regular checks to ensure all stock was in date.
- We saw medicines on the wards and theatres were stored safely and securely. We observed nursing staff locking medicines trolleys when they administered medicines to patients.
- On the wards medicines were stored in a secure room that had suitable storage and preparation facilities for all types of medicines, such as controlled drugs and antibiotics.
- However we found that the ward staff were not dating the opening times on the insulin vials (seven day expiry after opening) and we found one antibiotic drug was prepared and was in the fridge but no record of when opened or the expiry date. This was brought to the attention of the staff at the time of inspection.
- We looked at nine prescription charts which were completed comprehensively, dated, signed and had no missed doses. The sample of medication charts we looked at showed they were reviewed by a pharmacist. This demonstrated that pharmacists were reviewing medication charts to ensure medicines were correctly prescribed. We saw no medicines were omitted. Allergy recording was generally good.
- On the Ward Level 8 Tower we saw that medicines were safely administered and a patient commented "They watch and record what you take". Another patient commented "They are very good with medication".
- The trust carried out a medicines security audit in September 2016 with RSCH scoring 87%. For example Ward Level 8 Tower scored 85% and Recovery in main theatres scored 93% overall. There was detail of action to be taken to ensure that all drugs were secured.
- The trust used the Medicines Safety Thermometer form to collect the data which was then uploaded onto a national database and analysed and reported when required. This had been happening since approximately May 2016. Data was collected on one day each month and enabled the wards and departments to understand the occurrence of medication error and harm to patients.
- In January 2017, there were 129 medication incidents across the trust, results were broken down by ward for example Ward Level 8 Tower there were 20 incidents from February 2016 to January 2017. These results and analysis was made available to wards and departments.
- Antimicrobial stewardship was evident with completed analysis of antibiotic prescribing which showed that indication for prescribing and documentation of duration was present in 90% of prescriptions. Recommendations were made for example to modify the 72 hour review questions to ensure completion.
- Pharmacists were available Monday to Friday during opening hours and Saturday morning. However the emergency pharmacist was available outside of pharmacy opening hours.

## Records

- We looked at 17 sets of patient records across five ward areas and saw they were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with patient and families. They were generally compliant with guidance issued by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), the professional regulatory bodies for doctors and nurses. Patient records were easily accessible to those who needed them.

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- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. The service used patient pathway documents, preoperative records were seen, including completed preoperative assessment forms and completed WHO Safe Surgery Checklist. Records were legible, accurate and up to date.
- Medical notes included daily summaries, were legible, detailed and were signed and dated.
- We reviewed two Do not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and found them to be appropriately filled out, signed and dated in line with published guidance. There was clear evidence of discussion with patient and families, capacity assessment was stated and there were appropriate reasons documented.
- In general, medical and nursing records were stored securely either in trolleys behind the nurse's station or at the end of each bay. For example, on Ward Level 8A East we saw the records trolley was secured and locked computer screens which demonstrated good information governance. We saw a similar good standard on the theatre admission unit and noted the theatre care pathway which was last updated in 2015 was being edited for updated information. The pathway was clear, concise and easy to follow.
- However on one ward we did see some patient's notes in an unlocked doctor's office. We informed staff at the time of the inspection, we were told this office was not used for storage but a doctor had left them unattended, the notes were immediately secured.
- The trust conducted regular health records audit from April 2016 to January 2017, 50 sets of notes were reviewed each month resulting in a total audit of 400 case notes across 25 specialties. Results were compared with previous audit and showed some improvement however there were still areas of improvement required, for example nursing alterations were generally not countersigned in accordance with good practice. An action plan showed results were shared with the medical director and deputy chief of nursing for further action.
- We saw that the trust had a Safeguarding Adults policy which included reference to Prevent, one part of the government counter terrorism strategy.
- The chief nurse was the executive lead for safeguarding. Adult safeguarding was managed by the deputy chief nurse along with 1.6 whole time equivalent band seven safeguarding nurses and a band seven Mental Capacity Act/Mental Health Lead Educator.
- The trust failed to meet the safeguarding training completion target for all staff across all four modules. Adult safeguarding training completion was 75%. The module with the highest completion rate was Safeguarding Children Level 2 with 79% achieved.
- There were flow charts in each ward and department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures. Staff gave an example of when this involved the poor standards of care delivered by a staff member, this was reported to the line manager and appropriate referral was made with actions to ensure this did not occur again.

## Mandatory training

- At the last inspection we told the trust it must make improvements in the take up of mandatory training. At this inspection trust had made some progress. We found that in some areas mandatory training rates remained low.
- Mandatory training was differentiated by staff group but resuscitation training, conflict management, equality and diversity, fire and health and safety training, infection prevention and information governance were seen to be amongst the subjects that were compulsory across all staff groups. Compliance was monitored by human resources, all wards and departments had access to information to show what percentage of their staff had attended training.
- Since the last inspection the eLearning training programme on the trust wide electronic system had been extended.

## Safeguarding



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- There was a trust wide induction policy and procedure that included details of a corporate induction day programme for permanent and temporary staff. In theatres we saw evidence of staff attending a mandatory induction training day.
- Within the training policy there was clear guidance on what should happen when staff do not attend training, who ultimately was responsible and what actions would be taken.
- Staff told us they had completed induction but were not always given time in their working day to complete mandatory training. On a number of wards we visited we saw yearly and three yearly plans detailing what training staff had to complete and these were colour coded with red indicating training was overdue, this acted as a prompt to staff to complete the training.

## Assessing and responding to patient risk

- Patients having elective surgery attended a preoperative assessment clinic (Hickstead unit sited at the Princess Royal Hospital) where all required tests were undertaken. For example, MRSA screening and any blood tests. This was a nurse led service and there was a criteria in place that showed when a patient should be reviewed by a member of the medical team.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment.
- Staff met for a 'team briefing' at the start of each operating list in line with the WHO checklist. We observed team briefings to be comprehensive and discussed each patient, any risks, allergies or equipment requirements to minimise any potential risk to the patient. Staff told us that they felt empowered to speak up during this process.
- During the inspection we observed three different theatre procedures and we saw staff fully engaged with the sign in, time out and sign out of the process of the safer surgery checklist however on two occasions the final step of debriefing was not completed which

indicated this part of the process was not consistently completed. By not completing this process staff did not have an opportunity to evaluate the list, what went well, what did not and whether any lessons could be learnt.

- We saw observational audits had been carried out of the World Health Organisation (WHO) 'Five Steps to Safer Surgery' however it was noted that in the month of March the debrief was not completed in nine of the ten occasions audited. All stages of the WHO checklist should be completed to ensure the safety of the patient.
- We observed that swab and instrument counts followed the association of perioperative practice (AfPP) guidelines. There were standardised swab boards in each theatre this meant that there was a consistent approach to recording the swabs and instruments used during procedures.
- Nursing and medical handovers were well structured within the surgical wards visited. Nursing handovers occurred twice a day at the change of shift. We observed a handover which was carried out at the nurse station for all staff and patient privacy, dignity and confidentiality were maintained. Staff were then 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 National Early Warning Scores (NEWS) tool was in place across the service, to monitor all patients and to identify patients at risk of unexpected deterioration in accordance with National Institute for Health and Care Excellence (NICE) guidance. NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide additional support.
- NEWS recordings and scores were regularly audited. Data collected between February 2016 and January 2017 showed a general improvement in the standard of documentation relating to the NEWS. We saw that compliance across the surgical wards ranged from 95.8% on Ward Level 8 Tower to 85.3% on Ward Level 9a where the ward manager told us weekly spot checks were done to improve compliance.

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- The service used a communication tool called Situation Background Assessment Recommendations (SBAR) for both medical staff and nursing staff to use when escalating concerns about a patient's condition to their seniors.
- Staff on the wards told us that in the case of a deteriorating patient there was never any difficulty in accessing medical support or the trust's critical care outreach team. The outreach service was available 8am to 8pm seven days a week and provided support to the ward and department teams when a patient's condition changed and more complex support was required.
- The trust showed us agenda and minutes of the Deteriorating Patient Steering Group which meets monthly and was seen to be monitoring the development of the sepsis inpatient screening tool released in March 2017. A sepsis clinical lead and a clinical nurse specialist for sepsis had been appointed to enable audit and training of the staff. Staff were able to demonstrate the sepsis pathway which incorporated the sepsis six guidelines, a set of care interventions to improve the treatment of patients with sepsis.
- The service used a visual phlebitis-scoring tool for monitoring infusion sites as recommended by the Royal College of Nursing (RCN). We saw Visual Infusion Phlebitis (VIP) scores had been undertaken and correct action taken in the patient records we reviewed. This meant the need for intravenous (administered into a vein or veins) devices, signs of infection and comfort of the devices were reviewed on a regular basis.
- We saw in patients' records, that patients had a weekly falls risk assessment this was in line with NICE guidelines 'CG161 Falls in Older People, Assessing Risk and Prevention'. Risk assessments were also undertaken in areas such as VTE, malnutrition and pressure ulcers.
- Risk assessments were undertaken in areas such as VTE, falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate the risks identified and we saw these had been completed.
- The trust used an acuity and dependency tool, the Shelford model. The most recent review of staffing levels was carried out in March 2017. The report was not available at the time of the inspection.
- The trust reported a deficit of 77.1 WTE nursing staff across all wards and departments, with RSCH having the largest deficit of 45.4 WTE. Recruitment drives and advertising were taking place using radio adverts, posters displayed on buses and a recruitment open day was planned for May 2017.
- As at February 2017, the trust reported a vacancy rate of 11%, a turnover rate of 11% and a sickness rate of 4% in surgical care.
- Shift fill rates across all wards at RSCH were 93% to 100%. Between February 2016 and January 2017, this trust reported a bank and agency usage rate of 5% in surgical care. For example, abdominal surgery was 6%, cardiovascular surgery 6% and ENT 4%.
- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool, the Safer Nursing Care Tool. The planned and actual staffing numbers were displayed on the wards visited.
- On Ward Level 8 Tower we saw the nurse staffing was displayed, on reviewing the rotas we could see that required and actual staffing matched. We were told that there were no vacancies, no use of agency and that bank staff were used when needed.
- On Ward Level 9 we were told there were 9 WTE band 5 vacancies and 7 WTE band 2 vacancies, however, there were recruited staff ready to come into post for two of the band 2 vacancies. Staff told us that it was sometimes difficult to get bank staff to work due to the rates of pay, however we did see on the rotas that there were no agency nurses in the last two weeks and staffing levels during the day were one registered nurse to 3.3 patients and at night one registered nurse to 5.8 patients.
- On the day of our inspection in theatre we saw staffing levels met the Association of Perioperative Practice (AfPP) guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating

## Nursing staffing

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staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. We reviewed previous rosters, which demonstrated that this guideline was adhered to.

- On reviewing the nursing rota we could see the staffing in the recovery unit was one nurse per patient which followed a high dependency unit standard of staffing rather than the AfPP guidelines and this was seen as more appropriate given the complexity of care required for the patient. Recovery had a full establishment of staff, with no healthcare assistants employed within that area. Student nurses did work in recovery but were supernumerary to staffing numbers

## Surgical staffing

- The trust reported a deficit of 7.8 whole time equivalent (WTE) medical staff as of December 2016 with two of the four sites above establishment. The number of surgical medical staff in post at RSCH was 193.4 WTE with a vacancy factor of 9.4 WTE.
- As of November 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the average.
- As of February 2017, the trust reported a vacancy rate of 9% in surgical care and a turnover rate of 9%. Between April 2015 and March 2016, the trust reported a sickness rate of 9% in surgical care.
- The trust supplied rotas which showed twenty four hour consultant cover for the surgical services and out of hours cover for weekends and nights. All the specialist surgical services had Consultant cover available twenty four hours a day, seven days a week.
- The abdominal digestive diseases surgery service had three teams in place; upper gastro-intestinal, lower gastro intestinal and an emergency team. With on call cover at the weekend there was registrar cover for patients presenting in the emergency department out of hours.
- There was no consultant at night or weekend for digestive diseases. There was a consultant on call from home who would be able to cover any emergencies when necessary.

- The muscoskeletal service had an on call Consultant who was on site until 6pm and in Theatre One a Consultant was available from 7.30am to 6pm. One registrar level doctor was on call covering twenty four service and onsite until 11pm. The MSK directorate told us they were actively recruiting doctors with a focus on supporting trauma services.
- The trust had developed the role of clinical assistants, specially selected healthcare assistants, supporting junior doctors with paperwork and routine clinical tasks such as taking blood and cannulation. There were 4.5 WTE band 3 clinical assistants in post covering 7 days a week. These staff had completed task specific competencies for the role they undertook.

## 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.
- Senior staff were trained on the escalation policy and major incident planning command and control.
- Staff we spoke with who were aware of the policy. On Ward Level 8a East we found the policy was available on the ward.
- In theatres we observed the major incident policy and the manager confirmed it had been used for an occasion of loss of water and on the occasion of a local air crash disaster. There were plans in place for fire safety and evacuation plans at department level.
- Senior staff told us they were planning a major incident scenario to prepare for the upcoming Brighton marathon.

## Are surgery services effective?

Good



When we inspected the Royal Sussex County Hospital in April 2016 we rated the service as requiring improvement for effective, this was because:

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- Staff working in the recovery area were not trained to look after emergency medical patients who were transferred directly to the recovery area from the Emergency Department (ED) and High Dependency Unit (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 processes.
- There was 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:

- 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 needs were addressed.
- The nutritional needs of patients were assessed at the beginning of their care in pre-assessment through to discharge. 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 Saturday and Sunday.
- 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.

At this inspection, we have changed the rating to good. This was because:

- The service continued to treat patients in accordance with best practice and recognised national guidelines.
- The service could demonstrate collaborative working across directorates to deliver joined up care and ensured the timely management of patients through their pathway of care.
- Multi-disciplinary team meetings were taking place in all clinical areas visited.
- Staff reported that appraisals were being carried annually and where compliance was below the trust target there were plans in place to correct this and there was improved support for training.
- Progress had been made on reviewing and ensuring improved consent processes.
- Progress had been made on the uptake of MCA and DoLS training.

## Evidence-based care and treatment

- The trust policies were developed in line with current legislation and nationally recognised evidence based guidance. For example, infection control policies were written in line with national guidelines and staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- The service demonstrated the use of evidence based practice in caring for their patients such as the use of National Institute for Health and Care Excellence (NICE) guidance on the use of National Early Warning System (NEWS) with a graded response strategy to patients' deterioration in line with NICE guidance 'CG50 and sepsis 9 (infection) recognition'.
- Operating theatres followed the Association of Peri-operative Practice (AfPP) guidance and this was evident within their policies. Staff adhered to NICE guidelines CG74, related to surgical site infection prevention and staff followed the recommended practice. This guideline offered best practice advice to

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prevent and treat surgical infection. For example, we observed the patient's skin at the surgical site was prepared immediately before incision using an antiseptic preparation. Swab and instrument counts were carried out in line with AfPP guidance.

- The service took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme, the National Joint Registry (NJR) and National Bowel Cancer Audit 2016. PROMS are a series of questions or a questionnaire that seeks the views of patients on their health, or the impact that any received healthcare has had on their health.
- The trust demonstrated surgical audit activity for 2015 to 2016 and forward plans for 2016 to 2017 for each specialty. The plan consisted of active and scheduled national audit, ongoing local audit and implemented NICE guidance relevant to the specialty.
- A new straight to test pathway for colorectal referrals had been introduced to improve quicker access to medical tests. This was in line with NICE guidance for the management of suspected cancers.
- An audit looking at waiting times for surgery for acute cholecystitis (an infection of the gall bladder) or acute pancreatitis (inflammation of the pancreas) showed the trust was not meeting NICE 'CG188/BSG guidelines'. However, the percentage of cases being done laparoscopically versus open was meeting recommendations.
- The trust participated in the National Emergency Laparotomy Audit (NELA); current data showed there was poor case ascertainment currently low at 23% the target being 100%. This indicated incomplete collection of data.

## Pain relief

- We told the trust it should make improvements in reviewing the provision of its pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- At this inspection, the trust had made some progress. The trust had a review meeting in February 2017, which resulted in a locum consultant anaesthetist being commissioned one session per week to review patients with chronic pain. A nurse consultant in acute pain management had been appointed to cover both sites

and a consultant anaesthetist had been allocated time to discuss and review patients with complex acute pain. There remained no acute pain service out of hours and at weekends, however a junior anaesthetist covered this service.

- Staff told us they had access to an acute pain management team who supported them with post-operative patients if they had complex pain management needs. In recovery, the team told us they were supported by the nurse consultant specialising in pain management and out of hours, they had access to junior anaesthetist cover.
- We saw minutes of the Acute Pain Team meeting where incidents, audits and training were discussed.
- The service monitored the inpatient questionnaire responses which asked how staff managed patient's pain, for example the frequency of pain scoring. The prescribing and administration of pain medication scoring trends were monitored for the period February 2016 to January 2017. Scores appeared to be consistent through the course of the year.
- In response to the question 'Do you think the hospital staff do everything they can to manage your pain' the surgical wards scored 4.5 to 4.7 out of 5 on average over the year. Best scores for the surgical wards were in response to the question If the pain score was above 3 (on a scale of 1 to 10) was there evidence analgesia was given. These scores were ranked across the trust and results were available to ward staff to monitor their performance.
- Patient records showed that pain had been recorded using the scale found on the NEWS chart. We observed nurses asking patients if they were in pain. Patients we spoke to told us that their pain was well controlled and staff responded promptly to requests for pain relief, one patient said "Pain management is excellent".
- The service undertook a patient controlled analgesia (PCA) pump audit in March 2016. PCA is a method of allowing a patient to administer their own pain relief. This was a re-audit from 2015 and demonstrated there was a need for improvement specifically relating to the recording of observations and a continued non-compliance with hourly checks. A further set of actions were put in place with a re-audit planned for 2017.



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- The service undertook an epidural (an injection into the back, which produces a loss of sensation below the waist) re-audit in March 2016, which demonstrated poor compliance with the trusts epidural policy. For example, hourly observation for the first five hours were completed 47% of the time, vital signs observations following a rate change of the medicine was completed in 50% of the cases and problems inserting the epidural was recorded in 50% of cases. A further set of actions were put in place with re-audit planned for 2017.

## 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.
- The trust standard was that all patients should have a MUST assessment made within four hours of admission or transfer to the ward. At RSCH for the period February 2016 to January 2017 we observed that Ward Level 8a West were completing this assessment 63% of the time and Ward Level 9a 44%. There was evidence of a trust action plan to address this including additional training and a relaunch of the MUST tool which had been undertaken.
- The trust completed a MUST audit in 2016 across a number of wards and found that recording patient weight and calculation of patient body mass index (BMI) was a common failing. An action plan setting out changes to training aimed to improve this. There was a plan for an audit to be repeated in six months.
- Dietitians attended the wards daily and staff on the wards could contact the dietitians via an on line system, patients receiving parental nutrition were seen daily. Parental nutrition is a method of getting nutrition into the body through the vein.
- Patient Led Assessment of the Care Environment (PLACE) is a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of the teams to assess how the environment supports the patient. The PLACE survey showed the trust scored 87%, which was in line with the England average (88%) for the quality of food.
- In the patients voice survey from February 2016 to January 2017, when asked 'How would you rate the hospital food' the trust scored 3.7%, which was the same as the previous year's score.
- We saw food was delivered at meal times to the patient's bedside and patients told us the food was hot.
- Patients on one ward commented "The food is very good". We observed an assistant visiting each bed recording choice of lunch on an IPAD and the menu was comprehensive. Patients said they were offered tea and coffee at every mealtime. Another patient commented "Food is hot, well-presented and there is a choice".
- There was a process in place to ensure patients were appropriately starved prior to undergoing general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. Generally the amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to operation which was in line with best practice.
- In 2017 the general surgery department audited its practice to ensure it was in line with national standards for pre-operative fasting. Using a sample of 47 patients both emergency and elective cases, the audit showed that on occasions patients were starved for prolonged periods and fasting advice given was on occasions inadequate. As a result, the trust guidelines were updated, training for staff was to be improved and consideration was to be given to the introduction of carbohydrate rich drinks.
- In the theatre admission unit we saw that if a patient had a longer than anticipated wait for surgery then oral fluids were given and if necessary there were facilities to commence an intravenous infusion, a means of giving fluids directly into a vein, in order to avoid a patient becoming dehydrated this was in line with best practice.

## Patient outcomes

- At The Royal Sussex County Hospital between October 2015 and September 2016, patients had a similar expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

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- Based on criteria used by the National Hip Fracture Database (NHFD) the directorate's most recent performance in 2016 showed the proportion of patients having surgery on the day of or day after admission had worsened from 88% in 2015 to 82% in 2016, which was worse than the national rate of 85%.
- The length of stay had also worsened from 17.6 days in 2015 to 19.5 days in 2016, which was around the middle 50% of all trusts. The proportion of patients not developing pressure ulcers was 94%, which falls in the best 25% of trusts but was worse than 99% in 2015.
- However, the risk adjusted 30 day mortality rate had improved from 4.9% in 2015 to 4.3% in 2016, which was better than expected. The perioperative surgical assessment rate in 2016 was 95%, which did not meet the national standard of 100% and was worse than the 99% in 2015.
- At our last inspection in April 2016, the National Bowel Cancer Audit 2014 showed only 65% of patients had a reversal of a stoma, a small opening on the surface of the abdomen surgically created, within 18 months. From April 2016 to March 2017, the trust showed an improvement of 70%.
- In the 2015 Bowel Cancer Audit, 89% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate and an improvement on the 2014 figure of 104%.
- The same audit showed the risk-adjusted 90-day post-operative mortality rate was 4% which was within the expected range and better than the 2014 figure of 7%. The risk-adjusted 2-year post-operative mortality rate was 24% which falls within the expected range and was better than the 2014 figure of 30%.
- The risk-adjusted 30-day unplanned readmission rate was 13% which falls within the expected range.
- The risk adjusted 18 month temporary stoma rate in rectal cancer patients undergoing major resection was 65% which was worse than the 2014 figure of 59%.
- In 2017 the General Surgical department carried out a local retrospective audit of stoma complications in patients awaiting reversal of a stoma. This audit concluded that 50% of patients would have complications although there was no clear correlation

between waiting times and stoma complications. The results of the audit recommended that consideration be given to the implication of stoma formation and the need for appropriate follow up and reversal of stomas.

- Patient Related Outcome Measures (PROMS) are a series of questions or a questionnaire that seeks the views of patients on their health, or the impact that any received healthcare has had on their health. During the period April 2015 to March 2016 the results for groin hernia surgery showed all measurements within normal limits.
- The trust participation in PROMS was seen to be high. Results for hernia and varicose vein surgery was better than the national average. The outcome for hip and knee was worse than the national average which may reflect the complexity of cases treated. The results were reported to the Safety and Quality meeting.
- We saw completed audits for theatres covering eight separate headings including temperature monitoring, observations of vital signs and pain management. For example, 100% of patients had pain assessment completed on admission to recovery. The lowest scoring check was for checking the patient's temperature intra-operatively which was completed in 33% of cases. We saw there was an action plan in place to improve this.

## Competent staff

- We told the trust it must make improvements in ensuring all staff received an annual appraisal. At this inspection, the trust had made some improvements. We found that at the end of March 2017 the overall trust staff appraisal rate was 85%.
- For nursing staff the appraisal rate in the abdominal and medicine directorate was 88%, musculoskeletal directorate 86%, head and neck directorate 82% and peri-operative directorate 90%. Therefore all but the head and neck directorate had achieved the trust target of 85%. On the surgical wards, staff told us that there was a focus on completing appraisals and the process was of value and involved setting objectives for personal development.



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- For medical staff the appraisal rates across the trust were lower than nursing rates. The highest completion rate was 88% within the abdominal surgery and medicine directorate, 79% in cardiovascular. The perioperative directorate was 65%.
- The annual organisational audit showed the trust had a shortage in the number of appraisers for medical staff and that this was being addressed with additional training to increase the number of appraisers.
- We spoke to six junior doctors across two ward areas and all commented that they felt well supported on the wards by their seniors and department induction was good.
- The trust had started work on a Beacon Ward pilot, which supported health care assistants (HCAs) to progress through their career. This was a 12 month project that included eight study days, one to one coaching and 15 skills sessions based on the ward. We saw a completed HCA appraisal with completed objectives and an action plan.
- We saw the trust maintained a database of nurse registration and revalidation dates due for all staff members. This meant there was a system which highlighted when registration and revalidation was due.
- We saw information for staff on how to revalidate including pocket guides and posters on what to do, these were displayed on wards areas, which showed staff were being informed and supported to complete revalidation.
- All ward areas had the support of a clinical practice educator and staff told us this supported them in developing their skills and knowledge. Staff told us that professional development was encouraged.
- We saw that all recovery staff completed clinical competencies 'Introduction to the Post Anaesthetic Care Unit (Recovery)' reviewed 2017. The competencies reflected the complexity of patients that staff managed within the department. In addition there was a plan for staff development in specialist areas. In theatres, we saw evidence of scrub competencies taught by practice educators over a twelve week period. During the period of training, staff were supernumerary until assessed as competent.

- Theatres supported the placement of student nurses in their department and there were six mentors in the recovery department. Staff told us they felt there was good professional development available but limited funding was available for external training.
- On one surgical ward area, patients told us that the nurse in charge was training junior nurses. Patients commented that the 'ward manager took a keen interest in how the junior staff undertook their work'.

## 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 a physiotherapist and/or occupational therapist as required. We observed good interaction between those taking part and staff told us they were encouraged to participate and contribute.
- There were daily multi-disciplinary team (MDT) meetings on all the wards usually held in the morning that included medical and nursing staff, discharge co coordinator, occupational therapist, dietitian and relevant specialist nurses. Each patient was discussed including discharge plans and any required referrals or care packages that needed to be put in place.
- There were daily trauma meetings involving medical, nursing and physiotherapy staff which reviewed admissions over the previous twenty four hour period. These meetings were used to discuss new cases, outliers and patients progress.
- We attended a safety huddle on one ward, which was attended by the nurses, doctors and pharmacist. We saw good interaction between all staff. The safety huddle meeting was used to discuss any current concerns on the ward such as any safety issues, incidents and any other concerns. On all wards we visited safety huddles took place, usually early in the morning.

## Seven-day services

- There was consultant presence for each of the directorates, seven days a week at the RSCH site with ward rounds undertaken daily in order to plan patient care and improve the discharge rate in surgery.
- Theatres were staffed so they could provide emergency surgery twenty four hours a day. Trauma had one staffed

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list every Saturday and Sunday. There was also a poly-trauma team available seven days a week. There were no permanent elective lists at weekends but occasional lists were provided as need dictated.

- For surgical services there were consultants on call twenty four hours a day, seven days a week.
- The physiotherapy service was available twenty four hours a day, seven days a week.
- Pharmacy services were available seven days a week. Monday to Friday 9.30am to 5.30pm, Saturday, Sunday and bank holidays 11am to 1.30pm. An emergency duty pharmacist was available via switchboard outside of opening hours.
- The diagnostic imaging department provided a seven day, on call service. This was in line with; NHS services, seven days a week, priority clinical standard 5, 2016. This requires hospital inpatients to have seven-day access to diagnostic services such as x-ray, ultrasound, CT and MRI and radiology consultants.

## Access to information

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff told us that there were no issues with access to reports and results and they were able to demonstrate how they accessed information on the trust's electronic system.
- The electronic system enabled wards to see order of emergency and trauma lists. There was access to daily and weekly reports on emergency activity.
- There were arrangements to ensure staff had all the necessary information to deliver effective care. For example, risk assessments, physiotherapy notes, and dietetics referrals were included in patient notes. This meant staff, including agency and locum staff, had access to patient-related information and records when required.
- Medical staff used the Patient Archive and Communication System (PACS) system to download and view images of patients x-rays and tests. The PACS system is a central repository for radiology and medical images and objects

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

- At our previous inspection we told the trust it should make improvements in reviewing the consent policy and process to ensure confirmation of consent was sought and clearly documented.
- At this inspection, the trust had made some progress. We found the consent policy had been reviewed and consent champions had been appointed. A workshop was held in November 2016 to re-enforce the role of the consent champions who were responsible for training other staff on the updated policy.
- We saw that funding had been agreed for patient information and these leaflets were available for patients. A re audit of consent was carried out in April 2017, the results of this audit were to be presented in July 2017.
- We reviewed nine consent forms for surgery. They were all completed, signed and outlined risks of surgery. The consent forms did not contain any abbreviations that a patient may not have understood. In theatres we had seen that completion of the consent form was checked as part of the WHO safe surgery check list.
- One patient commented that the staff, "Always ask for consent" before carrying out care.
- The trust had a Mental Capacity Act Policy that incorporated Deprivation of Liberty Safeguards (DoLS), which was in date. The policy was in line with the Mental Capacity Act 2005 and DoLS 'Code of Practice' 2008.
- We spoke to staff on the wards who told us they knew the process for making an application to DoLS and when these needed to be reviewed. We saw two DoLS in place, which were completed correctly, and the patient's family had been informed and were involved in the patient's care.
- MCA and DoLS training was part of the mandatory requirement and the level of completion had improved since the last inspection and 74% of medical staff and 84% of nursing staff had completed this training.

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## Are surgery services caring?

Good



When we inspected the Royal Sussex County Hospital in April 2016 we rated the service as good for caring because:

- 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 surgery was shared with patients, and patients were able to ask questions.

At this inspection, we have retained this rating. This was because:

- Patients were very positive about the care they received and complimented all staff on being professional, kind and caring.
- We observed care to be respectful, patient centred and delivered with compassion. Patients were treated with dignity and respect.
- Patients were kept informed of their surgery and treatment plans and were supported appropriately.

### Compassionate care

- Throughout our inspection, we witnessed excellent staff interaction with patients. We observed how the nurses assisted patients with compassion and care. Patient comments included, "The nurses are excellent, they seem to know what you want before you tell them" and "All the doctors and consultants are polite and explain everything in simple terms".
- The hospital submitted data to the Friends and Family Test (FFT). The Friends and Family Test is a feedback tool that enables people who use the NHS to feedback on their experience and whether they would recommend the service. Between February 2016 and

January 2017, the (FFT) response rate for surgery at the trust was 17%, which was worse than the England average of 29%. For the Royal Sussex County Hospital, the response rate was 16%.

- The highest scoring ward at Royal Sussex County Hospital was Ward Level 7A scoring 100% for percentage of patients recommending the service for ten of the 12 months. The ward's average response rate for the 12 month period was 52%, which was above the England average of 29%.
- The trust carried out an inpatient survey called 'Patient Voice'. The overall results for the surgical wards over the past year were either the same as or slightly worse than the previous year. We saw that all wards displayed the results of the inpatient survey. For example, on Ward Level 9 we saw that 551 patients responded. Ninety-four percent recommended the service and 76% said they were treated with care and compassion. All wards displayed their own results.
- In theatres, we observed that consideration was given to preserving patients' dignity, for example, not opening theatre doors until patients were covered. In recovery, care was taken to preserve patient confidentiality during patient handover.
- On the Surgical Assessment Unit, we observed the use of curtains for privacy, there was good communication between the nurses and patients and the care was seen to be friendly and individualised. Patient comments on this unit included, "There is always someone on hand to assist and reassure you" and "They answer bells very promptly".
- On the wards, there were thank you cards from patients and wards had 'you said we did' boards displaying actions following patient feedback.
- On the ward areas, we received positive comments from all the patients we spoke with about their care. They described staff as "Outstanding", "Caring" and said that staff delivered care ensuring patients respect and dignity. Comments included. "Bells are answered promptly even in the middle of the night" and "There is a good spirit in the ward and the nurses look as if they enjoy their work".

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- Comments from a patient comment card for surgery described the care as, "Absolutely brilliant in all aspects, excellent reception staff, exceptional doctor and nurses"
- Several staff commented that they felt there was a greater focus on respect and dignity for patients and this had improved.
- The most recent PLACE score, completed in 2015 scored 79% for privacy, dignity and wellbeing at Royal Sussex County Hospital, which was worse the national average of 84%. However, during all of our observations during inspection we found patients' privacy and dignity was maintained.

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

- We spoke to 23 patients during the inspection and many of those patients commented that they felt they were kept well informed of their plan of care and one patient said, "There are lots of people about, I am always kept aware of what is going on".
- One patient who had surgery cancelled the previous day told us there had been a long wait before theatre, however, there was good communication from the staff about what was happening and they were able to have a drink. Following the procedure, information was given on the findings and plan of care.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate arrangements were in place. This reflected patient centred care and showed needs of the individual were taken into account. One patient told us that during the ward round the medical staff thought the patient was ready for discharge, the patient was concerned about how they would manage at home and they discussed this with the senior nurse. The nurse called back the consultant and after further discussion it was agreed that it was more appropriate for the patient to transfer to a rehabilitation unit before discharge home. The patient praised the nurse for listening and thought all staff had shown good teamwork.
- We observed nurses, doctors and other professionals introducing themselves to patients and discussing with them reasons for their admission and plan of care.

- We saw information for patients and relatives about how to leave feedback. In addition, the trust website contained information on how to leave feedback, how to join the patient feedback panel and how to complete the family and friends test.

## Emotional support

- There was a variety of specialist nurses to support and advise patients, for example stoma nurses, one patient described this support as excellent as it gave them confidence to plan how they would manage at home. On discharge, patients were provided with contact numbers of relevant support groups.
- There were other specialist nurses available to support patients including diabetes nurse, dementia specialist and Macmillan nurses.
- The hospital patients and staff could access the chaplaincy team who provided religious support twenty four hours a day. There was access to literature about other religions and there was a separate prayer room next to the chapel. Staff received training on the different faiths and had access to over 30 ward-based volunteers from a variety of faith traditions, who made visits to the hospital.
- Contact cards were available for visitors to take away and use if they wanted to contact the hospital and enquire about the patient when they got home.

## Are surgery services responsive?

Requires improvement



When we inspected the Royal Sussex County Hospital in April 2016 we rated the service as requires improvement for responsive because:

- The admitted Referral To Treatment (RTT) target was consistently below the England average for all specialties.
- 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 Emergency Department (ED) into the recovery area in the operating theatres.

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Patients stayed anything from four hours to over three days. Whilst in the area, patients did not have their privacy preserved and did not have free access to washing and toilet facilities, they could not move freely around the recovery area and could not see their relatives.

However:

- The service had reconfigured its vascular and plastic surgery 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.
- 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.

At this inspection, we have retained this rating. This was because:

- Whilst improvements had been made to meet the admitted RTT these still remained below the England average for all specialities.
- Work had been done on identifying patients on the waiting list for a specific colon (bowel) surgery but there was still a backlog of patients waiting for surgery.
- The surgical assessment unit had a high number of inpatients and were not always able to take patients from the emergency department as intended and this impacted on patient flow.
- Due to bed capacity issues the practice of 'boarding' patients on the ward put strain on the ward management and staffing of the ward. Boarding meant that patients from the emergency department were put on the ward before a bed was available.

However:

- Whilst bed occupancy across the service remained, high patients were no longer inappropriately admitted from

Emergency Department (ED) or High Dependency Unit (HDU) into the recovery area in theatre. A delay in moving patients to the wards following surgery, whilst not resolved, had improved and was closely managed.

## 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 its services.
- The abdominal and medicine directorate had recently reorganised its emergency services and there were now two teams for gastro-intestinal services dealing with emergency care. Two consultants undertook weekend ward rounds, which increased the number of patients discharged over a weekend period.
- The abdominal surgery and medicine directorate had a five year reconfiguration and development strategy to reduce the RTT. However, there were currently 82 patients still waiting more than 52 weeks for specific stoma surgery.
- Three new general surgery consultants had been appointed to the trust to tackle the waiting list patients for surgery by utilising the Princess Royal Hospital (PRH) site for more complex procedures. There were plans to transfer a range of emergency services from RSCH to PRH such as laparoscopic cholecystectomies (removal of the gall bladder), hernia repairs and abscesses.
- In addition, to address the delay in diagnostics for certain groups of surgical patients the service had introduced telephone triage clinics and recruited two new nurse endoscopists and new consultant posts.
- The trust has undertaken a trial of 4.5 WTE clinical assistants to support the junior doctors' caseload. The clinical assistants carried out routine clinical tasks such as taking blood and inserting cannulas in inpatient wards. Nominated for a Health Service Journal Award, this project had been praised for improving services for patients. Role specific competencies were in place for these staff.
- The musculoskeletal directorate had further developed the virtual clinics to include pre-operative assessment. The development of tailored rehabilitation videos enabled the standardisation of rehabilitation following surgery.



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## Access and flow

- At our previous inspection we told the trust it must make improvements in ensuring the 18 week RTT was addressed so patients were treated in a timely manner. At this inspection, the trust had made some progress. At the end of March 2017, the overall 18 week RTT had improved to 84%, which was still below the trust target of 92%.
- The trust produced a daily patient treatment list that showed all patients on both the admitted and non-admitted waiting list. Each patient's procedure and waiting times were highlighted with other key pieces of information such as clinical urgency. This enabled access and monitoring of this information and the medical staff told us this information was useful as they prioritised their workload.
- As of May 2017 there were 454 patients awaiting colon surgery, with a median waiting time of 22 weeks. The department (via the Patient Access Managers and Directorate Manager) tracked long waiting patients (any patient above 42 weeks) on a daily basis. Patients that breached the 52 weeks had a RCA undertaken and were reviewed as part of the Directorate Clinical Harm Review Process.
- The trust had recruited three new colo-rectal surgeons to support capacity shortfalls and had also recruited two advanced endoscopy nurses.
- Between February 2016 and January 2017, the trust's RTT for admitted pathways for surgical services was worse than the England overall performance. The latest figures for January 2017 showed 67% of this group of patients were treated within 18 weeks this was worse than the England average of 71%.
- Trauma and orthopaedics was 73% for admitted RTT (percentage within 18 weeks) which was better than the England average of 65%. All the other specialities were worse than the England average such as ear, nose and throat (ENT) 49% was worse than the England average of 68% and urology 71%, which was worse than the England average of 79%.
- Between November 2015 and October 2016, the average length of stay for surgical elective patients at Royal Sussex County Hospital was 5.6 days, this was worse than the England average of 3.3 days. For surgical non-elective patients, the average length of stay was 6.8 days, which was worse than the England average of 5.1 days.
- As of May 2017 there were 454 patients awaiting colon (bowel) surgery, with an average waiting time of 22 weeks.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.
- For the period quarter four 2014/15 to quarter three 2016/17 the trust cancelled 1,047 operations. Of these cancellations 158 (15%) were not treated within 28 days. The trust performance was worse than the England average for the entire reporting period.
- Cancelled operations as a percentage of elective admissions include only short notice cancellations. Cancelled operations as a percentage of elective admissions for the period quarter four 2014/15 to quarter three 2016/17 at the trust were better than the England average.
- Theatre utilisation at the RSCH site between October and December 2016 was on average 86%, and ranged between 80% and 91%. Theatre staff told us that the department had put processes in place to reduce the number of vacant operating sessions however capacity issues on the wards still caused cancellations.
- On the Surgical Assessment Unit, staff told us the main concern was bed capacity as the ambulatory trolley spaces were frequently taken by inpatients for escalation, therefore the unit could not always take short stay patients from the emergency department. There were 40 inpatients in the department in the week prior to the inspection. Therefore trolley bays were mixed sex.
- During this inspection, we saw examples on three wards of patient 'boarding'. When no beds were available patients would be brought to the ward and be



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positioned in the middle of a patient bay until a bed was available. The patient was usually positioned in a bay where there was known to be a patient to be discharged that day.

