University Hospitals Sussex NHS Foundation Trust

Royal Sussex County Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Royal Sussex County Hospital

Requires Improvement 

Royal Sussex County Hospital is one of the hospitals of University Hospitals Sussex NHS Foundation Trust. Royal Sussex County Hospital provides clinical services to people in Brighton and Hove. The hospital is a centre for major trauma and tertiary specialist services and provides some specialist services for patients from across the wider South East region.

At this inspection we inspected the surgery and medical care core services at Royal Sussex County Hospital. We found that since the previous inspections in 2021 and 2022, improvements had been made to some aspects of surgical services which resulted in an improved rating. However, there were still improvements required to the surgical services. We found there was a deterioration in the quality and safety of the medical care services since their last inspection in 2019, resulting in a drop in their rating. The improvements in the surgery core service resulted in an improvement of the overall rating for Royal Sussex County Hospital. More detail about the findings and required improvements can be found in the surgery and medical care core service sections of this report.

Surgery

Requires Improvement 

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

- The service did not have enough staff to care for patients and staff were concerned about the safety of the service in certain areas.
- Staff told us that some staff worked beyond their scope of practice and that new staff were rushed into positions of responsibility they did not feel ready for.
- Equipment was stored in unsuitable locations on some ward environments and general theatres and inhibited effective cleaning.
- Environmental concerns about lift maintenance meant that some patients were wheeled through patient areas following the conclusion of some surgeries to access the Intensive care unit and wards.
- The service needed to take extra steps to optimise safe medicine management.
- Staff did not always feel they were suitably trained or competent to undertake some tasks.
- Staff raised concerns over the incident reporting culture of the trust and did not feel they were kept informed of how the service had taken steps to prevent incidents from reoccurring.
- People could not always access the service when they needed it. Operations for patients were cancelled at the last minute and there was continued evidence of long waiting times and repeated cancellations to surgical operations.
- Staff morale for the theatre services remained low and staff still faced frustrations associated with raising concerns and understanding actions taken by senior leaders.
- Culture for some areas we inspected was very low and needed immediate improvement.

However:

- Staff understood how to protect patients from abuse, and generally managed safety well. The service managed most infection risks well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored some aspects of the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services using information systems and supported staff to develop their skills. They were focused on the needs of patients receiving care. The service engaged with patients and the community to plan and manage services and all staff were committed to improving services continually.

Surgery

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, training modules for mental capacity and Deprivation of Liberty Safeguards (DoLS) was not seen and mandatory training completion for learning disabilities and autism populations was very low.

Nursing staff received and kept up to date with most of their mandatory training. Nursing staff completed a range of safety related subjects. The overall completion rate for mandatory training across all modules was 92%, which was above the trust target of 90%. However, it was not possible to identify mandatory training compliance figures for Royal Sussex County Hospital. The surgical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital.

Medical staff had access to mandatory training. Medical staff completed a range of safety related subjects. The overall completion rate for mandatory training across all modules was 85%, which was below the trust target of 90%, although an improvement on the previous inspection findings. We found modules in adult basic life support, information governance and conflict management were below the trust target.

The mandatory training was comprehensive and met the needs of most patients and staff. Staff and managers told us they felt the training was suitable for the safety of patients.

Clinical staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Records showed mandatory training did not include training about meeting the needs of patients with mental health needs, learning disabilities, autism and dementia. Since July 2022 it is a legal requirement for all staff to receive training in how to interact with people with a learning disability and autistic people. Managers explained this training had been implemented in June 2023. However, there were limited records to ensure oversight and at the time of our inspection, showed only 18 people had completed the full training and 42% of staff completed the first section only.

The trust provided dementia training for staff, but we were unable to see how many staff from surgical areas had completed this subject, as no figures were available when we asked for this information.

Managers monitored mandatory training and alerted staff when they needed to update their training. Local managers monitored some mandatory training rates but there were governance processes centrally at trust level which provided central oversight. However, there were no figures available for some training modules including mental capacity and DoLS modules.

Mandatory training was completed mostly electronically but some modules were face to face. Staff could see what they needed to complete and when, and this was reinforced with email reminders which local managers had oversight of.

Surgery

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training for their role on how to recognise and report abuse, but this was not always at the required level. Staff received safeguarding training at level 2 for adults and level 2 for children. The completion rate for safeguarding adults' level 2 was 90.8% and for safeguarding children level 2 was 90.5%. This met the trust target of 90%. However, it was not clear how the service had considered national guidance when deciding what level of safeguarding training staff working on wards should have. The intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff, (2018) details that all registered healthcare staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns should have level 3 safeguarding training. Only the trust's central safeguarding team who led the review of safeguarding enquiries and contributed to internal and external safeguarding reviews had level 3 training. They also had responsibility for sharing the learning of cases with surgical departments. They were trained at level 3 for adults and children.

Staff knew how to identify harm and worked with other agencies. Staff and managers told us a central team managed safeguarding. Staff understood safeguarding concerns and who they would contact. A total of 5 safeguarding referrals were active in the surgery core service since the start of 2023.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew who the safeguarding lead was for the service and what they would do if they had concerns. This aligned with the safeguarding policies for the trust.

Cleanliness, infection control and hygiene

The service managed infection risks well. The service used systems to identify surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept the premises visibly clean, but equipment storage did not allow for thorough cleaning.

Ward and theatre areas were visibly clean and had suitable furnishings but were not well-maintained for equipment storage. In older wards and theatres, we saw some areas were cluttered with furniture and we saw overflowing equipment cupboards, which did not allow for thorough cleaning. Infection, prevention, and control (IPC) arrangements in these areas did not assure us checks were made by domestic or clinical staff for these areas and did not account for how they assured themselves of this.

The service generally performed well for cleanliness in audits. Managers told us the "Fundamentals of Care" audit completed by the trust provided IPC weekly assurance. We reviewed a sample of the audit from July 2023 and most environments reviewed during the inspection were in line with the average score of the trust.

Managers told us the IPC team undertook a monthly environmental spot check audit. Results were verbally fed back at the time of the audit so actions could be taken where needed. Staff told us hand hygiene audits were completed. Trust wide audit data for May 2023 showed 95% compliance across all trust sites and services.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore PPE correctly in all environments. Correct donning and doffing processes were observed in theatres and safe application and removal of surgical gowns was performed.

Surgery

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw checklists which showed equipment was cleaned on a regular basis. There was, however, an absence of labelling with "I am clean" stickers or alternatives seen in all environments. Surgical equipment used in operations were managed safely and in line with correct IPC procedures.

Staff worked to prevent, identify and treat surgical site infections (SSIs). Staff told us that SSIs were monitored in wards and that sterile environments in theatres were strictly enforced. We saw good practice of this in theatres we visited. Managers told us the trust completed a review of SSIs and identified more prominent microorganisms within the hospital environment. They started extra measures at the pre operation stage to reduce this risk such as MRSA and MSSA screening.

The trust had a nursing lead for SSIs. Staff from the IPC team supported staff knowledge development. November board papers also showed there was a planned and targeted training refresh centred on infection prevention and control.

Leaders submitted SSIs data from October 2022 to June 2023 for cardiac operations completed at the hospital which showed a mixed picture of SSIs performance. The lowest three-month period of SSIs following surgery was 2% of all cases, while the highest rate in a separate three-month period was 16.7%. Additionally, and in line with UK Health Security Agency (UKHSA) recommendations, the hospital monitored infection rates for all total hip replacements (THR) and total knee replacements (TKR) in 3 out of 12 months a year. Data for quarter 4 2022/23 showed the post-surgical infection rate for THR was 2.6% (which was above the national 5-year average of 0.8%) and for TKR was 0% (which was below the national five-year average of 1%).

The infection prevention and control and surgical teams were working together to examine potential factors which may have caused a rise in infection rates. This included examining processes at both theatre and ward level to ensure best practice was being followed. Work was ongoing with the surgery team at the hospital to examine practice within orthopaedics. Improvements included introduction of pre-operative suppression therapy for patients undergoing joint replacement, improved patient information pre-operatively and the introduction of a topical disinfectant for surgical skin preparation before surgery.

The trust also reported poor performance in MRSA, MSSA, E-coli and Klebsiella rates where they were in the bottom 25% compared to other NHS trusts.

The trust also had one death which originated from a surgical site infection according to the most recent Annual Infection Prevention and Control report 2022-2023.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment, but it could be substituted at short notice. This combined with staff turnover, meant staff familiarity with equipment was not always maintained. Staff managed clinical waste well.

The organisation of the environment was not always as suitable as it could be. Corridors were cluttered, and storage was limited on some of the older wards we visited and in general theatre areas. Staff told us there was a continued shortage of storage space. Theatre doors had signs to avoid obstruction, but we saw theatre equipment was still stored there. Senior leaders said this had been the case for 18 months in one example we raised with them. We escalated our concerns at the time of the inspection.

Surgery

Water testing on 1 ward found that bacterial strains were present in the ward's water supply. Leaders took action to close the ward and work was carried out to correct this between November and December 2022. The incident underwent a root cause analysis investigation to identify the cause and prevent reoccurrence in the future.

The same bacterial strain was also picked up in the Cardiac Surgery ward at three water points in January 2023. The trust IPC annual report stated that the trust's inspection of the ward showed several concerns regarding water hygiene which were rectified. The report also stated the ward was crowded with equipment which could have inhibited cleaning.

General theatres had recently failed an external audit on their ventilation. According to the 'Health Technical Memorandum 03-01 Heating and ventilation of health sector buildings' guidance, most clinical areas are required to have 6 air changes every hour. Leaders told us the Facilities and Estates Division were actively involved in addressing the challenges for theatres about ventilation. The theatre senior leadership had formed a multidisciplinary approach with estates, infection prevention and control and the Surgery Division. To mitigate and improve air quality, additional 'air scrubber' machines had been purchased. These are machines with high-efficiency particulate absorbing (HEPA) filters which remove particles in the air, so while not supplying fresh air, they effectively clean the air in a room.

Staff carried out daily safety checks of specialist equipment including anaesthetic and emergency equipment. Staff and managers told us, and we saw that equipment was serviced by the trust's maintenance team using a planned maintenance schedule. All equipment had a sticker showing when it last underwent an electrical safety test.

The service had enough suitable equipment to help them to safely care for patients, but some stock wasn't always available.

Staff told us some equipment was changed at short notice, which caused staff frustration and did not help them when conducting difficult operations. Managers told us there was a shortage of some equipment nationally and that the trust needed to seek appropriate Medicine and Healthcare Products Regulatory Agency (MHRA) approved alternatives where possible. Staff had oversight of this but did find the ongoing resourcing of equipment for theatres frustrating.

Leaders told us and we saw there was a formal business procurement process for purchasing new equipment.

Leaders explained they had oversight of implants used and registered this information with the National Joint Registry. Individual implants had unique identifier code labels which allowed implants to be traced back to individual patients.

Emergency trolleys were not always stored in easy to access areas. We saw one trolley was stored in a swipe card-controlled area which meant it would potentially not be readily available in an emergency. According to Resuscitation Council Guidelines (2021), emergency trolleys should be stored in accessible locations. We raised this with the trust who informed us the trolley had been used in emergency situations without any incidents or concerns. They also explained, the trolley needed to be in this location to allow access to power points to charge some emergency equipment. Following our feedback, the trust was looking to move the trolley to a more accessible location.

Staff completed risk assessments when considering the location of emergency trolleys. Current guidance from Resuscitation Council UK acknowledges risks associated with storing emergency medicines on trolleys but does not consider this a sufficient reason to store trolleys in a restricted access location. To mitigate this risk, all trolleys we saw used tamper evident tags to show staff when the trolleys were last accessed. These tags were checked as part of daily safety checks on the trolleys.

Surgery

Staff disposed of clinical waste safely. We saw effective arrangements for the safe handling, storage, and disposal of different types of clinical waste, including sharps across the environments we visited.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We reviewed 25 patient records in total and found a New Early Warning Score (NEWS) document had been used to monitor the patient's condition. Records had been filled in correctly and evidence was found of escalation when needed.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff in ward environments and pre operation clinics used a range of risk assessment documents to ensure the patient was assessed for all potential risks. For example, local leaders had focused on assessing patients at risk of falling as part of a wider falls' prevention project.

For elective pre operation processes, managers told us staff followed "Getting It Right First Time" (GIRFT) and anaesthesia and perioperative medicine (APOM) processes. The hospital had 2 pre assessment departments to manage demand. Preassessment nurses and the pre op anaesthetic leads met monthly to review updated guidance to optimise preoperative pathways.

Managers showed escalation pathways for surgery and told us high risk clinics ran with different processes. For example, an anaesthetist would undertake a direct notes review before authorising surgery. Preoperative nurses also had their own allocation of patients who they were responsible for assessing and passed fit for surgery. Managers provided figures which showed the preoperative nurses saw on average 180-200 patients a week and of these patients, 8-10% were found to need an enhanced risk review. There was an average deferral rate of 5%, with common reasons including blood pressure concerns, diabetes control and wound assessment.

Preoperative medical leads scheduled a daily session with preoperative nurses to discuss complex patients who were deemed high risk.

For urgent preoperative cases and emergency surgery, managers told us separate pathways were followed to streamline the patient to surgery. The processes followed the same procedure, but actions were completed in a faster timescale depending on the pathway they were put on.

Managers told us the World Health Organisation '5 steps to safer surgery' checklist was audited by an observation and record review audit. Both checklist audits showed good compliance with the WHO principles for safer surgery. We saw WHO checklists being used in theatres and there was a good safety culture associated with this. A divisional action plan update shared in November board papers showed 100% compliance with the WHO checklist.

Local and senior managers also used their monthly fundamentals of care audit which covered sections associated with assessing risk and risk escalation specific to surgery.

Surgery

Staff knew about and dealt with any specific risk issues. Ward staff told us that they were aware of risks associated with sepsis, pressure ulcers, falls, and Venous Thromboembolism (VTE) risks. Staff we spoke with had good knowledge of all areas associated with these risks and could tell us what they would look for and how they would escalate it within a specific ward. Staff told us they managed operational pressures as best they could, and local managers used safety huddles to focus resources.

The service had 24-hour access to mental health liaison and specialist mental health support. Managers told us the hospital wards and theatres had access to a mental health team that operated 24 hours a day, 7 days a week. The team was sub-divided to work with working age adults who were aged between 17 – 65 years old and older people who were 65 years and older. Staff could tell us how they would contact them and when it was suitable to do so.

Staff shared key information to keep patients safe when handing over their care to others. Staff told us safety huddles were conducted daily in all areas we inspected. Consultant rounds were completed once a day and within 14 hours of admission. Senior managers provided us with a performance dashboard showing 62% of patients had been seen within 14 hours of admission.

Anaesthetists carried out safety huddles in theatre. This practice was implemented to improve safety and communication. Key information from these huddles were fed into an all-staff safety huddle before operations began. Where skill mix concerns were identified, staff were moved to support a safe staffing mix. However, staff told us that this process did not always show skill gaps and that there were circumstances due to staff shortages where some staff were placed under unnecessary pressure to act beyond their clinical remit or confidence.

Ward rounds in surgical environments were not audited but observations were recorded in patient notes and we saw this in the notes we reviewed.

Senior managers had an electronic whiteboard where all urgent and emergency admissions for the hospital were logged. The whiteboard had the ability for clinicians to record the time they saw patients.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers we saw were clear and risks were outlined using Situation, Background, Action, Recommendation (SBAR) processes to support clear communication.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience but were still able to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. On wards, staff told us levels remained a concern, although we saw that in most wards we visited the risks were managed and staff worked well together to support the service. Local managers were flexible and planned ahead with staffing and showed good management. Out of the 5 wards we visited, only 1 was seen to be struggling with staffing directly affecting the service they were able to provide.

Surgery

In theatres, Senior managers told us the theatre capacity to operate on patients on a particular specialist cancer pathway had been significantly impacted by external factors beyond the control of the hospital. Staff told us staffing shortages were one of the primary reasons they felt operations were cancelled. However, data provided by senior managers showed other factors also contributed to on the day cancellations.

Local and senior managers had processes to support safe nursing staffing where possible and there were policies which supported the cancelling of operations or stopping theatre lists when staffing did not meet a safe level.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift following national guidance. Managers told us the trust used an electronic rostering system which was used to plan and manage staffing needs, including skill mix and roles.

Managers told us they completed a daily risk assessment every morning to look at the level of risk against the recommended staffing and skill mix template.

The ward managers could adjust staffing levels daily according to the needs of patients. Staff were assigned shifts 6 weeks in advance by local managers. Where gaps were found, agency and bank staff were used to fill vacant shifts. Local leaders ran a staffing safety huddle 3 times a week to review gaps across all areas of the hospital. There was evidence of staff moving between the hospital's sites. Local leaders told us that where needed, they had asked practice educators, matrons and ward managers to work clinically where safe to do so.

The service had reducing vacancy rates. The surgical division had just over a 3% vacancy rate across the registered nursing workforce at this hospital. Nursing support roles had a vacancy rate of 12% trust wide. However, it was not possible to identify the vacancy rate for Royal Sussex County Hospital. The surgical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital.

Senior and local managers told us an international recruitment business case for 75 nurses across the trust had recently been approved. It was agreed that the recruitment could be staggered so suitable support was available to support the onboarding of new nurses. There were recruitment campaigns to attract local nurses and links with local education providers to promote student nurse pathways. Senior leaders told us they were exploring the extended use of the nursing associate role.

The service had low and/or reducing turnover rates. The turnover rate for theatres and surgical wards was 12.86% in June 2023. The overall turnover rate in June 2023 for surgery was 7.36%, which was the lowest rate over the past 12 months. However, it was not possible to identify the turnover rate for Royal Sussex County Hospital. The surgical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital. Senior managers told us work was ongoing to improve the turnover rate for theatre and surgical ward staff.

Senior managers outlined initiatives to improve turnover rates which included improved development opportunities, protected time for local leadership to complete nursing workforce support schemes, and opportunities for staff to feed up to senior leadership about concerns they held. Staff feedback on these schemes was mixed and showed not all were effective. This was more prominent in theatre environments.

Local leaders completed exit interviews for staff who were leaving the trust, and an online questionnaire was reviewed for themes and potential actions.

Surgery

The service monitored sickness rates. The sickness absence rate for nursing in theatres and surgical wards at the hospital was 5%. Senior managers told us the rate had increased over the previous 12 months. Leaders told us staff absence was in line with national sickness absence rates for Nurses which was 5.31% in March 2023. However, it was not possible to identify the sickness rate for Royal Sussex County Hospital. The surgical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital. Senior leaders told us the figure was higher than they would like and were in the process of developing an action plan to improve this. Measures included long-term sickness management training for local managers.

Managers limited the use of bank and agency staff and requested staff familiar with the service. Bank and agency usage across the surgical wards at the hospital was stable over the last 3 months, with the number of bank shifts between May and July 2023 ranging between 202 – 291 shifts. The number of agency shifts across the same period ranged between 130 – 250 shifts.

Local managers told us available shifts were released to bank or agency workers up to 72 hours prior to shift.

Managers made sure all bank and agency staff had a full induction and understood the service. Bank and agency staff were supported by nominated clinical leads and the temporary staffing team. Staff were happy with the quality of the induction.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience but were still able to keep patients safe from avoidable harm and to provide the right care and treatment by restricting their operational capacity. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service operated with enough medical staff to keep patients safe or they postponed and cancelled surgery. Senior managers told us factors beyond the organisation's control had caused shortfalls in consultant surgeon staffing levels. This caused challenges for operational capacity and meant the full number of theatres could not be utilised. For example, in neuro theatres only 2 of the 4 theatres were operational. Medical staff told us the new building provided more capacity, but this could not be utilised due to the lack of staff available.

The medical staff matched the planned number. Senior managers and local managers used locum and temporary staff to ensure medical staff matched the planned number.

The service had moderate vacancy rates for medical staff. Medical staff vacancies in the Surgery division at the hospital were 10.15% in June 2023. However, it was not possible to identify the vacancy rates for Royal Sussex County Hospital. The surgical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital. Senior managers told us changes to some specialist cancer surgery services had resulted in some new posts which they were actively trying to fill.

Senior managers told us work had continued to recruit full time and fixed term surgeons. They told us 12 had been appointed since April 2023. Staff surveys reported feedback overall had improved for first year junior doctors and locally employed doctors following some historic challenges to training provision being resolved.

Surgery

The service had low turnover rates for medical staff. The medical staff turnover rate for theatres and surgical wards for between April and June 2023 was less than 2%. However, it was not possible to identify the turnover rate for Royal Sussex County Hospital. The surgical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital.

Sickness rates for medical staff were not available when we requested them.

The service had reducing rates of bank and locum staff. Senior managers told us agency and bank were used ensuring staffing levels remained safe. Senior managers expected the rates for bank and locum medical staff would reduce as staffing pressures improved.

Managers made sure locums had a full induction to the service before they started work. Medical locum staff usage had increased since our last inspection in 2022. In response to staff feedback, managers had modified the induction to include more detailed information and training about equipment. We also saw the service operated a buddy system for new locums to support their integration into the service.

The service always had a consultant on call during evenings and weekends. Consultant cover for services was planned using a consultant of the week model which provided 7-day cover. The on-call consultant also completed ward rounds of all emergency admissions at the beginning and end of each day.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were detailed, and all staff could access them easily. We reviewed 25 records as part of this inspection and found no concerns with their content or presentation. Records were stored on an electronic system where staff had individual login details that allowed them to access patient information easily and securely.

Staff did not leave computers unattended and locked computers when stepping away from desktop spaces. Staff used one system for patient records which allowed them to access information ahead of any proposed transfer.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. We saw some examples where medicines could be stored better.

Staff followed systems and processes to prescribe and administer medicines safely. The Trust had an electronic prescribing and administration (EPMA) system for medicines which had inbuilt safeguards and reports were run routinely to ensure safe prescribing. They were some issues that had been identified that were due to be addressed on the next upgrade. However, we saw incidents of medicines not being administered and staff not being able to confirm administration.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Surgery

Staff did not always store or manage medicines and prescribing documents safely. Medicines were not always securely stored, and staff did not dispose of controlled drugs in line with national guidance. We found a light sensitive medicine stored on open shelving and in glass fronted cabinets across multiple locations. When raised with staff the product of concern was removed from stock and replaced. Lockers at the patient's bedside used to store drugs were not always locked.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Although staff did not follow the discharge policy and keep a copy of the two-nurse signed discharge letter within the clinical notes.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. However, reporting was inconsistent and not always accurate during times of operational pressure. Managers investigated incidents but, in some areas, staff told us they did not always report all possible incidents due to operational pressures. When things went wrong, staff gave patients information and support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Most staff knew what incidents to report and how to report them. Staff reported a total of 724 safety incidents from the surgery divisions in the last 12 months in line with trust policy. The total number of patient safety incidents in surgical environments at the hospital in the past year was 2,911. Staff told us that operational pressures in both ward and theatre environments meant they did not always have the time to report all incidents which occurred. Theatre staff told us there was an under-reporting culture that was driven by operational pressures and the absence of actions resulting from the incident submissions. Review of national data indicated that trust wide from October 2022 to October 2023 the trust reported fewer incidents that trust of similar sizes and complexities. The trust also recognised, detailed in the Patient and Quality Committee report for August, September, and October 2023, that incident reporting across the trust was low. Managers told us safety incidents were managed centrally by a trust wide team who distributed alerts to all teams associated with the surgery division.

The service had one never event in the last 12 months. This event related to a wrong prosthesis being used during a surgical procedure. This investigation was on-going at the time of our inspection.

Managers shared learning about never events with their staff and across the trust. Local managers investigated and shared incidents with the team, however staff felt escalated incidents to senior management at trust level were not effectively considered and responded to.

Senior managers told us investigations followed a significant incident pathway and this was currently underway for the never event. Managers told us once this was completed, the findings would be shared with managers and distributed using email, newsletters and safety huddles for the departments concerned. The incident would also be reviewed at the surgical division's quality and safety meeting which occurred monthly.

Staff mostly reported serious incidents in line with trust policy. Managers gave examples of serious incidents which the surgery division reported in the past 3 months. We reviewed 5 serious incidents as part of this inspection and found the processes associated with this were followed correctly.

Surgery

Leaders told us the Significant Incident Review Group (SIRG) met weekly and all divisions including surgery presented incidents to the panel. Leaders showed the patient safety divisional monthly governance report which outlined the number of serious incidents, including progress of current, closed, and new cases.