- Staff told us that on occasion's patients for admission had been put into a bed space where a patient had gone to theatre, which would then delay returns from recovery. Senior nursing staff on the ward told us that when the hospital was at full capacity they felt under pressure to accommodate patients in this way and that this compromised patient safety putting pressure on the staff on the ward. Staff told us that the area would be cleaned and equipment changed between patients but this added pressure on the staff.
- On Ward Level 8A, we saw there were five medical outliers on the ward. Staff told us there had been no difficulty getting medical reviews for these patients.
- On Ward Level 8 Tower (cardiovascular directorate) staff told us that there was often a high level of outliers, which resulted in cancellation of surgery. We were told there were normally six outliers but on the day of inspection, we saw there were 10 and the previous day there had been 14, mainly orthopaedic and general surgery patients.

## Meeting people's individual needs

- At the last inspection, we saw the recovery area in the operating theatres was being used for emergency medical patients due to bed pressures and some patients were transferred from the HDU to allow admission to that area. Some patients were kept in recovery up to three days with a number of patients discharged home directly from there. This meant patient's did not have privacy 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.
- At this inspection, we saw good progress had been made. We saw that no medical patients were being admitted to the recovery unit and patients were not being transferred into the recovery unit from the HDU. This meant the facility was now being used appropriately and patient's care was not being compromised.
- The recovery unit staff told us they felt the department was much safer than when inspected a year ago. Fewer patients were staying in the department past their recovery time and good processes were in place to escalate to the duty manager when wards delayed in accepting patients back from recovery. A record was kept of any patients staying in the department over their required post-operative recovery time. Records showed that during the week before inspection, one patient per day was delayed in the return to the ward for between one to six hours.
- We saw data was being kept of any delays in admission to Intensive Care Unit or High Dependency Unit from recovery and that this showed monthly variation but generally improved in 2017. The medical lead for theatres kept all recovery data under review and discussed any breaches with the relevant directorate.
- The trust had a named dementia lead and a dementia strategy dated March 2017, which included recommendations about the training and use of the butterfly scheme. 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 were put by the patient's bed to remind staff to follow a special response plan.
- On the wards, we saw additional information for staff informing them about the scheme and how to make contact with the dementia lead and link nurses. Staff used specific care plans for patients living with dementia called 'Reach Out To Me'.
- For patients living with dementia, depending on their needs they could be assessed by a Dementia Nurse Specialist assessment, a Dementia Occupational Therapist Assessment, a Consultant Geriatrician, a Consultant Psychiatrist or a Mental Health Nurse or ward staff who had undertaken dementia training.
- A patient told us that she observed a nurse on the ward dealing with a patient with dementia and said, "She was so calm and reassuring even though it was very difficult".
- All patients living with a learning disability were referred to the Disability Liaison Team where information would

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be captured onto an electronic system for use when patients were being admitted and treated. This meant that if any adjustments or support had to be put in place this could be done in a timely way.

- The trust had a named learning disability lead, staff confirmed they were able to contact to discuss any concerns and to obtain advice. The trust had developed information appropriate for patients with learning disabilities for example information about consent in an easy to read and pictorial way that patients with learning disabilities could easily understand.
- There were a number of specialist nurses who supported the surgical directorate teams including digestive diseases, stoma and endoscopy nurse specialist. The musculoskeletal directorate had nurse practitioners and trauma leads and the peri operative directorate had pain nurse specialist and had appointed a nurse consultant for that specialty.
- We saw there was involvement of the outreach team with patients who had been in the critical care unit and that these patients were visited on the ward 24hrs after discharge from the unit, to assist the patient with any psychological issues.
- All bays on the surgical ward had showers and toilets that could be accessed by disabled people.
- During the period October 2016 to January 2017, Ward Level 8 Tower had three days when mixed sex breaches were recorded, Ward Level 8A West had breaches on 19 days and Ward Level 8A had 12 days. During our inspection we did not see any mixed sex breaches.
- Bariatric patients were assessed at pre assessment and any specialist equipment was organised prior to the patient's admission. There was a variety of equipment available to meet the needs of patients with a high body mass index (BMI). For example, all operating tables were able to withstand a weight of 450kg and there were specific bariatric chairs, which were larger and designed to withstand increased weight. Bariatrics is a branch of medicine that deals with the causes, prevention, and treatment of obesity.
- On the wards there was a choice of food options for patients, for example there was access to vegetarian, vegan and kosher meals.
- Patients had access to fluids at regular times through the day and water was available at all times. One patient who had a long wait for theatre told us there was good communication from the staff and the patient was offered a drink to avoid becoming thirsty.
- Patients who attended the pre-operative assessment clinic were given information leaflets regarding anaesthetic, preventing thrombosis (blood clots), wound care, pain management and fasting instructions. On the wards there was a variety of information leaflets on display about different conditions and treatments and in many cases these contained information about how to access the same information in different languages.
- The trust used two language providers who both provided face-to-face interpreting for patients and service users for which English was not their first language. Staff we spoke with told us they could access translation services from the trusts intranet when necessary. The trust produced an annual report showing the number of occasions when communication support was required including braille, British sign language and over forty language translations.
- There were contact numbers for support with patients who were visually impaired or who had more than one sense deficiency. We saw a workshop had been run for staff to enable them to understand the needs of these patients.
- The hospital had a communication book to help communication with people with a wide range of needs for example learning disabilities and autism. Autism is a condition where the sufferer may have difficulty in communication and using language.
- Within the theatre admission unit, we saw that patients had access to relevant information; they were given a phone number to call if there were any issues after discharge.
- On one surgical ward, we saw there was collaborative working with the substance abuse service that used the ward facilities to run a support group and would take referrals from the wards.

## Learning from complaints and concerns

- The trust had a policy and procedure for the management of formal and informal complaints from

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patients and their representatives, that set out the need for close collaboration between the Patient Advice and Liaison Service (PALS) and the trusts complaint services to ensure a means of resolving patients concerns.

- From April 2017 to March 2017, the directorates received 59 complaints. The abdominal and medicine directorate had 16 complaints, the head and neck directorate had six complaints, the peri-operative directorate had two complaints and musculoskeletal had 32 complaints. Complaints were discussed at the surgical quality governance meetings. The themes were mainly a lack of communication and delay in treatment.
- Between February 2016 and February 2017, there were 1,374 complaints received trust wide. The trust took an average of 73 days to investigate and close complaints; this was not in line with their complaints policy, which stated complaints should be responded to within 40 days.
- The trust held a monthly serious complaints and safeguarding meeting which contributed to a report presented to the safety committee. This report detailed the number of complaints and highlighted any complaints at stage two and any learnings and how this was to be shared with staff. This showed there was learning across the directorate and sites.
- The trust was undertaking some work with Healthwatch who were conducting a peer review of complaints. There was an action plan dated February 2017 with suggested actions to be taken.
- We saw 'How to Complain' posters were displayed on the wards we visited. 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 about how to raise a concern, which was available throughout the trust, and were available in other languages upon request. Alongside this, there was a reminder for patients and their families to report any concerns about abuse.
- Written complaints were managed by the matron and at directorate level. A full investigation was carried out and a written response provided to patients. Staff we spoke to were clear how complaints were dealt with in their area.

- The ward sisters received all the complaints relevant to their service and gave feedback to staff at ward team meetings regarding complaints in which they were involved. For example, staff on one ward were able to tell us that there had been no complaints for fourteen months but recently there had been three about managing patient expectations. This had resulted in reminders about the importance of clear communication with patients.
- Notice boards on the wards included 'You Said We Did', in response to patient comments.

## Are surgery services well-led?

Good



When we inspected the Royal Sussex County Hospital in April 2016 we rated the service as requires improvement for well-led 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:

- 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.

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- There was evidence of the public being engaged in some specialities.

At this inspection we have changed the rating to good. This was because:

- The trust had a plan for redevelopment and a clinical strategy in place. Each of the four directorates had strategies and business plans in place which could demonstrate progress over the last year.
- Governance structures across the four directorates were established and developing.
- Staff were aware of risks in their departments, risk registers were in place for all four directorates and generally the risks were mitigated and kept under regular review and there was assurance this was under review at board level.
- Staff told us there was improvement in the culture at the hospital they were still concerned at number of changes in the hospital senior management and looked forward to a period of stability and increased visibility of the management team.

However:

- The plan for improving staff engagement following the staff survey was not yet fully implemented although this was an issue for the executive leadership.
- The action plan resulting from the workforce race equality standard was underway but not fully established although this was a trust wide issue for which the executive leadership were responsible.

## Leadership of service

- As of January 2017, each of the four directorates had a lead clinical director, a directorate lead nurse, directorate manager and a number of clinical leads. For example, the peri-operative directorate had six clinical leads.
- Each ward and theatre had a manager who provided day-to-day leadership to staff members. There were matrons for the different surgical specialities who staff found responsive and supportive. Matrons kept staff informed of trust wide developments through ward manager meetings and provided guidance where required.

- On ward areas, we saw that ward sisters and charge nurses were visible and available to staff. Patients told us that senior nurses were always about and recognised by everyone. Patients told us they were aware who the nurse in charge of the ward was. One long term patient said the matron had been to visit the ward and seemed to be in control.
- The nursing teams, diagnostic team, physiotherapy team and administration team communicated well together and supported each other. Junior doctors told us they felt well supervised by consultants.
- Staff told us that members of the directorate and local leadership teams were visible and approachable; however the senior leaders at trust level were not always visible. A ward manager said the trust team had not been visible however the staff knew who they were and there were posters on the wall. The most recent staff survey in 2016 scored ten percent lower than the national average for staff reporting good communication between senior management and staff.

## Vision and strategy for this service

- The trust had a plan for the redevelopment of the hospital; there was a clinical strategy in place dated January 2017 which set out the vision to be a centre of excellence and to be the first choice for patients, families and staff. This strategy set out the values of the organisation. However, when asked staff were not able to identify the clinical strategy as this had not been clearly communicated by the trust leadership.
- Each directorate had either a strategy or a business plan for their services. For example, the abdominal and medicine directorate had a strategy to improve theatre utilisation, reduce its RTT and ensure surgical beds were used for surgical patients.
- The peri operative directorate had a business plan; their strategy was to ensure recovery was used appropriately, to deliver an efficient theatre and emergency service. They were actively involved in the new build and the expansion of the theatre department.
- The ear, nose and throat (ENT) service within the head and neck directorate had undergone a number of resource challenges but were settling in a new team and governance processes and had a business plan to look at new initiatives including cross hospital working. This

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directorate had a nursing strategy, vision and philosophy that incorporated the six Cs of care, compassion, competence, communication, courage and commitment.

- The muscoskeletal directorate had a business plan in place and told us they aimed to improve theatre efficiencies, continue sub specialisation and further develop the virtual clinics.

## Governance, risk management and quality measurement

- Each directorate held its own clinical governance meetings. We reviewed minutes of these, which included incidents, complaints, audits and training. These meetings were attended by members of the multidisciplinary team and minutes were available for those that could not attend.
- Staff told us that the surgical assessment unit had recently implemented weekly clinical governance meetings with mortality and morbidity review and audit results. Doctors told us they were pleased about this and said there was good attendance including consultants. Morbidity and mortality meetings were undertaken to improve and monitor patient care.
- Feedback from directorate leads was that trust governance was being established with a regular monthly multi directorate meeting where major issues were discussed.
- The trust had completed local and national audits. For example, environmental audits were conducted and compliance with the World Health Organisation 'Five Steps to Safer Surgery' checklist was monitored in line with the trust's policy and national standards. Medicine audits and new treatments were reviewed by the medication safety group.
- Directorates held their own risk register and clinical leads we spoke with were able to identify the top risks. Risks included inability to achieve 18 week RTT and surgical beds being used for medical patients, control measures included daily monitoring, daily ward rounds to include multi-agency staff and a review by the discharge team. We could see evidence of risk scoring and that information was updated and actions were taken. The directorate risk registers were seen to feed through to the trust risk register and a corporate risk summary analysis report which analysed the register and level of control in place giving the board assurance of risk across the organisation.
- The head and neck directorate risk register had identified equipment without a service contract in place; this was being addressed including plans to purchase new equipment. The directorate told us that they were concerned that paediatric audiology was taking place in the adult department, there was a plan to resolve this and we could see this detailed on the risk register. There was a plan to address this in the new build and that this was being kept under regular review. Each risk had an assigned owner and a review date.
- The peri-operative directorate risk register included as high risk the storage of combustible materials which could be a fire risk. There was a clear record of actions taken and that this has been partially resolved. Staff told us that the ventilation system needed refurbishment and this was on the risk register, this was down as a significant risk have been raised in May 2016, the risk register showed this as uncontrolled and part of ventilation review project. Staff told us that this was a concern and as it had not been resolved.
- Clinical leaders in the directorate told us they had oversight of all incidents. For example, the peri operative directorate maintained a log of serious and moderate incidents with actions taken. Minutes were seen of the perioperative quality, safety and patient experience showing audit results, case presentation and reviews of mortality and morbidity.
- Staff said they generally received information regarding incidents and were involved in making changes as a result of incident investigations. Staff understood and felt involved in governance processes.
- The trust had a quality performance committee and a performance monitoring system in place arranged under the five CQC domains.
- Each clinical directorate had a clinical scorecard and we saw these displayed in ward and department offices. The scorecard recorded monthly scores, for example, under caring there were scores for the number of complaints, time taken to answer and those still open



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after six months. Well led had results of completed appraisals, vacancy rates, staff turnover and costing. In the safe domain amongst other measurements, Never Events and Serious Incidents were recorded.

- There was cross directorate comparison of scorecard results and there was visibility of scorecards at ward and department level. Staff we spoke to told us that this enabled them to be aware of results and work on areas where compliance was poor.
- Matrons and ward sisters also had daily meetings to discuss staffing levels, patients' safety concerns and bed occupancy.

## Culture within the service

- Staff we spoke to described the culture as improving across the hospital during the past year. The many personnel changes and interim managers at trust management level had caused uncertainty but this was now settling and staff were generally more positive about the future. Staff were aware that senior managers from another trust were coming in to support the trust and were waiting to hear what would happen next.
- Senior managers said they were supported and there was better communication with the executive team. There was an improving culture of openness and transparency. Feedback from senior managers indicated the executive team were more approachable and more accountable.
- In theatres, the senior management team described working together to improve communications, engaging staff to improve safety, reporting and communication. Staff told us they felt involved with the current building project and expansion of their unit.
- We were told by a number of the nursing team that communication had improved and there was better working between the disciplines. All staff said they felt able to raise concerns. Some staff told us there was a less tolerance of poor staff behaviour, more accountability and communication had improved.
- We were told by some staff that the Human Resource (HR) department were supporting staff when they had to deal with colleagues' poor behaviour. Staff said the values and behaviour programme had been helpful and

staff felt more able to challenge behaviours. However, some staff expressed criticism of the recruitment process which was seen to be prolonged and described poor processes to manage long term sickness.

- The trust had a 'Raising Concerns and Whistle Blowing' policy. On ward areas, we saw information on how to report bullying and harassment and the role of the new freedom to speak up guardian. Not all staff could identify who the speak up guardian was but staff knew this was a new role.
- Staff told us that generally they did not experience bullying or harassment but some nursing staff on the wards felt they were put under a lot of pressure due to demands on bed capacity. They described feeling pressurised to use mixed bays or 'boarding' patients in full wards, which they said could compromise patient care.
- The trust's sickness levels between November 2015 and September 2016 were similar to the England average.

## Equalities and Diversity – including Workforce Race Equality Standard

- Brighton and Sussex University Hospitals Trust (BSUH) produced a Workforce Race Equality Standard (WRES) report 2016 and an action plan to be completed by 30 June 2017 in time for the next WRES submission. There were specific issues to address across all staff groups about induction, support, rostering and opportunities for Black and Minority Ethnic (BME) staff across the trust and the executive team had responsibility for this. The actions started with re-establishment of the Race Equality Workforce Engagement Strategy. The Equality Annual report was presented to the board in January 2017.
- The trust had established an equality and diversity in services committee and we saw the terms of reference dated February 2017. This meeting involved the freedom to speak up guardian. Staff told us that the appointment of a speak up guardian was a positive development.
- Staff told us that on occasions there can be "A lot of abuse" from patients and nurses could be vulnerable. However, staff were supportive to each other. A member



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of staff gave an example, when a member of staff was bullied by a patient who made inappropriate comments and they were actively supported by the ward team and management.

- The trust had a current equality, diversity and human rights policy and an annual report.
- The trust had a current Lesbian, Gay, Bisexual and Transgender (LGBT) forum equality and diversity action plan. This showed actions such as involving the LGBT forum in the development of HR policies. We saw the trust were commitment to support the Trans pride and the LGB pride events.
- We saw printed trust information for staff including ten tips for improving services for Transgender people.

## Public engagement

- The trust produced a newsletter for the public 'Your Trust' giving up to date information about the trust building work, departments, wards, new treatment and patient stories.
- The hospital website contained information about the services of the hospital, visiting times, parking, wards and the site redevelopment. This information was part of the trust website which also included information about new appointments, how to feedback, how to volunteer and local public events. The website was easy to navigate.
- The hospital participated in PLACE audits. These assessments invite local people to go into hospitals as part of teams to assess how the environment supports a patient's privacy, dignity, food, cleanliness and general building maintenance.
- Minutes of the Patient Experience Panel showed the meetings to be quarterly; this forum had representatives from all patient groups and had been recently reformed. The governance structure showed that this group reported through to the Patient Experience Committee and from there through to the Trust Board. The minutes showed discussion on Healthwatch reports, CQC feedback and disability users update.
- The hospital website contained information about the services of the hospital, location, parking and the current programme of redevelopment. The website was part of the trust website which contained information

about new appointments, how to feedback, how to volunteer, local events and news. The website was easy to navigate and also contained links to a range of patient information leaflets.

## Staff engagement

- The trust wide results of the National Staff survey in 2016 showed the trust performed worse than other trusts in a number of categories. Possible scores ranged from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's engagement score was 3.6, which was in the lowest 20% when compared with trusts of a similar type. Effective team working scored 3.6 compared to an average of 3.7 and staff satisfaction with resources and support scored 3.1 compared to 3.3.
- Following the staff survey, the HR department presented a paper to the senior management team analysing results and detailing actions to be taken to improve staff engagement, for example, the development of staff engagement events and how that was communicated across the trust. The action plan was reviewed in March 2017 and was still ongoing at the time of the inspection.
- The trust presented a conference for health care assistants (HCAs), assistant nurse practitioners (ANPs) and clinical technicians at the end of April 2017. This showed how the trust was going to support those staff who wanted to progress their careers. This was well attended and had positive feedback from those attending.
- Staff told us that there had been a focus on training and development and this was seen as positive. Some staff had attended a rapid improvement workshop which focussed on change and development.
- We saw an annual brochure for staff and patients called 'Best of BSUH' outlining achievements over the past year and including patient stories. The trust produced a magazine for staff called 'Talkback' which contained information on staff achievements and service awards.
- Staff told us there was a trust wide information network called 'Have Your Say' for staff to contribute to. Staff

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views of this were mixed, some finding it informative and others more critical about the content saying that some discussions on this network were not relevant for all staff.

- Staff were positive about the Health, Employee, Learning and Psychotherapy (HELP) service that have been used by wards and departments to support debriefing sessions after clinical incidents, which had been identified as traumatic meaning that staff may need support.

## **Innovation, improvement and sustainability**

- In January 2017 the muscoskeletal directorate launched the virtual fracture clinic enabling the collection of Patient Reported Outcome Measures (PROMS) and patient satisfaction data via a patient portal. This allowed patients to log in and access rehabilitation information. This was shortlisted for the Kent, Surrey and Sussex Leadership and Innovation Awards for 'Team of the Year'.
- The trust had developed the role of clinical assistant an initiative to support junior doctors with paperwork and routine clinical tasks. Evidence of competency training was seen. This was shortlisted for a Health Service Journal Value in the Healthcare Awards.

# Critical care

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

## Information about the service

We inspected the Royal Sussex County Hospital (RSCH) in April 2016, as part of a comprehensive inspection of the Brighton and Sussex University Hospitals Trust. At the time, we rated the critical care core service at RSCH as inadequate.

The purpose of this inspection was to see what changes and improvements had been made since our last visit. The inspection took place between 25 and 26 April 2017 with a follow up unannounced inspection on 4 May 2017.

The critical care service at the RSCH is part of the acute floor directorate. The department comprises 31 beds located on level five and level seven of the Thomas Kemp Tower. Level five is a 15-bedded intensive care unit (ICU), of which seven beds are designated for general ICU patients and the remaining eight for patients' neurological injuries or conditions. Two of the beds are located in side rooms which, are mainly used for patients who presented an infection control risk.

Level seven is a 15-bedded intensive care unit (ICU) with one side room. Level seven has, in addition to the 15 ICU beds, a cardiac critical care unit. This unit sits within the surgical directorate as the majority of patients there are recovering from cardiac surgery. The critical care team has limited interaction with the cardiac critical care team, although occasionally resources are shared. In the year prior to the inspection, there were 14 instances when cardiac patients had used a bed on the general ICU.

The critical care department had 1854 admissions in the year prior to the inspection.

As part of our inspection, we reviewed information from a wide range of sources and reviewed data supplied by the trust. We visited both of the critical care areas. We spoke with four patients and the family members of five patients. We also spoke with a range of staff including consultants, doctors, nurses (including, members of the critical care outreach team), healthcare assistants a physiotherapist and housekeeping staff. We reviewed three sets of patient records and we observed shift handover meetings as well as a number of periods of direct patient care. We also spoke with the acute floor senior leadership team.

# Critical care

## Summary of findings

When we inspected Royal Sussex County Hospital in April 2016, we rated critical care as inadequate. This was because:

- The skill mix of nurses on the mixed ICU unit was often insufficient to provide specialised care to neurosurgery patients.
- Medication management was poor and there were high numbers of medication errors.
- Incident reporting and learning from incidents was poor.
- Critical care services did not fully meet the National Institute for Health and Care Excellence guidance on the rehabilitation of patients.

At this inspection we have maintained the rating of inadequate. This was because:

- The critical care department had a large incident report backlog dating back to 2015 that still required investigation. At the time of the inspection there were 242 outstanding incidents to be investigated, dating back to 2015. Between February 2015 to January 2016 critical care reported 331 incidents; this meant that 73% of these incidents were not investigated.
- There was not a dedicated dietician which could have a significant long term impact on patients.
- There was a high number of delayed discharges which could have a significant long term impact on the recovery of patients.
- High impact risks were not identified within the risk register and therefore there were no measures in place to mitigate risks.
- The critical care outreach team (CCOT) did not provide cover to the hospital 24 hours a day seven days a week. This meant patients could be at risk of harm at times when cover was not provided.
- There was a lack of demonstrable improvements since our last inspection.
- There was a lack of impetus from the senior management team to drive improvements and develop a plan for improvement.
- Incidents relating to medication errors were high. There were no investigations or analysis undertaken of these incidents which meant themes and lesson learnt could not be identified.
- Not all staff complied with the “bare below the elbows” policy when delivering direct patient care which was a potential infection risk. This was highlighted during our previous inspection.
- A side room on level seven was being used for a patient that was highly infectious. Bedpans were being taken from the side room to the main dirty utility area due to the lack of sluice in the room. This was seen to have presented a significant infection risk to other patients.
- The hospital had failed a number of its own Key Performance Indicators in regard to the rehabilitation needs of patients.
- The critical care service at RSCH had failed to meet key performance and quality targets.
- There was not a dedicated pharmacist or pharmacy technician for the units.
- There was a lack of information available to patients or relatives in any language other than English despite the hospital seeing patients of different nationalities.
- The Senior Management Team (SMT) told us that they emailed a newsletter to staff with key themes covering a range of topics and would check with staff on their rounds to get assurance that their messages had been disseminated effectively. This was hard to quantify during the inspection, as there was no way of checking all staff had read the communications that had been sent.
- The SMT were looking at mitigating the risk posed when the neurology practice educator left by developing the other practice educators. However, there was no certainty among the SMT as to what

# Critical care

would happen and there were no firm plans in place to ensure continuity in this area. This meant the planned neurology education programme would be compromised.

- There was a lack of a proactive approach to the timely management of complaints.
- There was a divide between the two different staff groups; the neurology nurses and the general intensive care nurses. This meant there was not a cohesive approach to nursing on the units and could affect staff morale.
- There was not always appropriately skilled and qualified nurses to care for neurology patients.
- Patient's records were not always kept securely.
- There were frequent occasions when male and female patients were cared for in the same bay whilst awaiting bed placement in the hospital.

However:

- There had been an appointment of a Clinical Risk Nurse to review and investigate the large backlog of incident reports.
- Closed-circuit television (CCTV) had been placed in the room that contained the drug cupboards and fridges on level seven. There were also plans to install this on level five. This mitigates the risk that was identified during the previous inspection of drug fridges remaining unlocked.
- A simulation room was used in the recruitment process for band five nurses to enable potential recruits to demonstrate their clinical skills.
- There was a system that allowed staff to gain and maintain the necessary skills to care for neurology patients. However, it was unclear how this would be maintained when the neurology practice development nurse left.
- Nursing staff treated the patients with dignity and respect. Patients and relatives expressed satisfaction with the care received.

- Each patient on ICU had a 'patient diary'. This was a diary written to record what had happened to the patient and how they had been cared for. The patient could then take this with them when leaving the unit.
- The culture on the ICU had improved with staff feeling they can escalate concerns more readily.

# Critical care

## Are critical care services safe?

Inadequate



When we inspected Royal Sussex County Hospital in April 2016, we rated the safe domain in critical care as inadequate. This was because:

- The skill mix of nurses on the mixed ICU unit was often insufficient to provide specialised care to neurosurgery patients.
- Medication management was poor and there were high numbers of medication errors
- Incident reporting and learning from incidents was poor.

At this inspection, we maintained the rating of inadequate. This was because:

- The critical care outreach team (CCOT) did not provide cover to the hospital 24 hours a day seven days a week. This meant patients could be at risk of harm at times when cover was not provided.
- The critical care department had a large incident report backlog dating back to 2015 that still required investigation. At the time of the inspection, there were 242 outstanding incidents to be investigated, dating back to 2015. Between February 2015 to January 2016 critical care reported 331 incidents this meant that 73% of these incidents were not investigated.
- There was not always appropriately skilled and qualified nurses to care for neurology patients.
- Not all staff complied with the “bare below the elbows” policy when delivering direct patient care which, was a potential infection risk. Staff non-compliance with “bare below the elbows” was highlighted at our previous inspection. This meant the trust had failed to take action to address this and reduce the risk of infection.
- A side room on level seven was being used for a patient who was highly infectious. Bedpans were being taken from the side room to the main dirty utility area due to the lack of sluice in the room. This was seen to have presented a significant infection risk to patients.

- We saw a stack of chairs in the corridor next to the resuscitation trolley outside Bay B. Although there was limited storage space on the unit, this presented a risk if the equipment was needed quickly.
- There was no way to control the temperature on the unit on level five as this was controlled from somewhere else in the hospital. There were also no thermometers to measure the temperature should there be a need to alter it.
- Although pharmacy staffing had improved, it was still not in line with the Guidelines for the Provision of Intensive Care Services (GPICS). The trust had failed to address this despite the escalation of risk from senior clinicians and was highlighted in our previous report.
- There was a high number of medication errors which had not been analysed to identify lessons learnt and any themes.
- A hospital audit identified discrepancies with liquid controlled drugs.
- Patient's records were not always kept securely.

However:

- A Clinical Risk Nurse had been appointed to review and investigate the large backlog of incident reports.
- We inspected the emergency trolley on level seven and noted that everything was in order.
- All areas we viewed, including clean utility rooms, toilets and showers were visibly clean. All equipment had green ‘I am clean’ labels on them that showed that it had been cleaned that day.
- CCTV had been placed in the room that contained the drug cupboards and fridges on level seven. Plans were also in place to install this on level five. This mitigated the risk that was identified during the previous inspection of drug fridges remaining unlocked.
- Medicines waste was handled appropriately in line with current legislation and best practice,
- We saw good use of National Early Warning Scores (NEWS) and there was good awareness of this system across the critical care department.

## Incidents



# Critical care

- There had been no never events recorded in critical care in the period leading up to the inspection. Never events are serious incidents that are wholly preventable, where 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.
- The trust had an electronic incident reporting system where staff would input information when an incident had occurred. Incidents that had been investigated were discussed at management meetings and where learning was needed this was communicated through the management chain to the relevant staff. Staff we spoke with on inspection told us that there had been improvements in this area.
- At the time of the inspection, there were 242 outstanding incidents to be investigated, dating back to 2015. From February 2015 to January 2016 critical care reported 331 incidents; this meant that 73% of these incidents were not investigated. A significant period of time had elapsed since the incidents were reported and opportunities for learning had been missed. Between May 2016 and February 2017 the critical care department had reported 310 incidents. These were reported across level five and level seven. Fifty-nine of these incidents were reported as low harm, three were reported as moderate harm, 229 were reported as no harm: impact not prevented and 19 were reported as no harm: impact prevented. The highest number of incidents, 113 related to incidents with medication, in particular, medication errors. Although the information was available, no formal analysis of the incidents had been undertaken although themes were discussed at staff meetings. This represented a missed opportunity to fully mitigate any risks that were prevalent.
- The trust had appointed a clinical risk nurse to review, investigate and deal appropriately with the outstanding reports. The post was created for an initial two year period. The clinical risk nurse had been given incident reporting training and duty of candour training in order to carry out their role effectively. We were told that the priorities for the clinical risk nurse were to deal with the new and straightforward incident reports to reduce the numbers outstanding and then tackle the backlog. It was anticipated that it would take approximately six months to clear the backlog. The clinical risk nurse told us that they felt well supported by all clinical staff. At the time of the inspection, there was no confirmation of how performance or the benefits of the role would be measured.
- It was not known if the role of the clinical risk nurse was something that was replicated in any other department or if it was exclusive to critical care. This meant that learning from investigation, analysis and thematic reviews could not be taken.
- There was good staff awareness of reporting; staff we spoke with knew how to use the incident reporting system.
- The CQC inspection team were provided with minutes of the mortality and morbidity meetings for a two-month period December 2016 and January 2017. On review, the minutes were thorough and included detailed case summaries, comments about human factors, system failures and patient related issues. There was information about the patients' diagnosis, mode of death if applicable and summaries of learning points and actions arising from these.
- 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. Minutes of meetings concerning reporting showed that there was an understanding of when the duty of candour process should be used. Senior staff we spoke with gave clear explanations of the incidents that would need to be dealt with under the duty of candour process. Staffs in various other roles were aware of the duty of candour, their professional responsibilities and the escalation process.

## Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data collection took place one day each month and data submitted within 10 days of the collection date.

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- Information recorded using the safety thermometer was prominently displayed across the critical care unit and was clearly visible for staff and visitors to the units.
- Data from the Patient Safety Thermometer showed that the critical care department trust reported two new pressure ulcers, two falls with harm and three new catheter urinary tract infections between February 2016 and February 2017.

## Mandatory training

- Mandatory training included fire safety, infection control, mental capacity training, safeguarding adults at risk level one, safeguarding children level one to three, equality and diversity, blood transfusion, health and safety, information governance, and basic life support. Staff told us how they had annual mandatory training days. They are alerted to the need to complete mandatory training by their line manager and there were posters in the staff room.
  - We were told that the system for recording mandatory training recording system would flag if a member of staff was due to undertake mandatory training. However, we were told that due to a glitch in the system, staff who had undertaken mandatory training would sometimes show that they had some courses outstanding. As a result of this, the critical care team had implemented their own system to record when staff had attended their mandatory training. This was shown to the inspection team.
  - At the time of the inspection, compliance with mandatory training across critical care had improved but remained low. Senior staff were keen to improve this, to do this they had started a system where a number of the mandatory training courses were all completed in one day. There were 14 of these days scheduled every year at the RSCH to ensure all staff had the opportunity to complete their mandatory training.
  - Some medical, nursing and non-clinical staff had mandatory training modules that were over a year out of date. This meant that staff might have the up-to-date skills to do their jobs safely.
- the both level five and level seven. The flowcharts showed the contact details of the trust's safeguarding team. There were also references to online resources where staff could get more information.
- Staff we spoke with had a good understanding of how to report safeguarding incidents. The staff we spoke with had, as part of their mandatory training, completed level one safeguarding for adults and level two safeguarding for children.
  - Nursing staff in critical care were required to complete level two in child safeguarding. Compliance with this training was 88% this was better than the trust target of 75%. Although the target for mandatory training was 75% and this was met, the target itself was low.
  - Nursing staff in critical care were required to complete adult safeguarding training. Compliance with this training at 85% was above better than the trust target of 75%. Although the target for mandatory training was 75% and this was met, the target itself was low.
  - Medical staff in critical care were required to complete adult safeguarding training. Information received from the Trust showed that 16 of the 17 consultants in critical care had received safeguarding training. At the time of the inspection 81% of medical staff had completed this, better than the trust target of 75%. Although the target for mandatory training was 75% and this was met, the target itself was low.
  - Safeguarding training for both adults and children incorporated a section on female genital mutilation.

## Cleanliness, infection control and hygiene

- Hand hygiene audits carried out between June 2016 and February 2017 showed that the Level seven ITU had a compliance rate of between 53% (recorded on 15 August 2016) and 100%. The majority of audits showed that compliance was between 90% and 100%.
- Hand hygiene audits carried out between June 2016 and February 2017 showed that level five ITU had a compliance rate of between 83% (recorded on 30 December 2016) and 100%. The vast majority of audits showed that compliance was between 90% and 100%. Sinks for staff to wash hands were available across level five and level seven. The sinks had posters

## Safeguarding

- There were safeguarding and deprivation of liberty safeguards (DoLS) flowcharts displayed prominently on

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demonstrating how hands should be washed according to the World Health Organisation five moments for hand hygiene. However, on level five we saw that one of these had fallen behind the sink.

- Personal protective equipment was available to staff and was used appropriately in the patient interactions.
- However, not all staff complied with the “bare below the elbows” policy when delivering direct patient care which was a potential infection risk. During the inspection, we observed two medical staff attend a patient while not being bare below the elbows. One of these staff removed their jacket but still had long shirtsleeves on. They were then offered gloves, which they declined to take. This was contrary to hospital policy and national guidance based on NICE CG139. Non-compliance while providing direct care increased the risk of germs being passed from clothing to a patient.
- Staff non-compliance with “bare below the elbows” was highlighted at our previous inspection. This meant the trust had failed to take action to address this and reduce the risk of infection.
- There was one side room on level seven that was used to isolate patients who may have been highly infectious to others. This side room did not have its own sluice. At the time of the inspection, a highly infectious patient was using this room. Due to the lack of a dirty utility area in the room, bedpans were being taken from the side room to the main dirty utility area. This was seen to have presented a significant infection prevention and control risk to patients.
- All areas we viewed, including clean utility rooms, toilets and showers were visibly clean. We reviewed the cleaner’s checklist for the whole month prior to the inspection. This had been signed to indicate that cleaning had been completed.
- All unused equipment had green ‘I am clean’ labels on them, which showed that it had been cleaned that day. It appeared clean and ready for use. This was an improvement since our last inspection when equipment was not identified as clean. However, there was a central store of continuous positive airway pressure (CPAP) machines and humidifiers. There were no dates recorded as to when they had been cleaned. However, staff told us that infection control had told them that it was not necessary to do so as the turnover was so rapid.

- We observed staff segregated clinical and domestic waste and there were arrangements for the separation and handling of high-risk used linen. Used linen was moved a short distance from the dirty utility to the service lift without having to go through the main part of the unit.
- The critical care department had not had an incident of meticillin resistant staphylococcus aureus (MRSA) since 23 October 2013. There had been no incidents of meticillin sensitive staphylococcus aureus (MSSA). There had been no incidents of E.coli in the year prior to the inspection. However, there had been one incident of clostridium difficile (C.Diff). This incident was fully investigated and it was considered that it was unavoidable.

## Environment and equipment

- The ward environments were visibly clean although they were cluttered with equipment stored along most walls. Individual bays were small with curtains to help preserve privacy.
- The Critical Care Department employed a technician and three assistants to maintain stocks for the equipment store and to repair equipment faults.
- The lead technician had also received training in routine maintenance and repair from the company that provided ventilators to the unit. Ventilators are electronic devices designed to enable unconscious patients to breathe.
- The technicians had also attended elements of the intensive care nurse training courses to help give them an understanding of what the machines did and the context in which they were used.
- The Medicines and Healthcare Products Regulatory Agency’s Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices in addition to subsequent maintenance tests. We checked several devices in each of the areas we visited. These devices were labelled with the dates of the most recent electrical testing which provided a visual check that they had been examined to ensure they were safe to use.

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- We inspected the emergency trolley on level seven and the trolley was locked. Records showed the trolley was checked daily. All drawers contained consumables and medicines in accordance with the checklist provided. We saw that consumables were in date and trolley was clean and dust free. The automatic electrical defibrillator and suction equipment were in working order. This meant all items were ready for immediate use should an emergency occur. However, we saw that there was a stack of chairs in the corridor next to the resuscitation trolley outside Bay B. Although there was limited storage space on the unit, this did make it look cluttered and could have presented a risk if the equipment was needed quickly.
- Storage facilities within the unit for supplies were well organised and tidy. Consumable items were placed in marked storage bins, mounted on purpose-built racks that moved on casters. This meant the cleaners had easy access to the floor and walls in the store for routine and deep cleaning.
- Bay A on level five had two beds. There was no natural light, ventilation and the temperature could not be controlled on the unit. There was no way of measuring the temperature across the unit. This issue had been placed on the local risk register.
- On level five, there was a piece of equipment situated behind the nurses' station that would monitor the noise levels on the unit. If the background noise went over a certain level, a light would change colour. This meant that staff would be aware that the noise levels needed to be reduced.
- The entrances to the ITU on both level five and seven had been fitted with a video camera. Entry was gained by pressing a buzzer and identifying yourself through the camera. Throughout the inspection staff were vigilant when giving people access to the units and were aware of their surroundings when entering and exiting the units. A non-clinical member of staff also challenged two members of the inspection team when they were attempting to get on to the unit.
- Prior to the inspection, we were told that there had been no new assessment of compliance with Health Building Note (HBN) 04-02, (this gives best practice on the design and layout of critical care units that admit patients whose dependency levels are classified as level

2 or 3) had been completed during the last 12 months. We were told that a six-facet survey was in progress, and that the results were not expected until after the inspection was completed.

- We saw meeting minutes from the nurses meeting which talked of how the hospital was managing environmental risks, and in particular fire. Senior staff had met with the fire risk assessment department who had conducted a thorough review of the current fire procedures for level five and level seven at RSCH. Plans were made to have regular "walk through scenarios" on level five, to practice moving patients from that area in the event of a fire, as this was considered a difficult part of the building to evacuate from. Monthly precautionary checks were made for any obvious fire risks/hazards so that they could be reported and any faults were repaired straight away.
- A notebook had been placed on both level five and level seven for noting any calls made to the estates team, housekeeping issues and IT issues. This was a place to keep reference numbers and dates/times of calls so issues could be followed up and then removed when work have been completed.