Staff understood the duty of candour. They were open and transparent and gave patients and families an explanation if things went wrong. Managers told us there had been duty of candour incidents in the past 12 months but did not provide an exact number for the surgery division. Staff we spoke with understood duty of candour and the local processes they would follow.

We saw records of duty of candour conversations and letters were recorded in all five incidents we reviewed.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were offered feedback through email, newsletters, and safety huddles about incidents which had occurred. Senior managers shared minutes for the Quality and Safety Meeting monthly. The feedback focused on patient stories and promoted a format that reviewed the incident from the patient perspective.

Staff met to discuss the feedback and look at improvements to patient care. Managers gave examples where they provided immediate feedback and support for staff following an incident. For example, following an incident where a patient absconded and injured themselves, the teams and staff involved were invited to a staff forum to discuss the possible causes of this incident. Staff were reassured by management that measures in place at the time and action taken since were sufficient to prevent similar incidents occurring in the future. The team then had a wider debrief which included doctors where everyone was given opportunities to speak, give their perspective and talk about how they felt. The education team then followed up the incident with staff individually to provide individual support if needed. However, there remained a lack of confidence amongst staff that incidents escalated to senior management at trust level were effectively considered and responded to.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, there was lack of assurance that all staff followed national guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Leaders told us they had a policy for the introduction and review of national guidance which was reviewed by clinical governance teams. Leaders told us they felt this policy had a clearly defined purpose, responsibilities, accountabilities, and duties, and the document showed process flow diagrams for the implementation of National Institute for Health and Care Excellence (NICE) guidance. However, it was reported in the board assurance framework at the November board meeting that there were continuing gaps in quality assurance, with over 30% of NICE guidelines having no clinical lead. This meant it could not be fully assured the service was following national guidance.

Surgery

Leaders told us they were pleased and proud with their governance structure that oversaw and monitored the implementation of NICE guidance across the trust. The reporting process showed the status and risks of new guidance which allowed for discussion at a clinical governance meeting process.

Leaders told us the trust had a Clinical Outcomes & Effectiveness Group (COEG) that gave assurance for the improvement of clinical outcomes across the trust. The COEG reported to a Quality Governance Steering Group (QGSG) which then reported directly to the Trust Executives Committee and Quality Committee at board level.

The COEG team worked with clinical teams and the leadership to effectively implement new guidance. The surgical division nominated clinical leads who completed baseline assessments, identified gaps and risks and rated this against impact to patient outcome and patient safety. When action plans were produced, an assurance rating was assigned based on the resources availability to limit the risks to patient outcomes.

Leaders told us about an audit on NICE Guidance implementation which had been conducted in March 2023. Some improvements on the process had been found but at this stage the trust was unable to show any improvements or results due to the progression stage of the audit.

A learning disability team was available for all patients at the hospital including those under the surgery division.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw evidence of safety huddles that found and referenced patients that had psychological and emotional needs. In theatres, we saw examples of small adjustments being made by staff for emotional purposes such as holding a patient's hand before surgery.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff told us specialist nutrition and hydration needs were referred to their dietitian team. Dietitians triaged referrals sent by the wards and prioritised and allocated them to the team based on the clinical needs of the patient. The team provided details of out of hours feeding regimes available for reference, which staff told us were useful.

We asked managers and leaders about nutrition and hydration needs in recovery environments as we had noted the longer stays patients were experiencing. Leaders told us there were no nutrition and hydration services in recovery units at the hospital but reassured the inspection team that if there was a prolonged stay in the recovery unit, staff would review the needs of the patient and act upon them. Emergency protocols were available electronically to support this.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed the templates used to assess patient's needs. This included food diaries and fluid balance charts.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff on the wards showed the use of the Malnutrition Universal Screening Tool (MUST) as part of their nutritional assessment paperwork bundle.

Surgery

Specialist support from staff such as speech and language therapists (SALT) were available for patients who needed it. Managers and staff told us that dietitians and speech and language therapists were available through an electronic referral process. Referrals were accepted for neurosurgery, trauma, cardiac and critical care. The SALT covered all inpatient wards and all types of surgery undertaken.

Managers told us the SALT team were available to assist on more complex clinical processes associated with neurosurgery and oncology related procedures. The SALT team also followed up patients initially in the recovery unit to ensure patient safety alongside recovery unit processes post-surgery. There was a mandatory referral for patients, and they were reviewed by telephone post discharge.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff told us that despite the difficulties associated with surgery cancellations at the last moment, there were processes to ensure patients were not left in a nil by mouth situation for unsafe periods of time. We did not see any patients who were left for long periods of time without fluids or food prior to surgery. Ward staff adopted a process called “sip till send” to prevent dehydration of patients awaiting surgery so that safe amounts of fluid could be consumed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used paperwork associated with pain assessments following patient surgery in both recovery and the ward environment. Staff used a nationally recognised pain assessment tool to identify non-verbal signs of pain.

Patients received pain relief soon after requesting it. Patients we spoke with were happy with their care and felt staff in wards were attentive to their needs when it came to controlling pain symptoms.

Staff prescribed, administered, and recorded pain relief accurately. Staff completed and recorded pain medication clearly. The pain management team considered complex pain management at the pre-operative stage alongside medical and anaesthetist staff which made sure pain was considered throughout the patient journey.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical schemes.

The service participated in relevant national clinical audits. Leaders told us that the Trust audit schedule was interlinked with their wider clinical effectiveness work streams, including NICE Guidance.

Leaders told us the audit leads for the hospital were asked to select the standards and guidelines they were assessing when registering a clinical audit. This was included in audit registration forms and formed part of the clinical audit schedule.

Leaders told us new audit registrations and reports were reviewed during monthly clinical audit meetings where links to the wider clinical effectiveness work streams were discussed. These registrations and reports were documented using the clinical audit review summary template.

Leaders told us the national audits were linked to NICE guidance. These were reviewed at the start of the financial year, which was when the audit schedule was developed and documented.

Leaders showed evidence following the inspection that the surgery division conducted 10 national audits as part of their performance monitoring. Leaders also provided a total of 18 local audits associated with general surgery.

Outcomes for patients were not always consistent and did not meet expectations, such as national standards. The service monitored outcomes for patients. The latest Patient Reported Outcome Measures data (PROMs) published data from 2021 showed the hospital was performing worse than the national average for both total hip replacement and total knee replacements.

Managers and staff used audit results to improve patient outcomes. The service conducted an audit into antibiotic usage in March 2022 which found in 6 out of 33 cases, the patient did not have the best practice anti-biotic prescribed. The audit recommended a bigger sample size be used to assess the issue further which occurred in April 2023. The audit recommended improving access to guidelines and learning for all relevant staff. The follow up audit performed in April 2023 showed 74% of patients sampled had the correct antibiotic prescribed.

Managers and staff carried out a programme of repeated audits to check improvement over time. Leaders and managers conducted monthly internal audits which looked at minimum safety standards called the “fundamentals of care”. This was an audit conducted on all clinical environments across the trust that ranked them against a set criterion which included medicines management, environment and equipment, and infection, prevention and control.

Between May 2023 and July 2023, across multiple theatres and wards, the audit scores ranged between 87% and 99% which on all occasions was in line or below the hospital average.

Managers used information from the audits to improve care and treatment. The surgery corporate project utilised an action log system to track the delivery of its agreed improvements.

Managers shared and made sure staff understood information from the audits. Monthly audit results were distributed to staff via email and displayed on designated notice boards. Large audits and national audits were shared with clinical governance teams who then oversaw dissemination.

Competent staff

The service made sure most staff were competent for their roles, but staff did express concerns that some staff were working beyond their clinical remit in theatres due to staffing pressures. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, but sometimes did not have the right skills and knowledge to meet the needs of patients. A staff member shared an example from theatres where a new staff member was being pressured to take on responsibility that they were not ready for. We were told that a new nurse was asked to lead on a particular procedure where they had limited experience. The nurse only agreed to do it as there was a very experienced staff member with her for the procedure. An adverse event occurred during the surgery that required the staff member to act beyond their clinical remit as the nurse was unable to react to a clinical situation and panicked due to their lack of experience. This was escalated to managers, but we were unsure if it was reported as an incident. We were told this was due to culture fears within the theatres team and that they were discouraged to report incidents where themes were known to senior management.

Surgery

Theatre staff were regularly moved from Princess Royal Hospital to work in the theatres at Royal Sussex County Hospital to cover gaps in the rota. This made them feel vulnerable as they were allocated to theatre lists at the Royal Sussex County Hospital which they felt did not have the correct skills or experience to work safely. Leaders told us that the skills of the staff member were considered when moving staff to the Royal Sussex County Hospital. However, there was no formal guidance policy for moving staff between sites. Leaders told us staff were encouraged to raise any concerns, including any about colleagues' competence or behaviour, and the trust had recently strengthened its freedom to speak up guardian provision where staff could speak anonymously. The inspection team noted that this had recently been implemented in August 2023.

Leaders told us there were processes to raise a concern, investigate, and address them, with appropriate support and development as needed including from external partners and other professional bodies if necessary. Leaders and managers told us that where needed, retraining, behavioural support, or other reasonable adjustments could be made.

Leaders showed evidence following the inspection on how they ensured clinical appointments were suitable. All substantive consultants were appointed through an advisory appointments committee. This process reviewed an applicant's qualifications and experience against the job description. This was the same process for permanent and fixed term consultant appointments.

Leaders told us medical and nursing staff took part in annual appraisals. The service had a process to ensure staff were provided with annual appraisals. All staff were offered a formal appraisal every year. Departmental data showed a 79.5% compliance rate which was below the trust target of 90%.

Managers gave all new staff a full induction tailored to their role before they started work. Leaders told us the medical education team were working with departments to record all departmental inductions so they could monitor attendance and compliance. As part of this recording process, all new starters were required to complete their applicable mandatory training modules within 1 month of joining the trust.

Leaders provided formal evidence to support their induction processes for medical staff following our inspection. The arrangements were divided up by surgical disciplines and each discipline approached the induction process differently in terms of the support that was offered. This meant that trainees were provided with a bespoke induction tailored to their specialities.

Nurses new to the Nursing and Midwifery Council (NMC) register or the trust joined the preceptorship programme to ensure they had the skills and support they need during their first year with the trust.

Managers supported staff to develop through regular, constructive clinical supervision of their work, but some arrangements were unclear. Managers told us clinical supervision was offered to new nurses when completing their clinical competencies and arrangements were made to link them with a nurse in the speciality. The practice development team arranged regular meetings with new nurses and their buddies to review the competency document. If further support was needed, this was given, and an action plan set up if needed. However, it was not clear what clinical supervision existed and what experienced theatre staff received.

Managers encouraged experienced staff to complete a teaching and assessing programme such as the practice supervisor or practice assessor course, which was run by the post graduate matron. This training helped staff to support learners in practice.

Surgery

The clinical educators supported the learning and development needs of staff. Managers told us the practice development team had put a recent emphasis on staff wellbeing. The trust offered new staff 1 to 1 pastoral care and had an open-door policy with all staff in the team. If there was something raised which required help beyond what the department could offer, then professional or occupational health services for staff were offered. However, despite this support staff told us in theatre environments the culture had not improved and there were still problems associated with bullying.

Managers told us several apprentices were supported by the trust. Managers recognised the time pressures for staff to balance study around their work placement. Staff gave examples of where staff had struggled with these challenges and personalised plans had been organised to help them. Support included bi-weekly check ins, monthly 1:1s and talking therapies.

Leaders told us that 3 staff members had recently completed an associate theatre practitioner course in line with their general surgery action plan, and the next intake would occur in 2024.

Student nurses in their third year had a day in the trust where they were supported with applications for registered nurse posts in the organisation. The preceptorship programme was presented for them to see the support and progression offered by the service.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers told us daily safety huddles continued to run on wards and in theatres to ensure staff were kept up to date with safety concerns. Minutes from safety huddles were shared electronically for staff who could not attend in person. The frequency of meetings varied but we saw evidence of safety huddles occurring in all areas.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw a copy of nursing skill competencies and the courses staff needed to complete as part of their training. Some staff told us that being released for study time was difficult due to staffing challenges. Staff also told us availability of courses was another problem they encountered. However, the clinical education team were supportive and promoted training needs.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers in all environments were keen to promote training and staff on wards were very positive about their development opportunities in the role.