## Medicines

- The highest number of all incidents reported within the units (113) related to incidents with medication, in particular, medication errors. There was no evidence that the trust had analysed and used information gained through investigation of these errors which meant themes and lessons learnt were not identified. This meant patients were at an increased level of harm as the trust did not have assurances that the incidents would be prevented in the future.
- The rooms that were used to store drugs were accessed by a swipe card. The medicine store on level seven was covered by CCTV. However, the equivalent room on level five was not. Although we were told plans were in place to install CCTV on level 5, there was no confirmed date for this to be done. Following the inspection we were informed that CCTV had been installed on level five.
- The storerooms where medicines were stored contained medication fridges that remained unlocked at all times. These fridges contained a number of medicines, some

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of which could have been abused. Checks with various staff demonstrated that anyone with access to the main door in ITU would have access to the medicines including staff that would not have had any need to.

- Following the inspection, we were told by the trust that the new swipe card to the clinic room was installed around ten days before the inspection. The access control was originally set to allow everyone who had access to open the ICU main doors also to open the clinic room. The error was noted and the was amended so that only nurses working on the unit, intensivists and health care assistants who work on the unit had access.
- We saw that drugs requiring storage in a temperature-controlled environment were held in purpose-made drug fridges. These incorporated digital thermometers with an easily readable display that allowed performance to be monitored. The fridge temperatures were monitored by the department's technician. Although there were some gaps in recording of fridge temperatures, the vast majority were done and were within a safe range.
- Keys to the controlled drugs cabinet were held by the nurse in charge. Controlled drugs were stored securely and a medicine security audit had been carried out the week before the CQC inspection. For the level five HDU, this showed that not all stock levels checked were correct. For example, methadone mixture was missing 1ml. This showed that controlled drugs were not consistently being managed in line with hospital policy.
- The audit conducted on the level seven ITU showed that high and low dose diamorphine (a powerful painkiller) was stored on the same shelf. Protocol stated they should be stored apart. There were also instances where corrections had included crossings out. Staff were reminded of the correct method to make corrections. Not all staff were aware of the process for borrowing medicines outside of pharmacy opening hours.
- The audits for both level five and level seven showed that intravenous fluids were stored in a lockable clinical area / cupboard. The flammable gases and liquids were stored securely. Small oxygen cylinders were stored in designated racks and no empty oxygen cylinders were stored on the unit.

- During the inspection, we observed controlled drugs being used. Two nurses accessed the controlled drugs, counted the drugs out, double-checked and entered the details in to the controlled drugs register. This was in accordance with the trust policy regarding administration of controlled drugs.
- Although pharmacy staffing had improved, and there was a pharmacy lead, it was still not in line with the Guidelines for the Provision of Intensive Care Services (GPICS). Section 2.2.6, standard 1.4.1 of GPICS states that there must be a critical care pharmacist for every critical care unit. The critical department did not have a pharmacist exclusively working in critical care. This meant that access to the pharmacist was inconsistent. The trust had failed to address this despite the escalation of risk from senior clinicians and was highlighted in our previous report.
- There was no pharmacy technician support in ITU, which added to pharmacists' workload.
- On level seven the main medicines storage area was secured with a key card access. Medicines we checked were within their expiry dates.
- Medicines waste was handled appropriately in line with national guidelines.

## Records

- Records were primarily kept electronically although some information was kept in paper form. Paper records were kept securely in lockable cupboards. During the inspection, we did find that one cupboard was unlocked. This meant patient records were not stored securely in line with legislation.
- Each bed space had its own computer which allowed the nursing staff to access the electronic record in close proximity to the patient. The computers were password protected and open records could not be viewed by people passing through the ward because of the way they were positioned. The computers used to access the records were on trolleys. This made it easy for them to be moved in order to maintain patient confidentiality.
- We found that the paper records did not always have patient identifiers on each sheet and some sheets in the



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notes were loose. This meant that there was a risk they could fall from the record and be lost or, if they were found without patient identifiers, be hard to track who they belonged to.

- During the inspection, we were shown the electronic system, which contained details of the patient, including, but not limited to diagnosis and treatment pathway. This system also contained details of hospital policies.
- A review of two sets of notes showed that there were daily neurology intensive care notes, but no specific neurosurgical entry in place. We found that care bundles were not always filled in. An assessment for ventilator-associated pneumonia carried out on the previous day was not on the paper chart or on the electronic record. This meant that any member of staff needing to see the full record would not have been able to.

## Assessing and responding to patient risk

- The critical care outreach team (CCOT) did not provide cover to the hospital 24 hours a day seven days a week. The role of a specialist critical care outreach team is to support clinical staff in managing acutely ill patients in hospital in a major drive to improve outcomes for all ill patients. RSCH is a major trauma centre which cares for patients with a variety of injuries and illness some of these can be severe. This meant that patients may not always receive the expertise of the CCOT out of hours which may affect their outcome.
- We saw staff using the National Early Warning Scores (NEWS) system and there was good awareness of this across the critical care department. The records we reviewed showed good and consistent use of NEWS scoring.
- We observed nursing staff providing mouth care to patients. This meant that the risk of ventilator associated infections was greatly reduced.
- The trust had a standard Key Performance Indicator (KPI) of completing 95% of venous thromboembolism risk assessments on patients. Between April 2016 and December 2016, the hospital failed to achieve this KPI. Compliance with the KPI ranged from 48% in August 2016 and 85% in July 2016. Subsequent to the

inspection the trust provided information to demonstrate that 93% of risk assessments had been completed. This was an improvement but still below the trust's 95% target

- Nursing and medical staff we spoke with were aware of what to do in the event of patient deterioration. In this regard, there had been no serious incidents reported relating to a failure to escalate a deteriorating patient in the year prior to the inspection.
- The trust used an electronic system to help track and monitor patients. This used the National Early Warning Score (NEWS) to identify deterioration in a ward patient's physiological condition. The outreach team could assess patients in the ward environment and support staff in the management of a highly dependent patient. Ward staff could also contact the outreach team about any patient that may be causing them concern. It would be expected that any referral would be made using the SBAR framework. SBAR is an acronym for Situation, Background, Assessment and Recommendation; a technique that can be used to facilitate prompt and appropriate communication.
- The trigger for calling medical staff was a NEWS score of five. At this early stage, minimal intervention had been shown to have maximum benefit to the patient by reducing their morbidity and mortality. Early intervention or NEWS also facilitates the timely identification of patients who may require transfer to an area of higher care e.g. Level 2 and 3.
- The outreach team did not have admitting rights to ICU/ HDU but may refer a patient to the Critical team (in collaboration with the parent team) for assessment for admission.
- All referrals had to go through the ICU registrar. The patient would then be assessed and discussed with the consultant in charge of ICU. Once accepted for admission the aim was to admit the patient within one hour.
- The outreach team could assist with the transfer of critically ill patients within the hospital, ensuring that the patient was appropriately monitored. Where possible this could be used as a learning opportunity for nursing and medical staff.



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- In exceptional circumstances, the outreach team could provide support for the transfer of level three patients to other hospitals. The decision would be made in discussion with the nurse consultant or ICU consultant or clinical service manager.

## Nursing staffing

- The most recent data available (January 2017) showed that overall nursing staffing on the level seven ICU at Royal Sussex County Hospital reported a nursing fill rate of 88.8%. Gaps in any shift rotas were filled with bank and agency staff. Between February 2016 and January 2017, Brighton and Sussex University Hospitals NHS Trust reported a bank and agency usage rate of 9% in critical care. Bank and agency staff usage in critical care at RSCH had been consistently low over the reporting period. The lowest usage rate was 2% in July 2016 however there was a spike in October 2016 where the usage rate reached the highest at 36%, as of January 2017 it was at 9%, which is higher than the trust average of 7%.
- Nurse staffing levels did not always meet agreed staffing levels to provide safe and effective care. Minutes from a nurses meeting in January 2017 showed that there had been occasions when there had been no neurology-trained nurse at all in Bay D. Bay D was used for ventilated neurology patients.
- Information provided subsequent to our inspection showed 45% of shifts had excess neurology ICU nurse expertise, and 48% shifts had appropriate neurology ICU nurse expertise for the acuity of the neurosurgical patients on the ICU.
- The hospital had undertaken an urgent review of the skill mix. As a result of this, they had reduced the neurology ICU capacity to match the number of neurology trained staff.
- The critical care team had tried to recruit specialised neurology nurses to the trust. However, they had received no responses to the advertisements.
- At the time of our inspection, there were five specialist neurological nurses on duty. This meant that they were able to meet their own target of having one neurology specialist nurse for bay A, B, C and D with one extra.
- The Standards for Nurse Staffing in Critical Care (2009), produced jointly by the British Association of Critical Care Nurses and the Royal College of Nursing shows that ventilated patients should have a minimum of one nurse to one patient. During the inspection, we saw that the one nurse to one patient ratio was not maintained, and on one occasion, this was for a period of half an hour.
- Information provided to the CQC following the inspection stated that, following consultation with colleagues from other trusts they established that all units they had spoken to told them that they nursed ventilated patients on a 1:1 basis, all units regularly buddy up nurses so that those nurses caring for ventilated patients can leave the bedside to get drugs, talk to relatives, go to the sluice or go on break. Most units thought that practice was appropriate for up to 30 minutes, and a minority thought it was acceptable for up to 60 minutes.
- As at January 2017, Brighton and Sussex University Hospitals NHS reported a turnover rate of 13.3% in Critical Care; this is similar to the trust average of 13.38%. This equated to 23.7 WTE critical care staff that had left the trust.
- The hospital used the safer nursing care tool (SNCT.) This was based on the critical care patient classification (comprehensive Critical Care, DH 2000). We were provided with a copy of the acuity capture template, which was a patient acuity and staffing snapshot taken at 2pm and referred to the past 24 hours. This was a comprehensive document that allowed staff to report the acuity of each patient by bed number. Also recorded were the number of staff and the roles they performed.
- Patient handovers happened twice a day, at 8:30 am and 8:30pm. This involved nursing staff, outreach and members of the consultant team. We observed one handover in the morning. Patients were discussed for both level five and level seven. Patient condition and patient flow were discussed in detail and plans agreed for the day.

## Medical staffing

- We were told that there were two medical rotas, rota A and rota B and that rota A would tend to be less experienced than rota B. At night, there would be one member of staff from rota B and two from rota A. The rota B staff member was shared between level five and level seven ITU although they would predominantly stay

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on level seven due to the number of beds. The two rotas worked between levels five and seven. There was consultant cover across level five and level seven 24 hours a day. During the inspection we saw that there was consultant cover in better than the 1:8 patient ratio as recommending by the Faculty of Intensive Care Medicine. Although it was rare, locums were occasionally used.

- We were told that ward rounds had no set format but the clinical lead would do a full round but others liked to split the ward round up to allow rota a staff to take the lead as this was a key component of their training.
- We observed a consultants' meeting, which was attended by all consultants, therapy and nursing staff, including those off site, via video conferencing. This meeting was held daily. All patients were discussed and agreement was reached among the group as to how patients should be managed. However, towards the end of the meeting we observed that there were at least four separate conversations going on at the same time. There did not seem to be anyone with overall control or responsibility as to how the meeting was run or managed. There was no definitive end to the meeting, which in effect dissolved, and individuals left to carry on with their other duties. Although it did appear that appropriate plans were made for the patients on the unit, it was unclear how beds were going to be allocated. This was a busy unit with two neurosurgical patients due to come in.
- As at January 2017, Brighton and Sussex University Hospitals NHS Trust reported a vacancy rate of 24.5% in Critical Care; this is above the trust average of 6.4% it also varies between staff groups, the vacancy rate for specialty registrar is at 48%
- Between February 2016 and January 2017, Brighton and Sussex University Hospitals NHS Trust reported a bank and locum usage rate of 1.6% in critical care; this is below the trust average of 6.7%

## Major incident awareness and training

- During the inspection, we were shown a hard copy of the Major Incident plan. This was stored at the nurses' station on each level inside a red file. The red file also contained information regarding what to do in the event of a fire and how to evacuate ventilated patients.

- All policies and procedure relating to dealing with major incidents were available online as well as in hard copy. Staff we spoke with were aware of the major incident procedures.

## Are critical care services effective?

**Requires improvement**



When we inspected the Royal Sussex County Hospital in April 2016, we rated the effective domain in critical care as requires improvement. This was because:

- The lack of neurosurgery trained ICU nurses in the mixed unit meant patient care was often delivered by staff that lacked the competency to care for them safely. Multi-disciplinary teams did not work together consistently because of low levels of staffing in some specialties.
- There was no permanent dietician allocated to the critical care units, which was not compliant with the British Dietetic Association's national guidance.

At this inspection, we have retained a rating of requires improvement because:

- The hospital had failed a number of its own key performance indicators in regard to the rehabilitation needs of patients.
- There was not always enough appropriately skilled and trained neurology nurses to care for patients.
- There was a divide between the two different staff groups; the neurology nurses and the general intensive care nurses. This meant there was not a cohesive approach to nursing on the units and could affect staff morale.
- The hospital still did not have a permanent dietitian working in critical care. This could have a significant long term impact on patients.
- The hospital had failed to meet the 95% target in two of three key Commissioning for Quality and Innovation areas (CQUIN).
- Staff told us that there was limited training provided around how to deal with patients with mental health difficulties.

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- A patient under the age of 18 was admitted to the ICU on level five during the inspection. Staff had little understanding of what paediatric input there would be.
- We identified that the system for updating the acute list was confused in that there were multiple people feeding into it. The acute list was updated by outreach but handover at night was completed by the site manager.

However:

- The risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% for Intensive Care Unit at Royal Sussex County Hospital was 0.91. This was within the expected range.
- A simulation room was used in the recruitment process for band five nurses to enable potential recruits to demonstrate their clinical skills.
- There had been progress with developing an rotational educational programme for nurses who were not neurology specialist to give them the opportunity to gain the necessary skills to care for neurology patients. A number of staff had completed this programme.
- Appraisal rates for critical care staff had improved significantly and they had greater meaning than before.
- New outreach staff were appropriately inducted, assessed and their performance reviewed.

## Evidence-based care and treatment

- The critical care department at RSCH base their rehabilitation after critical illness in adults on the National Institute for Health and Care Excellence (NICE) guideline CG83. However, this was not fully embedded due to certain elements of the pathway being funded by different teams. It was acknowledged that the department needed its own team to be able to fully work to the guideline.
- During the inspection, we became aware of a patient on the unit who was under 18 years old. They had been placed in side room but there was little understanding of what paediatric input would be.
- The hospital had a standard key performance indicator (KPI) that 100% of eligible patients would be discharged with a rehabilitation prescription, in accordance with the National Institute for Health and Care Excellence (NICE) Guidance CG 83, rehabilitation after critical illness

in adults. The critical care scorecard we received covering the period from April 2016 to December 2016 showed that the hospital had failed to meet this KPI in any of the months in this period. Performance ranged from a low of 25% in June 2016 and a high of 49% in November 2016.

- The latest data provided by the South East Coast Critical Care Network (SECCCN) covering April 2016 to January 2017, showed the hospital's performance in three key Commissioning for Quality and Innovation (CQUIN) measures. These were: completion of rehabilitation needs assessment, completion of a rehabilitation pre-discharge assessment and number of patients requiring a documented pathway. In each CQUIN, the target for completion was 95%. In the completion of a rehabilitation needs assessment, the CQUIN was not met in any of the months between April 2016 and January 2017. Performance against the 95% target varied from 59% in September 2016 and 81% in December 2016. For the rehabilitation pre-discharge assessment, CQUIN the hospital failed to achieve the target of 95% in any of the months. Performance against the target ranged from 28% in April 2016 to 49% in November 2016.
- For patients that required a documented pathway the hospital met the CQUIN in August and September 2016, but failed in other months with no patients meeting the criteria in July 2016. However, actual numbers were low ranging from eight in April 2016 and Zero in July 2016. As such, these should be considered as neutral findings.
- The trust informed us that they had carried out audits which demonstrated compliance with the following local and national audits.
  - National Audit, ICNARC
  - NICE guidance CG103, CG50, IPG386, PSG002
  - Acute Problem, and Just Say Sepsis
  - DOH HII CVC insertion, PVC, CDiff transmission, VAP rates, Enteral feeding (in line with other units), Antimicrobial stewardship, Healthcare records
  - Local Trust Identified Audits, Readmission, referrals, unplanned admissions, MET calls, Neuro ICU nurse numbers, Management of traumatic brain injury, out of hours discharge quality audit, Pain, VTE, DOLS, Organ Donation, Medication errors.
- However, we did not review these during the inspection.

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## Pain relief

- We reviewed three sets of patient notes, which demonstrated that the patient's pain had been assessed and managed. Pain scores were recorded and pain relief given when necessary.
- Nurses attended the acute pain study day as part of local induction and receive training in patient controlled analgesia pumps (PCA) pumps and epidural pumps.

## Nutrition and hydration

- Patients unable to take oral intake had nutrition support (enteral or parenteral) commenced on admission to the unit, to ensure adequate nutrition in accordance with the guideline for the provision of intensive care services (GPICS). However, the critical care department at RSCH did not employ their own dietitian. This was against the guidelines for the provision of intensive care services (GPICS) standard 1.5.1 which states that 'There must be a dietitian as part of the critical care multidisciplinary team'. A dietitian was able to attend to patients three times a week which meant these patients might not always receive the care required.
- Patients that were ready and waiting to be discharged from the ICU were provided with food and drink when appropriate.

## Patient outcomes

- The trust has two units, which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report.
- There were 1854 admissions at RSCH General and Neurological ICUs between April 2016 and March 2017.
- For Intensive Care Unit at Royal Sussex County Hospital, the risk adjusted hospital mortality ratio was 0.91. This was within the expected range.
- Risk adjusted mortality for those with an expected risk of death is greater than two standard deviations better than expected (statistically significant).
- The hospital had a standard key performance indicator (KPI) of 1.2% of patients being re-admitted to ICU within 48 hours. Between April and December 2016 the ICU,

performance was worse than KPI on two occasions. This first was in June 2016 where 1.4% of patients were re-admitted within 48 hours. The second was in November 2016 where 4.1% of patients were re-admitted within 48 hours. Unplanned readmissions within 48 hours was at 1.3% full year effect. This was worse than the trust target of 1.2%.

- There were 75 emergency re-admissions between April 2016 and December 2016. Emergency re-admissions ranged from five in April 2016 to 14 in December 2016.
- Of the total of 798 admissions to the ICU at RSCH, 713 (89.3%) left the unit alive. Of the 713 patients that left critical care, 666 (93.4%) ultimately left the acute hospital alive.
- We saw that there were details of an audit of out of hours mortality following discharge from ITU displayed on the wall on level five. There was also a risk adjusted mortality quarterly quality report.
- There was an audit against unit guidelines of ITU management of traumatic head injuries displayed in the corridor on level five. We also saw that details of a new advice and support service for patients with brain injury and their families.

## Competent staff

- ITU on level seven had a simulation suite where staff training was undertaken. The simulation room had a control room that was fitted with one-way mirrors and two-way speakers, allowing observers to monitor the performance of staff using the simulator and offer guidance where necessary.
- The room was also used in the recruitment process for band five nurses to enable potential recruits to demonstrate their clinical skills. The practice educator would take an active role in any simulation exercises that formed part of the recruitment process.
- During the inspection, we observed teaching of a nurse and a doctor taking place. This was part of the planned teaching sessions that took place every Wednesday and was provided by a band six specialist neurology nurse.
- Nursing staff that were not neurology specialists were placed on a rotation, which lasted six months, split in to two periods of three months. Once the rotation has been completed, staff could care for level two and level

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three High Dependency Unit (HDU) and Intensive Therapy Unit (ITU) patients. In order to maintain their neurology skills, nurses were scheduled four or five neurology specialist shifts per month. However, the neurology practice development nurse was leaving the trust and there was not a plan as to how the programme would continue to be supported.

- Newer staff to the department reported that the induction to the unit was good and they felt well supported by managers. However, there was no specific teaching on strategies or equipment.
- Nursing staff we spoke with gave mixed feedback about whether they worked outside of their areas of expertise, for example, a neurology specialist had stated they were asked to look after general surgical patients although this was occasional rather than something that happened regularly. They were scheduled to go on a trauma rotation later in the year. Another nurse told us that they were not asked to do things outside of their competency.
- We received mixed message from non-clinical staff about access to training. Some reported that they had access to training when required and other told us that you cannot ask for training but got put on training when necessary.
- At the time of the inspection, the appraisal rate for all staff in critical care at the Royal Sussex County Hospital was 95%. This had greatly improved since the last inspection. This was better than the trust target of 80%.
- Staff we spoke with about their appraisals told us that the process had improved and that they were useful. We were told by one member of staff that they had been able to access a range of further training which had helped with their day to day role. This came about as a direct result of what was discussed and recorded during the appraisal process.
- For all new outreach personnel, an individual review of developmental needs in line with the job description and critical care outreach competencies took place within two weeks of appointment, with the Nurse Consultant. Ongoing review was conducted annually, in the form of an appraisal. In-between the annual appraisal regular reviews took place 3-6 monthly or by arrangement with the individual outreach nurse and the critical care nurse consultant. The critical care outreach team could also access clinical supervision to support their professional development.
- The critical care outreach team (CCOT) lead and participated in teaching on the ACUTE course, tracheostomy and transfer of the critically ill patient.
- CCOT also participated in teaching on programmes at a local university related to care of the highly dependent patient (e.g. Acute care module and Intensive care course).
- CCOT utilised informal teaching opportunities with ward staff at the patient bedside as appropriate.
- CCOT contributed to the critical care education programme (as requested by the practice educators).
- CCOT acted as assessors on the intensive care course for relevant skills such as transfer of the critically ill patient.
- As part of the generic induction, the senior ICU technician gives a demonstration and training session on basic ICU equipment.
- For targeted induction, the hospital had trainees from core medical training, respiratory medicine, emergency medicine, surgery and anaesthetics. For those trainees from non-anaesthetic backgrounds there was a targeted induction session for basic ICU equipment such as arterial lines, central lines, and non-invasive respiratory therapy.
- Clinical based training includes ventilator, hemofiltration, cardiac output monitoring, thermoguard cooling device, indwelling central lines, bronchoscopes, and advanced airway equipment. Training and competency was assessed as needed according to backgrounds and experience of trainees. Training was delivered by consultants, senior nurses and practice educators.
- Local induction was a four week supernumerary period and involved training on: arterial blood gas machine by point of care team, ventilators solar monitors by intensive care technician. BiPAP machines, arterial lines and transducers, central lines and transducers, and intubation equipment.
- There were 70% of nursing staff at RSCH that had a critical care post registration award.



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- All Band 5 nurses who are on the intensive care course and senior nurses who have completed the intensive care course have further training and assessment on ventilators, non invasive ventilation equipment, PICCO (PiCCO is a cardiac output monitor that combines pulse contour analysis and trans pulmonary thermodilution technique) and haemofilters.
- Nursing staff, as part of the appraisal process had completed reflective pieces that could also be used for revalidation. Support for those nurses going through revalidation was provided by senior nursing staff in critical care.

## Multidisciplinary working

- The critical care department had outreach nurses who worked cross-site and were accountable to the Critical Care Nurse Consultant. Outreach was provided between 7:30am and 8pm, seven days a week at Royal Sussex County Hospital and there would be a minimum of one outreach nurse per shift. The outreach nurse would attend the board round and patients would be identified at the site managers meeting. The aim of the service was to support ward nursing and medical staff with the care of acutely ill patients in BSUH Patients would be identified using the National Early Warning Score (NEWS) or by direct referral to outreach by any member of the multi-professional team.
- The critical care outreach team (CCOT) aimed to support ward staff caring for patients who had recently been discharged from ICU/HDU. CCOT also assisted the patient and their families with the often difficult transitional process from an area of higher care to the ward. However, the CCOT service did not provide 24 hour a day seven days a week cover.
- CCOT aimed to review all patients discharged from ICU at least once.
- We identified that the system for updating the acute list was confused in that there were multiple people feeding into it. The acute list was updated by outreach but handover at night was completed by the site manager. This meant that there was a risk of important messages not being communicated.
- There was a multi-disciplinary rehabilitation meeting weekly on a Tuesday. However, we were told by the senior management team that physiotherapy and speech and language therapy involvement remained sub-optimal due to a lack of staff.
- The hospital had a standard KPI that 100% of patients would receive a rehabilitation assessment within 24 hours. Between April 2016 and December 2016, the hospital failed to meet that KPI in every month. Performance in the time period varied from 58% in September 2016 and 81% in December 2016.
- Pharmacy staff attended the MDT meetings to optimise input into medicines use on the ICU.
- During the inspection, we were provided with a standard operating procedure that covered General ICU and Cardiac Surgery Joint Care. This explained how any cardiac surgical patient in general ICU would be under the joint care of cardiac surgery and general ICU. This was because the team recognised that the patient benefitted from the different expertise of both clinical teams. Where possible, significant decision involving changes to care would be made on a joint consultative basis.

## Seven-day services

- Due to the nature of patients, being cared for the ICU at RSCH was staffed fully, 24 hours a day seven days a week. There was a consultant available across the level five ITU and level seven HDU 24 hours a day, seven days a week.
- Access to imaging was available 24 hours a day, seven days a week
- There was no occupational therapist cover out of hours. Physiotherapists were available on-call 24 hours a day, seven days a week. Pharmacy cover was not provided out of hours although there was an on-call pharmacist available out of hours.

## Access to information

- Each patient bed space had a computer available which could be used by nursing and medical staff to access information about the patient. This included care plans,



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risk assessments, case notes and test results. The system this information was stored on also gave clinical staff access to a range of policies and protocols relevant to the critical care team.

- Other information regarding the work of the critical care department such as policies and procedures and the means to report an incident was also available to all staff.
- At the entrance to each ITU on levels five and seven there were pictures of the senior staff on the unit as well as pictures of all the consultants

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

- A Deprivation of Liberty Safeguards (DoLS) flow chart and guidance was displayed prominently on both the level five and level seven ICU.
- Training rates for Mental Capacity Act (MCA) and DoLS were not site specific but were instead provided for the critical care team across the Brighton and Sussex University Hospitals Trust.
- Nursing staff across critical care were provided with training in the MCA and DoLS. The most recent data available showed that of a total of 414 staff, 344 had completed the training. This represented 83% of nursing staff.
- Medical staff across critical care were provided with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The most recent data available showed that of a total of 37 staff, 26 had completed the training. This represented 70% of medical staff.
- Records reviewed showed that patients were consented correctly and consent was well documented.

## Are critical care services caring?

Good



When we inspected the Royal Sussex County Hospital in April 2016 we rated the caring domain in critical care as good. This was because:

- Staff consistently treated patients and their relatives with dignity, kindness and compassion.

- Families told us that 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.

At this inspection, we have retained a rating of good. This is because:

- Nursing staff treated the patients with dignity and respect.
- Patients and relatives reported to us that they had received good care.
- The commitment to the welfare of the patients was evident from both clinical and non-clinical staff.

## Compassionate care

- We witnessed a number of interactions between nursing staff and patients that demonstrated a real understanding of the need to protect a patient's privacy and dignity.
- All patients and relatives that we spoke with told us how the care they received was excellent. One patient told us it was the best care they had ever had and the staff were all excellent.
- A number of different nurses and consultants were identified by name as providing excellent care. A relative went on to say that the care provided could not be faulted. One member of staff who did not have a clinical role told us about their commitment to the patients and how they take pride in the work they do. In one case, the staff had developed a relationship with the family of a patient who sadly, later died. The family as a show of gratitude for the care they had received, invited the member of staff to the patient's funeral.

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

- We were told how family members had been allowed to stay with their relative following a serious injury to the patient. The fact that they were allowed to stay on site 24 hours a day had meant that they had 'had a voice' when decisions were being made about the patient's care.

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- We heard how a consultant had fully explained the situation with their relative and always took time to discuss any concerns. We heard that all doctors interacted well and visited daily.
- Patients were encouraged, where possible to assist in the care of their loved ones. This included washing, mouth care and other interactions that would make the patient comfortable and provide the contact the loved one needed. Guidance on how to carry out these tasks were given by the nursing staff.

## Emotional support

- We found staff made arrangements for families to support patients emotionally. For example, we saw that staff had facilitated a member of family to stay round the clock. Staff had also allowed family to personalise the area around the patient's bed with family photographs.
- A chaplaincy service was available to those patients and their loved ones who wanted to use it. Ward staff were able to contact the chaplain to ask them to attend. Information was provided to patients and loved ones about the chaplaincy service in the form of a leaflet. They were then asked to contact any member of staff who would be able to get in touch with the chaplaincy service.
- There was also a relaxation and meditation service provided once a week by the hospital. These were open to patients, families and friends, day visitors to the hospital and staff too.
- Patients with mental health conditions were able to speak with a mental health nurse when they were medically fit to do so.
- Staff were able to provide emotional support to patients that were orientated to time and place. We also saw that they provided the same level support to friends or families of the patients on the unit.
- Patients had access to post discharge counselling services to help them recover and understand what had happened during their stay in hospital.
- Patients could access a local branch of a national charitable support network (ICU Steps) for people leaving the ICU. This group was set up by and was run by a BSUH Consultant Intensivist and ICU Nurse

Consultant.. The service gave patients the chance to talk to people who had been through a similar experience. A comprehensive list of organisations that could provide post care support for patients and relatives was available. This included, but was not limited to conditions such as brain injury, cancer and spinal injuries. There was also a bereavement counselling service.

## Are critical care services responsive?

Requires improvement



When we inspected the Royal Sussex County Hospital in April 2016 we rated the responsive domain in critical care as requires improvement. This was because;

- 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.
- 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.

At this inspection we maintained a rating of requires improvement because:

- There was a lack of readily available information available to patients or relatives in any language other than English. This was despite the fact that the hospital saw patients of different nationalities. Information in different languages was available on request but this did not fully address the difficulties visitors to the unit would have encountered.
- The number of patients with a delayed discharge of more than eight hours was much worse than the national average.
- Between April 2016 and December 2016, there were 70 incidents of cancelled elective surgery due to a lack of a bed in critical care. This ranged from a high of 20% in June 2016 and a low of 0% in November 2016.

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- The percentage of patients discharged within four hours of a consultants' decision to discharge had a standard key performance indicator (KPI) of 57%. The hospital had failed to meet this KPI in any of the nine months between April and December 2016.
- There was not a proactive and timely response to the management of complaints despite the low numbers of complaints received.
- There were frequent occasions when male and female patients were cared for in the same bay whilst awaiting bed placement in the hospital.

However:

- Each patient on the ICU on both level seven and level five had a 'patient diary'. This was a diary written to record what had happened to the patient and how they had been cared for. The patient could then take this with them when leaving the unit.
- Staff had been able to accommodate some family members of patients so they could visit outside of the normal visiting hours.

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

- Facilities for family members to stay on the ICU were limited. This was primarily due to the lack of space available. This situation was likely to persist until the new unit was opened following the re-building of a section of the hospital.
- We were told by relatives of patients that the hospital had been very accommodating and responsive in allowing them open visiting hours. This reduced the stress of having to meet the regular visiting times
- We were told by family members visiting the unit that staff would always offer, and got them a drink when the offer was accepted
- Due to the long term nature of some of the patients cared for on the units, the hospital had a system where relatives could purchase a seven day unlimited parking pass at a reduced rate for use on the hospital site.

- There was information on the wall of the relatives room about the building works going on, various information leaflets including a 'visitors code'. The room was comfortable and relatives, in certain circumstances were allowed to stay overnight in the room.

## Meeting people's individual needs

- During the inspection, we were told that that a patient under 18 years old was being cared for on the unit. The patient had been transferred to the unit from the neighbouring children's hospital. Although they had not had any time to make any provision for the patient, they had been able to move patients' to ensure that they were cared for in the only side room available but had not had any paediatric input and there was little understanding of what the paediatric input would be. This meant that the patient may not have received care appropriate for their age.
- Across both ITU on level five and level seven, we found that there was limited information for relatives, particularly in languages other than English or alternative formats. This was despite the hospital caring for a wide range of nationalities. Although there was a greater range of information leaflets available to visitors on level seven than level five. When we asked staff about this, we were told that these were available on request. While the availability on request was in some ways helpful it relied on relatives or loved ones having to decide what they might want to know and then communicating the need for information in a language they may not have spoken.
- Interpreting services were available by phone or if booked in advance. There were no signs that informed relatives or patients of the availability of this service or how to access it.
- Staff told us they received limited mental health training. However, the trust's Mental Capacity and Mental Health Lead Educator is a registered mental health nurse and the trust had a psychiatric lead nurse. Both of these staff could be contacted and would attend should they be caring for a patient with a mental health condition. This was not a formal arrangement and staff told us that it would be better if it could be formalised.

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- The critical care department did not stock equipment for bariatric patients on either level five or level seven due to the lack of storage space. However, bariatric equipment was available if required.
- Each patient on the ICU on both level seven and level five had a 'patient diary'. This was a diary written to record what had happened to the patient and how they had been cared for. The patient could then take this with them when leaving the unit. This meant that the patient would be able to know what had happened and provide a timeline to their recovery.
- There was a poster at the entrance to each unit, which showed the different colours of the uniforms worn by staff across the units. However, due to some difficulties in the printing, particularly for the blue uniformed staff, it was hard to distinguish from the posters, which roles staff performed.
- We saw there was information available in one of the relatives' rooms. This included but was not limited to organ and tissue donation, the chaplaincy service, duty of candour and details of the independent mental capacity advocate.
- Effort had been made to make relatives' rooms more pleasant. The ITU had original artwork on the walls that had been loaned to the unit. These were placed to brighten up what were quite stark rooms.
- Patients who had cultural and religious dietary requirements were able to get food that met those requirements. Patients were able to make a request which was passed to the kitchen staff.
- Between February 2016 and January 2017, the trust has seen adult bed occupancy fluctuate, occupancy rates for Level 5 and 7 ICU averaged 90% across the year 2016-17.
- The ITU on both level five and level seven cared for male and female patients together. Where possible male and female patients were cohorted together, however this was not always possible. During the inspection we observed patients who were conscious and awaiting a move to a ward or home who were closely located to patients of the opposite sex. This meant the dignity and respect of patients could be compromised.
- The critical care department did not report mixed sex breaches, predominantly because the critical care environment was significantly different to other areas of the hospital. These instances were reported as delayed discharges or transfers of care. At the time of the inspection the staff were seeking clarity with the site management team as to what circumstances would be classified as a mixed sex breach. Although there were mixed sex patients in some bays we saw that nursing staff were conscious of this and did everything they could to maintain their dignity.
- We spoke with relatives of a patient who told us that that the diagnostic pathway was unsatisfactory from their perspective. This meant that the process of establishing what was wrong was not good. They believed that communications between different parts of the hospital could have been improved.
- For the intensive care unit at Royal Sussex County Hospital, there were 5,069 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 17.07%. This compares to the national aggregate of 5.16%. This meant that the unit was in the worst 5% of units nationally.
- For the ICU at Royal Sussex County Hospital, there were 754 admissions, of which 92.8% had a non-clinical transfer out of the unit. Compared with other similar units this unit was within the expected range.
- For the intensive care unit at Royal Sussex County Hospital, 3.48% of admissions were non delayed,

## Access and flow

- Discharge delays were worse than the national averages and there were some cancelled elective admissions. A delayed discharge is when the patient has been declared clinically ready for discharge from critical care but a delay occurs transferring the patient to a bed within the hospital. Delayed discharges has an adverse effect on the recovery of patients, other admissions, utilisation and increased cost.
- The hospital had a standard KPI that 100% of patients would be reviewed by a consultant within 12 hours of admission. This was an absolute requirement which the hospital had met.

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out-of-hours discharges to the ward. These are discharges, which took place between 10:00pm and 6:59am. Compared with other similar units, this unit was within the expected range.

- The percentage of patients discharged within four hours of a consultants' decision to discharge had a standard KPI of 57%. The hospital had failed to meet this KPI in any of the nine months between April and December 2016. Compliance with the KPI ranged from 15% in September 2016 to 38% in June 2016. Delayed discharges were recognised as a continuing challenge and risk.
- Between April 2016 and December 2016, there were 70 incidents of cancelled elective surgery due to a lack of a bed in critical care. This ranged from a high of 20% in June 2016 and a low of 0% in November 2016.

## Learning from complaints and concerns

- Between February 2016 and February 2017, there were five complaints about critical care. The trust took an average of 117 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be responded to within 40 days. Two complaints related to discharge complaints and a further two were related to communication between staff and patient and/or family. The other complaint was not specifically categorised. This demonstrated a lack of a proactive timely response to complaints, despite the low numbers of complaints received.
- There was a leaflet available to visitors to the critical care department called the visitors code. This gave details to those visiting how to raise concerns with the patient advice and liaison service.

## Are critical care services well-led?

Inadequate



When we inspected the Royal Sussex County Hospital in April 2016, we rated the well led domain in critical care as inadequate. This was because;

- 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.
- 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 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.

At this inspection, we have maintained the rating of inadequate because:

- The senior management team for critical care told us that the vision and strategy for the service had yet to be finalised as it would be led by the overall trust strategy.
- There was still a divide between the neurology nurses and the general intensive care nurses.
- There was a lack of impetus from the Senior Management Team (SMT) to drive improvements and have a improvement plan. Therefore there was a lack of demonstrative improvements since our last inspection.
- Although the ITU at Royal Sussex County Hospital (RSCH) and the Princess Royal Hospital (PRH) are part of one department, sharing senior management staff as well as nursing staff, the sites do not share a common patient IT system.
- The SMT told us that they emailed a newsletter to staff with key themes covering a range of topics and would check with staff on their rounds to get assurance that their messages had been disseminated effectively. This was hard to quantify during the inspection as there was no way of evidencing that all staff had read the communications that had been sent.

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- The SMT were looking at mitigating the risk posed when the neurology practice educator left by developing the other practice educators. However, there was no certainty among the SMT as to what would happen and there were no firm plans in place to ensure continuity in this area.
- The risk register did not reflect the highest risks and therefore there was no measures in place to mitigate the risks.
- We saw an example of inappropriate behaviour and poor communication from a senior clinician.

However:

- The critical care department had plans and funding in place to employ two academics to join the team.
- The culture on the ICU had improved with staff feeling they can escalate concerns more readily.

## Leadership of service

- The critical care department was part of the Emergency Floor directorate and was led by a triumvirate that was included the Directorate Lead Nurse, the Medical lead and the General Manager.
- The matron for critical care covered both the Royal Sussex County Hospital and Princess Royal Hospital. The matron had been appointed to the post having submitted and expression of interest in the role to cover a long-term absence.
- Below the matron there was a team of 11 band seven nurses who managed the nursing staff across the critical care department.
- We were told that the relationships between neurosurgeons and neurointensivists had improved and that the issues that came from the transfer of neurosciences from Hurstwood Park at the Princess Royal Hospital had improved as all were now more used to the situation.
- A number of non-clinical staff reported that they were confident in their immediate line managers and they felt supported. However, they were yet to see the change in senior management filter through. Due to the limited amount of time that had passed since these changes, this should be regarded as a neutral finding.