Managers identified poor staff performance promptly and supported staff to improve. Managers could not provide examples of poor staff performance. However, they explained the process they followed should this situation arise. Most managers recognised the pressures staff were working under at the trust especially at a local level and they expressed huge empathy for their teams.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Managers and staff across the surgery division held multidisciplinary meetings to discuss cases which involved social circumstances associated with discharge from hospital and learning meetings such as morbidity and mortality conferences.

Surgery

On a previous inspection we had raised concerns around morbidity and mortality meetings which involved the progression of patient care. We had previously found there had not been sufficient level of clinical specialist knowledge which could provide a balanced judgement of the needed care for some patients. Leaders had acknowledged our findings and were working towards our earlier recommendations as part of their action plans for the general surgery and neurosurgery services. We were reassured by the evidence seen as part of this inspection that improvements were occurring.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us they engaged with several different services across the hospital site. This included diagnostic imaging, dietitians, speech and language services, physiotherapy, occupational therapy, safeguarding, and mental health teams. There were arrangements for referral to these services and staff told us that they were available to support when needed.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The trust had a Mental Health Liaison Team provided by a mental health NHS Trust who gave support for people aged over 17 years of age with mental health needs in the hospital. The team was available 24 hours a day, 7 days a week.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including at weekends. Patients were reviewed by consultants depending on their care pathway. Leaders told us rotas provided 7-day cover to enable standards around time to first consultant review to be met. Ward managers did not have concerns about consultant availability and told us they attended once daily ward rounds. We saw rotas on most wards we visited that supported this and cover arrangements for weekends.

Staff called for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The mental health liaison team was available 24 hours a day, 7 days a week. Leaders confirmed that doctors from emergency specialities were available 24 hours a day. The hospital had access to imaging and pathology services 24 hours a day.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. The areas we visited had a wide range of literature to support health promotion. This included pre-operation and post-operation information which supported best recovery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, we did not see training for staff associated with the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS).

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with showed a full understanding of consent and how to assess capacity to make decisions about patients' care.

Surgery

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed 25 records and found consent was both obtained and documented correctly.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We did not find examples of this, but staff showed knowledge on how they would escalate this through safety huddles in ward and theatre environments.

Staff did not receive training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Mental Capacity Act training was not included in the mandatory training modules for staff. We requested all training associated with this, but the trust did not provide any information about this.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and DoLS. Staff told us policies were held on the trust intranet, and these included the Mental Capacity Act and DoLS. The trust's policy on the Mental Capacity Act and Deprivation of Liberty Safeguards was last reviewed in June 2022, and was due for renewal in 2025.

Managers monitored the use of DoLS and made sure staff knew how to complete them. Managers had access to information that checked how often DoLS were applied for. This was provided through the safeguarding adults divisional surgery report.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Leaders told us a trust wide review of consent forms, documentation and policy had been undertaken and once new processes were fully implemented, a consent audit was scheduled with oversight from the Clinical Outcomes & Effectiveness team.

The trust had one ongoing audit associated with the use of abbreviations in consent forms. This was started in July 2023 and no results were available at the time of our inspection.

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff gave examples of exceptional care on the wards we visited. For example, one healthcare assistant we spoke to took a patient's clothes home and washed them as they had no family. One staff member brought in nail polish for a patient's family so they could paint their relative's nails.

Surgery

Patients said staff treated them well and with kindness. Managers used national inpatient surveys and Friends and Family Test (FFT) surveys. Using FFT, based on 5,300 replies in the 6 months between February and July 2023, 93% of patients rated their care as good or very good. The top reason for a positive experience was the staff and quality of care. The top reason for a negative review was waiting times.

Staff followed policy to keep patient care and treatment confidential. Staff we spoke with on the wards and in theatres showed awareness and understanding of the importance of keeping patient's care confidential. However, some clinical areas did not have easy access to private spaces because they were being used for other purposes.

Staff told us that patient transfers from some surgical theatres included using a route that did not protect patient's privacy or dignity. This was because the route involved passing through areas where patients were waiting for treatment. Managers told us how they adapted the environment to enhance and maintain privacy. However, managers local to the area told us they were not always able to support patients in a way that maintained their dignity if it was busy, and staff were unavailable. Some of the concerns related to lift availability and maintenance issues associated with the building which are covered in the environment and equipment section of this report.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. For example, staff brought a chocolate cake in for a patient with complex needs who kept shouting "chocolate cake".

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. For example, Staff gave one example of a patient who loved horses, so staff played videos of horses to keep their spirits up.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Managers told us there were two transfer policies in place across the trust. The policies considered and underpinned privacy and dignity and included best practice for when or if a patient became distressed. Leaders also showed us their Privacy, Dignity & Chaperone Policy following the inspection, which covered the environments we inspected.

Managers in the recovery areas of theatres told us all new staff took part in a 5-day course on the foundation skills for Post Anaesthesia Care. This was followed by competency assessments for the skills which included privacy and dignity. Leaders also told us privacy and dignity was covered in interview questions when staff applied for the unit, so the area was prioritised at the beginning of their employment with the trust.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us that when surgery scheduled for the day wasn't going to happen, these conversations were done in private, so patients had an opportunity to process the news and ask questions.

There was no dedicated space on wards for patients and family members who may receive bad news or need their procedures explained in more detail. Managers told us this was not ideal but there was normally a room available on the wards for these discussions to take place.

Surgery

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Leaders provided information about a patient education team who provided leaflets which were audited to maintain their accuracy and relevance. Patients and their families felt staff communicated well with them before their surgical procedure and had awareness of the literature available to support their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Managers followed the accessible information policies of the trust which provided adjustments for patients who had sensory difficulties. Managers told us language translation was also available at the environments we visited. Patients told us they were aware of alternative communication methods, and they were happy with the way this was advertised in ward environments.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Managers gave examples of how they listened to feedback and implemented changes to practice as result. For example, patients provided feedback about the lack of entertainment in wards, so staff introduced a visual display board which allowed patients to interact with the staff and provide pieces of art. Staff supported patients who were unfamiliar with technology and needed support.

Staff supported patients to make informed decisions about their care. Patients we spoke with knew what their planned procedure was, and they felt comfortable with the level of information provided before their surgery. Records supported that informed consent was obtained prior to surgery and patients knew details about their operation and the risks associated with this.

Is the service responsive?

Inadequate 🔴 ↓↓

Our rating of responsive went down. We rated it as inadequate.

Access and flow

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Access to elective surgical services were impacted by waiting lists and hospital capacity. Waiting times for treatment were getting longer (worse). Emergency surgery was arranged promptly, and patients received the right care prior to and during their hospital admission.

Managers monitored waiting times and tried to ensure patients could access services when needed. Despite this, some patients did not receive treatment within agreed timeframes and national targets. Managers told us that between April and July 2023, trauma and orthopaedic teams were prioritising and managing pathways for patients close to waiting 104 weeks. There was 1 patient who waited 100 weeks to complete their treatment. Managers told us hip and knee surgery had been significantly impacted by the loss of staff capacity. Managers told us that when medical staff listed patients for surgery, they assigned priority codes as defined by the Royal College of Surgeons criteria. This helped decided theatre lists were based on clinical urgency.

Surgery

Managers told us all patients on the waiting list were clinically prioritised by medical staff. They started with the longest waiting patients and worked down the waiting list. This process did not consider the clinical need of patients, it increased the risk of harm to patients due to waiting for surgical treatment. We were told that at present there were currently no orthopaedic patients at risk of waiting over 104 weeks for their surgery. The orthopaedic team were working to treat patients close to 78 weeks whose treatment had been delayed due to staffing concerns beyond the control of the trust. The ongoing plan was to prioritise treating patients at risk of waiting longer than 65 weeks by the end of March 2024.

Managers told us that in addition to the priority cases outlined above, the hospital ran an emergency operating list for trauma and emergency cases. The emergency surgery list was available 24 hours a day, 7 days a week. A second emergency list was provided 2-3 days per week at the hospital if needed and utilised other theatre capacity.

For trauma patients, a safety huddle meeting occurred every morning at 7:45 am. Trauma co-ordinators liaised with the operating theatre team. Daily operating lists were discussed in conjunction with doctors, trauma coordinators and theatre teams. Staff told us these conversations were sometimes difficult as current waiting times for elective surgery meant the potential for the patient to come to harm was increased if operations were cancelled to accommodate trauma and emergency procedures.

Medical staff responsible for making decisions felt there could be better ways to manage this but acknowledged the primary reason it was so difficult was a lack of theatre capacity in the hospital. Staff explained they had escalated their concerns and suggestions to senior leaders for consideration.

When patients were waiting on wards, medical ward rounds and nursing observations were used to monitor potential harm of waiting and provided swift escalation using SBAR communication frameworks. This was further underpinned by the New Early Warning Scores (NEWS) assessment tool.

Trauma co-ordinators and lead medical staff escalated significant delays to the Divisional Management Team on a regular basis. Managers told us that if a delay resulted in harm an incident form was completed. However, staff told us there was an underreporting culture in some theatre departments. Senior managers did not have an oversight of this risk which raised concerns about how incidents and near misses were escalated to them and whether these processes were effective.

Managers told us that when demand overwhelmed capacity, the surgical divisional leadership prioritised emergency surgery over elective activity where needed. Senior managers told us decisions they had to make were difficult and often emotional, but they always tried to make the best decision with the information available.

Where time critical emergency surgery was needed, the next available operating theatre would be taken over.

Leaders told us the trust was currently undertaking a review of its operating capacity, specifically where elective and emergency lists were undertaken. The aim of the review was to reduce delays, improve outcomes and enhance patient experience.

Some patients requiring non-emergency surgery did not receive treatment within agreed timeframes and national targets. Senior managers reviewed and shared information with staff through a variety of meetings and action plans.

Despite these arrangements, there was a variable picture for how effective the hospital and trust was at managing RTT. For example, 52 week waits for admitted patients at the trust was 17.6% which was in line with the wider Integrated Care

Surgery

Systems (ICS) performance of 15.4%. However, national cancer waiting time data for two week waits (2WW) for cancer was 66.14% in July 2023 against a national target of 93%. This put the trust in the lowest 25% of NHS acute trusts in the southeast. This was lower than the 81% regional average and lower than the national average of 77%. Recovery plans formed part of the single improvement plan and it was forecast within the board assurance framework that improvements would take 12 months to complete and see.

Trust wide, between March and April 2023, 19 theatre sessions for colorectal cancer were cancelled as a direct result of staffing and capacity issues.

Cancellation rates at a preoperative stage were checked monthly and discussed at a team meeting. Over the past 3 months, 6 surgeries at the hospital were cancelled on the day because the patient wasn't fit for surgery. Of these 6, 1 was found to have potentially needed an enhanced anaesthetist review.

The trust was the second lowest for the proportion of patients that were treated within 62 days of an urgent GP referral at 57%. It should be noted that there were no regions that were meeting the national target of 85%. The regional average was 67% and the national average was 62%. This data was at trust level and not at hospital level.

Trust wide, there was a deterioration in the percentage of patients receiving their surgery within the national target of 18 weeks. In October 2022 54% of patients had their surgery within 18 weeks, in June 20203 this had reduced to 46% of patients received their surgery within 18 weeks. This data was at trust level and not at hospital level.

Trust wide there were increasing numbers of patients waiting over 65 weeks for surgery. In October 2022 there were 3282 patients waiting over 65 weeks. In September 2023 there were 5664 patients waiting over 65 weeks for surgery. This data was at trust level and not at hospital level.

Trust wide there were increasing numbers of patients waiting over 78 weeks for surgery and the trust had not met their target of no patients waiting over 78 weeks for surgery by March 2023. In March 2023 there were 257 patients waiting more than 78 weeks for surgery. In June 2023 there were 331 patients waiting more than 78 weeks for their surgery. This data was at trust level and not at hospital level.

We were not able to assess the performance of Royal Sussex County Hospital as there was no data specific to Royal Sussex County Hospital. We were not provided with a recovery plan for people waiting for surgery at Royal Sussex County Hospital or for those waiting for surgery across the trust.

Managers and staff worked to make sure patients did not stay longer than they needed to, but examples were found where theatre capacity impacted this. Senior managers outlined broad plans and strategy to ensure patients did not stay longer than they needed. However, at a ward and theatre level, we saw examples where patients had been waiting longer than expected for surgery. There were reasons beyond the service's control for this on occasions. For example, when social care provisions were stopping a safe discharge.

We saw examples where patients had their surgery cancelled on several occasions consecutively due to staffing and capacity in the theatres. One patient we spoke with told us she had been cancelled on 8 consecutive occasions for orthopaedic surgery.

Surgery

Additionally, when patients attended the theatre admissions unit prior to being admitted to the hospital, there were examples where they were left till the afternoon until they were informed, they would not be able to have their surgery that day. Managers told us this was very difficult, and they wanted to keep patients as long as they could before completely ruling out surgery could occur. Leaders in theatres told us the theatre lists were often delayed for a variety of reasons and this could not always be predicted but they did their best to keep the patient informed.

The theatre admissions team kept patients up to date with a timeline on their day of surgery. Staff completed a comfort round where they gave patients an update on their wait times.

Managers worked to keep the number of cancelled operations to a minimum but there were circumstances which meant this was not always possible. Between April 2023 and July 2023, the hospital cancelled 46 elective cancer operations.

The trust had the second highest volume of last-minute cancellations due to non-clinical reasons, 2,872, an average of 191 per month in England over the last five quarters since April 2022.

The trust had the fourth highest number of cancelled operations where the patient did not receive treatment within 28 days following re-booking after cancellation. The percentage of cancellations that result in breaches showed this was increasing over the last two quarters.

One third of cancelled operations in 2022/23 quarter 1 did not meet the standard for the patient to be treated within 28 days following cancellation. However, in the most recent data, we saw the number of reported cancellations was around 13% lower than the same time period the year before.

A variety of reasons were given for this which included capacity of suitable bed space, clinical prioritisation, and theatre lists overrunning. Managers and staff told us both theatre and bed capacity had been a challenge.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged but there were delays at times. Managers told us that if a patient cancellation on the day of surgery was unavoidable due to clinical or capacity reasons there was a standard process for rebooking them. This was managed by a theatre co-ordinator.

The rebooking of surgery was assessed by medical staff in terms of the clinical priority of the operation. Any operation cancelled was moved to a short-term theatre cancellation distribution list for actions associated with rebooking. If a patient was cancelled for non-clinical reasons on the day of surgery, all alternatives were considered, and cancellation would only go ahead if approved by senior management.

If cancelled, an incident was recorded to support any needed investigation into the reasons for the cancellation. A review group made up of pre-operative, ward, theatre, and clinical staff reviewed every cancelled surgery to explore lessons learnt.

When surgery was cancelled in neurosurgery, spinal, and vascular specialities, the consultant found a further date before speaking with the patient so that they left with a further date. However, as the team booked 2-3 weeks in advance, it was not always possible to do this, as it depended on theatre capacity. In some cases, surgery was rescheduled later after a consultant reviewed the priority status.

Surgery

Consultants told us capacity was frustrating for them and they felt let down by trust senior leadership due to promises that more capacity would be available when the neurosurgery theatres moved to the new building. Senior managers we spoke with acknowledged this frustration and expressed that it was shared at all levels of the organisation. Their primary concern was running a safe service and staffing difficulties meant the new theatre unit could not run at full capacity at this time.

Managers and staff started planning each patient's discharge as early as possible. Leaders and staff told us discharges were divided up between simple and complex pathways. Complex discharge pathways were started when the patient met a specific criterion. This criterion included but was not limited to, safeguarding, social issues, disability concerns, and palliative health concerns.

Leaders told us discharge planning was individualised and incorporated 3 stages which were assessment, planning, and finally the discharge or transfer of care from the hospital site. Leaders showed a flow chart to us that provided a visual example of the process. We saw discharge plans in records we looked at which were individualised and complete.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Following day surgery, when patients had met the discharge criteria, the discharge nurse would discuss all discharge information with the patient and their family or carers. The patient was also given a written discharge summary which included contact details to reach the medical team in an emergency or if advice was needed out of hours.

Patients transferred out of the service or discharged home all received a consultant review prior to transfer or discharge.

Service delivery to meet the needs of local people

The service planned and provided care in a way that mostly met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Members of the public had been involved in the development of the new Louisa Martindale building. The building and wards had been designed to take account of patients with needs such as neurodiversity, dementia and allowed access for disabled or bariatric patients.

Patient engagement was undertaken to support patients and their families on admission and discharge from the hospital, as part of a corporate project called "Length of Stay". We saw this was reported on in November trust board papers, but detailed information to support the success of this project was not yet available.

Patients were involved in the review of patient information for surgical patients to ensure it was appropriate prior to publication on the trust website.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Data from September 2023 showed the hospital, across all wards and specialities, had reported 50 mixed sex breaches. Surgical wards we visited were aware of the standards for mixed sex accommodation. Staff explained where a bed was added to increase bed capacity, staff strived to ensure genders were kept separate wherever possible.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Surgery

Patients could reach call bells and we saw staff mostly responded quickly when called. However, in the vascular ward, we noted care episodes where call bells had been ongoing for over 15 minutes. The ward was short staffed at the time. Managers we spoke with were frustrated that staff were not always able to answer call bells promptly. We saw patients and their family members expressing frustration about this too. Despite this, all other wards we visited were responsive to call bells and the better numbers of staff reflected their ability to do this.

Staff made sure patients living with complex healthcare conditions, such as dementia and learning disabilities, received the necessary care to meet all their needs.

Staff showed a good understanding of the needs of patients with these conditions across both ward and theatre environments.

Managers told us that hospital guidelines for the care of patients with a learning disability were collaboratively written with the learning disability leadership team and a learning disability and autism steering group which met every 3 months to provide governance.

Managers and staff worked towards the principles of the Mental Capacity Act policy of the hospital to ensure that patients with dementia were appropriately supported and had access to surgical services.

Wards we visited had the potential to meet the needs of patients living with dementia. Staff working on wards understood the additional needs required for dementia patients. For example, staff knew that patients required 1:1 care if their cognitive symptoms met an unsafe threshold. However, some environments were very busy and noisy which presented difficulties for patients with cognitive impairment. Ward staff told us that where possible, they would try to provide a side room for patients with these needs but acknowledged it may not always be possible due to the capacity issues and flow concerns encountered on some of the older wards.

Ward managers provided examples of personalised care. For example, staff ensured a dietary adjustment was implemented for a patient with learning disabilities.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports.

Ward managers and staff told us they encouraged people closest to the patient to fill out a ‘This is me’ document to promote person centred care during the patient's stay. The document made up part of the monthly audit programme for hospital clinical environments.

Managers told us all patients with dementia had access to surgical services and were supported by the dementia team when needed. Ward managers told us they helped in making any special arrangements needed by the patient and their family if they were an elective admission.

Managers told us surgical consultants also contacted the dementia team about advice on how a dementia patient who needed complex surgical intervention may present so their baseline cognition could be accurately established. This improved post operative care so symptoms such as delirium in post-surgical environments could be accurately identified and treated.

The dementia team reviewed 83 surgical patients between August 2022 and August 2023 at the hospital.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers told us a new Interpreting and Translation Policy was approved on 21 September 2023. These included flowcharts explaining to patients which resources and services would be available for interpreting and translation.

Managers made sure staff, patients, families and carers could get help from interpreters or signers when needed. Ward managers and staff were aware that there were systems and processes that would allow them to access translators when needed. Patients we spoke with were aware these services could be requested.

Interpreting, translation, and communication support services for disabled people were provided by a Sussex-wide framework contract to support patients and users with communication needs across services.

Leaders told us a communications campaign was being developed to promote flashcards as a first-line response for patients with communication needs such as hearing loss.

Leaders told us the British Sign Language (BSL) provision included In-person BSL interpreting for both elective and urgent cases. Staff could book a sign language interpreter through the trust intranet. Staff we spoke with had awareness of this service.

The service had information leaflets available in languages spoken by the patients and local community. Leaders told us as part of their communication support services, there was a tool which could also be used to translate leaflets for patients before their surgery.

Patients were given a choice of food and drink to meet their preferences. Patients we spoke with on some of the wards praised the food they had.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service had 112 complaints between June 2022 and June 2023. Patients we spoke with knew how to complain if necessary.

The service clearly displayed information about how to raise a concern in patient areas. Information on how to complain was seen on all wards we visited.

Staff understood the policy on complaints and knew how to handle them. Ward staff told us they tried to resolve any complaint informally in the first instance. Informal conversations were joined in by a line manager where needed. If this did not resolve the problem, then they recommend a formal complaint through the Patient Advisory Liaison Services (PALS).

Managers investigated complaints and identified themes. Complaints were managed centrally through the PALS team and themes or lessons were sent to ward managers at the conclusion of the investigation. If information was needed from staff, this was organised by managers, who supported staff in this process.

Surgery

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers told us that when a complaint investigation reached its conclusion, the chief nurse or chief medical officer wrote to the patient with their findings and any themes that had been found.

Managers told us that the duty of candour process was followed for patient safety incidents graded as moderate or above.

Managers completed a duty of candour audit on a quarterly basis. Compliance was measured using 3 measures, including recording of the initial duty of candour conversation, a record the duty of candour letter was sent, and recording that findings were shared with patients and their families. Managers shared results of the audit from general surgery which showed good performance in these measures.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers told us that any themes or lessons found through a patient complaint were shared through meetings and alternative communication methods such as email.

Staff could give examples of how they used patient feedback to improve daily practice. However, staff could not give examples of changes made from complaints, but they did confirm that it was an agenda item in ward meetings.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, at senior level they were not always visible and approachable in the service for patients and staff did not always feel supported.

The leadership team at the hospital was split across two triumvirate leadership groups which were Surgery/Critical Care and Specialist. The surgery triumvirate leadership team was overseen by the executive leadership team and there were leadership channels for operations and nursing, and this was overseen by the chief of service for the triumvirate. These leadership teams managed surgical services at both Royal Sussex County Hospital and Princess Royal Hospital.

Leadership positions below this were hospital specific and aligned to a particular area of the service, for example theatres. We defined local leadership as Matron and below.

Leaders we spoke with at all levels were clear about their role and responsibilities and they showed good awareness of the priorities and challenges the hospital faced. For example, all levels of leadership referenced staffing and their awareness of the challenges this was placing on the operational performance of the hospital.

Staff we spoke with on surgical wards praised ward leaders and we saw examples of improvements in culture and communication. This was particularly true regarding the gastrointestinal ward we visited where we saw the new leadership had improved workforce wellbeing.

Surgery

Managers in all ward environments were handling risks around staffing which were affecting access and flow associated with the operations undertaken at the hospital.

In theatres, staff were very upset with the continued challenges associated with bed capacity and staffing and did not feel that senior and trust leadership was visible. There were exceptions to this in local leadership positions, but staff did not feel senior levels above this were present and understood the nature of the environments and culture they were working in. Triumvirate surgery leadership we spoke with following the inspection showed awareness of the culture concerns and felt that operational challenges in theatres continued to make culture challenges difficult to manage and hard to navigate. They all told us that the culture in theatres was a long-term piece of work that needed to be handled delicately and that time was needed to show improvements.

The operations triumvirate lead told us that they had recently started to attend general theatres every morning when they were scheduled to work, but staff we spoke with told us that they did not see senior leadership in any capacity during their day to day working schedule and that they felt isolated and not listened to in terms of the concerns they raised. Senior leadership felt that the recent move of having an operations manager in theatres would help improve this.

Local leadership in theatres was praised by staff and we heard examples of leaders being available to staff in challenging circumstances. However, there was a negative culture found in general theatres that local leadership felt was difficult to manage and there were areas they still did not fully understand.

All levels of leadership showed high levels of frustration about the current circumstances in theatres and there was good intent seen by all leaders. However, there did not appear to be clear aims associated with how challenges would be met. There were areas such as general theatres where the communication and feedback mechanisms between senior and local leadership were lacking. Some staff were very upset about not feeling heard and they told us they felt frequently ignored by senior leaders when they raised their concerns or received no response at all.

This was not true in ward environments where ward leaders felt the challenges they faced were known to senior leaders, but formed part of larger operational challenges faced by the hospital site, which they proactively tried to manage.

Staff told us they had opportunities to progress in their careers and we saw examples of leaders who had been with the trust for a long period of time who had followed development pathways.

Medical staff told us they were frustrated with senior leadership due to a lack of action seen on the ground to known problems they were experiencing. But local medical leadership was praised for their communication and flexibility. These themes were consistent across both wards and theatres.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The Surgery Clinical Strategy was held within the trust's clinical strategy which was approved by the trust board in August 2023.