- We were provided with copies of the minutes from the trust wide consultant meetings that were held monthly. The minutes were brief but sufficient to record who had attended, who had been unable to attend and what had been discussed in the meeting. Any actions required following the meeting as well as the person responsible were clearly identified in the minutes.
- We received copies of the minutes from the nurses meetings which were also brief but clear as to what had been discussed, what actions needed to happen and who was responsible.
- There was a lack of short term, interim and long term planning from the SMT on how improvements and sustainability could be achieved, there was no overarching plan. Therefore, there was a lack of demonstrative improvements since our last inspection.

## Vision and strategy for this service

- The Senior Management Team (SMT) from the Emergency Floor Directorate told us that the vision and strategy for this service had not been finalised and would be led by the overall trust strategy. The trust strategy had never been embedded due to the changes in the trust executive team since 2014. We were also told that the SMT were targeting the move to a new 54 bed single floor unit in 2021 to provide the vision and strategy that would develop the service.
- There was a general acceptance among the SMT that an interim strategy was needed, however this had not been taken forward. There was a reliance that the recent changes in the executive team would provide the impetus that would help with the vision and strategy.
- Because recruitment and retention of appropriate staff was a challenge, the SMT were looking at different staffing structures to support the 54 bed floor. At the time of the inspection the SMT were looking at how they could use non ITU trained nurses and employing their own physiotherapist, however, no firm plans were in place as to how a new structure would look but given that the move was four years away, this should be viewed as a neutral finding.
- Although the ITU at Royal Sussex County Hospital (RSCH) and the Princess Royal Hospital (PRH) are part of one department, sharing senior management staff as well as nursing staff, the sites do not share a common



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patient IT system. The system is in use at RSCH is not available at the PRH. The SMT wanted to replicate the system at both sites but were constricted by a lack of funding. The difference in IT systems across the two hospital sites meant that staff from the Princess Royal Hospital who were required to work at the RSCH may, despite having had training in how to use the system, not be proficient which could impact on patient safety.

## Governance, risk management and quality measurement

- The critical care department had a monthly clinical governance meeting with a representative from all areas and roles across the department. The meeting was chaired by the clinical lead for critical care. It was attended by the matron, nurse consultant, practice educator, infection control lead, physiotherapist, technician, data manager and pharmacy. The meeting objectives were clearly set out and were the same for each meeting. The objectives were; to review clinical governance issues with care delivery team, monitor critical care performance data, identify trends and areas for concern, review and update the risk register as required, develop and manage improvement plans, escalate to other management or care teams as necessary, report relevant data and plans to the acute floor management team (and trust board).
- These meetings were minuted and any issues were disseminated to the wider team by those present in smaller meetings, for example, at handover from shift to shift. There were band seven nurse away days when there would be wider discussion in order for the band sevens to feedback to their teams. Topics covered in these meetings included, but were not limited to incident reporting, infection control, feedback from the morbidity and mortality meeting, education, staffing and clinical audit. We reviewed minutes of these meetings. The minutes were clear and when action was required, the person responsible was identified.
- The SMT told us that they emailed a newsletter to staff with key themes covering a range of topics and would check with staff on their rounds to get assurance that their messages had been disseminated effectively. It was hard to quantify during the inspection that these messages had got through, as there was no way of evidencing that all staff had read the communications that had been sent.
- The top risk on the risk register was the impending loss of the neurology practice educator. The SMT were looking at mitigating the risk by developing the other practice educators. This demonstrated a lack of insight from the SMT of the other risks that may impact of patient safety and care. For example, the high level of medication errors which have not been investigated.
- The use of taxis between the two trust sites was not recognised as a risk. The senior management team were unaware of the level reliance on staff taking taxis from one site to another to fill staffing gaps.
- We spoke with the SMT about how they managed change in the department, whether it was risk assessed and whether there was any impact assessments carried out. We were told that it depended on what the change was. We were told that if the change was non-controversial then there would not be a formal risk or impact assessment. However, if there were larger scale plans for change, a quality impact assessment would be carried out to determine how staff and patients would be affected. Most changes were described as 'day to day' business as usual changes and these would be discussed in routine meetings to discuss and debate whether they could be made.
- The trust had appointed a sepsis lead nurse in November 2016. Although they were the lead on sepsis across the trust they were based in critical care and managed by the critical care nurse consultant. Since the lead sepsis lead nurse had been in post they had started a project to increase awareness across the trust. They had provided drop-in sessions for staff and had held awareness days. As a result of this, there were 32 sepsis champions across the trust. Another aspect of the project involved a baseline audit of all patients NEWS (National Early Warning Score) scores. This involved the completion of a sepsis screening tool (the tool). The tool asked the staff member completing the form to answer specific questions, starting with the NEWS score. Depending on the NEWS score the member of staff completing the tool would be guided through a flow chart which told them what to consider and what action should be taken. The tool was developed with the assistance of the UK sepsis trust and was based on NICE guideline NG51 (Sepsis: recognition, diagnosis and early management). The tool would then remain on the patient record.

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- Because the role had not been there had only been limited audits carried out and data had, at the time of the inspection not been collated. There had however been random audit of 50 emergency department patients and 50 ward patients.

## Culture within the service

- We saw evidence in meeting minutes where, following an incident, the department invoked their duty of candour process. Duty of candour had become part of the remit of the recently appointed clinical risk nurse.
- When senior staff were challenged about a perceived reluctance to deal with poor performance, we were told that there was a desire to deal with the behaviour but there had been a lack of robust support from human resource (HR). This had two aspects to it. Firstly, the level of support provided when dealing with poor behaviour and secondly the support provided to managers when a counter allegation was made about them. Although we could not verify it as we could not speak to all managers, it was believed that all managers across the department would have the same concerns about the lack of robust support from HR.
- We saw an example of inappropriate behaviour during our inspection when a member of medical staff tackled a situation with a junior regarding the organising of scans during a ward round. We considered that the directness of the approach left the rest of the team that observed this, feeling uncomfortable. Although this was a one off event it was done in the presence of CQC inspection team members. The same member of medical staff then made a statement to a colleague and walked out of the meeting.
- We were told by senior staff that they had seen a change in culture amongst staff in the department, particularly in relation to the confidence they had in escalating concerns to senior managers. A number of non-clinical staff described how they believed that the department was now more stable and that there had been a change in the general atmosphere since the last time the CQC inspected the service.
- We were told that HR had started providing lunchtime training sessions for managers in how to deal with capability and sickness management. These sessions were classroom based and included face-to-face role-play and desktop exercises.

- Neurology trained nurses and general intensive care nurses did not work cohesively together and there was not a culture of teamwork across the different units.

## Public engagement

- The hospital had an ICU specific section of its website for loved ones to access. This have a comprehensive overview of what a stay in ICU may entail and what they may expect to see when visiting, what would happen after leaving the ICU and a chance to provide feedback. The content of the website was clear and explained in a way that was not clinical.

## Staff engagement

- Staff were not shared between the general and neurology ICU and the cardiac ITU. The SMT told us that they would welcome a rotation across the departments to widen the skill base.
- Staff across the department told us how the new executive team had been sending weekly communications with a particular emphasis on the 3Ts (3T is the hospitals role in teaching, trauma and tertiary care) messages.
- We were provided with copies of a monthly critical care newsletter that was sent to all staff in critical care. The newsletter summarised what had been happening, details of any starters or leavers in the unit. It also covered subjects such as infection prevention and control and medicine security. The newsletter was produced and sent by the critical care matron.

## Innovation, improvement and sustainability







- The critical care SMT told us how they were working on a plan to improve the flow through critical care. They had begun making plans for a rapid improvement pathway, which would enable those patients well enough to move to a ward or leave the hospital to do so more quickly. The plans had had multi team representation to bring together, make the change and implement. When the plans were completed, they would need to be ratified by the trust board.
- Following the difficulties in recruiting specialist neurology nurses and the funding for university courses

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being more difficult to obtain, the SMT were looking to develop their own neurology module to be accredited by a university. This had yet to be accredited so should be seen as a neutral finding.

- The critical care department was looking to employ two academics to join the team. They would need to be both researchers involved in clinical practice.
- The trust had appointed a clinical risk nurse for critical care. The role was intended to work across the trust although at the time of inspection they were only working at the Royal Sussex County Hospital. The role was full time and planned to last for a minimum of two years. The role was developed, as there were concerns among senior managers that themes from incidents reported on the incident reporting system would not be picked up and learning opportunities to prevent a repeat would be missed. We were told how the service was developing a new neurosurgical, polytrauma and spinal pathway. However, at the time of the inspection, this was in its early stages.
- It was envisioned that the Critical Care Outreach team would eventually be operational 24 hours a day at RSCH once additional funding (via a business case) had been identified.
- The trust had received agreement to appoint a qualified advanced critical care practitioner (ACCP) to supplement the junior doctor rota. There was also agreement in place to recruit two trainee ACCPs by September 2017.
- They had also received agreement to recruit a band four healthcare assistant to support rehabilitation in accordance with NICE guideline CG83.

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

## Information about the service

We last inspected Brighton and Sussex University Hospitals NHS Trust's maternity and gynaecology services in April 2016, we found the service required improvement overall. The purpose of this inspection was to see what improvements, if any, had been made by the service in the last 12 months.

Brighton and Sussex University Hospitals NHS Trust's maternity and gynaecology services are arranged across two sites covering 79 maternity beds that share the same guidelines and protocols. Of these beds, 39 are located within three wards at Princess Royal Hospital (PRH) and 40 are located within two wards at the Royal Sussex County Hospital (RSCH). Women have the choice to give birth at either location depending on their needs and preferences. The gynaecology service provides emergency and elective gynaecology services and has 21 beds across two sites. These are located within one ward at each site. Community midwifery services are provided by three teams of midwives and cover the whole Brighton and Sussex University Hospitals NHS Trust community area. There is a dedicated homebirth team which supported a high homebirth rate averaging 5.6% from April 2016 to January 2017. This report focuses on the services at the Royal Sussex County Hospital.

There were 2,822 births reported at the RSCH from April 2016 to January 2017 with an average of 282 births a month in the same period. This accounted for 58% of all births across the trust. The maternity and gynaecology departments are both located within the Thomas Kemp Tower.

The maternity department provided triage and postnatal facilities (situated on level 12), with antenatal care and day assessment unit (situated on level 11) for women who may have had concerns relating to their pregnancy or those requiring closer monitoring. The service also ran antenatal clinics, routine screening and ultra sound scanning, as well as foetal abnormalities screening which was a separate clinic. There is a special care baby unit (SCBU) located on level five which accepted all babies that required additional monitoring and supported care at level three. The gynaecology department is located on level 11 and has 9 beds; level 11 also incorporates an early pregnancy unit, a gynaecology assessment unit, and gynaecology outpatients. The labour ward is located on level 13 with nine delivery rooms, one theatre, recovery room, a two bedded induction room and three birthing pool rooms.

Termination of pregnancy, for foetal abnormality was carried out at the RSCH, within the delivery suite for women with 14 weeks gestation and above and on the gynaecology ward for women who are under the 14 week gestation period. The service provided seven surgical and ten medical terminations of pregnancy from April 2016 to February 2017.

We carried out a comprehensive inspection from the 25 to 27 April 2017 and reviewed all areas where maternity and gynaecology patients received care and treatment. These included the day assessment unit, antenatal unit, postnatal unit, labour ward, theatres and recovery, scanning areas and the gynaecology ward and theatres. We spoke with staff from across the department including clinical leads, consultants, doctors, midwives, maternity support workers, clinical staff, housekeepers and specialist midwives. We

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also spoke with 11 patients and relatives. We reviewed 13 sets of maternity and gynaecology records and before, during and after our inspection reviewed the hospitals performance and quality information. This information included meetings minutes, policies and performance data.

Our inspection team included two inspectors, a consultant obstetrician and a midwifery matron.

## Summary of findings

On our last inspection we rated the maternity and gynaecology services as requires improvement because;

- Staff were routinely not reporting incidents as they felt there was nothing done following reporting and no feedback was given.
- During our last inspection we found mandatory training figures were low in many areas across the whole department.
- Staff shortages raised concerns over patient safety and staff felt exhausted and unsupported. Midwives were acting as scrub midwives in theatres which also took staff away from the wards.
- Low consultant numbers and obstetric staff led to high locum doctor use.
- The main obstetric theatre had problems with the ventilation system which posed an infection control risk.
- There was no midwife led unit meaning women had less choice in where their babies were delivered.
- Medical outliers on the gynaecology ward led to delayed admittance from the gynaecology assessment unit and a high cancellation rate. Referral to treatment times in gynaecology were routinely not being met.
- Last time we inspected we found safeguarding training was below the trust target for level two and three in children's and adults safeguarding.
- On our last inspection many guidelines were out of date and past the review dates.
- During our last inspection we heard from staff that the head of midwifery and leadership team were not visible.
- There was a culture of bullying and mistrust across the directorate and poor culture between sites and in the community.

During this inspection we rated the service overall as good because;

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- During this inspection we found incident reporting was much improved and feedback routinely given via a number of methods.
- On our last inspection many guidelines were out of date and past the review dates. This had now been addressed and all guidelines had been reviewed and were in date with good monitoring processes in place for further reviews.
- During our last inspection midwives were acting as scrub midwives in theatres. This had now stopped, and from April this year there was a separate theatre team to ensure that the midwives role in theatre was to aid the mother and baby only.
- Although there was still no midwife led unit for women, the staff were committed to providing and promoting normal birth. Women were offered a choice of birthing options and the trust had high homebirth rates.
- Safeguarding training targets had improved since last time but they still fell below expected targets in level three safeguarding in both adults and children.
- The gynaecology ward were accepting many patients that were medical outliers on our last inspection. This was still evident on our recent inspection; however, there were strict criteria the department followed to ensure patients were not admitted inappropriately to the ward.
- Appraisal rates during our last inspection were poor at 59%. This had been addressed by implementing a new initiative whereby band seven midwives took on responsibility for a group of lower band midwives. The appraisal rate at the time of inspection stood at 91%.
- All guidelines and policies had been reviewed and were up to date and there was a clear process for highlighting when these were up for review.
- Referral to treatment times had much improved since our last visit and women were being seen in a timely way, in-line with the England average.
- There was now a designated triage team allowing for better continuity of care and improved

communication via an online shared drive and an improved system for recording calls. The improvements have led to a reduced number of triage closures and reduced complaints about triage.

- Staff treated patients with dignity and respect. We saw compassionate interactions between all staff members and the patients they interacted with.
- Universally staff felt that there had been improvements in the culture of the organisation since our last inspection. They all reported that it was a different place to work than a year ago and that positive changes to the consultant body and leadership had been the driving force behind the changes.
- The women's directorate had three, six and 12 month plans which were drawn up in March 2017. This included short and long term initiatives.
- Staff we spoke with during this inspection were positive about the leadership team. The role of the lead midwives had made a positive impact on moving the department forward and had introduced many new initiatives.
- The trust is one of 44 trusts throughout the country engaged in the Maternal and Neonatal Health Safety Collaborative. A three-year programme to support improvement in the quality and safety of maternity and neonatal units across England.

However;

- There was some improvement in mandatory training figures however; the trust's target for mandatory training was lower than other similar NHS hospitals with completion targets at 75%. This meant one in four members of staff were not expected to have completed mandatory training. Despite having a low target the department was still falling behind in some areas with worse than expected mandatory training attendance.
- Staff felt they were under pressure despite an increase in staff numbers. Last time we inspected staff felt that patient safety was compromised by low



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numbers of, and exhausted staff. This time we saw an improvement in staff numbers and 1-1 care in labour had improved, but was still not achieving the national and hospital target of 100%.

- There were a higher than expected number of hypoxic-ischaemic encephalopathy (HIE) cases within one year. This had not been fully explored by the department and although individual Root Cause Analysis (RCA) reports had been completed there was not an overarching internal investigation into the high numbers to identify any common themes.
- The ventilation system in obstetric theatre on L13 is over ten years old and failed the recommended air change frequency level for each hourly period. This remained on the risk register but had not been addressed and still posed a potential risk to patients.
- The risk register needed to be reviewed as we found some areas of risk that had not been included, for example fire safety issues. There were 13 outstanding fire safety concerns highlighted since June 2016. There had been no trust wide collation of any actions as a result of these concerns being completed.
- Despite improvements to the governance structure we still found that some staff were not fully engaged and messages from the board were not routinely heard by all staff groups.

## Are maternity and gynaecology services safe?

Requires improvement



During our last inspection we rated the service as requires improvement this was because:

- Last time we inspected staff were routinely not reporting incidents, and there were limited opportunities for feedback to be given.
- Staff felt that patient safety was compromised by low numbers of, and exhausted staff.
- During our last inspection we found mandatory training completion fell below trust targets in many areas across the whole department. Last time we inspected we also found safeguarding training was below the trust target.
- The gynaecology ward were accepting many patients that were medical outliers and this was reported to have a negative impact on gynaecology admissions and staff pressures.
- One to one care in labour was only met for 65% of women against a target of 100%.
- During our last inspection midwives were acting as scrub midwives in theatres meaning two midwives were needed to attend each caesarean. This further impacted on staffing in the rest of the department.
- Low consultant numbers and lack of obstetric staff had resulted in high use of locum doctor use.
- The trust identified that a lack of second obstetric theatre posed a risk to women and that the ventilation system in this theatre was inefficient and could be an infection control risk.

During this inspection we still found services required improvement because:

- The trust reported an average of 85% of women were now receiving one to one care in labour. This was an improvement but still fell below the recommended target set by the Royal College of Obstetricians and Gynaecologists (RCOG) and the trust target which both stand at 100%.

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- The directorate were using the 'Shelford Safer Nursing Care Tool' to assess required staffing levels. However, maternity services were not using a recognised specific maternity acuity tool, such as Birthrate Plus. We found the tool informing the staffing and skill mix required on each shift was not applied appropriately at all times. Staff were still reporting feeling busy and often missed breaks and one to one care in labour was not achieved.
- The trust's target for mandatory training was lower than other similar NHS hospitals with a target of 75%.
- There were 11 cases of hypoxic-ischaemic encephalopathy (HIE) cases within one year. This had not been fully explored by the department and although individual Root Cause Analysis (RCA) reports had been completed there was not an overarching internal investigation into the high numbers to identify any common themes.
- The ventilation system in obstetric theatre on L13 was still inefficient. It was over 10 years old and failed the recommended air change frequency level for each hourly period. This remained on the risk register but had not been addressed and still posed a potential risk to patients.
- Fire safety was not being addressed adequately across the department. There were 13 outstanding actions since June 2016. There had been no trust wide collation of any actions as a result of these concerns being completed.
- We saw a confidential waste bin that was full and paperwork which could be retrieved by hand outside the midwives station on labour ward. This could compromise patient confidentiality.

However:

- This inspection we found incident reporting was much improved and feedback routinely given via a number of methods. We did see some incidents were not categorised in line with trust policy.
- There is now a separate theatre team to ensure that the midwives role in theatre was to aid the mother and baby only.
- The gynaecology ward was still accepting medical outliers, however, there were strict criteria from which the department followed to ensure patients were not admitted inappropriately to the ward.
- The department had recently employed more consultants and on this inspection consultant numbers were in line with trust expectations.

## Incidents

- Between March 2016 and February 2017, the trust did not report any 'never events' for maternity or gynaecology at the Royal Sussex County Hospital (RSCH). Never Events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- In accordance with the Serious Incident Framework 2015, the maternity & gynaecology directorate reported three serious incidents (SI) which met the reporting criteria set by NHS England between March 2016 and February 2017. One of these related to the RSCH. We reviewed the serious incident report. This indicated multidisciplinary meetings were held, cases were reviewed at several staff meetings and a root cause analysis had been undertaken. Clear and specific recommendations and action review dates were in place. However, these review dates hadn't passed at the time of inspection so we were unable to ascertain if they had been completed.
- There was a further trust-wide SI relating to maternity and gynaecology services in July 2017. This incident involved antenatal screening cohort data and results affecting 907 women. There was a multidisciplinary approach to the investigation including a panel review with members involved from outside the directorate and national and regional representatives. Following this incident, a named IT lead is now in place for the department. Changes had also been made to the recording of antenatal screening data.

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- Incidents were widely reported and openly discussed. During our inspection we saw discussions at handovers, daily huddle meetings and saw incidents had been discussed and minuted in ward meetings.
- The severity of an incident was graded using the National Patient Safety Agency framework, these were: no harm (impact prevented (near miss), impact not prevented), low, moderate, severe and catastrophic.
- We reviewed the last four months of reported incidents and Incidents should be graded according to the actual harm caused'. The policy gave examples of appropriate measures of grading, stating no harm as 'No injury (either prevented or not prevented)' and Low harm as, 'Minor injury or illness requiring limited medical treatment /extra observation'. We reviewed an incident report where a patient was found following a procedure with blood loss of more than 1500mls who required emergency treatment, being categorised as no harm. We also saw an incident where the death of a baby following delivery against recommended guidelines had been classified as moderate. If incidents are classified wrongly it could lead to trends and themes not being identified early enough and may not identify clearly if harm had actually occurred but was not reported as such.
- All low or no harm incidents were reviewed and logged for trend analysis and local resolution if possible. Any incidents believed to be moderate were further reviewed through a multidisciplinary case review and a report form completed. This included any immediate actions that needed to be taken to ensure patient safety, before a full report was produced. If it was decided after further review by the Director of Nursing that an incident was classified as a serious incident (SI) then it was passed on to the patient safety team and a root cause analysis (RCA) investigation was conducted. Once the RCA report has been completed, and approved by the trust corporate team, it was sent to the Clinical Commissioning Groups (CCG) in accordance with national policy for approval.
- Staff could access any Serious Incident (SI) reports. There was however, no record of who had read these so therefore no assurance that lessons learnt had been seen by all staff members. Staff we spoke with gave mixed accounts of their awareness of these reports.
- There was a weekly Women's Services incident review meeting. This included maternity and gynaecology staff. All incidents were discussed at this meeting including ongoing investigations and any learning points. All staff were invited to attend. The meetings gave assurance that investigations and complaints were being handled in a timely way. We spoke to several members of staff who said these were successful and that often-higher band staff would enable lower grade staff to attend by covering their roles temporarily.
- At the end of the weekly meeting, the 'lessons of the week' were agreed and fed back to both the maternity and gynaecology departments via the 'message of the week' newsletter. We saw these displayed on the wards and in the staff rooms and members of staff across the service confirmed they were useful.
- Staff previously felt that feedback from incident reporting was poor, however during our recent inspection this was widely recognised as having improved. All datix reports are reviewed daily by the risk lead and assigned to a staff member for conclusion. Staff told us they received feedback about incidents they submitted and felt that the culture had changed and was more positive.
- Incidents were also fed back to clinical leads at the monthly audit and safety meetings. This meeting provided appropriate oversight to senior clinicians within the trust of what incidents were occurring. Feedback from these meetings was fed back via an e-mail newsletter to all departmental staff.
- There were daily 'huddles' on both the post and ante-natal wards, on the gynaecology ward and the labour ward. These involved multidisciplinary staff members including anaesthetists, junior doctors, senior midwives and clinical leads. We witnessed three of these meetings during inspection. They followed a set structure and were well attended. These meetings were at a set time, however on one of the days the meeting had not been held at the allotted time and only occurred after a reminder from an inspector. We were told this was often the case, as they had to be held at a time that was most appropriate. This could lead to poor attendance as staff may arrive for a meeting that has already happened or had to leave before it had started.

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- The safety huddle attendance was also highlighted in the monthly departmental meetings, in December 2016 it was reported they were not happening as expected and would be re-launched in the new year. This could have meant that the huddles are not as embedded as they could be and staff were not receiving daily feedback.
- Duty of candour (DoC) was included as part of induction training for new starters across the maternity and gynaecology department. The DoC is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014, 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 them with reasonable support.
- The trust recently provided training sessions for staff on Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. Staff could describe DoC and their responsibilities relating to it.
- We reviewed incident data for the service and actions staff took following incidents and saw evidence staff applied DoC appropriately. We witnessed the duty of candour being discussed in the daily huddle and saw references to it in several meeting minutes and SI and RCA reports.

## Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data was collected monthly.
- From April 2016 to March 2017 the gynaecology ward achieved 97.2% harm free care. From February to 2016 to February 2017, the department reported nine patient falls. This was better than the England average of 20, based on the ward size.
- Across the maternity and gynaecology departments there were no pressure injuries reported in the previous 12 months.
- The trust recorded all birth information on the maternity dashboard. This covered organisational aspects, such as

closures, activity, workforce and clinical indicators. The dashboard was reviewed at the monthly audit and safety meetings and also reviewed monthly at board level during the ‘confirm and challenge’ meetings.

- It was reported that the total number of women with a blood loss of over 2500mls was better than the target set by the trust with 0.9% reported against a target of 1% within the reporting period.
- Venous thromboembolism (VTE) risk assessments were carried out in line with the trust target of 95% between April 2016 and June 2016.

## Cleanliness, infection control and hygiene

- The trust had implemented a new Infection Prevention meeting structure from September 2016. This included an Infection Prevention Review Group (IPRG), Operational Meeting (IPOM) and Infection Prevention Committee (IPC). The women’s directorate had representation at these meetings. However, we reviewed minutes of IPOM meetings and the women’s services representative did not attend for three out of the six meetings we reviewed.
- There were no reported cases of MRSA from April 2016 to March 2017 in maternity and gynaecology.
- There were no cases of Clostridium Difficile (C Diff) reported within maternity and gynaecology at the hospital from April 2016 to March 2017. If there were any cases, there were arrangements for a comprehensive multidisciplinary post infection review focusing on identifying the cause and learning.
- BSUH has a reduction target of 46 C Diff infection (CDI) for 2016/17. Part of the strategy for this reduction target included auditing the high impact interventions for CDI reductions; this reflected national guidance (Department of Health, 2008). During the spot check audits in December 2016, gynaecological ward was 80% compliant. The average across the hospital was 91% meaning they were worse than the hospital average.
- The service had not met the national specifications for cleanliness (NSC) during our previous visit in April 2016, due to all staff not having a work schedule. 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

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the form of a work schedule'. However, we were shown work schedules the trust had produced and these were accessible on the trust's intranet. This meant staff would be aware of what tasks other staff had completed and minimised the risk of areas not being cleaned. We saw cleaning rotas were displayed in the cleaning cupboards and checklists were completed daily. This ensured no areas were missed or cleaned twice.

- We observed all cleaners wearing disposable aprons and following the correct procedures for preventing the unnecessary spread of germs.
- Theatres had specific housekeepers and a separate checklist for cleaning. We saw audit results from the September 2016 to February 2017, these showed the housekeepers were not adhering to the checklists on labour ward (level 13) theatres throughout this period, with compliance as low as 70% for one of the week's against a target of 98%. This was highlighted alongside other departments who fell below targets at the Infection Prevention Operational Meeting (IPOM), but there was no action plan to address it.
- Birthing pools were cleaned after every use, pools we saw on inspection were clean and we saw evidence of a cleaning checklist for staff to follow.
- All departments within maternity and gynaecology were considered high risk or very high risk for infection control. The hospital was compliant with the Department of Health guidance recommending: 'All patients admitted to high risk units and all patients previously identified as colonised with or infected by MRSA, should be screened for MRSA. In addition, local risk assessment should be used to define other potential high MRSA risk.'
- 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 hand hygiene policy followed the National Institute for Health and Care Excellence (NICE) guidelines.
- The trust undertook daily hand hygiene audits in all departments, once a department had three consecutive audits that met the target they moved to weekly audit and then monthly, depending on compliance.
- In maternity post-natal, antenatal labour ward, gynaecology wards and the gynaecology outpatients

and colposcopy they were having monthly audits they achieved scoring of 96-100% for all months reported. This was in line with trust targets. However, the theatres on Labour ward fell below expected targets with average compliance of below 85%. Therefore they were audited daily to check for compliance.

- In line with NICE QS61 statement 4: people who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and removal as soon as it is no longer needed.
- We saw alcohol based hand sanitizer available on the wards and units in maternity and gynaecology at the hospital. We observed good use of these in all areas we visited.
- Personal protective equipment (PPE) was available in all clinical areas. Staff followed correct use of PPE, we saw staff members following trust policy and NICE guidance, QS61 statement 3: 'People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.'
- Side rooms were available for women who had infection and needed isolation on both the gynaecology ward and within the postnatal and labour wards.
- We observed midwives wearing uniform and everyday clothing. On the trusts 'maternity matters' website it states 'Our maternity team is made up of a diverse range of health care professionals and support staff. We do not have a uniform and staff are encouraged to wear their own clothes to fit with our ethos of promoting normality in pregnancy and birth.'
- The trusts uniform policy states 'Trousers should be tailored and smart. Jeans, ski pants, leggings, jeggings or combat style trousers are not permitted'. However. On inspection we saw staff members wearing jeans and leggings. This is not in line with the trust's policy and it showed that the leaders were not insisting on adherence to trust policy.
- All staff we observed on inspection had bare skin below the elbows with long hair tied back.



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- Maternity and gynaecology services were using, “I am clean,” stickers on equipment to indicate that the equipment had been cleaned and was safe for use, as well plastic covers to protect clean equipment.
- We saw sharps bins were available in treatment areas where sharps may be used. The bins automatically shut when full to prevent overfilling. This was in line with Health and Safety Regulations 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.
- Specific hand washing sinks were available in all rooms and at the entrance to bays on wards. All sinks we saw were compliant with lever handles and taps positioned to cause the least amount of splash. Sinks also had hand washing technique posters displayed to ensure staff used the correct technique.

## Environment and equipment

- The maternity and gynaecology department consisted of antenatal clinic rooms, a day assessment unit, Gynaecology assessment unit, gynaecology outpatients, and an early pregnancy unit were on level 11. The antenatal ward and a post-natal ward and the triage facilities were on level 12, and the delivery suites and one theatre were on level 13.
- The theatre on level 13 was used for all planned and unplanned (emergency) caesarean sections. If the use of a second theatre was needed then patients had to be transferred to level 5 which was accessed via a staff lift. RCOG guidelines ‘Operating theatres dedicated for obstetrics should be close to the birth unit or preferably within it. One theatre is probably sufficient for the birth of up to 4000 babies a year, although there is no specific evidence for this figure’. As the department delivers fewer than 4000 births a year they were in-line with guidance.
- On inspection we were told patients that needed to be transferred to level 5 for surgery would be transferred via the staff lift. We were told by two senior staff that the staff lift had no override facility meaning time could be lost during the transfer. However, during the un-announced part of inspection we were told there was a lift (currently used by porters for rubbish removal), that should be used in an emergency, and that staff did hold an override key for this lift. We were shown evidence following inspection that staff had been reminded to use the override lift in an emergency and that it had been a regular reminder in staff safety huddles and handovers following inspection.
- Following concerns around maternal satisfaction and safety concerns of women and their babies being transferred in a lift from level 13 to level 5 with inherent delays, the department recently undertook an audit of all cases where a second obstetric theatre on level 13 would have prevented significant delays (until next day or out of hours). The audit took place from January 2015 to December 2015. This included emergency transfer in labour/foetal distress to level 5 theatres. It identified 46 women who fell under these criteria. The recommendations following the audit included for results to be shared with the lead for labour ward and that a second (emergency) obstetric theatre was needed for emergency cases to reduce the risks posed by emergency transfer to level 5.
- The main theatre had its own resuscitaire, a resuscitaire is where babies are cared for whilst being assessed and if necessary, resuscitated. However, if a patient was transferred to the second theatre on level five then equipment needed to be bought down before the patient arrived. This could cause a delay in an emergency transfer.
- The ventilation system in obstetric theatre on L13 was over 10 years old and failed the recommended air change frequency level for each hourly period. This is a breach of national standards, HTM 03-01, states in 3.8 ‘In non-standard applications such as operating theatres the particular requirements for each area should be considered independently in order to determine the overriding minimum requirement for ventilation’. In Appendix 2 of this document it recommended that operating theatres have 25 changes of air per hour. In the minutes of the ventilation safety group dated 11th April 2017 it was reported that the air changes were down to ten per hour. This was 40% of the required standard and 50% less than the plant was achieving during our last inspection. This could potentially lead to impaired outcomes, increased length of stay and hospital acquired infection. We reviewed meeting minutes that stated a paper had been written for the



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senior management team and would be part of the next board meeting on the 24th of April 2017. The paper stated that the whole of the ventilation plant was in a poor state and proposed that three theatres per year were shut down for 16 weeks each for refurbishment. There was no evidence that the paper had been approved so the refurbishments were aspirational at the time of inspection.

- Fire safety was still a concern across the department. A full fire risk assessment was outsourced to a private company. The antenatal and postnatal fire risk assessment was carried out on 15 June 2016. We saw a hard copy of this document. There were actions agreed and some assessments had dates of completion on, but not all. The document showed 14 priority two risks with only one having been recorded as complete, but with no date of completion. Priority two actions should be completed within one month. This indicated that there were 13 outstanding actions since June 2016. There was no trust wide collation of the actions being completed as staff were unable to update actions on the central document. Therefore no one in the trust was able to inform us of how they ensured compliance with its fire risk assessments.
- Antenatal and post-natal wards were un-cramped and had enough space to manoeuvre beds between bays and other areas if needed. We saw some equipment in the corridors but it was well ordered and felt un-cluttered.
- We checked resuscitation trollies on all levels and found they contained the correct equipment and all consumables were in date. We saw checklists were completed, however there were some gaps where trollies had not been checked, reported in a recent audit. This could lead to missing equipment not being replaced, and in an emergency, lead to delays.
- The department maintained security within the maternity department in line with the Royal College of Obstetricians and Gynaecologists (RCOG) 2008, 2.2.26 'Security is an issue of importance for staff, mothers and babies. A robust system must be in place for their protection. Babies born in hospital should be cared for in a secure environment to which access is restricted.' Between the antenatal and post-natal wards a swipe card was needed to enter. The entrance to the day assessment unit, surgical, post and antenatal wards and the delivery suite also had swipe card access and an intercom for patients and visitors. This ensured all people were monitored arriving on the wards. There was a push button needed to exit the wards, which was not monitored, and anyone could leave the wards freely without monitoring. This meant although people entering the ward was monitored people could leave without monitoring.
- The RSCH had three water birth rooms. We saw these had been regularly serviced and had a cleaning checklist completed after every use. There were special waterproof monitors that could be used to enable higher risk women to birth in the pools if needed.
- On the days of our visit we saw two separate lavatories that were out of use for visitors. When asked, staff said that maintenance teams were better now than in the past, and they would not expect too much of a delay to get them fixed.
- A system was in place that tracked all requests to the estates teams. E-mails were saved on to an action planner so information was easily accessed and tracked. Staff reported this had helped to speed up the process.
- We checked 25 pieces of electrical equipment throughout all areas we visited. The majority of equipment we looked at had a servicing maintenance sticker on to show when it was last checked and the date of the next service. We saw five pieces of equipment that were past the review date. Staff told us that equipment was taken away by a contracted maintenance team and that they felt that this was enough to ensure the equipment was serviced regularly. However, when asked, senior staff could not access these records so were unable to know the equipment they were using was safe and regularly serviced.
- Maternity and gynaecology services had asset register of equipment for servicing and repair. The asset log was held by the equipment store and technicians, who informed the ward when equipment was due for servicing.
- There were new foetal blood sampling, postpartum hemorrhage (PPH), pre-eclampsia and an epidural trolley available on labour ward. These were well organised and checks carried out daily to ensure that all equipment was in date and available.

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- In theatres we saw specific packs for caesarean section, 3rd degree tear and hysterectomy. The packs contained sterile equipment specific to the surgery and aimed to help surgeons and theatre staff by ensuring there was the correct equipment to carry out surgery safely.
- Staff told us they had adequate equipment needed to deliver safe care. We saw adequate numbers of CTG machines, resuscitation equipment, foetal blood analysers and foetal heart rate monitors.
- In September 2016 the trust completed an overall compliance with medicines storage and security standards audit. Postnatal and labour wards were both above 90% compliant showing good medicine management.
- We checked the storage and management of medication in theatres. The theatre practitioner held the keys to the drug cupboards to ensure they were safely stored and records were maintained. This ensured availability and all medicines were in date.

## Medicines

- We looked at the arrangements for storing medication on the postnatal ward. We found that they followed best practice and had a locked controlled drug cupboard, inside another cupboard, and all the drugs we checked were in date.
- Medicines that needed to be stored within fridges were also all in date and stored at the correct temperatures. Fridges were checked daily and the minimum and maximum temperatures recorded. Staff signed to say these had been checked and we saw a protocol which should be followed if the fridges were not in the correct temperature limits. This was in line with best practice guidelines.
- Staff told us that the pharmacist visited daily and checked the drugs and charts.
- We looked at controlled drugs (CD's) (medicines liable to be misused and requiring special management). Checks of controlled drugs were mostly complete. The labour ward lead told us that controlled drugs were checked once each shift. The target for this to be completed was 100%; during March 2017 the compliance was recorded as an average of 91%. This could mean there were shifts when the controlled drugs were not checked.
- There were no medication errors reported in gyne-oncology from March 2016 to January 2017. There were 27 reported in gyne- surgery which was rated as 'not significant' although a slight rise on the previous year which reported 21 medication errors. Labour ward (delivery suite and theatre), postnatal ward and antenatal wards all reported less medication errors from March 2016 to January 2016 than the previous year.
- 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.
- We witnessed a patient being discharged with specific medication for diabetes. The patient was reminded, when and how to administer the drugs including the time of day and they were provided with a sharps bin which the community midwife could collect during routine visits.
- Patients were not provided with individual drugs for self-administration but could ask for medicine such as pain relief if needed. Staff told us when women brought their own medicines to the hospital that two nurses would check and record the medicines.
- Antibiotics were prescribed in-line with NICE QS 61: people are prescribed antibiotics in accordance with local antibiotic formularies.
- There was an ongoing pharmacy audit from comparing the factors influencing the analgesic requirements on discharge from the maternity services at PRH and RSCH. There were no results from this audit at the time of inspection.

## Records

- Women held their own paper maternity records. These were used throughout the pregnancy and recorded information from antenatal appointments. These were in addition to the hospital recording system. These included useful information about pregnancy, screening, pain relief and birth choices. Babies had a separate record created after birth.

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- Patients are given a 'red book' on discharge to keep records of their baby's growth, development and for use in the community and transfer between services. We saw midwives check with women prior to discharge that they had this book before they left.
- We saw a variety of different forms filled out prior to discharge, including to the community midwives, social workers and GP surgeries. This ensured that the care of patients continued after discharge.
- Records were stored securely both within offices and on the wards. Patient's records were locked safely in cupboards when not in use. There was a lockable trolley for use on ward rounds.
- We reviewed 10 sets of patient notes at RSCH across the maternity and gynaecology departments and saw they were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with patient and families. They were generally compliant with guidance issued by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), the professional regulatory bodies for doctors and nurses. Patient records were easily accessible to those who needed them.
- All women had a named consultant (for high-risk pregnancies) or a named midwife (for low risk). We saw appropriate risk assessments had been undertaken.
- We saw a confidential waste bin that was full and paperwork could be retrieved by hand outside the midwives station on labour ward. This could compromise patient confidentiality.

## Safeguarding

- Two specialist safeguarding midwives worked across the two hospitals with dedicated time to address safeguarding issues. Staff were aware of which staff member to contact if they needed any support with regards to any safeguarding issues.
- Training data supplied by the trust indicated that 92% of eligible staff in this service had current training in safeguarding children and young people training at level 1, 87% eligible staff had completed level 2 and 44% of eligible staff were up to date with this training at level 3. Overall 87% of staff had current training in adult safeguarding." This showed the trust's stated target of 75% compliance was generally being met with the exception of Level 3 training for children and young people. However this target is low as national guidance states that all staff should have completed the appropriate level of training and a target of 75% means one in four staff were not expected to have completed the training.
- We saw information behind nursing stations with a clear flow chart of processes for reporting safeguarding, acting as a reminder to staff.
- Staff completed a common assessment framework, which all staff could complete. These highlighted any safeguarding concerns or women who may be vulnerable. These were available online and shared with the safeguarding midwife, community midwife, social services and GP services.
- We saw policies that reflected automatic safeguarding referrals were made for pregnant children less than 14 years of age and consideration of referral for children up until they were 16.
- During our visit we reviewed the notes of a patient who had a safeguarding plan. The notes were robust in the information recorded and showed good multidisciplinary working between hospital departments, the community and social services. Staff were aware of the woman's situation and informed staff during the safety huddle of the situation to protect staff and patients.
- We saw evidence that women were asked if they felt safe at home during initial booking in. There was information for women with regards to domestic abuse via the maternity matters website including contact details for help and advice.
- We saw that the trust had a Safeguarding Adults policy which included reference to Prevent, one part of the government counter terrorism strategy.
- We saw medical records of how these women were to be cared for after admission and found these to be in-depth and complete. They took into account the needs of both mother and baby and documented the other agencies that were involved, for example, social services.
- Community midwives received group supervision each month from the safeguarding midwife.

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- Since September 2014, it had been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had Female Genital Mutilation (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 and clear guidelines on FGM including recognising and supporting women who may have experienced FGM.

## Mandatory training

- Mandatory training included fire safety, infection control, mental capacity training, safeguarding adults at risk, safeguarding children level one to three, equality and diversity, blood transfusion, health and safety, information governance, and basic life support.
- Staff were given five days to complete training a year and training was by e-learning or booked training courses. Each day of training incorporated several aspects of the required training.
- We saw an improving picture but mandatory training targets were still not being met. The third training day which included manual handling, safeguarding adult and child level three and adult basic life support, was only attended by 71% of staff against a target of 75%. However, all other days had achieved attendance of 84% or higher which is better than the trust target.
- The day five training included medical devices, IV update, VTE update, mental capacity act, and trust e-learning was completed by 87% of midwifery staff.
- Staff also received mandatory training in specific maternity safety systems, including responding to childbirth emergencies such as post-partum haemorrhage (excessive bleeding following delivery) and CTG interpretation as well as normal birth and infant feeding.
- We spoke to the nurse practitioner about mandatory training and she told us of a new initiative to make sure staff completed training and the introduction of a new computer-based system which alerted managers of any staff members who were not up to date with training. However, the system was not fully integrated in maternity as it did not allow the addition of maternity

specific training. Also, within gynaecology not all staff were on the system yet. Both these factors contributed to data not reflecting a true picture of the mandatory training figures.

- Staff were given advance warning of training days. We were told that if staff did not complete mandatory training in a timely way that it would be reported to their manager and would be brought up at 1-1 meetings or reviews.

## Assessing and responding to patient risk

- Patients were continuously risk assessed using the Modified Early Obstetric Warning Score (MEOWS). Patient notes we reviewed showed comprehensive completion, however the total score was not written. We didn't review any notes in which escalation was needed however, this could mean deterioration of a patient could not be seen quickly and acted on appropriately.
- The gynaecological wards were continually risk assessed using the National Early Warning Scores (NEWS). We saw these were fully completed and escalated appropriately as and when necessary.
- The service followed the 'Five Steps to Safer Surgery' World Health Organisation (WHO) checklist, which included a sign in, time out and sign out checks. We observe red appropriate use in the obstetric theatre. Patients also had a copy of the 'Five Steps to Safer Surgery' (WHO) checklist in their notes and is recorded on the theatre database. Where appropriate, this had been fully completed in notes we reviewed.
- As of April 2017 the team took the lead on WHO audits in theatres, however, responsibility for audits of practice, safety checks and swab counts in delivery rooms remained with the midwifery team.
- There was a consultant led multidisciplinary ward round on labour ward at 8am and 5pm, this continued down to the postnatal ward where higher risk women were seen as part of this round. Women involved on the postnatal ward rounds were highlighted by the midwife in charge depending on need. We were told during focus groups by a junior doctor that they were in charge of postnatal ward rounds and were told which patients to

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see by the midwives. We asked and were told that sometimes juniors or registrars could do the ward rounds with consultant available if concerns were raised.

- Women with high risk pregnancy were routinely attended by consultant obstetricians during birth to ensure the safety of mother and baby.
- There was a daily safety huddle on Labour ward, postnatal ward and on the gynaecology ward which gave staff the opportunity to discuss patients who may require extra care and update staff on the progress of women throughout the service. This was attended by multidisciplinary staff members including consultants and junior doctors.
- During the daily huddle meetings we saw effective discussion around patients' needs and clear indication of women who needed extra vigilance. For example a woman with mental health issues was highlighted as a risk for trying to leave the department before she was well enough to do so. During the discussion about her care, it was clear that staff felt able to challenge each other in a friendly environment.
- Babies were not electronically tagged to alert staff if they were being removed from the postnatal ward.
- Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour 2.2.26 states: 'A robust and reliable baby security system should be enforced, such as baby tagging, closed-circuit television, alarmed mattresses. Strict criteria for the labelling and security of the newborn infant are essential. Babies born in hospitals or birth centres should be clearly identified as soon as possible after birth with two labels, each with their surname, date of birth and individualised hospital number'. We saw babies were identified soon after birth with two identity bands in-line with recommended guidelines, however, no baby security system was in place.
- There was a dedicated triage service available 24 hours a day, women could call with any concerns or worries and for advice.
- Women could access an early pregnancy unit (EPU) if they had bleeding and/or pain. The EPU helped women identify the cause of symptoms and offered advice, support and any treatment which may be needed.
- A midwife carried out checks on mother and baby every day at 8:30am, 1pm, 5pm and 8pm to ensure appropriate care was being delivered in a timely way. These checks included pain scoring and checks on whether patients needed anything to make them more comfortable. We saw this documented in the patients records.
- From the period April 2016 to April 2017 there were 11 reported cases of hypoxic-ischaemic encephalopathy (HIE). HIE occurs when there is a lack of oxygen and/or blood flow to babies from the placenta during the birthing process. This accounted for 0.39% of all births at RSCH. We reviewed some RCAs in relation to individual HIE cases but the trust did not carry out any investigations to try and identify any common themes or trends. This could lead to missed opportunities to prevent further HIE cases. We did request that the trust sent us any data they had on investigations into trends or common themes in relation to the cases of HIE but this was not provided to us.
- Babies had hearing screening within the postnatal ward, if this was not possible there was a clinic available, women were given an appointment before they left hospital.
- All preterm deliveries over 33 weeks with an estimated foetal weight of over 2kg would be attended by a neonatal team doctor and a nurse. All preterm deliveries with an estimated foetal weight of 1kg would be attended by a consultant neonatologist, neonatal doctor and neonatal nurse.
- A 'Complex Care' meeting was held each week these involved a multidisciplinary team discussion around women with high-risk pregnancies. The meeting was run by the labour ward and obstetric leads and had a representative from all departments. Including antenatal, postnatal, community, anaesthetics, neonatologists and any specialist midwives.
- A new training plan had commenced in 2016 for all maternity staff to complete the new CTG guideline training throughout the educational year. The time available to staff was increased from half a day to a full day in July 2016. An audit was undertaken in April 2017 following the implementation of the guideline and training completion.



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- The department uses a system of 'fresh eyes' on all CTG monitoring. This is a system where a review of the CTG printout is undertaken by another midwife or medical staff to check there is agreement in its interpretation. This system helps identify possible misinterpretation. We spoke to staff who said they felt able to challenge colleagues if they disagreed with a reading.
- Staff were aware how to request blood if needed, it was available from level 5 and could be requested in emergencies.
- In line with NICE QS3 statement 1: all patients on admission, receive an assessment of VTE and bleeding risk. We saw this documented in patient records in both maternity and gynaecology.
- Staff were involved in regular weekly unannounced 'skill drills' these had a running theme each month and were run by the education team leads. During these exercises photographs were taken and reviewed with the working party and consultants. For example just prior to our there was a skills drill in emergency pool evacuation.
- We were given a recent example where an emergency situation occurred following a post-partum haemorrhage. There was a rapid response from staff and registrar meant the patient had a good outcome.
- Staff we spoke with said the post-natal and labour wards always felt busy and that despite having the correct number of staff on shift the acuity of patients meant that the demands on staff were higher. There is a planned Birthrate plus staffing review to be held in May 2017 which staff were positive about. The trust last undertook the Birthrate plus evaluation in 2009.
- We were shown evidence that the department staffing was reviewed annually to ensure the needs of women using the 'Shelford tool'. This determined if the needs of women were met and that the ratio of midwives to women was correct. NICE NG4 1.4.2 Monitoring and evaluating midwifery staffing requirements states departments should: 'Compare the results of the safe midwifery staffing indicators with previous results at least every 6months'. This meant the department was not assessing staffing levels as regularly as guidelines recommend.
- We looked at the trust's fill rate indicator return dashboard for the period October 2016 to March 2017, for planned and actual staffing levels in maternity obstetrics and gynaecology. This indicated the actual staff hours on the maternity ward night and day were less than the planned hours for all nursing staff groups. The difference between planned and actual midwife hours for night time shifts in October 2016 was 4278 hours however the actual fill rate provided 4003 hours. However, in regards to the gynaecology ward the planned and actual hours were met on all occasions with 713 hours.
- Staff still reported feeling overworked. This was reflected in one to one care in labour not being achieved in the department. The target of 100% was not met for all but one month from April 2016 to January 2017. On average the department delivered one to one care 85% of the time. The figure fell as low as 63% in June 2016. This was not in-line with NICE NG4: 'safe midwifery staffing,' which states all women in labour, should receive one to one care.
- A supernumerary labour ward co-ordinator was planned for all shifts, however sometimes staff shortages meant this did not always occur.
- We viewed the Women's performance scorecard for the period April 2016 and January 2017. The scorecard gave divisional data across all the trust sites and was not

## Midwifery staffing

- Most approaches to planning staffing rely on quantifying the volume of nursing care to be provided on the basis of the size of population, mix of patients, and type of service and relating it to the activities undertaken by different members of the team. As of December 2016 the trust reported their maternity staffing numbers as 145.67. Royal Sussex County Hospital (RSCH) had 4.32 more whole time equivalent (WTE) staff in post than the trust determined necessary to provide safe care. Community midwifery had 2.33 WTE less than targets. The post-natal ward had 7.02 more WTE in post. Although staffing levels show that overall maternity staffing was high the impact of maternity leave, sickness and annual leave might impact on staffing levels.
- The planned midwife to birth ratio target was 1:30. From April 2016 to January 2017 this target was met all months from April 2016 to January 2017 and is in-line with national targets. These targets were achieved with the use of bank staff when needed.



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specific to RSCH. The scorecard recorded the vacancy rate across the Women's division as between 4.5% and 4.8% in the period April 2016 to January 2017. This was worse than the trust's target rate of 3.4%.

- In February 2017, the trust reported a turnover rate of 30% in Maternity and Gynaecology. The service did not use agency staff often but employed its existing staff undertaking additional shifts as part of the trust 'bank'. This ensured regular staff worked who knew the common processes and procedures on the wards. However, staff reported that they often had to cover shifts and that it could leave them feeling overworked.
- Between April 2015 and March 2016, the trust reported a sickness rate of 4% in Maternity and Gynaecology.
- Staff numbers were displayed on each ward with the planned and actual numbers shown. This was updated daily and during our inspection all targets were met. This was 12 midwives and four Midwife support workers (MSW) on each day shift. There was a senior band seven lead midwife on each shift. We analysed the past two months of rotas and saw that this target was mostly met.
- On the gynaecology ward we saw the planned and actual staffing numbers were met for the last two months. Staff told us they would use bank staff to cover shifts if needed. We saw this had happened for five shifts between March and April 2017. The ward manager told us agency would be used as a last resort and had to be approved by the head of nursing if needed. The last time agency staff were needed was February 2017.
- There were three community midwives' teams based across the trust. The community midwives worked set shifts and did not work on call. If there was no work in the community the midwives would come into the hospital and assist in post-natal and antenatal wards and in the triage area. Staff said this worked really well and allowed staff to plan better and feel more integrated within the team.
- Community midwives we spoke to during our inspection said they felt very busy. They felt that the home birth rate was high but no extra support had been provided to support the extra mothers they had to care for. On the night before our inspection midwives had to attend to three home births with two midwives present at each birth. It was reported that this was not uncommon.
- Until recently all practising midwives in the United Kingdom were required to have a named Supervisor of Midwives (SOM). A Supervisor of Midwives was a midwife who had been qualified for at least three years and has undertaken a preparation course in midwifery supervision (Rule 8, NMC 2012). The overall SOM to midwife ratio was 1:15 which was in-line with the recommended ratio. Since the change we were told the trust is still maintaining the role as they felt it was valuable. Staff and patients had access to a senior manager on call at all times.
- The trust provided some specialist services for maternity in-line with NICE guidance. These included, practice development midwife, perinatal mental health midwife, alcohol and substance misuse midwife, a teenage pregnancy midwife, Infant nutrition midwife, breastfeeding lead, bereavement midwives and safeguarding midwives.
- A new early pregnancy lead had been appointed in gynaecology which staff said had led to new ways of working and improved patient experience.
- The maternity department also employed maternity care assistant (MCA), maternity support worker (MSW), and nursery nurses.
- Maternity care assistants performed a variety of roles including the daily care given to women and their families.
- Maternity support workers are support staff based in the community who specialised in postnatal care and provided support to the midwives. They had additional training to support women and babies during the first days at home, and provided newborn screening and ongoing breastfeeding support.
- Nursery Nurses specialised in caring for newborn babies. They were role included promotion of breastfeeding and assistance with bottle feeding. They also supported paediatrician doctors to assess and care for babies requiring additional treatment and observation after birth.

## Medical staffing

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- Consultant obstetricians provided 60-hour presence on delivery suite to support junior staff. This exceeds recommended Safer Childbirth and RCOG guidelines of 60 hours of consultant presence for 6000 births a year or greater.
- There was a consultant on call 24 hours, Monday to Friday, consultant is resident from 8:30am - 8:30pm, Monday to Friday and 8.30am to 2.30pm Saturday and Sunday. Outside of these hours they were on call from home within 30 minutes of the hospital. There is a registrar and junior doctor for the labour ward 24 hours a day seven days a week (shift time 8:30am to 8:30pm, 8:30pm to 8:30am).
- There was a junior doctor covering post-natal and day assessment unit. The consultant on call also covered gynaecology.
- During the day Monday to Friday between 8:30 and 5pm there is a separate registrar and junior doctor on call covering gynaecology. At the weekends the registrar covers both obstetrics and gynaecology, there is a separate junior doctor for gynaecology from 8:30am to 5pm.
- The early pregnancy unit was supported by a senior house officer and a registrar; however the registrar also covered gynaecology theatres.
- Consultant obstetricians provided 60-hour presence on delivery suite to support junior staff. This exceeds recommended Safer Childbirth and RCOG guidelines of 60 hours of consultant presence for 6000 births a year or greater.
- Between February 2016 and January 2017, Brighton and Sussex University Hospitals NHS Trust reported a bank and locum usage rate of 7.9% in maternity and gynaecology.
- There had been three new consultant appointments which staff told us had helped ease the pressure managing the rota and improved the service for women.
- A copy of the consultants on call rota could be found at the nurse's station. Staff had to call the switchboard to be transferred to the consultants. There were no reported problems getting hold of an on call consultant.
- Anaesthetist were available throughout the day including weekends, we saw anaesthetists attending daily huddle meetings and staff reported good working relationships.
- As from November 2016, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was slightly higher.
- The department had links with the neonatal team and paediatricians for complex patients or any postnatal concerns. Midwives told us they had never experienced trouble seeking advice or arranging a consultation if needed.
- The obstetric team did not participate in the hospital at night generic cover due to the specific skills required for obstetrics. In addition, the nature and breadth of cover did not allow the obstetric team to assist with the other wards.
- There was a room dedicated for handovers within each unit. This ensured confidential discussion about patients. The handovers we witnessed followed an order to ensure consistency. We saw paediatric consultants were involved in huddle meetings within the department. We heard that paediatric doctors were available if needed and there was a good relationship between the departments.

## Major incident awareness and training

- There was a mandatory major incident training course for all staff. Between April 2016 and February 2017 only 61% of registered nurses and midwives had completed the training and only 41% of medical staff. Both these figures were worse than the target of 100% set by the trust.
- We reviewed the trust's This document was available in electronic format and could be accessed by all staff. The chief executive has overall responsibility for emergency preparedness and was accountable to the board.

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## Are maternity and gynaecology services effective?

Good



During our last inspection we rated the service as requires improvement, this was because;

- On our last inspection many guidelines were out of date and past the review dates.
- Targets for elective caesarean sections were below the trust targets.
- Multidisciplinary working was not good when the hospital was last inspected, with some poor behaviour from staff, including consultants.
- Consent was not always obtained correctly before procedures.

During this inspection we rated the service as good, this was because;

- All guidelines had been reviewed and were in date with good monitoring in place for further reviews.
- Targets for elective caesarean sections were below the trust target during our last inspection. This had improved, recent figures showed improvement with the target being met from November 2016 through to January 2017.
- Staff behaviours were reported as improved with a new consultant body and we saw a much improved multidisciplinary approach across the directorate.
- Gaining consent had been addressed through a variety of means and we saw consent was given the appropriate importance and staff followed trust policy.
- Although there was no midwife led unit for women the staff were committed to providing and promoting normal birth. Women were offered a choice of birthing options and the trust had high homebirth rates.
- Appraisal rates during our last inspection were 59%, this had been addressed by getting band seven midwives to take on responsibility for a group of band five and six midwives. The appraisal rate at the time of inspection stood at 91%.

- The trust now employed a dedicated preceptorship midwife and a midwifery placement educator who met with midwives throughout their employment. They also helped with the training development of student and newly qualified midwives.

However:

- The maternity dashboard showed the maternity department were not meeting expected targets for some patient outcome indicators. These included vaginal birth after caesarean (VBAC), emergency caesarean section, and meconium aspiration.

### Evidence-based care and treatment

- We found from discussions with staff and patients as well as our observations that care was being provided in line with The National Institute for Health and Care Excellence (NICE) quality standard 22. This standard covers the care of all women up to 42 weeks of pregnancy. It covers all areas of antenatal care including community and hospital settings.
- Women who needed a caesarean section, whether planned or not mostly received care in line with the NICE recommendations (Quality standard 32).
- There was evidence to indicate that NICE Quality Standard 37 was being adhered to in respect to post-natal care. Examples included staff discharging patients with appropriate checks and with correct medicines. All patients we spoke with had been given breastfeeding advice and support.
- The observations and discussions we made reflected that the trust were following recommendations from NICE Quality Standard 190: Intrapartum care. Women were offered a choice of birthing locations and choice of care throughout labour. We witnessed several discussions between staff over patient's choice and how they could accommodate them; this showed they were focusing on the women's needs.
- Although there was no midwife led unit for women the staff were committed to providing and promoting normal birth. Women were offered a choice of birthing options including midwife led and if women requested no consultant presence on labour ward, this was adhered to as long as it was safe to do so.

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- The homebirth rates were higher than the national average at 5.6% from April 2016 to January 2017. Staff gave examples where midwives had enabled women with high-risk pregnancies, such as twins, to give birth at home. High risk women were encouraged to give birth in hospital but if they still wished to give birth at home, against guidance, they would try to accommodate this.
- Growth was monitored from 24 weeks by measuring and recording the symphysis fundal height as highlighted by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBBRACE) UK (2015) and in line with current NICE guidelines (NG3, 2015).
- The department did not carry out termination of pregnancy on women where there was indication the foetus was over 21 weeks. This was in line with RCOG evidence based guidelines related to feticide: section 6.7.
- From evidence we reviewed and from talking to staff, the service adhered to The Abortion Act 1967 and the Abortion Regulations 1991. We saw the correct completion of HSA1 form which were signed by two doctors before admission. The correct procedure was also followed for the HAS4 form which was sent to the Department of Health after completion.
- We reviewed 12 policies and all were within their review date. We saw evidence that all guidance and policy within the department had been reviewed and was using current guidance.
- Staff showed us a colour coded data sheet which would indicate if a guideline was due for review and was monitored by the governance lead for compliance.
- A set of standards and expectations has been developed for all audits that were conducted within women's services. Audits were undertaken in line with national strategic directives, and linked to NICE Quality Standards. These included core audits from Clinical Negligence Scheme for Trusts (CNST) Standards. The department felt that the use of the CNST maternity standards were considered national best practice.
- The department also carried out specific audits from National Strategy and direction or best practice as well as audits arising from serious incidents, duty of candour incidents, complaints, and feedback.
- An example of this was a recent audit undertaken by the Substance Use, Homeless & Travellers Specialist Midwife published in October 2016. The audit aimed to find out if the one stop clinic care plan was effective. We saw several action plans were introduced as a result of the outcomes, including training during mandatory training days and on new starters' induction. These cases were also included in the complex care planning meetings.
- We also reviewed an audit undertaken from April 2014 to April 2016. It was a retrospective audit of 97 cases of ectopic pregnancy. It saw that each year some cases were inappropriately managed. As a result there has been a change in practice, these included when a woman presented more than two scans should be reviewed by senior member of the team or a named consultant and that a pain score should be applied to the protocol.
- We saw areas of evidence-based antenatal practice. For example, the trust offered foetal anomaly screening in accordance with current UK National Screening Committee programmes. This was in line with NICE quality standard QS22: Antenatal care.
- Guidelines were discussed at the risk meetings. The role of this group was to review latest guidelines and implement any changes to policies in a timely manner. Once guidelines had been changed all staff groups were able to review for consultation and changes before publication.
- We were told new NICE/RCOG guidelines were passed down from the trust, obstetricians or the practice development lead.
- The department had a Newborn and Infant Physical Examination Programme (NIPE) lead midwife and recently six midwives had undergone training to aid the screening of new-borns before they left hospital. These figures show that there had been an improvement in babies receiving NIPE screening before discharge home.
- A new 'NIPE smart' system had been introduced to ensure that neonatal screening and referral pathways were in place and included a mechanism that meant that babies not screened within 72 hours of birth would be identified.

## Pain relief

# Maternity and gynaecology

- Women had access to a range of pain relief methods in accordance with NICE guidance CG190. This included Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour.
- Epidurals were available 24 hours, seven days a week. Women generally received epidurals within 30 minutes of request.
- Pain on the gynaecology wards was scored numerically with 10 being severe. Pain relief was planned before surgery. We witnessed patients being asked to score their pain and offered options for pain relief.
- Alternative pain management was encouraged including the use of transcutaneous electrical nerve stimulation (TENS) machines, (these are machines which are used as an alternative to medication, and they can ease pain in some people with certain types of pain).
- Aromatherapy oils were kept in fridges for all women to use throughout birth.
- We spoke to several women over the three days of our inspection and all reported their pain was managed well. One woman described feeling pain following delivery and said she felt listened to and was offered options for pain relief 'within minutes.' She also described midwives returning to check on any improvements in her pain.
- 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 Entonox 'gas and air' or pethidine pain medication. Patient information also encouraged the use of birthing pools for pain relief and management.
- We were told women requesting an induced abortion were routinely offered pain relief in line with RCOG guidance 'the care of women requesting induced abortion'. We saw guidance that women should routinely be offered pain relief such as non-steroidal anti-inflammatory drugs (NSAIDs) during surgical abortion.
- Patients were offered a choice of menu options and dietary requirements were taken into consideration. Patients we spoke with reported the food was good and options were available.
- Patients were invited to help themselves to a variety of breakfast items from the day room on wards; if a woman was not mobile then staff helped her choose and delivered it to the bedside..
- Peer support workers were trained to support women with feeding their babies. They were in attendance every week and women reported positive feedback about the care they received.
- The department offered a breastfeeding room and had a specialist breastfeeding midwife to support women. We spoke to a woman who was struggling with feeding and she said she had a midwife attend every time she fed her baby to support and help her.
- Workshops were held twice a week. These aimed to help women struggling to breastfeed and support them to do it.
- In the 'Walking the patch' exercise carried out by the maternity support liaison committee (MSLC) we reviewed several responses from women who felt pressure to breastfeed and were not supported to bottle feed as they would have liked. Comments included: "More options on feeding - not just breast feeding it wasn't explained to me how to bottle feed - I feel that I was shut down a lot." And "More help navigating the mass of bottle feeding equipment - when breast feeding failed I found it very tricky to get help and I felt guilty. I had great breast feeding support."
- Women were given appropriate advice prior to surgery about fasting for both elective caesarean and gynaecological procedures.
- All patients we spoke to said they had received support to breastfeed soon after birth, and that this had continued on the post-natal ward.
- Patient information of breastfeeding support was seen throughout the department. We also saw information on the drop in breast feeding service.
- Women were given advice on healthy eating in their maternity notes along with risks associated with weight gain and diabetes.

## Nutrition and hydration



# Maternity and gynaecology

- There was a breastfeeding room for women to use with breast pumps and a fridge to store breastmilk. If women wished to bottle feed, sterilisers were readily available.

## Patient outcomes

- There were 2822 births reported from April 2016 to January 2017 at RSCH. Normal deliveries accounted for 61% of these births, this is worse than the trust target of 70% or higher. Births by caesarean sections (planned and unscheduled) on average accounted for 27%, which was worse than the trust target of 20% but in-line with national averages.
- The department aimed for a rate of 50% of women who chose to have a vaginal birth after caesarean (VBAC). This target was met, in all but two months, from April 2016 to January 2017. Women who then went on to successfully have a VBAC delivery averaged 62% which was worse than the trust target of 75%.
- The trust target for emergency caesarean section was 13%. This target was not met for half the months reported with a high of 20% being reported in January 2017. However, the figures reported were in-line with national averages.
- The trust also performed worse than the 10% target for elective caesarean sections. From April to October 2016 percentages were as high as 20% and an average of 16%. However, these figures were showing improvement with the target being met from November through to January 2017.
- The number of term babies admitted to Special Care Baby Units (SCBU), neonatal intensive care or the neonatal high dependence unit was worse than the trust target, with an average 4% of all births, this was against a target of 0%.
- The trust also reported ten babies born with meconium aspiration against a target of 0 from April 2016 to January 2017.
- From 2015 to 2016 the trust reported that 32% of women with suspected or confirmed foetal anomaly being seen by an obstetric ultrasound specialist within three days against a target of 100%.
- The national neo-natal audit programme (NNAP) standards report babies of less than 29 weeks gestation should have their temperature taken within an hour after birth. It was reported at RSCH that 88% of babies had their temperature recorded, this was worse than the NNAP standard of 98% or above.
- The trust target for women experiencing third or fourth degree tears was set at 5%, between April 2016 and January 2017 this was met for four out of the 6 months with an average of 4.9%, this is in-line with trust targets.
- The trusts homebirth team achieved a national RCM award for Better Births in 2016 and have achieved an average rate of 5.6% homebirths, better than the national average.
- There were no reported term neonatal deaths between April 2016 and January 2017. This was below the national average of 0.27% and in line with the trust target of none.
- An average of 93% of all mothers who delivered babies between 24+0 and 34+6 weeks gestation were given a dose of antenatal steroids. This is better than the NNAP target of 85%.
- The trust had less antepartum stillbirths than the national average. During the period April 2016 and January 2017 there were 12. This accounts for 0.42% of births in the reporting period.
- The trust reported no intrapartum deaths of babies for the period April to January 2017, however just prior to our inspection one case had been reported. This was under review and a full root cause analysis (RCA) was due to be completed.
- The gynaecology department was, at the time of the inspection, developing the Urogynaecology service to work towards BSUG (British Society of Urogynaecology) accreditation, alongside this they are also developing the nurse led services.
- The supervisory team had undertaken a range of clinical audits over the preceding year. We saw audit reports and action plans for peripheral vascular cannula (PVC) carried out in 2017, the results were below the standards expected and as a result the department now reviewed cannula patients at every safety huddle. This showed the department were actively trying to benchmark and keep a continuous record of activity within the department to ensure high standards.



# Maternity and gynaecology

- As of February 2017 we reviewed data submitted by the trust and found there were no active maternity outliers. We viewed the maternity table for measuring medical outliers, this indicated that between the period April 2012 and February 2017 there was no evidence of risk for elective caesarean section, neonatal readmissions, puerperal (relating to childbirth) sepsis and other puerperal infections, maternal readmissions, and emergency caesarean sections.
- Brighton Hospital University Trust were taking part in the Maternal and Neo-natal Health Safety Collaborative. This is a national initiative to reduce the rates of maternal deaths and stillbirths and brain injury. They introduction to this scheme was attended by the matron, obstetric lead and labour ward leads.

## Competent staff

- Between April 2016 and January 2017, 76% of staff in maternity and gynaecology had received an appraisal, worse than the trust target of 85%. However, this was an improvement on the previous year where appraisal rates were 59%.
- Labour ward leads had recently introduced band 7 midwives being allocated a group of midwives for which they were responsible. The role included increasing the usability of appraisals to set realistic goals. Since the new system had been implemented in January the appraisal rate at RSCH has improved to 91% showing this was having a positive impact.
- We spoke with staff at all levels who had reported appraisals were positive and included development within the department.
- New midwives joining the trust completed a comprehensive preceptorship programme. This included completing a midwife development handbook, where evidence of competency was documented and awarded. There are trust wide competencies for bands five to seven. The band 2 maternity care assistants (MCA) had a separate booklet setting out competencies.
- Maternity care assistants (MCA) recently undertook an away day for training which was well attended and aimed to extend the role. Staff who attended were given an MCA care certificate. We spoke to an MCA who said the training was useful and made them feel included in the team and more informed.
- Matrons supported band sevens clinical competencies which included a comprehensive list including administration of oral medication, administration of intravenous (IV) medication, epidural infusions, bereavement care, maternal resuscitation and CTG interpretation.
- We spoke to a band six midwife who had recently joined the trust. She said she felt welcomed and had one month in a supernumery position and felt that her orientation had been good.
- The trust employed a dedicated preceptorship midwife and a midwifery placement educator who met with midwives throughout their employment. They also helped with the training development of student and newly qualified midwives.
- In line with NICE guidance many specialist midwives were employed by the trust. These included substance misuse /travellers midwife, teenage pregnancy midwife, pregnancy loss midwife, birth stories midwife, Infant feeding midwife, birth options midwife, safe guarding midwife, clinical skill facilitators, practice development Lead and a practice educator. All specialist midwives were band six or seven meaning they had the necessary experience.
- The trust also employed a NIPE lead midwife, newborn screening coordinator and a governance support midwife.
- Consultant appraisals were managed centrally by the trust. All consultant appraisals were up to date. Obstetrics and gynaecology staff were usually appraised by consultants or associated specialists in other specialties.
- The foetal anomalies obstetric sonographer worked in line with accepted authorities in this field and followed Antenatal Reproductive Choices (ARC) and had relevant accreditation and audit in line with the National Screening Committee guidance for screening for detection of foetal anomaly.
- The department had recently trained several members of staff to carry out the Newborn and Infant Physical

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Examination (NIPE) check prior to discharge. The department now employed a NIPE lead midwife who had led on the changes. This was having a positive effect on the flow through the department and reduced delayed discharge.

- We viewed three sets of minutes from the Women's Directorate audit/clinical governance meetings dated October 2016, November 2016, and January 2017. We saw that the meetings regularly offered medical staff opportunities for learning. For example, minutes from the meeting dated 9 November 2016 recorded that a presentation had been given to medical staff from across the Women's Directorate. This involved a case study of the misdiagnosis of early pregnancy; lessons learnt from the case were disseminated to staff at the meeting. This approach offered staff opportunities for learning during daily routines and enabled staff to remain up-to-date with educational developments.
- We saw the trust's Local Supervising Authority Audit Report for 2015-16, although supervision of midwives is no longer nationally recognised we felt it was still relevant as the changes only came in on the 1st April 2017. The report showed 75% of midwives had an annual review with a supervisor of midwives (SOM) in 2015-16. One of the purposes of the annual review was to determine that individual midwives met the NMC requirements for revalidation, including evidence of continuing professional development. We were told that nurses and midwives had hours put aside for revalidation to ensure they had appropriate support. The LSA reported all members of the SOM team had completed their self-assessment competency document and activity sheet.
- We were told that nurses and midwives had hours put aside for revalidation to ensure they had appropriate support.

## Multidisciplinary working

- Staff we spoke to reported good multidisciplinary working relations between midwives, midwifery support workers, paediatricians, consultants and other staff. Midwives told us they contacted consultants if they needed advice, for example, around risk assessments, and found consultants approachable.
- We heard from managers and staff that multidisciplinary working was essential for the smooth running of the department. We heard good examples of community midwives engaging with midwives and consultants on site.
- We saw several examples of multidisciplinary working. The daily huddle meetings were well attended by staff across the whole women and children's department including paediatricians, anaesthetists, junior doctors, lead clinicians, ward clerks, midwives and department leaders.
- We observed a prompt multidisciplinary response to a crash call on the gynaecology ward. This showed good team working and correct procedures were followed, for example correct use of PPE and hand hygiene even in emergency situations.
- Bereavement services had improved communication links with the mortuary services, mental health teams and midwives and as a result they were all notified of any deaths within the service via an email. An alert was sent when the e-mail was received so the bereavement lead was ensured they had been notified.
- Meetings across the department were attended by multidisciplinary teams, for example the weekly risk meeting was attended by midwives, matrons, consultants, physiotherapists, and specialist midwives.
- We were given example of external working between maternity departments in neighbouring NHS hospitals with regards to transferring babies to higher dependency units with specialist care facilities.
- We saw effective working between other hospital teams, social services, local GPs and the midwifery team when dealing with women with mental health problems.
- We were told of good working relationships between the physiotherapists and staff within the maternity and gynaecology department.
- We saw evidence that women with multiple pregnancy were cared for in line with NICE guidance. For example QS46:statement 3 'women with a multiple pregnancy are cared for by a multidisciplinary core team'.

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- Patients were discharged with a contact number to call for any issues which arose after leaving hospital. We saw a midwife explaining to a patient they were available 24/7 and to call if she had any worries.
- Patients received a paper discharge summary from the gynaecology wards, an electronic copy was sent to GP surgery's for review.

## Seven-day services

- Midwife support, consultants and anaesthetists were available on site 24 hours seven days a week. This ensured women had access to support and advice at all times.
- The gynaecology assessment unit was open 24 hours seven days a week for all emergency gynaecology. There was an onsite pharmacy which was accessible at all times of the day and night.
- Maternity services offered a 24 hour telephone triage service. This service could be accessed at any stage of pregnancy.
- The day assessment unit in maternity accepted patients at all times. As there was a dedicated team that worked 24 hours, seven days a week. Supported by community midwives if available.
- Pathology services were available at all times.
- Foetal anomaly screening was available Monday to Friday and routine ultrasounds examinations were available on the day assessment units at all times.

## Access to information

- Staff told us they could access policies, protocols and other information they needed to do their job through the trust intranet. They also had internet access to evidence-based guidance from bodies such as NICE and the Nursing & Midwifery Council (NMC). We saw computers available to allow them to do this.
- Women who used maternity services had hand-held antenatal records that they brought with them to all appointments. This allowed multi-disciplinary staff to access up-to-date records to enable ongoing care.
- Midwives sent discharge summaries to community midwives and GPs when a woman and baby went home from hospital. This enabled ongoing care within the community.

- The trust has published its own website for women; who included pages specific to screening and electronic links to information leaflets, both national and local. The web address is given out to all women and can be found within the antenatal hand held notes.

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

- Following our last inspection we told the trust it should make improvements in reviewing the consent policy and process to ensure confirmation of consent was sought and clearly documented.
- We saw evidence that an audit of consent processes had taken place and an action plan including the availability of patient information had been undertaken. We found the consent policy had been reviewed and consent champions had been appointed. A workshop was held in November 2016 to re-introduce the consent champions. A consent audit was scheduled in April 2017 the results of this audit would be presented in July 2017.
- We saw staff verbally gaining consent before commencing any treatment. Staff were seen fully explaining procedures and the associated risks of accepting the treatment or not.
- Staff followed the trusts Policy for Consent to Examination or Treatment dated 18th February 2016. We reviewed this document which was detailed and highlighted the duty to appoint an Independent Medical Capacity Advocate (IMCA) for patients who lacked capacity.
- The document also outlined the use of 'Gillick competencies' in relation to children. Gillick competence reflects a child's increasing development to maturity. The parents cannot overrule the child's consent when the child is judged to be Gillick competent. The understanding required for different interventions will vary considerably and therefore a child under 16 may have the capacity to consent to some interventions but not to others. Staff we spoke with understood their roles in relation to this.
- Staff were aware and followed the trusts Mental Capacity Act Policy (Incorporating Deprivation of Liberty Safeguards) dated March 2016. We were shown how to access this policy through the staff intranet, if they needed it for reference.

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- We spoke with staff members about the Mental Capacity Act 2005 and staff demonstrated a good awareness of consent procedures. A midwife we spoke with explained she had recently had concerns about a patient in her care and had escalated to the perinatal mental health specialist.
- The trust has, in accordance with the Department of Health (DoH) Guidance (2009), adapted the previous DOH standard consent forms. There were two versions of the standard consent form one for adults or competent children/young people, one for parental consent for a child or young person. There was also the assessment of capacity form for adults found unable to consent to investigation or treatment following an assessment of capacity.

## Are maternity and gynaecology services caring?

Good



During our previous inspection we rated caring as good because:

- Patients were positive about the care they received. We saw kind interactions between staff and patients.
- Women were involved in the care they received and supported emotionally.
- The department considered the needs of patients and their partners and family in decisions about the care they received.

We rated caring as good because:

- Patients we spoke with were positive about the treatment they had received and the staff they encountered.
- Staff treated patients with dignity and respect. We saw compassionate interactions between all staff members and the patients they interacted with.
- Patients were involved in the care they received and their wishes were met if possible.
- Women were supported in making informed choice about birth settings which were appropriate to clinical need and risk.

However:

- Friends and family data showed worse than expected results in community postnatal care and the recent 'walk the patch' initiative showed not all women felt they had received the best care.

## Compassionate care

- Between January 2016 and January 2017 the trust's maternity 'Friends and Family' antenatal performance was generally similar to the England average. In the latest month December 2017 the trust's performance for antenatal was 100% compared to a national average of 95%. From February 2015 to December 2016 trust performance was mostly in line with the England average.
- The trusts recommendation rate Between February 2016 and November 2016 was generally similar to the England average. In latest month December 2016 the trusts performance for birth was 97% compared to a national average of 97%.
- Between February 2016 and January 2017 the postnatal ward performance was generally similar to the England average. However, in latest month January 2017 the trusts performance for postnatal ward was better with 97% compared to a national average of 94%.
- Between February 2016 and January 2017 postnatal community was generally worse than the England average. In latest month January 2017 the trusts performance for postnatal community was 94% compared to a national average of 98%. From March 2016 to January 2017 trust rates were on average 9% lower than the England averages for post-natal community services.
- The trust performed better than other trusts for two out of 16 questions in the CQC Maternity survey 2015. The two areas were for the questions: "If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?" and "Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby. The trust scored similarly to other trusts for the remaining 14 questions.
- Women received a text from the 'Friends and Family' feedback service and could rate their experience on the

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units. Staff told us that the response rate was not high as they felt that once women left they forgot to leave feedback or were too busy with their new babies to respond.