Surgery

The trust had a strategy for its Surgery department which involved ongoing action plans started from earlier CQC inspections, which covered both General Surgery, Upper Gastrointestinal Surgery and Neurosurgery. We found the senior leadership had a good vision and strategy but that some areas of the plan were not always implemented or communicated, which frustrated staff and local leadership.

Leaders told us a project was launched in October 2022 to drive the improvements needed to ensure an effective service delivery within General Surgery. Leaders told us the project had seen significant improvements in several areas of the service. This included changes to the leadership structure and clinical leads for clinical governance and enhanced clinical governance.

Processes had been developed, along with national audits, data submission and local audits in line with best practice. Leaders said that Morbidity and Mortality conferences and multidisciplinary team meetings were also now consultant led. There was also a quality committee that met for oversight of the project.

Further to this, the project focused on creating a new service provision model for upper gastrointestinal services that supported collaborative working with other hospitals. Options were being considered and due to be submitted as a business case. There was also ongoing work developing a workforce model which factored in the needs of new units at the hospital, including a new surgical assessment unit.

The improvements were led by a steering group and 5 working groups. The working groups covered behaviour, equipment and estates, job planning, quality, and governance. The working groups met monthly. An example was given by the behaviour working group of a new behaviour contract that was consulted with medical staff at the hospital to improve culture. It was reported as welcomed but with some resistance from some staff.

For general surgery, they told us they had considered many external reports about the culture and recognised through their interventions that culture needed to be improved and support and recognition needed to be given for a team that had suffered from significant staff turnover. They had looked at this through the new development of workstreams to address culture and leadership.

Despite this, there were examples seen where leadership had awareness of an ongoing problem but had not acted or incorporated the problem into their strategy. For example, estates at the hospital were struggling with storing equipment. We told senior leaders about an exit we saw blocked by equipment in one theatre. Senior leaders told us they had a plan to move the equipment into theatres, but this had not yet happened. They were currently looking into it and hoped the new building at the hospital would provide more space. They told us a plan was made with the estates but none of the changes have been made since 2019. Local leaders in general theatres told us they considered it disappointing as it had been in the location for over a year.

We also gave a second example to the estates team about how lift maintenance concerns were causing staff to transfer patients across clinical environments to access ward areas after surgery. Theatre staff told us during our visit that only one lift was operational in the building when we visited. Senior leaders acknowledged the concern had been ongoing for 18 months and that they had no solution yet but referenced the new building as a solution or direct discharge from the recovery area. They had confirmed local risk assessments and adjustments had been made where possible to preserve safety and patient's privacy and dignity.

Local theatre managers spoke with great frustration about both situations and that they felt they were not being communicated with in terms of ongoing action to correct these problems.

Surgery

Culture

The culture in theatres was still poor. Not all theatre staff felt respected, supported, and valued. Staff in theatres did not feel they could raise concerns without fear of reprisals. However, there was an improving culture on the wards where staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care across all environments.

At senior leadership level we asked the triumvirate for surgery how they were feeling and if they felt supported by executive leadership. All leaders of the triumvirate expressed frustration at the ongoing situation but said they felt supported by the executive team and focused on supporting each other.

Senior leaders told us they were hopeful the local leadership team within theatres would change the culture in theatres which they acknowledged was complex and not easy to solve. Senior leaders told us that an emphasis was placed on walking around meeting staff and leading from within the team. But theatre managers and staff we spoke with described the senior leadership as not visible and distant from the problems they were experiencing.

Staff in general theatres told us the culture continued to be negative. We spoke with 30 members of staff who gave us examples of bullying in the unit with a divided workforce and a perception that some staff were treated differently to others. Staff told us they were placed in difficult circumstances daily and they did not feel listened to when they reported these concerns.

Local theatre managers acknowledged the difficulties their staff raised, but when raising this with senior managers, met difficulty in receiving responses to the problems if the theme was already known. This led to theatre managers and staff feeling unvalued and disillusioned with their work.

We asked theatre staff if they reported incidents associated with culture and they told us they did not feel safe to do so due to previous experiences. They told us there was no evidence of action being taken, so they did not see the point in doing so.

Medical staff for theatres told us they were often pressured to attend work because of staff shortages. Senior medical staff reported feeling emotionally targeted when being asked to work and felt there was a threat of career consequences for not doing additional work. This was also reported when trying to take annual leave with leave requests frequently denied by senior leadership.

The themes outlined above were also spoken about in neuro theatres but were less extensive and widespread. Medical staffing in neuro theatres told us they were very upset with the ongoing capacity issues which they felt had not been resolved. For example, increased theatre capacity had been promised with the completion of the new building but had not yet happened. This had caused resentment among the medical workforce and arguments over who had which theatre which was complicated further if emergency surgery was suddenly scheduled.

Medical staff told us they felt unsupported making difficult decisions on who they should treat which led to frustrations and impacts on their mental health.

Executive and senior leadership told us that in theatres, it was clear to them that staff were suffering from high moral distress as a team because they were not able to deliver good care. They believed the staff needed to see change before they felt heard, and they understood why they were still feeling unhappy in their jobs. In neuro theatres, they told us It was important to have a new environment to enable them to recruit and keep staff. Senior leaders stressed that they knew more time was needed as it was hard to change things quickly regarding culture.

Surgery

Senior leaders told us they knew they needed to create a feeling of stability within the theatre department. An emphasis had been put on staff wellbeing. They offered one to one pastoral care and an open-door policy with all staff in the team. If there was something raised that required help beyond the scope of what was offered, then they were referred to services that could support staff professionally, such as Occupational Health.

Senior leaders told us an action plan was designed to improve staff confidence in feeling comfortable to speak up and that something would be done about it. The action plan had 44 points. Of the 44 points, 21 had been implemented and 17 were considered on track to be implemented.

Senior managers had continued to promote equality, diversity, and culture in the department. A session was arranged for a key speaker to speak at a quality, safety, and patient experience session in the unit via video conference. The session was recorded and shared within the surgery division. The speaker had offered to attend the department again in person to share more of their knowledge in equality, diversity and culture.

Senior managers also told us they had started an initiative in the perioperative division called “Your Voice Counts”. They told us staff had been given the opportunity to take part in this initiative. Objectives had been set up and there was a work stream to continue the work.

Senior managers also told us that since March 2023 there had been wellbeing sessions provided for all the staff in the perioperative division, offering a 15-minute slot of a choice of therapy from a back, neck and shoulder massage to reiki. They said feedback had been extremely positive.

The service also developed a raising concerns route map and the intranet link had been shared electronically with all staff and via an electronic messaging group. A departmental flow chart was included to guide staff on who to contact if concerns needed to be raised.

Staff told us that freedom to speak up posts had been intermittent and had only recently been permanently appointed. Senior managers we spoke with acknowledged this and told us they had named individuals now for both neuro theatres and general theatres. Freedom to Speak Up fed into the trust’s speaking up processes. At the November board meeting it was reported that since August 2023, 52 staff had reported a concern and 24 of those concerns had been resolved. The highest reported issues were around systems and processes, followed by management issues and other relationship breakdowns or behaviour.

On wards, there was a different picture where the culture had improved due to new ward leadership or exceptional existing local leadership. On cardiac surgical wards, we found responsive ward leadership and staff who told us they felt respected and offered opportunities to develop. On a trauma and orthopaedics ward, we found staff were respected at all levels. A member of domestic staff expressed the pride they felt in working on the ward.

All ward environments were busy and on a vascular ward we visited we noted a stressed workforce who were working with minimal staff on a very busy day. Despite some frustrations seen from patients, ward leadership showed a connected approach for staff working on the ward and this was reflected in how they spoke with us. One staff member was emotional and said they felt they could do so much better but just didn’t have the resources to do it. Despite this, ward local leadership supported one another, and we saw effective team working during our time at the ward.

Ward managers showed kindness using patient centred experiences that reflected the changed culture of the wards we visited at all levels of local leadership.

Surgery

Senior leaders spoke about their ongoing commitment to culture, sharing examples of this through an annual award ceremony and individual awards recognising staff across the surgery division.

Governance

Leaders operated governance processes but communication between frontline staff and leadership was still a concern. Some governance processes operated throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service but this did not include front line staff and we did not see how messages from governance and working groups were passed to them.

Staff in theatres told us they felt very frustrated by the lack of messages associated with the short notice cancellation of operations. They told us that communication structures in the department were not working well and that when they raised information of concern this was not responded to.

Staff told us that operations being cancelled at short notice did not appear to follow a strategy and that at times they did not understand why a patient had been selected for surgery over another. Medical staff told us that they found this difficult and that they felt they often did not have full oversight of how operational managers were making decisions.

Senior Leaders told us that they could improve their communication processes. They told us that communication issues were discussed at governance forums and that staffing capacity had a direct impact on staff having time to receive messages.

Senior Leaders told us that there was a lot of activity happening at the hospital and that was directly affecting their ability to ensure messages were clear and reaching staff. However, there were ongoing initiatives to improve this. For example, in responding to a staff request, the operations senior manager changed their working schedule to start and end their day in general theatres or the intensive care unit. This was a new initiative at the time of our visit that had only been in operation for two weeks. By doing this, the operations senior manager hoped to gain oversight of decisions being taken in relation to access and flow which they acknowledged were difficult and sometimes emotive due to the operational pressures in general theatres.

Staff on wards also found that communication about theatre list progress and cancellations was last minute and, on some wards, staff told us they tried to manage expectations with patients scheduled for surgery due to the operational pressures theatres were under.

Senior leadership told us that decisions were communicated to staff differently depending on the speciality. For example, orthopaedic trauma and general surgery patient cancellations or changes were discussed verbally with their clinical team. Where a speciality was not managed within the surgery directorate, communication messages were more difficult to keep oversight of. Operational managers would communicate with their peers from other divisions, but due to the vast number of specialities, they acknowledged that communication systems could not be standardised, and local arrangements had been setup.

Staff in ward environments communicated well with daily safety huddles and scheduled ward meetings. Meetings were normally scheduled monthly but local leaders acknowledged that this could not always occur due to staff availability and operational pressures.

Surgery

Local managers in all departments continued to raise awareness in meetings of clinical risks with staff using a theme of the week. The themes shared were varied and covered a wide range of topics associated with risk management including skin moisture damage, deteriorating patients, and independent mental capacity advocates.

At senior leadership level there was a meeting structure that looked at surgery divisional performance. This meeting reviewed data from the monthly divisional governance meeting, quality governance meeting and the quality and safety division meeting. These meetings fed into the trust quality governance steering group and the quality committee of the trust.

On a previous inspection we had raised concerns around morbidity and mortality meetings which involved the progression of patient care. We had previously found there had not been a sufficient level of clinical specialist knowledge which could give a balanced judgement of the needed care for some patients. Leaders had acknowledged our findings and were working towards our earlier recommendations as part of their action plans for the general surgery and neurosurgery services. We were reassured by the evidence seen as part of this inspection that improvements were occurring.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However, some staff did not feel they contributed to decision-making and staff felt that senior level oversight was lacking when assessing the quality of care in theatres.

The trust ran two risk registers associated with the surgical services we inspected. These were the Surgery and Critical Care Divisional Risk Register and Specialist Divisional Risk Register Trust-wide for Neurosurgery. There were also risk registers for the separate specialities involved with surgery at the hospital. The registers had active risks approved by the Surgery or Specialist divisional leadership team with evidence of mitigation and regular reviews.

The trust had a business continuity plan that underpinned service operations.

Staff in theatres told us it was unclear who they should raise concerns too. They told us that they did not know who to individually approach in most circumstances and that when they did raise concerns, they were unclear what action had been taken. This raised concerns that senior managers were not fully aware of all risks associated with the division when planning services.

Senior managers told us that escalation pathways for raising concerns specific to the managerial structure in the hospital theatres department has been agreed and communicated to staff for clarity through safety huddles, noticeboards, and e-mail.

Senior managers told us that the surgery division recognised staff engagement and communication across such a large department was challenging. As part of their engagement plan, the weekly operations huddle to the whole division. Senior leaders told us they made efforts to join smaller team meetings, hold coffee mornings and evening meetings for all staff.

Senior managers, when planning for the upcoming winter, acknowledged that recovery areas would need to act as escalation areas potentially and were engaging with the local theatre leadership team in the planning and standard operating procedure associated with this.