- The gynaecology department 'patient voice' scores were displayed on the ward. Between February 2016 and February 2017 there had been 490 patient responses of these 99% said they would recommend the services on level 11, with 93% saying they were always treated with kindness and compassion.
- We saw staff introducing themselves to patients and explaining their roles within the department. This was in-line with NICE guideline QS15, statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.
- We saw staff taking time to interact with patients and saw examples where staff demonstrated the importance of gaining the trust of women they were seeing.
- Staff pulled curtains around patients before undertaking examinations or providing care, maintaining patient's privacy and dignity.
- Members of the gynaecology team were involved in the Care and Compassion team which was involved in the introduction of trust wide cards for patient feedback around experiences and staff members.
- When asked, patients were mostly able to tell us the midwife that was in charge of their care on that day. A lady told us that she had seen "several different midwives, but they had all been lovely."
- Positive comments included: "All staff were busy, but seemed really nice," and "Community teams were amazing, couldn't fault them."
- We saw photographs of all staff displayed within the department. This helped patients to identify staff members during their stay.
- consultant clearly telling a woman the risks associated with her situation and gave her several options and respected her decision. She was given plenty of time to ask questions throughout.
- Women's introduction pack included advice on completing a birth plan which identified the risks associated with some methods of pain relief. Community midwives were involved in helping women make informed choices about where they wished to give birth and any pain relief they may want.
- Staff demonstrated an understanding of how to support mothers and their loved ones to understand and be involved in their care and treatment.
- We spoke with a mother who was due to have an induction that day. She explained she had waited a while to come up to the ward as there had been a miscommunication that had meant she was held in the day assessment unit for over an hour. Despite this she still spoke positively about the care she had received.
- Antenatal classes were offered to all women. These could be booked through the maternity matters website or arranged with community midwives.
- We were given examples where women had used a Doula. A Doula is a non-medical person who assists a person before, during, and/or after childbirth, as well as her spouse and/or family, by providing physical assistance and emotional support. The midwives we spoke to were open and respectful of women's' birth choices.
- The Trust performed better than the England average in the CQC Maternity Survey in November 2015 for the question, 'If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted? The trust scored 9.8 out of 10 for this question.
- We reviewed 'Walk the Patch' reports from April 2016 through to January 2017. Feedback from women was mixed, with several comments about midwives being busy, and feeling that they didn't have time to spend with the women. Comments like 'I was left in recovery for 3.5 hours after the birth with no indication of what was happening or when /if I would be moved.' Another

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

- Staff communicated with women and their families and care partners making sure they understood the treatment they were to receive and the risks associated with this in line with NICE QS 15 statement 5. We saw a



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reported, 'I got left waiting in triage for 1 and half hours, once I was assessed another 2 hours to be moved upstairs'. More comments included, 'How good can someone be under that pressure.'

## Emotional support

- The trust had two named bereavement midwives who supported women and their families following stillbirth or neonatal death. Their role included attending 'Stillbirth and neonatal death' (SANDS) meetings and working with the SANDS guidelines to provide women with adequate support following the loss of a child.
- All midwives undertook bereavement training as part of their mandatory training.
- Patients were assessed for any extra care needs they may require at booking in with the community midwives. This includes an assessment for post-natal anxiety and depression.
- Women had access to counselling and could be referred to by consultants, if needed. We saw patient information on these services and advice to women about support services available.
- The bereavement lead told us they could refer women to the hospital Chaplaincy including multiple faiths for emotional support.
- Staff also said they had a very good relationship with the local authority social work team and would refer women in need of emotional support to a social worker, to ensure women had access to information on community support on discharge from hospital.
- Extra staff training on transgender was undertaken after a complaint dating back to 2015. We heard about a case recently where patient who identified as male gave birth in maternity service, according to staff this was handled much better due to learning from 2015 incident.
- There is a Birth Stories service offered to women in the first year after birth. Birth Stories gives women, especially those who may have experienced a traumatic labour, the opportunity to talk through any aspect of their experience. It provided a one to one session with obstetric notes available on request. Referrals were accepted from midwife, GP or health visitor and also

from mental health and wellbeing services.

Appointments are generally available within 8-10 weeks of referral. The Birth Stories midwife worked 3 days a week clinics were available across sites.

- Women undergoing termination of pregnancy were offered support and counselling before and after procedures.

## Are maternity and gynaecology services responsive?

Good



During our last inspection we rated responsiveness as requires improvement this was because;

- Referral to treatment times (RTT) in gynaecology were not being met for admitted patients pathways completed within 18 weeks.
- During our previous inspection we found women were often being transferred and units were being closed due to lack of staff.
- The Gynaecology ward was often admitting medical outliers which caused delays and problems admitting women from the GAU if needed.
- There was no midwife led birthing unit.
- The day assessment unit was not open every day as it was closed on Sundays.
- There was a lack of antenatal classes and some women were not able to access these in a timely way.
- Triage was often closed because of staffing issues.

During this inspection we rated responsive as good because:

- Referral to treatment targets were improving with RTT targets being met 94% of the time compared to the England average of 95% reported in February 2017.
- All patients received diagnostic tests with six weeks between July 2016 and February 2017, which was better than the national target. This showed an improving picture and that the gynaecological needs of women were mostly delivered in a timely way.



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- The department had recently introduced a computer system that allowed a real time assessment of activity across both sites. The aim was to improve patient flow and it allowed staff to increase ownership and monitoring rationale for caesarean section. There were no closures reported at RSCH from April 2016 to January 2017 and 38 diverts. This was compared to 83 diverts during the last inspection period, showing that improvements had been successful.
  - There have been improvements to the availability of antenatal clinics and the trust has a 'Maternity matters' website which has up to date information for women accessing the services. This included email addresses to specialist midwives and an online booking form to enrol on antenatal classes.
  - The individual needs of patients were considered across maternity and gynaecology departments.
  - There has been no further development of a midwife led birthing unit since our last inspection, however women were given choices about the type of birth they wanted and their needs were met wherever possible.
  - The day assessment unit is now available 24 hours a day
  - There was now a designated triage team allowing for better continuity of care and improved communication via a shared drive and an improved system for recording calls. The improvements have led to a reduced number of triage closures and reduced complaints about triage.
  - A range of specialist midwives were available ensuring women's individual needs were met.
- addressed and the area showed some improvement including a refreshment trolley and a privacy screen. The staff took part in a fund raising event to raise the money for improvements to the environment.
- There was now a designated triage team allowing for better continuity of care and improved communication via an online shared drive and an improved system for recording calls. The improvements have led to a reduced number of triage closures and reduced complaints about triage.
  - Foetal anomaly screening was available Monday to Friday and routine ultrasounds examinations were available on the day assessment units at all times.
  - The gynaecology department consisted of gynaecology outpatients including colposcopy, a gynaecology assessment unit and an early pregnancy Unit. Acute gynaecology was provided at the RSCH which was also a tertiary centre for gynaecology oncology. As a result three gynaecology lists were conducted each week to allow women to access treatment in a timely manner.
  - Alongside emergency referrals from the emergency department, community midwives, local GP's referred women for gynaecological procedures.
  - Antenatal care, parent craft and postnatal clinics were provided in a variety of locations including GP surgeries and children's centres throughout the area. This encouraged attendance by taking services closer to where women lived.
  - The trust's maternity dashboard showed an average of 89% of women receiving antenatal care at RSCH saw a midwife for their booking appointment by 12 weeks and six days of pregnancy from April 2016 to January 2017. This was slightly worse than the trust target of 90% agreed with the local strategic health authority.
  - Patients are triaged before arrival onto the unit. Patients with additional needs were flagged at this point so staff were aware pre-admission if any extra care needed to be provided.
  - We reviewed the trust website which included a range of welcoming information for women and links to a variety of useful information. New developments to this include information for women when they have been discharged home after the birth.

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

- Bed occupancy levels for maternity services were higher than the England average, the trust had 79% occupancy from December 2016 to March 2017 compared to the England average of 59%. To address this increase the trust had recently employed more midwifery staff and adjusted the structure to provide support to staff, for example by employing a governance lead and a maternity and gynaecology manager.
- The triage area had recently been developed following a number of complaints from patients. The area was highlighted on the last CQC inspection as not giving patients enough privacy. This had been mostly

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- Women were given a discharge date when they were booked in for a planned caesarean section. This enabled women to plan discharge arrangements and family support if needed. We asked two patients post caesarean if they had a date for discharge and both were aware of their planned discharge date. The trust employed a specialist midwife to lead the planned caesarean section pathway of care.
- The gynaecology wards operated a system of 'enhanced recovery' for all post-operative patients. Enhanced recovery is a modern evidence-based approach that helps people to recover more quickly after having major surgery.
- Women could attend a 'Vaginal Birth After Caesarean' (VBAC) clinic. This served to help women who wished to have a VBAC and offered information and advice from an obstetrician and a midwife. An average of 46% of women opted to try for a VBAC.
- Parents could attend classes if they were interested in having a home birth. These sessions were also attended by parents who had recently had home births to share their experiences. The home birth rate was one of the highest in the country indicating women were supported to choose this service.
- There was no allocated room to talk to patients about difficult situations on the day assessment unit, however we were told there are lots of side rooms and assessment areas that would offer privacy if needed.
- The trust followed Human Tissue Authority (HTA) guidance (2015) of the disposal of pregnancy remains following pregnancy loss or termination.
- A perinatal mental health specialist was employed within the department. This ensured a specialist midwife was available to advise on patients and help patients who needed extra support.
- Patients with mental health issues are put on a care pathway and have regular contact with the perinatal mental health midwife and lead consultant. An alert was placed on the system so anytime the woman contacts the department staff were aware of her extra needs and care plan.
- There was a mental health 'one stop' clinic that provided a psychiatric assessment and development of a care plan; this was shared with GPs, health visitors and midwife as necessary. A copy of the care plan was sent to patients and kept with hand held notes and included actions needed if a patients mental health deteriorated at any time during the pregnancy or after the birth.
- Women were referred into the clinic by GPs, midwives, health visitors or mental health professionals. Appointments were offered within 28 days of referral. Clinics ran once a week and did not offer urgent appointments.
- The trust offered a diabetic clinic for women identified as at risk of gestational diabetes. It is located in a separate area of the hospital. Mothers had dedicated diabetes notes and a new diabetes protocol which aimed to reduce inductions of labour for women with gestational diabetes.
- The trust has a 'Maternity matters' website which had up to date information for women accessing the services. This included email addresses to specialist midwives and an online booking form to enrol on antenatal classes.
- There was a Facebook page for mothers to get support from peers and meet new people. Staff and patients said this had been a useful tool in helping new mothers feel more prepared and supported.

## Access and flow

- The maternity and department had reported no closures since April 2016, however the unit did report 38 diverts within the trust from April 2016 to January 2017. Staff said the reason for transfer between sites was usually risk to mother or baby and the need for more specialist care at RSCH. The trust does not report on whether women were able to give birth in their preferred hospital. All women were told from the booking stage that they may have to go to either the Princess Royal or the Royal Sussex County Hospital.
- The referral to treatment targets (RTT) in gynaecology did not meet the England average for admitted patients pathways completed within 18 weeks in any month from April 2016 to February 2017. However, the percentage rates were improving throughout the reporting period with rates of 94% compared to the national average of 95%, reported in February 2017, this was an increase of 8% from August 2016.

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- All patients received diagnostic tests with six weeks between July 2016 and February 2017, which was better than the national target. This showed an improving picture and that the gynaecological needs of women were mostly delivered in a timely way.
- The gynaecology ward had nine beds and often admitted patients that were not gynaecological patients (medical outliers). We were told that this was a daily occurrence and that it could impact on staffing. However, a strictly followed criteria was adhered to in these circumstances. For example, patients were not admitted if their estimated discharge date was more than 48 hours and only female patients who were screened and MRSA negative were accepted.
- Staff told us there was a lack of beds and that the fact they offered an enhanced recovery service meant they were often called upon to accept non-gynaecological patients. This could lead to delays from patients in the gynaecology assessment unit being transferred to the gynaecology ward.
- Staff spoke positively of the impact that Newhaven hospital had been having since it opened a step down hospital, accepting patients to ease the pressures on wards in BSUH. Staff reported that they were cancelling fewer women's appointments as a result.
- Early pregnancy assessment unit was open from 8am - 4pm daily, with early ultrasound scanning from 8-12 Monday to Friday and a later afternoon session running until 7:30pm for use within the gynaecology and early pregnancy unit.
- Community midwives provided care in children's centers, GP practices and the home. They provided antenatal and postnatal care from the first pregnancy appointment until discharge, usually around ten days after birth, when they hand over care to the health visiting team.
- Women had 24 hour access to the triage phone line for advice or if they were in labour or experienced any immediate problems, such as bleeding. The triage system for all women went through a dedicated triage midwife and depending on the women's needs they were brought into the day assessment unit, triage room or directly to labour ward.
- We looked at the triage consultation form, which was completed for all calls coming into the unit. It included planned place of birth, risk factors (for example: headaches, raised blood pressure), past history, medical conditions, foetal movement, vaginal bleeding (PV), pain and any blood loss.
- On the postnatal ward women were placed in bays specific to their needs post birth, for example, women who may need more assistance following a caesarean section. A transitional bay with six beds allowed mothers and their babies to receive extra care and was located opposite the nurse station. Higher risk patients across all wards were placed near the nurse's station so they were close to medical staff if needed.
- The hospital planned for three caesarean sections a day on weekdays. Occasionally four patients were booked in on one day but staff told us that often they could move patients to ensure an even workload.
- Women who were booked for planned caesarean section or emergency cases were given spinal and general anaesthetics in theatre, and post-surgery were taken to the recovery area and then to the post-natal ward.
- The department had recently introduced a computer system that allowed a real time assessment of activity across both sites. The aim was to improve patient flow and it allowed staff to increase ownership and monitoring rationale for caesarean section.
- Discharge planning included information packs for women outlining medication needs, doctor's appointment and follow up, and women's contraception methods. We saw all of this discussed with patients before departure and advice was given on cot death risks including smoking and sleeping positions for baby. Patients were given an opportunity to offer feedback about the care received.

## Meeting people's individual needs

- Safer childbirth standard 2.2.20 states 'Women have the right to choose where to give birth. If a woman chooses to give birth at home or in a midwifery unit contrary to advice from midwives and obstetricians, there needs to be clear documentation of the information given'. We

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saw documented evidence that this standard had been met in patient's notes and speaking to women on the postnatal ward where their birth plan had not been possible.

- There was a dedicated home birth team which had recently won a Royal College of Nursing award for better births (2016). We saw a strong collaborative workforce which allowed community and hospital midwives to work effectively between sites and in the community.
- Beds were to the side in all rooms to make it feel less clinical with a birthing ball in situ and mats and other bathing aids. Recent maternity matters guidelines suggest 'All birth environments designed to offer a home-like comfortable environment with ensuite facilities, including equipment such as comfortable chairs, beanbags, mats, balls, baths and birth pools.'
- Women were given a named midwife and contact number on booking, in line with NICE guideline QS22 statement 2.
- Community midwives identified patients who would need translation services at booking. Staff within the hospital were made aware before admission and translation services put in place. These were primarily face to face although if this was not available telephone translator services could be accessed.
- The postnatal ward and special care baby unit (SCBU) were not located on the same floor. Although this could mean mothers did not have easy access to their babies, the department had put in measures to ensure women could spend as much time as they wanted with their newborn. An example of this was texting women who were visiting the SCBU if their meals had arrived or if a consultant was doing ward rounds. This allowed mothers on postnatal ward recovering from birth to visit and spend time with their babies and to enable breastfeeding without the worry they were missing activity on the ward.
- Bariatric patients were catered for with wider chairs in the department and beds which could hold patients up to 220lbs, if a further weight limit was needed a suitable bed from other areas of the hospital could be requested.
- The department had pathways of care for patients with learning disabilities. Patients were identified in the booking stage and offered advice and extra support if

needed. Patients could be referred to the Learning difficulty Liaison Team (LDLT); the specialist team liaised with the client and multi-disciplinary teams and family members regarding the person's needs. This included attending outpatient appointments if necessary or home visits to discuss individual needs.

- Patients with mental health issues were placed on a care pathway and had regular contact with the perinatal mental health team. An alert was placed on the system so anytime the woman contacted the department staff were aware of her extra needs and care plan. The trust has recently employed a specialist mental health lead midwife although they were not in post at the time of inspection.
- Midwives were able to recount times when they had tried hard to meet the needs and preference of individual patients with additional needs. A recent example of this was a woman who wished to give birth to twins at home. During the weekly 'Complex Care' meeting, staff volunteered to assist the delivery depending on their individual skills. This enabled the mother to have the birth she wanted and the department were able to make reasonable adjustments.
- We were told conditions such as dementia were hard to manage on the gynaecological ward due to the time consuming nature of their condition. There was a link dementia nurse who would be involved if dementia outliers were admitted. The hospital also used "this is me" dementia passports. Dementia passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient's individual needs.
- A teenage pregnancy specialist midwife was in post; her role was to offer extra support and education to younger people who were pregnant. This included ensuring single rooms being offered to younger mothers and parents being able to stay with them at all times.
- Staff identified some issues around getting more vulnerable woman to attend antenatal check-ups within the hospital and community midwives were mindful to allow the women to choose a time that was suitable for them and if necessary provide transport for them to get to hospital. This showed an understanding of the

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woman's vulnerable situation and a positive team approach. This is in-line with NICE CG 110: Recommendations for pregnant women who have complex social factors.

- The department had two bereavement midwives across both sites. Their role included attending 'Stillbirth and neonatal death' (SANDS) meetings and working with the SANDS guidelines to provide women with adequate support following the loss of a child.
- There was no dedicated bereavement suite on the labour ward although a room was set aside if possible which is away from the main delivery suites. This room was in need of development as it was clinical and had only a medical bed in situ. We were told that the local SANDS group along with the bereavement midwives were fundraising to make improvements to this area.
- Bereavement services had improved since our last inspection. There was now 15 hours a week dedicated to the bereavement leads. The service included bereavement training as part of mandatory training and improved links with Child Death Overview Panel (CDOP) and The Trevor Mann Baby Unit (TMBU) in Brighton a specialist unit for the care of premature and sick newborn babies. This helped to ensure all losses received the appropriate care.
- The bereavement lead gave us an example where a bereaved mother had enlisted the help of a charity to make some age appropriate clothes for babies born before 25 weeks, this enabled babies to be photographed in clothes that fit and families have been positive about the impact of this.
- The bereavement services also had connections with a charity that specialise in loss that would come and take professional photographs as and when needed free of charge.
- Post mortem examination was offered in all cases of stillbirth and neonatal death. This was following recommendation four of the MBRRACE UK to improve future pregnancy counselling of parents. We saw the documentation related to this in a checklist, which was completed following stillbirth or neonatal death. The bereavement lead had developed a walk through folder to help midwives fill out the appropriate forms correctly and personally checked all paperwork to ensure completion was handled in a timely way.
- Extra support was offered for women with multiple births. This included being offered a side room on the post-natal ward.
- Extra staff training on transgender was undertaken after a complaint dating back to 2015. We heard about a case recently where patient who identified as male gave birth in maternity service, according to staff this was handled much better due to learning from 2015 incident.
- Partners were able to stay on post-natal wards, a leaflet explained some ground rules and outlined expectations. Partners could visit at any time and parents own children from 9am-6pm. General visitors from 2pm-8pm and were limited to two at one time. Women we spoke with generally thought visiting hours were reasonable. Women who did not have partners staying were generally kept in different bays so that they did not feel vulnerable
- Patients were offered food options and this included religious choices, for example, halal options. Staff could ring the kitchen to make meal requests and cater for patient needs if possible.
- 'Congratulations on your birth' information was given to all women post birth. This included information on meal times, time of drug rounds. Patients were informed to ask staff outside of these times for pain relief if needed.
- Leaflets were readily available; we saw several relevant leaflets available throughout the maternity and gynaecology wards and departments. The leaflets had information on the back on how to access the information written in several different languages. Staff told us these were printed off as and when they were needed.

## Learning from complaints and concerns

- Between January 2016 and February 2017 there were 74 complaints about maternity and gynaecology. The trust took an average of 54 working days to investigate and close complaints, this is not in line with their complaints policy, which states that 90% of complaints should be responded to and closed in less than 40 days.
- Only 35% of complaints were responded to and closed in less than 40 working days. Most complaints, 78% were about deliveries (20%), care and treatment (19%), staff attitude (15%), treatment pathways (12%), communication (8%) and delays in treatment (4%).



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- The complaints policy stated that complaints were acknowledged within three to seven days. This contact was, where possible, by phone. If this was not possible, a letter was sent outlining what exactly would be investigated and complainants were asked to confirm they were happy with this process.
- Following on from this, a letter was sent to clinical teams asking them to respond within a set timescale. There were dedicated complaints advisors who were attached to specific departments.
- We saw evidence of appropriate responses to complaints, including apologising to patients and meeting with them to review their notes and offer explanations. We saw evidence of learning from complaints. An example of this was recent change to the environment in the triage area.
- Complaints were discussed as part of the weekly risk meetings. We asked several staff members if they could give us examples of any learning from complaints. We were told complaints were fed back to staff but nobody could give us any specific examples of change as a result of a complaint.
- Evidence of any actions taken must be updated on the electronic recording system before a complex complaint was closed down.
- A ward manager we spoke to on the gynaecology ward told us she handled all complaints immediately. If possible she would try to resolve on site directly with the patient. If this was not possible she would signpost to the PALS department. The complaints department handles all formal complaints.
- Gynaecology department were involved in two 'away days' annually recently this included reviewing recent complaints to check the process was fair and the outcome was agreed.
- We saw information on making complaints across the department. When asked patients were not aware how to make complaints but generally said they would raise it with the midwives.
- At the entrance to the day assessment unit there was a board with information on staffing levels and patient information. It also included a 'You said, we did' section. When asked we were told this was updated regularly.

## Are maternity and gynaecology services well-led?

Good



During our last inspection we rated the service as requires improvement, this was because;

- A vision and strategy for the service had been developed but the senior leadership team had not had involvement and it did not include timescales for strategic initiatives.
- During the last inspection we saw a workforce which had poor behaviours and poor relationships between midwives and consultants.
- The gynaecology department rarely attended safety and quality meetings for women's services.
- The Head of Midwifery and clinical director were not visible or approachable.
- There was a general mistrust between staff and tensions across site and in the community.

During this inspection we rated well led as good:

- Universally staff felt that there had been improvements in the culture of the organisation since our last inspection. They all reported that it was a different place to work than a year ago and that positive changes to the consultant body and leadership had been the driving force behind the changes.
- The women's directorate had a three, six and 12 month plans which were drawn up in March 2017. This included short and long term initiatives.
- We saw noticeboards for governance in every clinical area within maternity and gynaecology. These included information on the risk register, recent serious incident investigations and recent learning from complaints among other information
- Staff were positive about the role of the lead midwives and that they had had a positive impact on moving the department forward and had introduced many new initiatives.



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- The trust is one of 44 trusts throughout the country engaged in the Maternal and Neonatal Health Safety Collaborative. A three-year programme to support improvement in the quality and safety of maternity and neonatal units across England.

During our recent inspection we focused mainly on local and departmental leadership. This was because of recent changes at Executive and Board level. We saw improvements throughout the well led domain however; we still found that there were some problems at executive level which needed addressing, these included;

- There were no assurances that all staff were engaged in feedback received from the trust although staff were positive about departmental leadership.
- Prior to our inspection directorates were asked to self-rate their service. The staff we spoke to, even at senior level, had no input into these self-ratings, this showed a lack of engagement with staff from the executive team as they did not seek the opinions of staff working in the directorate to form a judgement on any improvements.
- The directorate did not take part in specific morbidity and mortality meetings. These meetings are an opportunity to review all deaths and adverse incidents including any incidents that have significant learning opportunities being discussed to explore key themes and identify any trends or themes. This could mean that any deaths or incidents within the service are not given thorough review by a multidisciplinary team.
- The risk register needed to be reviewed as we found some areas of risk that had not been included, for example fire safety issues.

## Vision and strategy for this service

- The service has been through several changes to the governance structure in recent times. Despite the recent changes, the service has adapted well and staff felt positive about the future of the service.
- We saw the visions and values of the trust displayed on noticeboards throughout the department. Staff were mostly able to relate to these and could tell us when questioned improvement plans, such as the development of a bereavement suite.

- The women's directorate had a three, six and 12 month plans which were drawn up in March 2017. This included short and long term initiatives. For example within three months the directorate plans to introduce gynaecology mortality and morbidity meetings and within 12 months the development of a second obstetric theatre and digitalise the community midwife teams.
- Staff were able to tell us about upcoming improvements and talked enthusiastically about recent changes in the department.

## Governance, risk management and quality measurement

- Within the trust there are 12 directorates, the directorate managers met fortnightly and feedback to the department on any hospital wide information.
- There were appointed clinical leads in all departments within the women's directorate, the role of the clinical leads was spoken about positively and the roles included knowledge of what challenges and opportunities are coming up in all departments.
- The department also attended practice improvement meetings on a monthly basis, these were for band seven and eight matrons to discuss issues with the chief nurse. What they discussed would depend on what was happening around the trust for example the education team attended recently and delivered a presentation. Staff told us attendance was variable depending on pressure on the hospital.
- The service had also introduced an 'action tracker' to track the implementation of action plans from the Women's Directorate operational meetings. The 'action tracker' tracked actions the directorate were taking to improve services, including: staffing needs, pathways and guidance, education and training, and equipment including IT.
- We viewed the 'action tracker' dated 6 January 2017. This highlighted that performance had improved in regards to referral to treatment (RTT) times. The 'action tracker' also identified obstacles to plans being implemented, for example, the service had identified that anaesthetists and surgeons were regularly not

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ready to start procedures at 8.30 as they were still seeing patients on the ward. In response the service were liaising with theatre co-ordinators and had communicated with theatre staff to be ready by 8.00am.

- Staff told us foetal loss would be 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.
- During a recent directorate review of clinical governance it was recommended that stronger governance systems, process and procedures needed to be developed and embedded within the service. This has been the key priority over the last twelve months and had formed the basis of quality improvements within the service over the past twelve months.
- The structure of meetings had improved since the last CQC inspection and it had improved team working. Some of the leadership team had been in post for nearly three years so had managed to embed processes.
- We saw noticeboards for governance in every clinical area within maternity and gynaecology. These included information on the risk register, recent serious incident investigations and recent learning from complaints among other information. Staff were encouraged to read these but some staff we spoke to were aware of the noticeboards but could not tell us what information was on them.
- Staff said they generally received information regarding incidents and were involved in making changes as a result of incident investigations.
- The trust had a quality performance committee and a performance monitoring system in place arranged under the five CQC domains. The scorecard recorded monthly scores for example under responsive there were scores for operations cancelled and referral to treatment time (RTT) data. Well led had results of completed appraisals, vacancy rates, staff turnover and costing. In the safe domain amongst other measurements, Never Events and serious incidents were recorded. Staff we spoke to told us that this enabled them to be aware of results and focus on areas where compliance was poor.
- Staff were positive about the role of the lead midwives and that they had had a positive impact on moving the department forward and had introduced many new initiatives.
- Midwives and maternity support workers (MSWs) reported to the ward leaders. The ward leaders then reported to the maternity and gynaecology manager who reported to the head of midwifery. Clinical services managers and the head of midwifery sat on the trust's ‘Safety and Quality Meetings’ for the women’s directorate. The committee met monthly and provided quality and safety assurances to the trust board. We saw that matrons received copies of the minutes and disseminated any learning points or changes of practice to all relevant staff. We heard from staff that they were informed about any changes in ward meetings, or via e-mail.
- Maternity services held a weekly maternity risk meeting held on rotation across each site. Matrons and clinical services managers attended these meetings, as well as the head of midwifery. Risk meetings were open for all staff to attend if they wanted to. Midwives said they were often too busy to attend, but that they always received learning feedback from these meetings.
- Incidents were monitored weekly at Women’s Services Incidents Meetings and monthly at Audit and Safety Meetings.
- Each month the Board of Directors reviewed and made recommendations against the Integrated Performance Report of each directorate. The report describes monthly and quarterly performance against national and local key performance indicators including local trajectories where agreed and a forecast position against standards for the year end.
- The Board Confirm and Challenge Meetings were also held monthly, these meetings involved oversight of the directorate scorecards.
- A monthly Audit/Clinical Governance Meeting was well attended with a multidisciplinary team including

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women's services governance lead, risk coordinator, specialty midwives, consultants in obstetrics and gynaecology, registrars, managers, students, fellows and senior house officers. We reviewed minutes of these meetings which followed a clear agenda and had valuable insight into practice changes and upcoming audits.

- We spoke to the midwife leading on patient risk, we found there were reliable risk management processes in place including systems for learning from incidents and implementing change. When action plans were developed following incidents, we saw the changes were tracked at department level but little was fed back at trust level.
- Performance management issues in maternity and gynaecology were managed by the head of midwifery, the head of midwifery was managed by the chief executive.
- The ventilation system in the obstetric theatre was over ten years old and failed the recommended air change frequency level for each hourly period. Which could potentially lead to impaired outcomes. We saw evidence the ventilation system was performing worse on this inspection than when we inspected last year. Currently the theatre was being used for both elective and non-elective cases. The risk on the register was reduced from a level of 20 (highest rating) to 16 on the 1st of February 2017. There is no indication on the risk register what further controls measures have been put in place to reduce the risk rating, only "Risk grade reduced to more accurately reflect the corporate view point - though still high risk." This indicates the risk has been lowered despite no change in the ventilation system and the system is reported in meeting minutes as having deteriorated over the last year.
- The risk register did not include fire safety issues, this was something highlighted on our last inspection and we found the same issues within the department during this inspection.
- The directorate did not take part in specific morbidity and mortality meetings. These meetings are an opportunity to review all deaths and adverse incidents including any incidents that have significant learning

opportunities being discussed in detail with key themes and trends identified. This could mean that any deaths or incidents within the service are not given thorough review by a multidisciplinary team.

## Leadership of service

- The directorate lead nurses/head of midwifery, clinical lead consultants and directorate managers reported to the clinical director of the women's directorate.
- The trust had a manager working across departments within the directorate. The patient access managers, finance partners and manager, HR business partner all reported to them.
- Ward leaders reported to the maternity and gynaecology manager. This manager and the community maternity manager, governance lead and risk co-coordinator all reported to the Head of Midwifery. The Head of Midwifery reported to the Clinical Director and the Chief Nurse.
- The department had direct access to the Chief Executive every month through a performance meeting.
- Recent changes included recruiting a permanent head of midwifery. She had only been in post for a few weeks at the time of inspection. We heard mixed views on her visibility with some staff members saying they had not met her while other reported she was visible and approachable.
- All staff members we spoke with were positive about the leadership of both the maternity and gynaecology departments and the support they were offered. Most acknowledged there was a more positive working atmosphere across the directorate, and many staff members mentioned a change in the consultant body as being partly responsible for this shift in attitude. Positive comments included "We are very supportive team" and "I am able to challenge colleagues without worrying about their reactions."
- Staff felt there had been a shift in the effectiveness of the directorate leadership. Staff told us this was due to the trust tackling a legacy of challenging behaviours from some members of staff in the service. We found both staff and managers reported improved team working and improved channels of communication across the Women's directorate.

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- The staff and managers we spoke with in maternity and gynaecology felt there was visible leadership from the clinical director and said this was as a result of the trust tackling issues in the directorate, and supporting leaders in their roles. For example, ward managers told us they had received training in anti-bullying and a consultant told us about a new ethical code staff were expected to adhere to.
- Staff told us that although members of the directorate and local leadership teams were visible and approachable, the senior leaders at trust level were not as visible. A number of staff across both maternity and gynaecology said the trust team had not been very visible.
- We saw that interactions between staff of all grades were effective and friendly. Although we did witness a consultant talking down to a trainee midwife during a ward round. This was not witnessed at any other point on inspection and trainee midwives generally reported feeling very supported and listened to.
- We witnessed a lead midwife challenge a midwife in a professional and courteous manner. It was well received and showed a cohesive way of working where team members of all levels were listened to.
- We met with staff during focus groups during our site visit to allow as many staff members as possible to give their views on working for the trust. Staff we spoke with were positive about the new chief executive telling us they were hoping for some stability. However, some staff felt that it did not really matter who the chief executive was as they worked well as a team and were used to changes being implemented.
- There was a weekly CEO newsletter that was e-mailed to staff with trust news and updates. Some staff knew about this. When questioned, a higher ranking midwife said that she didn't think that there was much engagement from the lower bands with trust wide issues, but that they were hoping that this would change. Two band five midwives we spoke with were not aware of the e-mails specifically, as they said they did not always read e-mails.
- Universally staff felt that there had been improvements in the culture of the organisation since our last inspection. Staff reported a "much nicer working atmosphere," and "Staff are willing to help each other out, we are more of a team." This was something that was echoed by every staff member we spoke to. They all reported that it was a different place to work than a year ago and that positive changes to the consultant body and leadership had been the driving force behind the changes.
- All staff had to sign a recent behaviours charter that outlined expected behaviours and what to do if staff felt they had been mistreated. There was an online module that all staff were expected to complete and this was monitored for completion.
- Staff were encouraged to report any incident of bullying or racism through the trusts 'speak up guardian'. Most staff were aware of who this was however, nobody could name them or knew exactly how to contact them.
- The inspection team were welcomed into the unit by all staff members. Staff were willing to talk to us and be open about what the service was like. This showed an open work force who welcomed review.
- We saw a clear process for escalating any concerns over performance issues and staff felt able to challenge each other and take ownership of the department.
- Staff across maternity and gynaecology services said there was improved cross-site working with staff at the RSCH. For example, bi-monthly meetings between the early pregnancy units at PRH and RSCH had been introduced.
- The trust had a Raising Concerns and Whistle blowing policy. On ward areas, we saw information on how to report concerns bullying/harassment and the role of the new freedom to speak up guardian.
- Results from the NHS staff survey 2016, Question 17b, 'In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?' Showed 8% of white staff had experienced discrimination compared to 21% of BME staff. The national average of BME staff experiencing discrimination was reported as 14% which showed the

## Culture within the service

- The directorate had some historical cultural issues. These were also identified in the last visit from the CQC.

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trust was performing worse. This data was trust wide not maternity and gynaecology specific, but still showed BME staff felt discrimination more than white members of staff.

## Equalities and Diversity

- There was a clear policy around staff behaviours in regards to equality and diversity and bullying. Staff we spoke with felt there was a 'zero tolerance' approach and a new policy had been produced on race equality and bullying in the workplace.
- If patients behaved in an unacceptable manner a letter was sent to the patient explaining it would not be tolerated.
- We saw information displayed advising staff of the trust's black and minority ethnic (BME) network emphasising that "discrimination" would "not be tolerated." There was also details of the 'listening ear' service for BME staff that had experienced abuse or harassment.
- The 2016 NHS staff survey question KF21: 'Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion' showed staff felt opportunities were not always equal. Responses from white members of staff showed 82% felt there were equal opportunities which was worse than the national average of 88%, however, only 64% of BME staff reported the same opportunities which was also worse than the national average of 76%.
- In the recent 2016 NHS staff survey we saw that Key Finding 26: 'Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months' was 32% this was worse than the average of 25% for acute trusts, and an increase on the 2015 result which was 29%. The percentage rates from white and BME staff were similar with 32% and 37% respectively.

## Public engagement

- Women were signposted to comprehensive information for women through the 'My Pregnancy Matters' site. There is information about choosing a homebirth including links through to the Brighton Homebirth Blogs where women write their stories.

- Maternity users were involved in governance through the Maternity Services Liaison Committee (MSLC) they met every two months.
- The department took part in a 'walking the patch with supervision' exercise. Walking the Patch with supervision is where the Supervisor of Midwives has undertaken a visit of the ward areas and asked women their opinions.
- These are undertaken by members of the Maternity Services Liaison Committee, on a quarterly basis. The reports are then fed back through the Maternity Services Liaison Committee meetings and then into management meetings within the Directorate.
- Service users were also engaged in a 'Normalising Birth Group' and the 'Better Beginnings' service consultation process.
- We were told that supervisors complete 'Walk the Patch' forms with women to gain feedback and discuss at SOM meetings with a view to actioning change. These were planned to continue despite the recent change to the SOM role.
- The bereavement leads had established good links with the local SANDS group and were working with them to develop a new bereavement suite.
- The maternity matters website signposted women to local groups such as NCT and support groups for vulnerable women.

## Staff engagement

- Staff reported feeling valued but overworked. Many staff of all grades mentioned feeling particularly supported by their managers.
- We heard several examples where staff had identified issues several times, and come up with plans and solutions but changes had not been pushed forward. An example being the need for a midwife led unit, and a dedicated bereavement suite. The main issues seem to be several changes of leadership leading to further reviews of services alongside funding issues.
- The most recent (2016) NHS staff survey results showed the 'Overall indicator of staff engagement' scored 3.62 across the whole of BHUT. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with

# Maternity and gynaecology

their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.62 was in the lowest (worst) 20% when compared with trusts of a similar type.

- Staff were able to nominate their peers for an 'Extra mile award' each month. This was for recognition of excellent care and achievements. The award is for all staff within the department not just midwifery staff. For example a lead pharmacist received the award recently. Staff were presented with a certificate and posters put up, alongside being shared via e-mail and newsletter. Staff that are nominated but don't win are also given individual feedback.
- A closed Facebook group had been set up for all staff to engage in service changes. This group included midwives, student midwives, nurses, maternity support workers and ward clerks it did not include labour ward leads and heads of departments as they felt it would not be appropriate. It also enables staff to get shifts covered and support when needed. It was reported to have been successful in maintaining no agency use.
- We saw minutes of regular team meetings within maternity and gynaecology. If staff were unable to attend the meetings minutes were e-mailed to staff and we saw them displayed in the staff rooms within the department.







- There were regular newsletters displayed as well as distributed to staff via newsletter. These included upcoming events, training opportunities and changes to the department.
- Prior to our inspection directorates were asked to self-rate their service. The staff we spoke to, even at senior level, had no input into these self-ratings.

## Innovation, improvement and sustainability

- The trust is one of 44 trusts throughout the country engaged in the Maternal and Neonatal Health Safety Collaborative. A three-year programme to support improvement in the quality and safety of maternity and neonatal units across England. The programme aims to reduce the rates of maternal deaths, stillbirth's neonatal deaths and stillbirths by 20% by 2020 and 50% by 2030. The introduction had been attended by the matron, obstetric lead and labour ward leads, participation shows the trust is striving towards better services for mothers and their babies.
- The gynaecology unit had a clear future vision including 'one stop' services for cystoscopies (a procedure to look inside the bladder using a thin camera called a cystoscope) and the management of surgical miscarriages.