Surgery

Senior managers from the surgery division held information sharing forums where winter planning was discussed. The Divisional Director of Nursing had a twice weekly huddle with heads of nursing, matrons and local theatre managers. The Chief of Service led a surgery divisional huddle for the operational and clinical teams weekly.

Local ward leadership told us that joint weekly manager meetings between hospitals within the trust provided a constructive forum to capture risk in ward environments so that this could be promptly escalated.

The ward matrons and heads of nursing in surgery had also developed a minimum safety standard for daily work and this was scheduled for completion shortly.

Senior managers told us that local audits including the Fundamentals of Care audit was used to identify and mitigate risk.

Senior managers told us that ongoing risk associated with long waiting times was being monitored through a detailed governance process. This included rebooking processes that factored in clinical need, theatre availability and staffing projections. Senior managers told us that individual medical consultants handled assessing the clinical risks associated with patient rebooking for their surgery. They also held responsibility for reviewing all long wait patients to assess the potential for harm which may result through long waits.

Consultants told us that senior managers did not always communicate how decisions were made when re-booking cancelled operations to other staff. We found that some methods of communication overlapped between the surgery division and the specialist division which had confused staff. We also found that messages about operational risk were given to a certain level of leadership with the expectation it would be shared to all staff. However, there was limited oversight of this process which sometimes added to the friction between medical staff when competing for theatre slots for their patients.

Information Management

The service collected some data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were submitted to external organisations as required.

Managers collected some data that was relevant to the service for performance purposes. Information was available and accessible from email, newsletters, reports, policies, and notices in staff areas. Leaders encouraged staff to be aware of data associated with incidents, complaints, and feedback.

The information systems used by the service were secure and the trust had policies and processes for the safe and secure storage of data. This included password protected staff accounts. Staff were conscious of data security and the trust had a named Caldicott Guardian if they had any queries with data and confidentiality. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

External information was triaged and allocated to the most suitable team by the central governance teams of the trust.

Engagement

Leaders and staff engaged with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, improvements were still required in their engagement with staff, in particular how concerns are responded to.

Surgery

Leaders had made some efforts to engage with staff and the wider public as part of their improvement programme.

The national NHS staff survey results published in March 2023 showed the trust performed below the national average against 7 out of the 10 questions asked. Staff engagement, morale, safety and having a voice that counts were highlighted as areas for improvement.

Senior leaders had set up schemes to speak with staff and hear their views through several initiatives. These were culture focused and covered in the "Culture Sub Section" of this report. But staff told us that this needed improvement and that they did not always feel listened to despite these initiatives. Staff also told us that they did not feel that they knew how larger operational concerns were being managed and that there was an absence of information from leaders about what was being done to support and improve the hospital's current challenges.

Leaders had also considered public, and diversity needs with the development and building of their new hospital building at the site which included disability, equality and neurodiverse needs.

Leaders had also engaged with partner organisations as part of their gastrointestinal surgery improvement plans to improve the delivery of the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had an ongoing programme of research which was summarised in a dedicated report to board as part of the November board meeting.

Examples of recent and ongoing research and improvement projects included community involvement and engagement activities to better understand patients' understanding of research activity of the trust. The trust was also developing research champions and was successful in a bid to secure funding to establish community researchers to aid the development of research projects that engage with underrepresented communities.

The committee also noted the work with the Sussex Partnership Trust to join up studies on physical and mental health.

Outstanding practice

We found the following outstanding practice:

- We found several examples of staff who went beyond their expected remit of care to ensure that patients were both reassured and had an individualised care experience during their stay.
- Staff demonstrated passion over the service and often went beyond what was expected of them to ensure the service was safe and ran effectively.

Surgery

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it not complying with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that all ventilation recommendations associated with the external audit of general theatres are implemented. Regulation 12.
- The trust must ensure equipment in ward and theatre environments is moved or stored to a suitable location and avoids emergency exits being blocked. Regulation 12.
- The trust must ensure equipment stored on wards does not inhibit cleaning in any way. Regulation 12.
- The trust must ensure appropriate training, in line with guidance, is in place and completed by staff to support patients with learning disabilities, and autism. Regulation 12.
- The trust must ensure that staff complete mandatory training in line with their role and that oversight of targets is effectively monitored. Regulation 12.
- The trust must ensure action is taken to improve their compliance with national waiting list targets, and that performance data for the trust can be separated to show site performance. Regulation 17.
- The trust must ensure that workforce data for the trust can be separated to show individual site performance. Regulation 17.
- The trust must ensure communication structures for staff are clear, easy to follow, and that there are feedback mechanisms implemented for staff who raise individual concerns. Regulation 17
- The trust must ensure cultural concerns in the theatre department are addressed, and action is taken to ensure this improves. Regulation 17.
- The trust must ensure that staff in theatres are supported to work within their clinical competency and that there are suitable arrangements for monitoring this. Regulation 18.

Action the trust SHOULD take to improve:

- The trust should ensure that patients' privacy and dignity are supported when being moved by following surgery. Regulation 10.
- The trust should review safeguarding arrangements in line with the intercollegiate guidance for safeguarding to ensure staff training is suitable for frontline staff.
- The trust should improve systems for monitoring induction compliance and oversight.

Medical care (including older people's care)

Requires Improvement 

Our rating of this location went down. We rated it as requires improvement because:

- Staff did not always dispose of clinical waste safely.
- Patient records were not easily accessible for all staff and patient records were not audited.
- Not all staff received training to effectively support people with learning disabilities, autism or mental health needs.
- Staff did not complete audits to provide assurance around high-risk pathways such as sepsis.
- The trust did not provide chaperone training or include information about chaperoning as part of staff induction.
- Not all staff were competent for their role in relation to caring for patients with specific mental health concerns or for caring for patients under section.
- Not all key services were available seven days a week.
- Outcomes for patients were not always positive, they did not always meet expectations consistently in accordance with national standards.
- Staff did not have a system to make sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff did not always complete fluid and nutrition charts accurately.
- The service did not have a vision or strategy.

However:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- Shift changes and handovers included all necessary key information to keep patients safe.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff provided good care and treatment, gave patients pain relief when they needed it. Managers monitored the effectiveness of the service.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Patient feedback about staff was consistently positive.
- The service had enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Medical care (including older people's care)

- The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The trust target rate for compliance with mandatory training was 90%. Compliance across all staff groups was currently at 86% and nearly met the trust target.

Staff told us that it could be challenging to get all their mandatory training completed. The majority of the training was e-learning, and staff were able to complete this at home in their own time and could claim bank payment rates for this.

The mandatory training was comprehensive and met the needs of most patients and staff. Mandatory training modules covered a range of topics to meet the needs of staff including basic life support, infection prevention and control, fire safety and conflict management.

Some clinical staff completed training on recognising and responding to patients with dementia, and the trust was in the process of rolling out training on learning disabilities and autism, however there were no additional training modules on mental health. A new training package entitled Communication and Interaction training (CAIT) was being rolled out to help staff acquire greater 'dementia care literacy' and to promote consistent care for people living with dementia. We spoke to staff who had completed this training who told us it was helpful to their role. New healthcare assistants joining the elderly care and dementia ward now had this training as part of their induction. The trust told us that they were introducing training on autism and learning disability, however this was in early stages and we saw that trust-wide, only 18 members of staff had completed this. There were also no additional training modules covering additional mental health needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers we spoke with had oversight of their staffs training needs. Managers were able to tell us what their overall training compliance was and knew where the gaps were.

Safeguarding

Staff understood how to protect patients from abuse. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Not all nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff completed training up to level 2 in safeguarding adults and the compliance rate for this was better than the trust target at 94%. Staff were required to complete either level 2 or level 3 training in safeguarding children depending on their role.Staff compliance with level 2 training was 94% which was better than the trust target of 90%. However, staff

compliance with level 3 training was 57% which was worse than the trust target of 90%. Preventing radicalisation level 1 training was a module all staff had to complete and was delivered as part of safeguarding training. For those staff whose role required level 2 training, this was delivered via e-learning as a separate module and compliance with this was at 80%.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff completed training up to a level 2 in safeguarding adults and the compliance rate for this was slightly worse than the trust target of 90%. Medical staff were required to complete either level 2 or 3 safeguarding children training depending on their role. Data from the trust showed that compliance with these modules was worse than the trust target at 83% for level 2 and 64% for level 3.

Staff could give examples of how to protect patients from harassment and discrimination. Staff had a good knowledge of what constituted harassment and discrimination. Staff understood protected characteristics and could give us examples of these. The protected characteristics defined by the Equality Act are: age, sex, race (including ethnicity and nationality), disability, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity and marriage or civil partnership.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We spoke with staff who gave examples of safeguarding concerns they had raised and the outcomes from these.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were generally clean and had suitable furnishings which were clean and well-maintained, however some areas were cluttered, making it difficult to clean. The acute medical unit (AMU) was clean but visibly cluttered with equipment such as hoists, mattresses and observation machines stored across the ward. This meant it could be difficult to keep equipment clean and free of dust. There was a very small equipment room that used to be a toilet but did not have enough space and was overflowing. On the respiratory ward, we saw that alcoves were used for storage of equipment as well as an equipment store. The alcove on this ward was deep, with lots of equipment stored including hoists and wheelchairs that weren't identified as clean or dirty.

There was a noticeable difference between the wards in the newly built Louisa Martindale building (LMB), and wards in the other, older buildings such as the Millenium wing or the Thomas Kemp Tower. All patient rooms in the LMB were individual rooms, some with en suite facilities. The Louisa Martindale was a purpose-built building designed to help mitigate the risk of infection. For example, areas such as bathrooms and patient bedrooms, corridors had floors with rounded edges with the flooring material extending up the wall. This helped prevent dirt getting caught in the joint from floor to wall and meant ease of cleaning and better infection control.

On the gastroenterology ward, we observed that there was no physical partition on an 11 bedded area comprising of two bays. This meant that if there was an infection control outbreak, all 11 beds would have to be closed.

We were unable to establish how the trust performed over time with infection, prevention, and control compliance. The trust told us that infection control audits were regularly undertaken by members of the infection prevention and control team, however we were not provided with data that could be broken down to ward level to review this.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE, including surgical facemasks, nitrile gloves and plastic aprons, were available in all areas we inspected. We observed staff cleaning their hands before and after patient contact. We observed a doctor taking bloods with the correct PPE, procedure and carefully explained to the patient what she was doing and why.

There were adequate handwashing facilities and sanitising gel throughout the wards and departments we visited. Throughout the hospital we observed effective cleaning by domestic members of staff. Out of hours ward staff could call a housekeeping phone that was accessible 24 hours a day, 7 days a week if they needed a cleaner out of hours and staff told us there were no issues. Deep cleans could also be booked through an internal system.

On the respiratory ward we saw that some notices for staff were unlaminated which was an infection control risk as they could not be wiped clean. We reported this to the nurse in charge.

Hand hygiene audits sometimes showed low compliance. The trust told us that ward staff completed hand hygiene audits weekly, and we were sent results for June for the AMU where a score of 85% was recorded. However, the infection prevention and control team carried out spot check audits on hand hygiene monthly and we saw that in July 2023, the hand hygiene audit score for MAU was 16%. This meant that there had either been a sudden deterioration in hand hygiene, or that scores were not accurately recorded. We did not receive results for other areas in the medical division.

Staff cleaned equipment after patient contact but did not always label equipment to show when it was last cleaned. We observed variable use of 'I am clean stickers' throughout the service. 'I am clean' stickers are used to indicate to staff that an item has been cleaned and on what date. This meant that although equipment appeared clean, staff could not always be assured that it was. For example, in the AMU we saw two commodes that appeared to be clean, however only one of these had an 'I am clean' label and this was not dated.

Decontamination of endoscopes was carried out in the Central Sterile Services Department (CSSD) and was observed to be compliant with Hospital Technical Memorandum (HTM) 01/06 Department of Health 2016 Management and decontamination of flexible endoscopes parts a – e.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff did not always manage clinical waste well.

Access to wards and staff-only areas were secure. All wards had a locked entry door system and visitors needed to be admitted by staff after pressing an entry buzzer. All cleaning cupboards and staff-restricted areas we saw on wards were locked with staff-only access.

Patients could reach call bells, however staff were not always able to respond quickly when called. We saw that patients had call bells within reach, however on some occasions we observed call bells ring for more than 5 minutes before being answered. We also observed at a later time that a patient was ringing for assistance but no-one answered. On a further occasion, we observed a call bell rang 28 times before being answered. The trust told us that they did not audit call bell wait times and that the only thing that was routinely checked was whether call bells were working correctly. This means that the trust may not have oversight of any delays or good practice in call bell response times.