# Services for children and young people

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

## Information about the service

We inspected this core service in April 2016. Overall the service was rated outstanding. We did not inspect this service at this inspection, and have retained the ratings from 2016.

## Summary of findings

We did not inspect this service on this occasion. In April 2016 we reported the following.

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.

# Services for children and young people

- 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.

## Are services for children and young people safe?

Good



We did not inspect safety in this service at this inspection.

## Are services for children and young people effective?

Outstanding



We did not inspect effective in this service at this inspection.

## Are services for children and young people caring?

Outstanding



We did not inspect caring in this service at this inspection.

## Are services for children and young people responsive?

Good



We did not inspect responsive in this service at this inspection.







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

Good



We did not inspect well led in this service at this inspection.

# End of life care

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

## Information about the service

We inspected this core service in April 2016. Overall the service was rated good. We did not inspect this service at this inspection, and have retained the ratings from 2016

## Summary of findings

We did not inspect this service on this occasion. In April 2016 we reported the following.

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

# End of life care

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:

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

# End of life care

## Are end of life care services safe?

Good



We did not inspect safety in this service at this inspection.

## Are end of life care services effective?

Requires improvement



We did not inspect effective in this service at this inspection.

## Are end of life care services caring?

Good



We did not inspect caring in this service at this inspection.

## Are end of life care services responsive?

Good



We did not inspect responsive in this service at this inspection.






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

Good



We did not inspect well led in this service at this inspection.

# Outpatients and diagnostic imaging

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

## Information about the service

We inspected the Royal Sussex County Hospital (RSCH) in April 2016, as part of a comprehensive inspection of the Brighton and Sussex University Hospitals Trust. At the time, we rated the outpatients and diagnostic imaging core service at RSCH as inadequate.

The purpose of this inspection was to see what changes and improvements had been made since our last visit. The inspection took place between 25 and 26 April 2017 with a follow up unannounced inspection on 9 May 2017.

Outpatient staff worked across seven out of the 12 clinical directorates in their individual speciality. The majority of outpatient staff sat in the head and neck clinical directorate, with some staff such as staff working in the sexual health clinic sitting under the Speciality Medicine directorate. Diagnostic Imaging was part of the Central Clinical Services directorate, along with physiotherapy and occupational therapy.

RSCH 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 384,495 outpatient attendances at the hospital between November 2015 and October 2016.

The diagnostic imaging department carried out routine x-rays, magnetic-resonance imaging (MRI), computerised tomography (CT), mammography and ultrasound. In 2016, 35,3641 patients used this service trust wide.

During the inspection, we spoke with 21 members of staff, which included consultants, senior clinical staff managers, nurses, physiotherapists, healthcare assistants, administrative staff and allied healthcare professionals.

We spoke with eight patients and their relatives. We visited the main outpatients, ears, nose and throat (ENT) outpatients, the Sussex Eye Hospital outpatients, the booking hub, pathology, sexual health clinic Sussex Cancer Centre, diagnostic imaging (including paediatric diagnostic imaging) and the fracture clinic.



# Outpatients and diagnostic imaging

## Summary of findings

When we inspected the Royal Sussex County Hospital in April 2016, we rated outpatients and diagnostic imaging as inadequate. This was because:

- 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.
- 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.

At this inspection, we have changed this rating to requires improvement. This was because we saw improvement since the last inspection, but there were still improvements to be made:

- World Health Organisation (WHO) checklist compliance was worse than the target set in interventional radiology.
- Local rules for lasers (devices which emit powerful lights for eye surgery) were not updated and signed, and the policy was overdue review.
- Mobile equipment in diagnostic imaging had not been cleaned.
- Room cleaning checklists had variable rates of completion across the outpatient department.
- Staff understood their responsibilities to report incidents and near misses; however, incidents were not regularly discussed at team meetings.
- Mandatory training compliance rates were low.
- Staff appraisal compliance rates were worse than the trust target.
- Privacy and dignity was not maintained in all areas.
- The trust was not meeting national targets for patients that should be seen within 18 weeks of their referral.
- The trust was not meeting national targets for patients that should receive their cancer treatment within 62 days of urgent referral.
- There was no formal strategy in place for the outpatient or diagnostic imaging departments.
- Not all staff knew which directorate they sat in or who the directorate leads were above the directorate nurse level.

However:

# Outpatients and diagnostic imaging

- Safety huddles were in use across outpatients and diagnostic imaging.
- We saw that prescription forms were stored safely and securely.
- Rooms were consistently cleaned and documented in the diagnostic imaging department.
- We observed good radiation compliance in accordance with national policy and guidelines during our visit. A radiation protection supervisor was on site for each modality and a radiation protection advisor was contactable if required. This was in line with Ionising Regulations, 1999 and Radiation (Medical Exposure) Regulations (IR(ME)R), 2000.
- The trust was meeting national targets for patients that should receive their urgent appointment within two weeks of referral and receive their cancer treatment within 31 days of a decision to treat being made.
- Local leadership and line management were good and managers were visible across the departments.

## Are outpatient and diagnostic imaging services safe?

Requires improvement



When we inspected the Royal Sussex County Hospital in April 2016, we rated safe as inadequate. This was because:

- Not all staff were confident to report incidents, incidents were not always discussed at staff meetings and could not demonstrate 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.

At this inspection we have changed this rating to requires improvement. This was because:

- Mandatory training compliance, including safeguarding training was low.
- World Health Organisation (WHO) checklists audits compliance was worse than the target set in interventional radiology.
- Local rules for class 3B and 4 lasers were not updated and signed, and the policy was overdue review.
- There were two serious incidents that occurred between March 2016 and February 2017, however we were not given the root cause analysis for these incidents.
- There was no paediatric cover for diagnostic imaging outside of normal hours.
- Mobile equipment in diagnostic imaging had not been cleaned.
- Cleaning checklists had variable documentation across the outpatient department.
- Staff understood their responsibilities to report incidents and near misses; however, incidents were not regularly discussed at team meetings.
- The head and neck directorate business continuity plan was incomplete.

# Outpatients and diagnostic imaging

However:

- Safety huddles were in use across outpatients and diagnostic imaging.
- We saw that prescription forms were stored safely and securely.
- We observed good radiation compliance in accordance with national policy and guidelines during our visit.

## Incidents

- Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between March 2016 and February 2017, the hospital reported no incidents which were classified as never events for outpatients or diagnostic imaging departments.
- In accordance with the Serious Incident Framework 2015, the hospital reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England between March 2016 and February 2017. Both incidents were reported as diagnostic incidents including delay including a failure to act on test results. We requested the root cause analysis performed for these SIs but did not receive them.
- Outpatient services reported 117 incidents across the whole trust between April 2016 and March 2017. This was 20 incident less than the previous year, indicating either that there were less incidents occurring, or that the department was under reporting. All of the incidents were reported as low or no harm. Leaders told us that they felt empowered to escalate incidents and concerns to their line managers and they felt confident their teams would report concerns also. Safety huddles were held in all areas of the department and we saw that incidents were a fixed agenda item. However, we did not see minuted evidence of regular discussion of incidents at team meetings which meant that staff may not be able to learn from incidents.
- We saw that the diagnostic imaging department reported and investigated incidents under the Ionising Radiation Incidents (Medical Exposure) Regulations 2000 (IRMER). Eight incidents were reported to the CQC between April 2016 and March 2017. Six of these

incidents were reported under the category of 'much greater than intended dose' and two were reported under 'unintended dose' and we saw examples that showed these incidents were discussed in the Radiation Safety Committee meetings in December 2016. For example we saw that a much greater than intended radiation dose that occurred in October was discussed in December 2016.

- Staff in diagnostic imaging told us about an incident that occurred about a week before the inspection – where a patient was sent antibiotics rather than bowel preparation medicines before their diagnostic imaging examination. No harm was caused to the patient and a review meeting was in progress to share learning.
- Not all staff we spoke to could describe the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which related to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person.

## Cleanliness, infection control and hygiene

- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance. The PLACE assessment for cleanliness across four outpatient areas for the period 1 January to 31 December 2016 was 99%, which was better than the England national average of 98%. It was not possible to break this down further by area. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings. During our inspection, we found the hospital to be clean.
- Infection prevention and control training formed part of the mandatory training all staff at the trust attended. Due to outpatient's staff sitting in several different directorates, it was not possible to break this down to an

# Outpatients and diagnostic imaging

outpatient staff compliance figure or by hospital site. The trust-wide compliance for infection prevention and control training in the head and neck directorate was low.

- Diagnostic imaging staff sat in the Central Clinical Services directorate and we saw 88% compliance for infection and prevention control training trust-wide.
- The outpatients department monitored hand hygiene compliance by completing daily, weekly or monthly audits. Departments that consistently achieved results below 90% would remain on daily monitoring, between 90% and 96% on weekly monitoring and between 96% and 100% moved onto monthly monitoring. We saw the results of these audits from May 2016 to March 2017, and saw that all areas were now auditing their hand hygiene results monthly, following consistent scores of 100%. We saw hand hygiene results displayed in the ear, nose and throat (ENT) clinic and maxillo facial departments for March 2017 – these scores were 97% and 98% respectively which meant they remained on monthly monitoring.
- Posters were displayed which explained the ‘5 moments for hand hygiene’ and alcohol-based hand sanitising gel was available at the entrance to the hospital and clinic areas. We saw staff using the hand sanitising gel, in line with the ‘5 moments of hand hygiene’ and National Institute for Health and Social Care Excellence (NICE) quality standard (QS) 61, statement three.
- All staff who interacted with patients had visibly clean uniform and were ‘bare below the elbow’ to help prevent the spread of infection.
- In outpatients we saw variable documentation of cleaning checklists in clinic and treatment rooms. For example, cleaning schedules in the Sussex Eye hospital intravitreal (into the eye) injections treatment room showed that the room was meant to have deep cleaning daily prior to the list, but this was not consistently recorded. This meant there was no assurance that the room was being cleaned in line with the recommendations for the treatment room.
- We saw cleaning audit scores from March 2017 were displayed within waiting areas showing compliance of 91.4% for the Maxillofacial area, 95.5% for main outpatients and 97.5% for the diabetic clinic area. These scores were all better than the hospital target of 90%.
- The fracture clinic was based in a different part of the hospital in a pre-fabricated building which appeared clean. We saw a cleaning audit score on the wall for March 2017 scoring 99% which was better than the hospital target of 90%.
- In diagnostic imaging, we saw that several pieces of mobile equipment were not regularly cleaned. The ‘last cleaned’ dates on some of the equipment dated back to September and November 2016. We raised this with staff who told us that the equipment had been cleaned since then but not documented. This meant that assurance that this equipment was clean could not be provided. The equipment did not look clean.
- Complete, daily, cleaning checklists were visible in all areas of diagnostic imaging examination rooms that we visited. We saw staff cleaned equipment between patient use.
- The hospital conducted environmental audits of all areas of outpatients and diagnostic imaging. The audit consisted of 49 checks that were a combination of estates or nursing staff responsibility, including the availability of hand hygiene alcohol containers and chairs for each room or area. All outpatient and diagnostic imaging areas had a score of 96% or above, which was better than the target of 95%, with the exception of the interventional radiology suite situated in the Barry building which scored 86%. One of the issues identified with this area was insufficient ventilation, which was identified as a departmental risk on the risk register.
- Each outpatient area had an infection control link nurse and an infection control link nurse meeting had been set up in March 2017. We saw the minutes from this meeting which included staff from both the RSCH and Princess Royal Hospital outpatient and diagnostic imaging teams. Issues regarding hand hygiene audit compliance, audit matrixes and overview of the trust infection rates were discussed.

## Environment and equipment

- The Patient Led Assessment of the Care Environment (PLACE) for the period of 2016, which showed the hospital average, across four outpatient areas, scored 75%, for condition, appearance, and maintenance, which was worse than the England average 93%. The assessment for condition, appearance, and

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maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds. Our observations were consistent with the low PLACE scores.

- We saw examples of poor condition of clinic rooms. In clinic room three in the main outpatients department, we observed that the paint on the wall was cracked and flaking under the window sill. The placement of the couch in the room meant the patient was directly looking at this when undergoing examination or treatment on the couch. Other clinic rooms (five, nine and the nurses room) required re-painting and there was damage to the door frames.
- We observed 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 2013 and ensured safe waste disposal.
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with Health and Safety at Work 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. This was to reduce the risk of sharps injuries to both patients and staff. We also saw labels on sharps bins which carried the signatures of the staff who assembled the box and the date it was assembled.
- We saw empty sharps boxes stacked under a counter in the notes room in the eye hospital and in a rooms housing the laser in the Sussex Eye Hospital. There were eleven empty sharps boxes stored on the floor, and more than 30 sets of notes were stored in here.
- We saw eye protection suitable for the class of machine being used for each of the laser machines in place, however one of these was worn and required urgent replacement. The doors on the rooms that housed the lasers were locked and no keys were found in the laser machines when they were not in use.
- Laser machines had service contracts in place which required annual servicing to ensure the machines were safe and effective to use. We saw records of servicing for

two out of the three laser machines but the third service record was not available. Following the inspection, the trust informed us that the third laser machine had gone beyond its annual service date but it was not clear how long it had been without its service. A fault had occurred on the machine in February 2017 which the manufacturer was called out to review, repair and ensure it was safe to operate and we saw the record of this. However, this meant that the laser was being used for an indeterminate amount of time without its annual service, which could not have guaranteed it was safe to use during that period.

- Pre-use equipment checks were on the wall next to the laser machines, but no signatures were on these to demonstrate that these had been completed. This meant there could not be adequate assurance that pre-use equipment checks were being completed before use.
- We checked the resus trolley in diagnostic imaging and records demonstrated saw that this was checked in line with trust policy.
- We spoke to staff who told us they felt that many of the areas they worked in were not fit for purpose due to the age of the buildings and footprint of some of the department. However they felt they did their best to work around this.

## Medicines

- An audit to assess the security of the FP10 (medicine prescription form) was carried out in February 2017. The audit found that 100% (22) of the FP10s checked were stored securely.
- We checked storage of FP10 in the areas we visited and found all of these to be securely stored, along with their log books to record which FP10 was assigned to who and on what date. This was in line with NHS Protect: Security of prescription form guidance (2013).
- We checked the FP10 log books and found that one FP10 was missing in the Sussex Eye Hospital. We alerted the staff to this and we saw that this was immediately escalated and logged on the incident reporting system. We were later informed that after an investigation, the prescription form was located and had been allocated



# Outpatients and diagnostic imaging

appropriately to a patient who was in the clinic the previous day. The form had been taken by a doctor for a patient but this had not been documented in the log book.

- Some medicines need to be stored within a limited temperature range and require storage in a dedicated medicines fridge. Daily temperature checks should be undertaken to ensure that the fridge temperature is within the appropriate range to ensure that the medicine has been stored safely and is appropriate to use. In most outpatient areas that we reviewed, we saw that fridge temperature checks were completed and documented daily. However in the Sussex Eye hospital we saw that these were not consistently documented. This meant there was no assurance that medicines requiring refrigeration were always kept at the correct temperature.
- Medicines were stored securely and drug cupboards in outpatients were locked and only registered nurses held the keys for these. This was in line with National Institute for Care Excellence (NICE) guidance MPG32. Emergency medicines were in date, accessible and stored in a tamper-evident trolley. Medicines we checked were within their expiry dates.

## Records

- Between January and December 2016, an average of 1% of patients were seen without their full medical record. When the full medical record was not available, a temporary set was made up and included full patient details, a copy of the most recent referral letter and any recent diagnostic tests that could be accessed from the electronic patient systems. We reviewed a set of clinic notes that were due for an afternoon clinic – we saw that the full medical records were available for all patients on the list.
- We saw that patient records in the main outpatients were stored in a lockable room in the staff area. Staff told us that records were prepared and stored in this locked room at the beginning of each clinic.
- However we found more than 50 sets of notes stored in a room that housed one of the lasers. Although this room was locked when not in use, this was not a suitable place to store patient notes as they were

uncovered and could be accessible. Patients attending their appointment in this room would be able to see that there were patient records stored there and this could breach patient confidentiality.

- We reviewed ten sets of patient records. We saw that all sets of notes were tidy and easy to navigate with no loose filing. We saw that clinic letters and results of investigations were available and the notes were contemporaneous and fit for purpose.
- A trust wide medical records audit to monitor compliance with the trust healthcare records policy was carried out between April 2016 to January 2017. We saw that the compliance had decreased from the previous audit, with 93% of case notes being presented in good physical order, and 52% not having history sheets. These results were both worse than the trust target of 95%.

## Safeguarding

- The trust had up to date safeguarding adults and children policies that reflected national guidance.
- These policies stated that managers were responsible for ensuring their staff had received sufficient training to ensure they could protect the people who used the service.
- Safeguarding adults at risk and safeguarding children and young people training was part of the mandatory training required for all staff at the trust.
- Due to outpatient's staff sitting in several different directorates, it was not possible to break the level of safeguarding training compliance down to an overall outpatient staff figure. In the head and neck directorate, where a large number of outpatient staff sat, the compliance rate for safeguarding adults at risk training was low. Compliance for safeguarding children and young people level one training, was higher. Compliance for safeguarding children and young people level two training was low.
- Diagnostic imaging staff sat in the Central Clinical Services directorate. Compliance for safeguarding adults at risk training was low. Compliance for safeguarding children and young people level one training was also low as was the compliance for safeguarding children and young people level two training.



# Outpatients and diagnostic imaging

- Staff we spoke to understood their responsibilities regarding safeguarding vulnerable adults and children and knew the process of how to do this. We saw safeguarding process posters on the walls in some clinic areas.
- In the paediatric diagnostic imaging unit, we saw a female genital mutilation (FGM) poster displayed in one of the staff areas, reminding staff to be vigilant about this type of issue.

## Mandatory training

- Due to outpatient's staff sitting in several different directorates, it was not possible to give an overall outpatient staff figure of compliance. In the head and neck directorate, where a large number of outpatient's staff sit, the compliance rate was 77%. Although the target for mandatory training was 75% and this was met, the target itself was low. In the speciality medicine directorate, where the sexual health outpatient's team sat, the compliance rate was 68%, which was low.
- The diagnostic imaging department was part of the central clinical services directorate and reported a 78% compliance in mandatory training, this was better than the trust target but the target itself was low.
- Basic life support training (emergency airway, breathing and circulation support) was part of the mandatory training for all clinical members of staff. We saw that in the Head and Neck directorate, only 59% of staff had completed this training which was low.
- The diagnostic imaging department sat in the central clinical services directorate and we saw that this directorate had achieved 67% compliance, which was low.
- The trust had recently started using a new electronic system to monitor and provide reminders to staff when their training was due. Staff told us that this system was useful and made it easier to access e-learning where available.
- The low training rates meant that staff may not have had the most up to date training needed to carry out their role.

## Assessing and responding to patient risk

- A Clinical Harm Review Panel had been set up to review any patients waiting longer than 52 weeks to see a

consultant. We saw that since February 2016, 264 patients waited longer than 52 weeks, of which, three (1%) were known to have come to some harm. We saw that the oversight of these was discussed at executive board level in the quality and safety committee meetings.

- Patients referred on a two week wait pathway for suspected cancer had a dedicated booking team within the booking hub. Patients were consistently booked for an appointment within the two week time period. We saw examples of patients that were contacted on the same day of their referral to arrange their appointments. This meant that patients with a potentially serious diagnosis were responded to quickly and within national timeframes.
- The outpatient department held safety huddles at the beginning of each day. We attended one of these huddles and observed that these were led by the nurse in charge of the department, and included standard agenda topics such as staffing and the fire warden on duty for that day. We observed an issue with supplies being raised at this meeting and this was escalated by the nurse in charge. All issues discussed were recorded on the white board for all staff to see.
- We reviewed tamper proof resuscitation trolleys in outpatients and diagnostic imaging. We found that these had regular checks for the contents, and all consumables were found to be in date. During an allergy clinic we found that medicines needed to treat severe allergic reactions were accessible, which was in line with the Resuscitation Council guidelines.
- For interventional radiology procedures (such as CT guided biopsies), checklists based on the World Health Organisation (WHO) checklists were used to ensure the procedure was carried out safely. The checklists contained questions relating to identity checks, allergy status and the location of the site for treatment. We saw an audit of the WHO checklist dated June 2016 that showed the hospital achieved 45% compliance with this audit, which was worse than the 95% target. Trust-wide, this audit result had deteriorated since the previous year, with 48% overall compared to 57% in 2015.
- Staff told us that the WHO proforma checklist was scanned onto the computer system at the end of the day of procedure, or the following day. We looked at an

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electronic patient record of a patient who had an interventional procedure the day before, and this checklist had not been scanned onto the system. This meant there was no assurance that all checklists were being uploaded onto the system. We reviewed other records of interventional procedures and saw that these had been uploaded onto the system.

- Some eye treatments were carried out using light amplification by stimulated emission of radiation (Laser) therapy. Class 3B and 4 lasers are capable of causing injury to both the eye and skin and will also present a fire hazard if sufficiently high output powers are used. Medicines & Healthcare Products Regulatory Agency (MHRA) guidance states that in the NHS, an employer should appoint or consult a Laser Protection Advisor (LPA) for class 3B and 4 laser systems. The Sussex Eye Hospital had two class 3B lasers and one class 4 laser and had an LPA and a laser protection supervisor (LPS) in post.
- The LPS had attended an in hospital training session on laser core of knowledge training in 2015, but we were unable to see any signed competency documents relating to this. We spoke to the LPA who advised us that the competency based training programme for laser users and supervisors was currently under development and was awaiting approval.
- The laser safety policy was incorporated into the Radiation Safety Policy and Procedure which expired in January 2016. Within this policy there was no responsible officer listed for laser safety such as the LPA, however, the LPS was identified.
- The signage placed on consulting rooms that held the laser systems met with Health and Safety Signs and Signals at Work Regulations 1996 Guidance to prevent staff or service users entering the room when potentially harmful lasers were in use. However, on one of the rooms, there were more than five different signs in place, which could be confusing.
- We saw local rules in place for each of the lasers. However, these were not signed or dated and there was no version control or ratification details in place.
- There were no laser safety reports available. These are reports usually completed on an annual basis by the LPA that would give assurance of the over-arching governance and quality and safety review. We saw that issues regarding lasers were discussed at the Ionising Radiation Safety Committee meeting, and that there were ongoing discussions regarding the possibility of creating a new sub-group for laser issues.
- We saw how the electronic patient system identified a patient who had previously been aggressive towards staff. The nurse who was due to see this patient discussed this with the charge nurse who arranged for the patient to be seen with two nurses to ensure the safety of staff. Personal alarms were also available in each of the clinic rooms in the sexual health clinic.
- In diagnostic imaging we saw that a radiation protection supervisor was on site for each diagnostic modality and there was a contract with a local NHS trust for provision of a radiation protection adviser. This was in line with the Ionising Regulations 1999 (IR99) and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- We observed good radiation compliance in line with policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated.
- Diagnostic reference levels (DRLs) were performed and documented in diagnostic imaging. All diagnostic imaging procedures carry some level of radiation, and DRLs are used to help manage the radiation dose to patients so that the dose is appropriate for the type of procedure a patient is undergoing.
- We saw local rules in place for most of the equipment used in diagnostic imaging, with the exception of mobile scanning machines. These were not available on the machines but staff were able to show us where these were kept on the shared drive on the computer.
- Not all staff in the Sussex Eye Hospital were in the correct uniform during the inspection. For example, we spoke with a band 6 nurse who was in a band 5 uniform. Uniforms were different colours and styles, depending on the banding and competency levels of nurses therefore if staff were to wear uniforms that were not correct for their level, they could be asked to perform tasks outside of their competency level.
- Basic life support training (emergency airway, breathing and circulation support) was part of the mandatory

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training for all clinical members of staff. We saw that in the Head and Neck directorate, only 59% of staff had completed this training which was worse than the trust target compliance rate of 85%.

## Nursing staffing

- During our inspection, we saw that the levels of nursing staffing were sufficient for the clinics being run. Any staffing issues were discussed at the daily safety huddles, and staff who were not at the safety huddle could easily see the whiteboard where all issues were recorded.
- As of February 2017, the trust reported a vacancy rate of 4% in outpatients. The sexual health clinic had the highest vacancy rate of 9%, followed by the head and neck directorate with a vacancy rate of 5%.
- Between February 2016 and January 2017, the trust reported a bank and agency usage rate of 1% in outpatients. It was not possible to split this data by hospital site.
- Radiographers and associate practitioners worked in the diagnostic imaging department. We saw rotas for February which demonstrated that actual staffing levels often fell below planned staffing levels during the week.
- Radiographer cover was available in CT and MRI at the weekend and we saw that actual shifts matched planned shifts throughout February 2017.

## Medical staffing

- Consultants worked in the outpatient department during their individual clinic days.
- In the diagnostic imaging department there were currently five consultant radiologist vacancies and 22 whole time equivalent (WTE) radiographer vacancies based on establishment of 108 WTE. This meant that diagnostic imaging had a 25% vacancy rate. There was no paediatric radiology cover outside of normal working hours. This meant that children were treated by staff who were not specifically trained in treating children.
- Radiology consultants worked seven days a week, on a rota basis, to provide consultant-directed diagnostic tests and completed reports.
- On weeknights, outside of normal working hours, a specialist registrar (consultant radiologist in training)

and a non-resident consultant radiologist was on site between the hours of 8pm and 8am, ensuring 24 hour access to radiology services. At weekends, a consultant was onsite between 9am and 5pm, non-resident consultant 5pm to 8am and a specialist registrar 24 hours a day.

## Major incident awareness and training

- Each area in outpatients had a fire warden allocated to each day and we saw this was discussed at the daily safety huddle before clinics started. Fire safety training was part of the mandatory training required for all members of staff, and we saw that in the head and neck directorate, 85% of staff had completed this training, which was low.
- Staff were able to describe a recent major incident, but did not receive training on how to deal with these. Staff had identified an issue with security staff allowing patients into the main outpatients building during a recent bomb threat, but no follow up or learning was put in place following this.
- We saw the head and neck directorate business continuity plan (BCP) dated June 2017. There was no version control, name of author or responsible individual recorded on the document, and no date for review. The contents of the plan included actions and mitigations to take in the event of various occurrences that would affect business continuity. However, the 'essential staff' section of the plan was left blank, which means in the event of a major incident, anyone using the policy may not know who the essential staff for the service were. The section where administrative staff who may be able to help the emergency control centre (ECC) in the event of a major disruption, was also left blank, indicating that this section may have been missed, or that no staff from the directorate would be available to support the ECC.
- The imaging BCP was version controlled and dated, and listed a responsible individual and author. We spoke to staff who knew how to access this policy on the shared electronic drive.
- The bookings hub did not have a formal business continuity plan in place in the event of power outage.

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We were told that in this event the CCGs would be notified to limit referrals and when power was restored the team would work to clear any backlog (if any) had been accrued.

## Are outpatient and diagnostic imaging services effective?

We do not rate effective for outpatients and diagnostic imaging. When we inspected Brighton and Sussex University Hospitals Trust in April 2016 we found:

- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. We saw that the majority of staff had a good awareness of National Institute for Care Excellence (NICE) guidelines and this was demonstrated in their practice.
- Staff had received appropriate support to ensure they were competent to meet peoples' individual care needs.
- The diagnostic imaging department had policies and procedures in place in line with national and best practice guidance.

At this inspection we found:

- Peoples' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Staff could access the information they needed to assess, plan and deliver care to people in a timely way.
- We saw good examples of multidisciplinary care.
- The appraisal rates within the trust wide diagnostic imaging directorate were better than the trust target.
- The diagnostic imaging department had been re-accredited by the Imaging Services Accreditation Scheme (ISAS).

However:

- Appraisal rates were variable across the outpatients department, with trust wide directorate compliance worse than the trust target. However one team within the directorate was able to demonstrate 100% compliance.

- There was not adequate assurance that all patient outcome forms were received and processed following clinic appointments.
- Consent for interventional radiology procedures was taken immediately before the procedure, which was not in line with best practice.

## Evidence-based care and treatment

- The trust aimed to treat all suspected cancer patients in line with NICE guidance NG12 (Suspected cancer: recognition and referral) which outlined the suspected cancer referral pathway timescales of two weeks to see a consultant, 62 days from referral to treatment, and 31 days between decision to treat and treatment.
- We saw from the ear, nose and throat (ENT) outpatient team meeting minutes, an external representative attended to give education and support regarding wound care and dressings. As part of this, NICE guidance for wound care 2009 was discussed and included on the shared drive for staff to access and utilise.
- The trust offered a nurse led photodynamic therapy service. Photodynamic therapy is a type of light that is used to treat some skin cancers. We saw that this type of therapy was provided in line with NICE guidance IPG55.
- We saw that physiotherapy staff used the Tinetti scale (a tool used to test a patient's balance and gait) in line with NICE guidance CG161 – Assessment and prevention of falls in older people.
- Diagnostic imaging services had been re-accredited in the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focussed assessment and accreditation programme, which 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 department which could demonstrate that best practice was being achieved.
- 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.

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## Pain relief

- If pain relief was required in the outpatient department, staff could give patients a prescription, which they could take to the pharmacy department within the hospital.
- We saw a variety of pillows and pads that were available to make patients as comfortable as possible whilst undergoing an examination in the diagnostic imaging department.
- A chronic pain nurse specialist ran a pain management programme. This involved a programme of consecutive weekly appointments for patients experiencing chronic pain, including patient information meetings and pain review meetings.

## Patient outcomes

- Patient outcomes in physiotherapy were monitored by recognised outcome measures such as range of movement, pain scores and the quality of life measures in order to establish the effectiveness of treatment.
- Every patient that attended an outpatient clinic had an outcome form and we saw blank copies of these attached to the front of patient's notes at the start of clinics. Outcome forms were completed by the consultant during the appointment and given to the patient to hand back into reception staff at the end of the appointment. The form indicated the next step for the patient, whether this was discharge, further follow up or diagnostic tests. The reception staff would then ensure the next stage was recorded and booked appropriately on the system.
- We spoke to reception staff who told us the biggest issue with these forms was that they did not always receive these from patients at the end of their appointment. This meant that if they required urgent further tests, there could be a delay to these being booked. The booking centre team were completing an audit of these forms, to establish where forms were missing or incomplete.
- We saw the results of two audits which monitored the percentage of patient outcome forms that had been received and processed following clinic appointments. The first audit identified that ophthalmology and oncology had the worst compliance rates, with only 58% and 56% respectively of forms returned following appointments. This meant that patients could be lost to

follow up. We saw that an action plan was in progress to follow up this audit. The next step was for one to one training with consultants regarding 18 week referral to treatment training and a re-design of the patient outcome form itself which was due by August 2017.

- Patients undergoing photodynamic therapy for basal cell carcinomas (a type of skin cancer) would have two sessions of photodynamic therapy, two weeks apart. Photographs would be taken at the first treatment session, and then the second, to document improvement or progress. The hospital undertook a clearance rate audit of these but were unable to provide us with the outcomes of this.
- The plaster room in the fracture clinic offered a procedure called total contact casting (TCC) for diabetic patients with foot ulcers caused as a result of diabetes. TCC is a specialised form of plastering, which results in the patient's weight being off loaded from the ulcer, allowing it to heal. We saw the results of an audit undertaken since June 2016, showing the healing rates of 15 patients treated with contact casting. Patients were reviewed at six and twelve month intervals. We saw that seven of that patient's ulcers had healed within six months, with the remaining patients were either continuing in TCC to be reviewed at the twelve month interval, or being discontinued on TCC.

## Competent staff

- Staff told us they completed a corporate induction upon joining the trust. This included three months of a structured induction to the department and being assigned a mentor.
- We spoke to student nurses who were on a placement in outpatients. They told us they felt well supported by the team, and had lots of learning and development opportunities. We saw a student competency document that mentors completed with their student. We saw an ex-student return to the outpatients department during our visit to personally thank staff for their support during their placement.
- We spoke to a healthcare assistant who had been seconded to the department. They felt able to follow patients through their pathways and had been assigned a mentor who guided them through the available learning opportunities. They also told us they were able to observe patient consultations which aided learning.



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- The department used a competency based development framework to support staff learning. We saw documents that evidenced they were in use. Competencies included catheter care, blood taking and cannulation. We saw that these had to be completed with the oversight of a trained member of staff ten times before they could be signed off as competent. This ensured that staff learning had appropriate support whilst learning and becoming competent in new skills.
- Appraisal rates were variable across the outpatients department. As staff sat in several different directorates, it was not possible to break this down to an overall outpatient compliance figure. In the head and neck directorate, where a large number of outpatient staff sat, the overall compliance figure was 82%, and in specialist services, where the sexual health team sat, the figure was 84%. This was worse than the trust target of 85%.
- However we saw when we visited the ear, nose and throat (ENT) outpatients, that their appraisal rate was 100%, which was better than the trust target.
- The diagnostic imaging department sat in the central clinical services, which reported 91% compliance in appraisals, this was better than the trust target of 85%.
- We saw evidence that staff in diagnostic imaging completed reflective look backs as part of their supervision paperwork. This was considered good practice and encouraged learning amongst staff.
- Nursing revalidation dates were recorded as part of appraisal paperwork. Revalidation is the process that all nurses have to go through in order to renew their registration with the nursing and midwifery council (NMC).
- A snapshot audit was taken to assess the quality of appraisals trust wide. We saw that of 14 appraisal documents reviewed in the head and neck directorate, all had documented that clear objectives and personal development plans were discussed. However, values and behaviour discussions did not always include specific examples and some showed that values and behaviours were not discussed at all, (7 out of 14), and not all appraisals (4 out of 14) had documented a level of achievement for the individual. There was a plan to do a second audit later on in the year to monitor compliance and see whether quality had improved.

## Multidisciplinary working

- The diagnostic imaging department offered trans-rectal ultrasound (TRUS) fusion biopsies. This is where a TRUS is performed at the same time as an MRI to enable a consultant radiologist or (highly trained) advanced practitioner radiographer to target the best visualised area for a biopsy.
- We saw that the sexual health clinic huddles were a combination of consultants, nurses, healthcare assistants and student nurses, which demonstrated good multidisciplinary working. They had also recently set up joint dermatology clinics looking at combined sexual health, dermatology and psychology issues as a multidisciplinary team.
- The outpatient department ran 'one stop' clinics, where patients could attend and have diagnostic tests and consultations in one appointment slot. Examples of these included the fast-track gynaecological clinics that were supported by sonographers, and the sarcoma (rare type of cancer) clinic that was supported by radiologists. Medical, nursing and diagnostic imaging staff also worked together in the fracture clinics.
- The BSUH hand service was run for patients who attend the emergency department with hand or wrist injuries. Patients that are suitable can be referred to the hand team by an e-referral form which is then reviewed collaboratively by a hand therapist and consultant hand surgeon. Patients could then be placed on one of eight treatment pathways following a telephone consultation.
- Clinical nurse specialists liaised with cancer multi-disciplinary team co-ordinators regarding patient's pathways. This helped to ensure that patients received their care within the national cancer pathway targets.

## Seven-day services

- The diagnostic imaging department provided a seven day service. This was in line with; NHS services, seven days a week, priority clinical standard 5, 2016. This requires hospital inpatients to have seven-day access to diagnostic services such as x-ray, ultrasound, CT and MRI and radiology consultants to be available, seven days a week.



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- Radiology consultants worked seven days a week, on a rota basis, to provide consultant-directed diagnostic tests and completed reports.
- On weeknights, outside of normal working hours, a specialist registrar (consultant radiologist in training) and a non-resident consultant radiologist were on site between the hours of 8pm and 8am, ensuring 24 hour access to radiology services. At weekends, a consultant was on site between 9am and 5pm, non-resident consultant 5pm to 8am and a specialist registrar 24 hours a day.
- Radiographers worked seven days a week on a rota basis. Outside of normal hours during the week, four radiographers were on site, and at the weekend there was cover between 8am and 9pm.
- Staff understood the requirements of relevant legislation and guidance including the Mental Capacity Act 2005. Staff also demonstrated good knowledge of the Deprivation of Liberty Safeguards (DoLS) and were able to describe the process of dealing with a patient who may not have the capacity to consent to treatment.
- We saw that consent for interventional radiology procedures such as CT guided biopsies was taken immediately before the procedure. Best practice dictates that consent should be obtained well before the procedure is performed and away from the relevant department as it is felt that patients may find it difficult to change their mind so soon before a procedure.

## Access to information

- Clinical staff were able to access results of diagnostic imaging tests via a picture archiving and communication system (PACS). This is medical imaging technology that provides storage and access to diagnostic images from multiple machine types. Other areas of the hospital were able to access the PACS system when required.
- This meant that both electronic systems promoted care continuity, and a MDT approach to care.
- Ionising Regulations 1999 (IR99) and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000 folders were accessible and staff knew where to access these.
- In diagnostic imaging we saw a non-medical referrers list that was in date. All staff we spoke with knew how to access this list.
- Imaging Service Accreditation Service folders and standard operating procedures were fit for purpose and up to date in the diagnostic imaging department and staff knew how to access these.

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

- Staff were expected to complete Mental Capacity Act training as part of their mandatory training requirements. We saw that there was low compliance of both outpatient staff and diagnostic imaging staff with this training.

## Are outpatient and diagnostic imaging services caring?

Good



When we inspected Brighton and Sussex University Hospitals Trust in April 2016, we rated caring as requires improvement. This was because:

- 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.

At this inspection we have changed this rating to good. This was because:

- Friends and Family test (FFT) results were better than the England average for four out of six months we reviewed.
- We saw positive interactions between staff and patients.
- Patients commented positively about the care provided from staff they interacted with.
- Comment cards we reviewed were positive about the care received.
- Clinical nurse specialists were available in certain specialities and were able to provide emotional support to patients.

However:

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- The Patient Led Assessment of the Care Environment (PLACE) score for privacy and dignity was slightly worse than the England average and privacy and dignity could not always be guaranteed.
- We saw some areas where patient's privacy and dignity could not be maintained due to the clinic environment not offering adequate privacy during appointments.

## Compassionate care

- The Patient Led Assessment of the Care Environment (PLACE) for the period of 2016, which showed the hospital average, across four outpatient areas, scored 78%, for privacy and dignity, which was slightly worse than the England average of 83%. The place assessment for privacy, dignity and well-being, focuses on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also includes the practicality of available services such as bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.
- In nearly all clinic areas that we visited, consulting rooms had 'knock and wait' signs on them to prevent people entering during a consultation or procedure, and we saw staff knocking and waiting. This helped to protect patient's privacy and dignity. However, in the main outpatients we observed patients being weighed and their height measured in a corridor beside a staff area which did not provide any privacy.
- In the Sussex Eye outpatient's department, clinic rooms were in a block of eight and six of these were accessible from both sides. Internally, the walls were not complete which did not provide privacy between cubicle areas. Cubicle four had a transparent glass window which was open to the public thoroughfare and where patients were waiting in the corridor. We could observe patient care through this window, as could any patient or visitor in the waiting area. Following the inspection, this issue was escalated and the trust had put mitigations in place to improve privacy in this area.
- There was no designated waiting area, such as a bed bay with curtains, for inpatients transferred on trolleys in the CT waiting area. This meant inpatient's privacy and dignity could not be guaranteed when waiting in this area.
- Staff told us that patients had fed back that they felt exposed sitting in the waiting area with hospital gowns on. We also saw leaflets given to patients that advised them of the need to wear underwear that does not contain metal parts as metal parts, such as bra clips and zips would interfere with the CT scanner. By following the guidance provided, patients could enter the CT scanner in their underwear, thus protecting their dignity. The leaflet also advised patients they would need to wear a hospital gown, and therefore invited patients to bring a dressing gown or coat to wear over this to maintain their dignity. There were future plans to close the reception on CT and to change the area to a private area for patients waiting for their CT.
- We saw examples of the privacy and dignity questionnaire run by the diagnostic imaging department. These questionnaires were completed twice a year and we saw the results from July 2016 compared to January 2017. We saw that improvements in patient satisfaction was demonstrated in the paediatric diagnostic imaging department, along with main CT and X-ray areas, however all other areas including the MRI department, had seen a decrease in patient satisfaction.
- We reviewed the results of the outpatient Friends and Family Test for a six month period (November 2016 to April 2017). This data was at a trust-wide level and it was not able to split these by site. We saw that for four of the months, the score was better than the 93% average for NHS trusts in England. However, in December 2016 the score dropped to 92%, and in January 2017 the score was 82%, both worse than the 93% average.
- We reviewed results of the Friends and Family Test carried out by the imaging department. This questionnaire asked whether the patient was likely to recommend the department to friends or family. We saw between April 2016 and March 2017, an average score of 96% was achieved, meaning the majority of patients would recommend the service to friends and family.
- We reviewed 39 comments cards for the outpatient department, 20 related to main outpatients, 19 related to the Sussex Eye Hospital outpatients. The main outpatients had 95% positive comments about staff, stating they were "friendly", "caring" and "helpful". However, nearly all responses commented on the long waits in clinic. The Sussex Eye hospital had 95% positive

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comments including “treated with respect”, “staff kind and professional” and “excellent service”. The comments that were negative related to length of time waiting for appointments.

- We saw chaperone notices in some of the outpatient departments but these were not on display in every area we visited. This meant that some patients may not be aware of the service.
- We observed staff politely talking to patients, offering assistance and giving directions. A patient told us “We have always been treated with courtesy and kindness”.
- One patient commented that “staff were nice and friendly which makes up for the grotty building”
- We saw multiple plaudits and thank you cards for staff in the photodynamic therapy clinic.
- Fracture clinic staff told us that often patients waiting for transport until late in the evening and staff would always wait with patients to ensure they are looked after.
- The diagnostic imaging friends and family test FFT result February 2017 – 96.8% would recommend, 483 returned, only two stated extremely unlikely to recommend.

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

- Patients were provided with sufficient information to be able understand their care and treatment choices.
- We observed three patients undergoing x-ray procedures. All patients had their identity checked before staff introduced themselves and explained how to get the results of their procedure.
- Patients that we spoke with felt they had a good understanding of the care that was given to them and told us they felt involved in their care.
- All of the patients we spoke with were satisfied with the clinical care they received at the hospital.
- In the waiting area of the Sussex Cancer Centre we saw a large poster with suggestions for boosting patient’s diets and healthy recipes. This is important for cancer patients as their treatment can sometimes have side effects of appetite loss.

## Emotional support

- In the Sussex Cancer Centre, we saw that volunteers brought therapy dogs into the clinic areas to visit patients. Therapy pets can help improve patients’ emotional wellbeing in hospital. There were also notices for cancer patient support groups and events for patients and relatives to attend.
- We saw that patients with a cancer diagnosis had access to clinical nurse specialists (CNS). CNS’s formed part of a multi-disciplinary team that provided support to patients with a cancer diagnosis, as well as their families and carers. We spoke to a CNS who had level two training in psychological support which meant that she had received advanced training in dealing with patients who may be undergoing high levels of distress.
- In some clinical areas such as the Sussex Cancer Centre, there was a ‘quiet’ room, which enabled staff and patients to have potentially upsetting news delivered in a private and quiet environment.
- Some clinics were dedicated as ‘breaking bad news’ clinics, where patients would receive their diagnosis. We spoke to a CNS who told us they always try and have a CNS present for these clinics to work alongside the consultant. If for any reason the CNS was unable to attend these clinics the contact details to the CNS would make telephone contact - the following day, to introduce themselves and answer any questions.

## Are outpatient and diagnostic imaging services responsive?

Requires improvement



When we inspected Brighton and Sussex University Hospitals Trust in April 2016, we rated responsive as inadequate. This was because:

- The trust was failing to meet all three of its cancer waiting times targets and the England 18 week referral to treatment standard.
- The pathology department was not providing diagnostic results for suspected cancer in a timely way.
- Call centre data demonstrated that almost half of incoming calls had been abandoned and unanswered.

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- Sixty percent of all cancelled clinics were cancelled in less than six weeks' notice.

At this inspection, we have changed this rating to requires improvement. This was because:

- The trust was performing worse than the 92% standard for patients been seen with 18 weeks of a routine referral.
- The trust was performing worse than the operational standard of 85% for patients receiving their first treatment within 62 days of urgent GP referral.
- The trust could not provide us with data for the turnaround time of biopsies which meant there was no oversight of delays or issues within this department.
- Signage around the outpatient departments was poor and patients feedback that they had found it hard to navigate.

However:

- The trust was performing better than the operational standards for both people being seen within 2 weeks of an urgent GP referral, and for those waiting less than 31 days before their first treatment following a cancer diagnosis.
- Call centre abandonment figures had significantly improved since our last inspection.
- The hospital now monitored waiting times for patients in clinic which meant they were aware of problem areas or clinics.
- The trust had introduced two way texting for patient appointments and had seen a significant improvement in number of calls abandoned by patients calling into the booking hub.
- All complaints were investigated and closed within the trust-wide target for investigating complaints.

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

- The sexual health clinic offered a walk in service, where patients did not need to book an appointment in advance. There were also late night appointments available and a Saturday morning service.

- In the sexual health clinic there was a form to complete if patients reported a sexual assault. This information could, with the patient's consent, be shared with local police.
- In all outpatient clinic waiting areas we saw that there was an adequate amount of chairs and space for patients and their relatives. White boards displayed the name of the consultants and nurses on duty, along with the expected wait or any delays for their clinics.
- However, the CT waiting area in diagnostic imaging was cramped and did not offer a sufficient amount of chairs for patients waiting for their procedure. We saw that this had been commented on by patients in surveys carried out by the department. Staff were aware of the concerns raised and the limitations of the department, but due to the footprint of the building were limited in how they could address this issue.
- We saw documented on the risk register that the accessible toilet in the main outpatients department could not accommodate a mobility scooter. There had been occasions where patients had been sent to a different building to access a toilet. This involved crossing a main road and did not promote patient dignity.
- Since our last inspection, the trust had introduced a two-way text reminder for patients to confirm their appointment. This meant that patients could access information about their appointment through their mobile telephone, rather than relying purely on a paper letter. We spoke to two patients who advised us that they found this system met their needs.
- The trust access policy stated that clinics should be cancelled with at least six weeks notice. Between October 2016 and January 2017, the hospital cancelled between 1% and 3% of clinics with less than six weeks' notice; the main reasons for these was sickness, compassionate and annual leave. This had improved significantly since the last inspection where 60% of clinics were cancelled within six weeks.
- Since our last inspection a patient pathway co-ordinator had been appointed for diagnostic imaging to help ensure that the patients experienced a smooth transition along the patient pathway and identify any problem areas.

# Outpatients and diagnostic imaging

- There was a drinks machine in the X-ray waiting area – we spoke to patients who liked being able access fluids whilst waiting for their procedure.
- In the diagnostic imaging department we saw waiting times displayed for each modality. This meant that patients were kept informed of how long they were likely to be in the department.
- A reporting radiographer provided ‘hot reporting’ for the emergency department between 9am and 5pm, Monday to Friday, which gave the referrer an immediate result of the investigation and led to the patient receiving appropriate treatment in a timely manner. Outside these hours, if an x-ray was required by A and E, it would be performed by a radiographer and routinely reported the next day unless a more urgent report was required when it would be provided by the on-call radiologist.
- We saw that staff in the paediatric imaging department could add flavourings to contrast (a special dye which is ingested to show up organs on x-ray and CT) to encourage children to drink them. We saw this being offered.
- We visited the paediatric diagnostic imaging department which worked from 8pm until 5pm Monday to Friday. Outside of these hours, children and young people had to use the main diagnostic imaging department. This meant that children may not have as good as experience compared to the department set up solely for children, and may be exposed to sights and sounds that may be scary. The lack of paediatric trained radiologists outside of core hours was listed on the diagnostic imaging risk register as the highest rated risk.

## Access and flow

- Between November 2016 and January 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance. As of January 2017, 81% of this group of patients were treated within 18 week versus the England average of 90%. RTT times improved between December 2016 and January 2017. Non-admitted pathways are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital.
- Patients who have suspected cancer should expect to see a specialist consultant within two weeks of referral

from their GP. They should have received their cancer treatment within 31 days of receiving a decision to treat the cancer being made; and overall should receive their cancer treatment within 62 days from being referred from their GP, in line with national standards.

- The trust performed better than the 93% operational standard for patients being seen within two weeks of an urgent GP referral in quarters one, two and three of 2016/17. This was an improvement from quarter 4 in 2015/16 where the trust fell below the operational standard.
- However the trust performed consistently worse than the operational standard of 85% for patients receiving their first treatment within 62 days of urgent GP referral, and the performance had worsened in quarter 3 of 2016/17, dropping to below 75%.
- The trust performed consistently better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis.
- Patients should wait no longer than six weeks for their diagnostic test. Between February and December 2016, the percentage of patients waiting more than six weeks to see a clinician for a diagnostic test was worse than the England average. However, in January, February and March 2017, 99.7% of patients received a diagnostic test within six weeks which showed an improvement in performance. We saw a comprehensive appointment booking system in the diagnostic imaging department that consistently provided appointments to patients within six weeks of request, which met national targets.
- We visited the pathology laboratory which dealt with the processing and reporting of all biopsies for the trust and spoke with the site lead for Brighton histology. The trust aimed to process urgent biopsies within 24 hours, and non urgent biopsies processed within seven days. We asked the trust to provide us with data on the targets for reporting and turnaround times for the reporting of biopsies, but were told they were unable to provide us with this information due to technological issues with the systems. This meant the trust was currently unable to monitor issues or delays with biopsy reporting.
- Staff in the pathology department told us one of the biggest issues they faced was the IT systems used to track histology samples. The department used one type



# Outpatients and diagnostic imaging

of software interface, the trust used a different version of this interface, and the system used to track samples was incompatible with both of these. Meaning that in effect, biopsies had to be tracked manually to ensure they were completed within the appropriate timeframes.

- 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 histology lead informed us that TATs of samples were impacted by having to manually track the status of samples. We were informed that a new piece of software had recently been purchased with the aim of allowing electronic tracking of samples to decrease turn-around times in future.
- Staff liaised with cancer services staff to ensure that cancer/urgent biopsies were processed quickly enough to avoid breaches of 31 and 62 day cancer targets.
- Since our last inspection, the trust had introduced a two-way text reminder for patients to confirm their appointment. Calls into the booking hub had reduced from 20158 incoming calls received in September 2016, to 9605 incoming calls in February 2017. With this reduction in number of incoming calls, the percentage of calls abandoned unanswered had also improved, with 57% of calls abandoned in September 2016, and 8% of calls abandoned in February 2017. Since November 2016, abandoned calls had not gone above 10% of the total incoming calls. This indicated that patients were able to access their appointment booking more easily. We spoke to staff in the booking hub who told us they were proud of this achievement.
- We saw that the number of calls coming into the booking hub over the last six months had decreased from 20158 in September 2016 to 9605 in February 2017. During this time the number of calls abandoned by patients reduced from 56% in September 2016 to 7% in February 2017, indicating that more patients were able to make contact with the team regarding their appointment during this time.
- As of October 2016 the trust reported that 40% of patients waited over 30 minutes to see a clinician.
- Between October and December 2016, an audit of overrunning clinics in outpatient areas was completed. This indicated by speciality, that rheumatology and haematology clinics were frequently overrunning. As a result of this, reception staff now consistently record arrival time of patients as well as time called into the consultant. This meant the trust could monitor frequently overrunning clinics and assess where any issues were occurring.
- We saw poor signage in the main outpatients department. For example, the sign for the diabetic clinic was a small poster at the entrance of main outpatients but was not signed further, and we observed a patient at the entrance unable to locate the nearest toilet. We observed a staff member helping them and guiding them to the nearest facility. We spoke to a patient who was a regular to the main outpatients building. They told us they were able to find their way round but as a new patient would find it difficult. Another patient commented that the “signage was woefully bad”.
- We visited the CT department and found the reception closed and a sign asking patient to check in at the X ray reception, however, there was no signage towards the x-ray department and it was not adjacent so patients may not be able to easily locate the area.
- In the fracture clinic we saw a ‘patient’s voice’ notice board with April 2017 comments an action plans displayed. One comment was that patients would like to be kept informed of any delays whilst waiting in the upstairs waiting area although we did not see that this had been actioned on our inspection, although waiting times were displayed in the downstairs waiting area.
- We observed bariatric chairs (chairs that could accept patients with a higher body mass index) were available within the main outpatient’s waiting room.
- There was a whiteboard in each waiting area with the names of staff on duty and the current wait time or delays for appointments.
- A ticketing system was in place for phlebotomy services to manage patient waits.
- The booking hub staff aimed to book patients on a two week referral within 24 hours of receiving the GP referral. This was in line with the patient access policy. One patient told us of the “Rapid response” they had received to their referral.



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- Staff highlighted there had been a challenge to meet two week referral times for neurosciences, however, dedicated appointments were now reserved to ensure this time frame is met.
- The provision of toys and child friendly areas had been developed since the last inspection through a joint initiative with the play lead nurse.
- We saw data that indicated that between January and March 2017, 55% of all clinic letters from outpatients were completed within seven days, 24% were completed within 14 days, and 22% took longer than 14 days to be completed. This meant that the department was not meeting the set target time of seven days.
- As of October 2016, the trust reported that less than 1% of patients were seen in outpatients without their full medical record being available. This was an improvement since 2016 where 8% of patients were seen without their full medical record. We were told that in the event of a medical record not being available, a temporary set would be created by medical records staff, which would include the patient's details and a printed copy of the referral letter sent by the referrer and any related test results.
- In the sexual health clinic we saw a registration form for patients to complete that offered several gender types (in addition to male and female) to select including trans-male, trans-female and non-binary. This meant that patients' individual needs regarding their identity could be met.
- We saw several clinics had access to 'quiet rooms' such as in the cancer outpatient clinic.
- The trust could access both face to face and audio translation and interpretation services for patients who did not speak English fluently. The trust website advised patients to contact the department they were visiting as detailed in the clinic letter they received prior to their appointment.
- The hospital had a chapel on the first floor of the Barry building. This was open 24 hours a day and was open to anyone who wished to use it. The hospital also had access to chaplains who were on call. The hospital website advised that patients and their families could use these for not only religious matters, but also for spiritual advice. The hospital also had a Muslim faith prayer room, located in the same building as the chapel.

## Meeting people's individual needs

- The Patient Led Assessment of the Care Environment (PLACE) for 2016 showed the hospital scored 56% across three outpatient areas for dementia, which was worse than the England Average of 80%.
- The PLACE assessment for the period of 2016 showed the hospital scored 50% for disability across four outpatient areas, which was worse than the England average of 81%. The place assessment for disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.
- The reception desk in the main outpatient's area was high and staff explained that it was previously lower but was raised for security reasons. If a wheelchair user required access to reception they would be able to access this at the end of the desk where it was at a lower height.
- Between January 2016 and February 2017, there were 344 complaints about the outpatient department trust wide. The trust took an average of 18 days to investigate and close complaints, which was in line with their complaints policy, which stated that 90% of complaints should be investigated and closed within 40 days. A large proportion of complaints received were in relation to treatment pathways, staff attitude, treatment and procedure and cancelled appointments.
- We saw that complaints were a standing agenda item in the imaging patient experience group meetings that were held quarterly.
- We saw posters in various waiting rooms advertising the Patient Advice and Liaison Service (PALS) and leaflets that patients could take away. We also saw that comment boxes were available to allow patients to raise concerns and to give feedback on the service.
- The CQC received ten enquiries relating to outpatients between April 2016 and March 2017. All of these were negative feedback relating to cancelled or delayed appointments.

# Outpatients and diagnostic imaging

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

Requires improvement



When we inspected Brighton and Sussex University Hospitals Trust in April 2016, we rated well-led as inadequate. This was because:

- 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.

At this inspection we have changed this rating to requires improvement. This was because:

- There was no formal strategy or vision in place in the outpatient or diagnostic imaging departments.
- Some risks that staff told us about in outpatients were not documented on the risk register.
- Not all staff we spoke with knew what directorate they belonged to indicating a lack of engagement with senior staff.
- The presence of governance meetings and processes differed across each speciality within outpatients.
- The 2016 staff survey results indicated that staff engagement had worsened since the 2015 survey results.

However:

- We saw that the culture in the services was good.
- Local leadership was good and staff in outpatients and diagnostic imaging felt supported by both their immediate line managers and their directorate lead nurse.
- There was staff engagement at department level with team meetings and forums for staff to attend and discuss best practice.

### Leadership of service

- The head and neck directorate were responsible for delivering outpatient services at the trust, with the clinical activity monitored by the relevant directorate. For example, the majority of outpatient teams sat in the head and neck directorate which included the Sussex Eye Hospital and ENT outpatients; the sexual health clinic sat under the speciality medicine directorate and physiotherapy sat under the central clinical services directorate. Each clinical directorate had a leadership team which included a Clinical Director, Lead Nurse and Directorate Manager.
- Diagnostic imaging services and the pathology teams sat under the central clinical services directorate. Administration teams and the booking hub were managed by central administration services.
- There was an interim lead directorate nurse for Head and Neck who managed the nursing teams in main outpatients, the Sussex Eye hospital and ENT outpatients. Underneath the lead directorate nurse there were six outpatient nurse managers who managed the nursing and health care assistant (HCA) staff.
- Outpatient nurse managers told us that the lead directorate nurse was visible and supportive. All staff we spoke to knew the lead nurses name and could tell us when they last saw them in their department, which for most areas was weekly or daily. This meant that the leadership team was visible in the department.
- The majority of staff we spoke with felt well supported by their managers.
- The lead directorate nurse had set up the outpatient nurse forum to look at practice across all clinics and we spoke to outpatient nurse managers who said how valuable and useful this forum was. Outpatient nurse managers managed their own areas within different buildings across the site, and the forum was an opportunity for staff to improve joint-working and discuss any issues. They told us this meeting was valuable, and helped facilitate consistency in the department.
- Staff felt that the culture of the outpatients department had improved under the current manager. The staff we talked with told us that the manager was 'visible, caring and helpful and escalates problems on behalf of staff'.

# Outpatients and diagnostic imaging

- All members of staff we spoke to were able to tell us who they reported to, but the majority of staff we spoke to were unaware what directorate they sat in. Staff told us that the directorates changed so often that it was difficult to keep up indicating that communication from senior leadership was not always effective. A further change to the structure of directorates was planned for 2017 but not all staff were aware of this.
- In diagnostic imaging, all staff we spoke with told us that the managers were supportive and visible. Radiography staff told us the new manager has empowered the superintendent radiographer and worked well with the team.

## Vision and strategy for this service

- There was no strategy or vision for outpatients or diagnostic imaging. We spoke to the lead directorate nurse for outpatients who told us whilst there was no formal vision in place, the aspirational vision was to celebrate outpatients and empower staff.
- We spoke to staff managed by the lead directorate nurse who told us that they had felt empowered by the directorate lead nurse.
- Senior staff in diagnostic imaging informed us that whilst there was no current updated strategy, one was being refreshed in line with the new trust-wide clinical strategy.
- We spoke to staff about the trust visions and values and whilst not able to articulate the hospital values of communication, kindness, working together and excellence, staff spoke of the importance of quality patient care, which fitted with the trust vision of providing safe, high quality services.
- There was an outpatient improvement project which focussed on administrative processes, patient experience of waiting times and technology projects. This included process improvement milestones such as processing referrals within 24 hours, two week wait appointments booked within 30 minutes of receipt and auditing of overrunning clinics. Each stage was red, amber, green (RAG) rated to indicate what stage the process was at. This enabled staff to visualise the improvement of administrative services within outpatients. We saw the terms of reference for the

outpatient improvement group meetings, and membership included members of the central administrative service and the lead nurse for outpatients.

## Governance, risk management and quality measurement

- The majority of data we reviewed was not site specific, such as mandatory training data. This meant that whilst they were recording important information about the performance of the service, it was not clear whether a problem or poor compliance was a trust-wide issue or site specific.
- We saw that some outpatient specialities had clinical governance meetings that were held monthly such as the ophthalmology team that the eye hospital outpatients staff attended. We also saw that some outpatient staff attended the cancer clinical governance meetings. However we did not see any governance meeting minutes relating to the other specialities in outpatients such as main outpatients or ENT.
- The lead directorate nurse had initiated a Patient Quality and Safety Measurement tool. This was a matrix that was completed bi-monthly by either the directorate lead nurse or their deputy. We saw a completed matrix for the main outpatients from November 2016 to April 2017. This measured against four standards: risk management, incidents, medicines management and infection control. The assessor would check against the various performance indicators such as if gel dispensers were present, whether there was a daily huddle and if appropriate risk assessments had been completed. We observed most of the checks had been completed on the sheet we saw, however there were some gaps where it was not clear whether a check had been undertaken or not. There was also a column for 'agreed person to action' which had been left blank on all entries we viewed so it was not clear who was responsible should one of the checks be found missing.
- The Quality and Performance Committee (QPC) was an executive level meeting that met monthly. We reviewed the minutes from February and March 2017 which demonstrated that compliance with the 18 week, diagnostics waits and national cancer targets was discussed at board level, demonstrating that the board had an understanding of these issues. Also discussed at

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the QPC was the clinical review of patients waiting longer than 52 weeks for review by a clinician, indicating that the board had an awareness not only of the breach of standards, but the potential of patients coming to harm as a result of this.

- The six outpatient nurse managers met monthly for the outpatient nurse manager meetings. We saw minutes from two sets of these meetings, and saw topics such as complaints and infection control issues were discussed, however quality issues such as incidents and risks were not discussed at these meetings.
- We also noted from the minutes of the meetings, two nurse managers brought the 'safety huddle' idea back from a visit to a nearby NHS trust. This was a system of discussion of key safety issues before clinics started and we saw that these had been incorporated throughout outpatients and the hospital. We viewed the outpatient risk register which contained six risks. The highest rated risk was the capacity issues experienced by the ENT department, both in the clinics and in the clinic booking team. Also listed was the inappropriate use of the mezzanine level in main OPD and the lack of handwashing facilities in the main OPD. Staff in the Sussex Eye hospital told us that during the summer months rooms got very hot, regularly reaching temperatures of 26 degrees. However, this was not documented on the risk register which indicated there were no controls or mitigating actions in place to resolve this. We did not see that any incidents that had been reported relating to this.
- The highest rated risk for the diagnostic imaging department was the lack of paediatric radiology cover outside of hours. There were controls in place for this which involved an external company providing advice over the telephone if required, although this did not resolve the issue if a paediatric radiologist was required on site out of hours.
- The imaging department did not hold its own governance meetings, instead holding imaging discrepancy meetings and quality and safety updates. Whilst we did not see minutes from these meetings, we saw that they were a standing agenda in the diagnostic imaging department. We also saw minutes from the Ionising Radiation Safety Committee meetings, where incidents reported in the previous month were discussed.

- The outpatient improvement project (OIP) and outpatient nurse forum (ONF) both fed in to the Quality and Performance Committee (QPC). The ONF focussed on clinical processes, environment & patient experience.

## Culture within the service

- We spoke to senior members of staff regarding the management of poor performance and behaviours not in line with the trust values. There was a policy in place for managing performance and poor behaviour and we were told that the human resources department had been supportive of managers who were dealing with these types of processes. Furthermore, the lead directorate nurse for head and neck had set up a weekly meeting with HR to discuss any outstanding issues regarding performance, recruitment or other workforce concerns.
- However, below manager level, some staff we spoke with at focus groups felt there was poor management of bad behaviour and performance, and felt that when concerns were raised about these issues, nothing was done.
- We spoke to a number of staff who had been on the 'achieving dignity at work' course. They felt this was a useful course but told us that senior managers and executive staff were not expected to go on this course, and felt this did not encourage a good culture of working together.
- Not all staff in the Sussex Eye Hospital were in the correct uniform during the inspection. For example we spoke with a band 6 nurse who was in a band 5 uniform. Staff told us this was because the trust has stopped purchasing uniform which had affected the morale of some staff and did not make them feel valued.
- We spoke to several members of staff who felt that their work was not recognised by the trust and they felt that this affected morale and motivation.

## Public engagement

- The hospital participated in patient led assessments of the care environments (PLACE) audits. These assessments invite local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance.

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- There was a patient experience panel that had been set up in a revised format from April 2017. We saw the terms of reference for this panel which stated that a minimum of two patient representatives must be present at this meeting in order for it to be quorate. We saw minutes from the May meeting which demonstrated that two patient representatives sat on this meeting and were able to share their views and experience at this meeting.
- Patients and relatives could use the NHS Choices website to leave feedback regarding their experience. We reviewed the feedback left for the last 12 months; however the feedback could not be broken down to outpatients services or diagnostic imaging.
- The trust had a public website that patients could access to find out more information about their outpatient appointment or to feedback their experience. Patients could click on the 'your outpatient appointment' section to find out useful contact numbers, how to access transport and could cancel or re-schedule their appointment by a form should they need to.
- We saw that the ENT OPD team had monthly meetings. These included discussions around education, equipment and annual leave; however, we did not see any discussion around incidents, risks or complaints, or other performance indicators.
- Some staff told us about attending a 'human factors' workshop and how beneficial this has been for team building. The workshops aimed to increase attendees knowledge of the impact of human factors in the workplace, how to reduce human error and improving confidence in challenging behaviours that could lead to human error. We saw data from the trust that showed that on average 45 members of staff attend these workshops across 2017, the majority of which were BSUH staff, with some staff from other neighbouring healthcare organisations.
- The trust participated in the NHS staff survey. This data could not be broken down by hospital site. This survey assessed staff engagement by asking a range of questions about working lives, assigning a score between one (indicating poor engagement) and five (good engagement) and then comparing these scores against other similar trusts. The 2016 staff survey showed a decrease in overall staff engagement compared to the 2015 staff survey. The trust's score of 3.62 was in the worst 20% when compared with trusts of a similar type.

## Staff engagement

- The six outpatient nurse managers regularly met for the monthly outpatient nurse manager meetings. We saw minutes from two sets of these meetings, and saw relevant issues such as complaints and infection control issues. We also saw that during one of these meetings, two nurse managers brought the 'safety huddle' idea back from a visit to a nearby NHS trust. This was a system of discussion of key safety issues before clinic started and we saw that these had been incorporated throughout outpatients and the hospital.
- Staff in outpatients talked about a new initiative called the outpatient nursing managers forum. We saw the terms of reference for these meetings, however these were incomplete in a draft format. The forum was due to meet quarterly, and we saw an agenda from the first meeting which took place in February 2017. We saw that governance, education and service development was due to be discussed, however, we were not able to see the minutes from this meeting so it was not clear how any of these discussions were taken forward.

## Innovation, improvement and sustainability

- The Sexual health clinic was trialling a 'safer sex' text message pilot scheme and was aimed at reducing the number of people contracting sexually transmitted infections (STIs) and unplanned pregnancy. The texts provide sexual health information and information on where to seek advice and contraception.
- We saw a proposal for a teletriage (telephone consultation and review) system for patients referred to the ENT department with symptoms of dizziness. The proposal outlined that with the patient's consent, after referral from their GP, patients would be sent a questionnaire regarding their symptoms. ENT consultants would then review the answers and would send initial advice or exercises in advance of the clinic

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appointment. This meant that the patient had earlier interaction with medical advice, and when the patient came to clinic the consultant would have more detailed information regarding the patient symptoms.

- In the ENT outpatient department, a band 6 nurse was starting a local anaesthetic clinic for a trial of three months to reduce the waiting list for general anaesthetic patients.

- The diagnostic imaging department had introduced the assistant practitioner role. This was a role where radiographers could undertake further specialist training and competencies to provide a higher level of support within their department such as performing TRUS biopsies.



# Outstanding practice and areas for improvement

## Outstanding practice

- In ED, the new self-rostering approach to medical cover had a significant impact on the department. Medical staff appreciated the autonomy and flexibility this promoted as well as the effective and safe cover for the department. Because of this initiative, the department was able to provide round the clock medical cover without the use of temporary staff.
- The introduction in ED of the clinical fellow programme that had improved junior cover in the department and also the education and development opportunities for juniors..

## Areas for improvement

### Action the hospital MUST take to improve

- The trust must ensure that the (WHO) Five Steps to Safer Surgery checks are fully completed for all patients undergoing surgery.
- The trust must ensure that safer sharps are used in all wards and departments.
- The trust must ensure anaesthetic equipment checks are consistently completed.
- National Specification of Cleanliness (NCS) checklists and audits must be in place including a deep cleaning schedule for theatres.
- The trust must ensure that in theatres controlled drug dose given and amount destroyed is consistently recorded.
- The trust must ensure records in ED are held securely and kept confidential.
- The trust must ensure ED patients' dignity and privacy is respected by ensuring there is adequate space in holding areas, adequate screening is available and by avoiding the use of mixed sex accommodation.
- The trust must ensure that medications in ED are stored safely, securely and at the appropriate temperatures.
- The trust must ensure that all staff within the medicine directorate have attended mandatory training, that there are sufficient numbers of staff with the right competencies, knowledge and qualifications to meet the needs of patients.
- The trust must ensure all staff within the medicine directorate have an annual appraisal.
- The trust must ensure fire plans and risk assessments ensure patients, staff and visitors can evacuate safely.
- Medical wards must ensure all areas where medicines are stored have their ambient temperature monitored in order to ensure safety and efficacy.
- The trust must take action to ensure that information in the critical care department is easily available for those patients and visitors that do not speak English as a first language.
- In critical care, measures must be put in place to check that stock levels of controlled drugs in critical care are correct and that the list of authorised signatories is also correct and up to date.
- The trust must make arrangements so pharmacy provision meets the national guidelines.
- The critical care department must employ a dedicated dietitian to meet national guidance with a critical care pharmacist for every critical care unit.
- The trust must ensure that adequate oversight of laser safety is provided and that laser protection supervisors who are assigned to look at this at a local level are sufficiently trained to oversee and enforce this. All laser machines must be serviced annually and taken out of use if annual service check has expired.
- The trust must ensure that worn protective eyewear in outpatients and diagnostic imaging is replaced.

# Outstanding practice and areas for improvement

- The trust must take action to ensure that patient privacy and dignity is maintained, particularly in the Sussex Eye Hospital and CT waiting area.
- In maternity, the trust must ensure that fire safety issues are addressed, monitored and reviewed to ensure that all areas where patients receive care and treatment are safe and well-maintained.
- The trust must ensure appropriate measures are taken to improve the ventilation system in the obstetric theatre on level 13.
- The trust should review any possible data confidentiality issues that may occur from the use of large electronic displays at the nursing hub in ED.
- The trust should review the provision of the medical pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- The trust should review the provision of pharmacy services across the seven day week and improve pharmacy support.

## Action the hospital SHOULD take to improve

- The trust should 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 should continue to work on reducing the waiting list for a specific colon surgery.
- In surgery the trust should improve attended mandatory training rates.
- The trust should review patient flow through the surgical assessment unit.
- The trust should review its policy of boarding patients on the ward areas before a bed is available.
- The trust should effectively communicate the clinical strategy to all staff and the arrange for the plan to improve staff engagement to be fully implemented.
- The trust should make arrangements for patients in ED with impaired capacity to have these risks identified and managed appropriately.
- The trust should improve ED mandatory training and appraisal rates to meet the trust's own compliance rates.
- The trust should consider how to improve continuity with incident, complaint and risk management processes across both ED sites.
- The trust should improve engagement between the ED's in RSCH and PRH site.
- The trust should improve learning and the sharing of best practice between ED's at the RSCH and PRH site.
- The trust should prioritise patient flow through the hospital as this impacted on length of stay, timely discharge and capacity.
- The trust should devote sufficient time and resources to address the backlog of incident investigations in critical care.
- In critical care, the trust should make arrangements for mandatory training modules to be completed in a timely manner and any outstanding modules completed.
- In critical care, level two training in child safeguarding should be completed to meet the trust target.
- In critical care, the trust should take action to improve compliance with the trust policy that says staff should be bare below the elbow.
- The practice of removing used bed pans from side rooms in critical care should be done in accordance with the trust's infection prevention and control policy.
- The trust should introduce a method to monitor the temperature across the unit on level five critical care.
- In critical care, the trust should take action to ensure that patients are clearly identified in their records, that no records are kept loose and care bundles are filled in.
- In critical care, the trust should consider how to improve screening for venous thromboembolism.
- Arrangements should be made so neurology trained nursing staff are available to cover the critical care area where ventilated neurology patients would be cared for.

# Outstanding practice and areas for improvement

- The trust should take action to ensure it meets its own standard/KPI of discharging all patients with a rehabilitation prescription.
- The trust should display that any information collected in relation to the friends and family test in critical care is available on the NHS England website.
- In critical care, the trust should introduce a process to follow when they take a patient that is under the age of 18 and that paediatric input is sought in these circumstances.
- The critical unit should clarify with the site management team what would amount to a mixed sex breach on their unit.
- The critical care unit should replace the neurology practice educator post which was vacant.
- The trust should improve mandatory training completion in the outpatient and diagnostic imaging departments.
- The trust should make arrangements for outpatient and diagnostic imaging staff to receive annual appraisals.
- The trust should share learning from incidents and complaints handling with staff to prevent recurrence within outpatient and diagnostic imaging services.
- The trust should have systems to check fridge temperatures within outpatient and diagnostic imaging. They should be undertaken in line with trust policy and national guidance.
- The trust should monitor that compliance with WHO audits in interventional radiology and improve performance.
- Consent for interventional radiology procedures should be taken in line with best practice.
- The trust should develop a strategy in place for the outpatients and diagnostic imaging department.
- In maternity, the trust should fully explore recent hypoxic-ischaemic encephalopathy (HIE) numbers and consider an internal investigation into the high numbers to identify any common themes.
- In maternity, the trust should consider how improvement to training targets are met and consider revising the target percentage.
- In maternity the trust should make arrangements to update the risk register to reflect all risks to the service, and check that there are clear reasons documented for any changes to risk ratings.
- In maternity the trust should consider how targets for adult and child safeguarding level three are met.
- The maternity department should consider participation in morbidity and mortality meetings to ensure robust learning and review.

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	<p>Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs</p> <p><b>Regulation 14 (1) (2) (3) (4) HSCA (Regulated Activities) Regulations 2014</b></p> <p>Receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health.</p> <p>Dietetic support in critical care did not meet national guidance which states there must be a dietitian as a part of the critical care multidisciplinary team (Guidelines for the provision of intensive care services). Dietetic support was not provided to the number of hours recommended.</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p><b>Regulation 10 (1) (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</b></p> <p>Ensuring the privacy of the service user.</p> <p>At busy times, the ED department was unable to provide patients with a suitable environment that meant they had their dignity, respect or privacy upheld. We saw patients were kept too close together, in inappropriate holding areas. There was not enough space or screens to support temporary partitioning. There were instances of mixed sex accommodation.</p> <p>The Sussex Eye Hospital did not provide sufficient privacy in the outpatient department.</p>

## Requirement notices

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**Regulation 17 (1) (2) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

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.

In ED, we saw a large box containing medical records on the floor of in an unlocked room in the ED. This meant that records were not stored securely is kept confidential.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

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

**Regulation 12 (1) (2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

**The proper and safe management of medicines.**

- We reviewed the ED Controlled Drug (CD) register and found gaps on the two person signature lists where we would have expected to find a double signatures as a record of a controlled drug being signed out of the stock.

In ED, a box of IV antibiotics was left on the worktop behind the ED hub.

In ED, here were omissions in the checking of fridge temperatures.

Controlled drug registers within theatres and recovery demonstrated instances of block signing of controlled drugs at the three stages, supply, administered and discarded. On occasions the amount administered of a controlled drug was not consistently recorded and the

This section is primarily information for the provider

## Requirement notices

amount destroyed was not always recorded. This contravened the Misuse of Drugs Regulations 2001 and "Safer Management of Controlled Drugs: a guide to good practice in secondary care".

In critical care, measures to check stock levels of controlled drugs were correct were not consistently completed and the list of authorised signatories was not correct and current.

In critical care, pharmacy support did not meet national guidance (Guidelines for the Provision of Intensive Care Services) which state that there must be a critical care pharmacist for every critical care unit.

On all medical wards we visited, staff did not ensure that in areas where medicines are stored, ambient temperatures were taken daily to ensure the efficacy of medicines.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1) (2) (h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.

During busy times, the ED department was unable to maintain a safe distance between patients' trollies in line with national guidance and best practice guidelines.

A deep cleaning of theatres has not been completed since September 2015.

The obstetric theatre ventilation system was known to be ineffective, and this had not been addressed.

### Regulated activity

### Regulation



This section is primarily information for the provider

## Requirement notices

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

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1) (2) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and treatment must be provided in a safe way for service users.

We observed theatre staff carrying out the World Health Organisation (WHO) 'Five steps to safer surgery' checklist for procedures. However we observed three different theatre procedures and on two occasions the final step of debriefing was not completed which indicated this part of the process was not consistently completed.

### Regulated activity

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

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1) (2) (e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way.

In theatres it was decided not to adopt safer sharps initiative. The Health and Safety (Sharp instruments in Healthcare) regulations 2013 healthcare state providers must use safer sharps.

In theatres, the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) was not consistently adhered to.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Surgical procedures

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

## Requirement notices

Treatment of disease, disorder or injury

Regulation 12 (1) (2) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

The hospital did not ensure all staff within the medicine directorate had received an appraisal. Therefore, there was no assurance that staff were receiving adequate development or that issues were being identified and reviewed.

Mandatory training rates within the medicine directorate were low. Therefore, there was no assurance staff knew up to date and best practice methods or that staff would know correct procedures during an emergency.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

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

Regulation 12 9 (1) (2) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Doing all that is reasonably practicable to mitigate any such risks.

Fire risk assessments within the medicine directorate were incomplete and there was no over-arching governance of fire issues. Fire training rates were also below the trust target. Therefore, there was no assurance staff would know correct procedures in the event of a fire.

In the maternity department, actions resulting from a fire assessment had not been completed in a timely manner.

### Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

## Requirement notices

Regulation 15 (1) (e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All premises and equipment used by the service provider must be properly maintained.

In the out-patients department a laser machine had exceeded its annual service date at the time of our inspection and it was not clear for how long the machine had been outside of its service date.

Protective eyewear in outpatients and diagnostic imaging required replacing.

### Regulated activity

Diagnostic and screening procedures

Maternity and midwifery services

Personal care

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9 (1) (2) (3) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or of the competent person, the balance of risks and benefits involved in any particular course of treatment.

In critical care, information was not easily available for those patients and visitors that did not speak English as a first language.