The design of the environment generally followed national guidance.

Medical care (including older people's care)

On care of the elderly wards, kitchenettes which were open access had boiling water dispensers which posed a potential scald or burns risk to patients with dementia. At the time of our inspection these were not operational and it was not clear whether they would be made operational in the future.

The Louisa Martindale building (LMB) was newly opened in June 2023 as part of the trust's Teaching, Trauma and Tertiary Care (3Ts) development project to support patients across all of Sussex. There were 100 inpatient beds in the LMB.

In AMU, which was based in the Thomas Kemp Tower behind the emergency department, we found that the flooring was fully compliant with Hospital Building Note (HBN) 001/10 part A with curved fixings for effective cleaning. The toilets and bathroom were clean and fit for purpose and compliant with HBN 00/09 infection control in the built environment. However, we also saw exposed plaster on some of the walls which was non-compliant with HBN 00/09 infection control in the built environment.

The endoscopy department had some areas of flooring that had temporary repairs or tape used. The department were aware of this, and this had been noted as part of their Joint Advisory Group (JAG) accreditation as being needed to be repaired appropriately before next inspection.

There was a drop off bay at the front of the LMB which had been designed for ambulance transport services to collect and drop off patients and to improve flow in and out of the hospital. However, this was cordoned off during our inspection and this was because of concerns raised by the transport services about the suitability and safety for patients and staff. The trust advised that they were working with contractors to review the concerns and make any necessary changes to the design. Whilst this bay was out of use, hospital transport services used a bay at the back of the hospital, however hospital transport staff told us that this was not fit for purpose due to the location and size of the bay, and meant additional time was taken collecting or dropping off patients. This meant there was often a backlog of hospital transport vehicles waiting to come into the bay which we saw during the inspection. This caused delays to some patients discharges.

Some ward environments were a risk to patients at risk of absconding. On the elderly care wards, the ward doors once opened stayed open for 20 seconds. Staff felt this was a concern for patients who were at risk of absconding due to their confusion.

Staff generally carried out daily safety checks of specialist equipment. Most of the wards we visited completed daily safety checks of specialist equipment such as the emergency crash trolley. Equipment had a bar code on which was linked to a central asset register where it could be monitored for servicing and updates.

The service had suitable facilities to meet the needs of patients' families. In the Louisa Martindale building, ward such as respiratory and elderly care had kitchenettes for patients and visitors, and there was a dining room with a sofa and television for patients to use. There was also a quiet room available.

The service had enough suitable equipment to help them to safely care for patients, however not all areas had access to a ward technician to help with the management of stock and equipment.

PPE, including surgical facemasks, nitrile gloves and plastic aprons, were available in all areas we inspected.

All equipment had an asset number or barcode on it which was tracked by the clinical engineering team. We saw data that showed all assets were monitored for their next servicing date.

We checked multiple single use and disposable items and saw that the majority were in date and stored appropriately. Staff told us they did not have issues with getting hold of equipment and that broken equipment was generally dealt with quickly.

Some wards that we visited did not have access to a dedicated equipment technician. This meant that nursing staff had to manage and update the stock and we observed a ward manager having to do this during our inspection. On the wards without a technician we found consumable items and stock that were out of date.

Staff did not always dispose of clinical waste safely. We found three sharps bins on AMU that had temporary closures open and one bin had not been signed or dated. This was non-compliant with HTM 07/01 safe management and disposable of healthcare waste 2013 DH.

On our inspection we observed good offensive waste streaming to reduce the carbon footprint.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. NEWS2 scores were recorded on an electronic patient tracking system. The trust told us that the recording of observations for NEWS2 was audited bi-monthly, however, the results data was not included so we were unable to assess the outcomes.

During the inspection we observed an emergency alarm being pulled in error and we observed a fast and effective response from the full multi-disciplinary team.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, but did not always review these regularly.

Venous thromboembolism (VTE) occurs when a blood clot forms in the vein and can cause serious health problems. VTE risk assessments were not always completed fully. We reviewed the notes of four patients and observed that VTE risk assessments had been completed for three out of four patients on admission, however only two patients were re-assessed during their hospital stay. The service had commenced a VTE prophylaxis quality improvement project which audited if the VTE assessment had been completed in full. There were some months missing, but for the five months of data results that were recorded, none of the results met the 95% target set by the trust. The results ranged between 65% and 73%. The trust told us that this will become a trust-wide standard audit.

Falls risk assessments were completed. The service audited falls risk assessment completion as part of a wider patient safety documentation audit and we saw that between May and August 2023, a daily falls risk assessment was completed in 90% of those records (22) audited.

Other assessments completed in patients records at admission included pressure areas and mouth care assessments. We observed these had been completed.

Medical care (including older people's care)

Staff knew about and dealt with any specific risk issues however did not always audit high risk pathways. We saw admission to do lists which included tasks to do straight away such as checking allergies, tasks to do within an hour of admission such as pressure area checks, and tasks to do within 24 hours of admission such as lying and standing blood pressure.

The service had a risk assessment for boarding patients. Patients need to be boarded (on an additional temporary bed space within a ward) when the service or site is at full capacity. There was a trust full capacity protocol and we saw that the risk assessment for the MAU took into account hazards, control measures and risk scores for each element of this. At the time of our inspection there were no boarded patients.

The site had daily 'bed meetings' to assess capacity and pressure on the service. At the time of our inspection, the trust was in Operational Pressures Escalation Levels (OPEL) four. This meant that pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. We observed at the bed meeting that various risks and issues were discussed including the overview of ambulances waiting, pressures across the hospital site, broken diagnostics equipment and outliers.

The service did not routinely audit sepsis or neutropenic sepsis care pathways. Sepsis is a life threatening reaction to an infection. The trust told us that this was because audits were determined at a local level and were not felt to be an issue.

The service had 24-hour access to mental health liaison and specialist mental health support. The local NHS mental health trust provided a mental health liaison service which could be accessed via a pager 24 hours a day. The team provided a range of services, including assessment, treatment, and support for patients with mental health conditions.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We did not see any risk assessments that asked trigger questions for alcohol or smoking consumption. We spoke to staff on a ward where they had seen an increase in absconding patients and they explained that if patients had capacity they could not prevent them leaving. Staff told us that when patients absconded they followed the missing persons policy but they were unsure if this was the correct process.

Staff shared key information to keep patients safe when handing over their care to others. We observed the handover on AMU which was attended by all members of the MDT including doctors, nurses, occupational therapists, ward managers, matron and a representative from ED. Other medical specialities (for example from gastroenterology or respiratory) do not attend the handover so the nurse in charge runs though all patients and plans but there is only medical input for the AMU patients. We did observe the oncology team handing over to a nurse in the bay about a patient they had seen, there was a thorough handover with a clear plan and opportunity for the nurse to ask any questions.

Shift changes and handovers included all necessary key information to keep patients safe. We observed handovers on the AMU and saw that staff were comfortable raising concerns about issues. We observed an efficient, well-run handover with contributions from all members of the multi-disciplinary team. Patients we spoke with told us that staff that had just come on shift knew about their history and concerns. One patient told us that "handover was meticulous" and gave an example where they had a temperature overnight and that the morning staff "knew all about it". There is a hospital at night handover attended by doctors and outreach with a medical emergency team (MET) call team meeting included and run through of unwell patients.

Medical care (including older people's care)

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. NEWS2 scores were recorded on an electronic patient tracking system. The trust told us that the recording of observations for NEWS2 was audited bi-monthly, however, the results data was not included so we were unable to assess the outcomes.

During the inspection we observed an emergency alarm being pulled in error and we observed a fast and effective response from the full multi-disciplinary team.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. During our inspection we found that most ward areas we visited were short of nurses. For example on the respiratory ward, there were 5 nurses and 3 HCAs where there should have been 6 nurses and 5 HCAs. The nurse in charge had to be included in the actual numbers and was therefore not supernumerary.

Staff managed this by moving staff around and using healthcare assistants (HCA) to support. We observed during our inspection that call bell wait times were often long and staff told us this was due to staff shortages. There was often difficulty finding registered mental health nurses (RMNs) to support patients with severe mental health needs or those under section. We observed that sometimes HCAs were used to provide one to one care to patients under section even though they did not have the correct training in order to do this safely.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staff working on the new wards told us that their staffing template had not changed since moving to the new building. They reported an increase in patient falls since moving to the new building. This was felt to be due to the larger space and less staff to cover the area.

We requested the actual vs planned staffing numbers for nursing, medical and Allied Healthcare Professionals (AHPs) at the service but were only provided with AHP data. We could see from the data provided that where actual numbers of staff did not meet planned numbers, there were either staff that had been recruited that were due to join the service, or that there was active recruitment in order to get the actual numbers to match the planned.

The service had a 14% vacancy rate across the registered nursing workforce in the medical directorate. The trust told us that they had recently approved a business case to recruit 75 international nurses. However, it was not possible to identify the vacancy rate for Royal Sussex County Hospital. The medical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital.

The service had reducing turnover rates. The trust turnover rate target is 9%, registered nursing and midwifery turnover rate of 6.98%. The trust told us that over the last 6 months the turnover rate had been slightly reducing. However, it was not possible to identify the turnover rate for Royal Sussex County Hospital. The medical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital.

Medical care (including older people's care)

The service had low and/or reducing sickness rates. At the time of the inspection the trust advised us that the sickness rate was 4%, in line with the divisional target. However, it was not possible to identify the sickness rates for Royal Sussex County Hospital. The medical division was across both Royal Sussex County Hospital and Princess Royal Hospital and the staffing data was not separated into data for each individual hospital. The trust told us that this rate had fluctuated over the previous six months but did not provide us with the data behind this.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff told us that bank staff were often used but there was a hospital policy to reduce the use of agency staff.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. Staff across various wards told us that junior doctor staffing was an issue as there were not enough of them. Staff told us the imaging service was short of nearly 5 consultant radiologists. On AMU, staff told us that consultants were only available on site until 5pm with a consultant on call. This meant that some patients admitted after this time were not seen by a consultant until the next morning.

The service had low vacancy rates for medical staff. The medical staff vacancy rate could not be broken down to site level and so the data provided included both the Royal Sussex County site and the Princess Royal site. For June and July 2023 the vacancy rate was around 3%. This had seen a slight increase since February 2023 when the rate was -7%.

The service had low turnover rates for medical staff. The medical staff turnover rate could not be broken down to site level and so the data provided included both the Royal Sussex County site and the Princess Royal site. The turnover rate varied between 9% and 5% between February and July 2023.

Sickness rates for medical staff were low. The medical staff sickness rate could not be broken down to site level and so the data provided included both the Royal Sussex County site and the Princess Royal site. Between February and July 2023 the sickness rates varied between 3% and 4%.

We were unable to assess the rates of bank and locum staff usage within the medical services at Royal Sussex County Hospital. We requested bank medical staff rates for the service. However, the trust provided the number of bank and locum medical staff for both surgery and medical services across Royal Sussex County Hospital and Princess Royal Hospital for the 12 months prior to the inspection. The information did demonstrate that most bank and locum staff were used to fill vacant posts.

The service always had a consultant on call during evenings and weekends. We saw rotas that showed consultants were available on call. On MAU, consultants generally worked until 5pm, however we saw some occasions where consultants were on site until 7pm. There was also a medical emergency team (MET) team that could be called upon out of hours.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and stored securely. However they were not easily available to all staff providing care. The service did not audit records completion.

Patient notes were comprehensive, however not all staff could access all notes easily. The trust had multiple ways in which to record patient notes, some electronic, and some paper-based. For example, observations were recorded

electronically, nursing and medical notes were generally handwritten, prescribing was electronic, except for on MAU, and some risk assessments were electronic (such as the mental health liaison team notes). This meant you could not view a patient's entire record at a glance. Also, trust staff told us they could not access the mental health liaison team notes which presented a risk when reviewing patients with mental health concerns. During our inspection we could not locate deprivation of liberty (DoLS) paperwork for three patients and we could not locate the section paperwork for one patient who staff told us was under section. The trust told us that they did not complete records audits, which meant they may not have oversight of issues and quality of patient records.

Records were generally stored securely. Paper-based patient records were kept in lockable trolleys on the wards. The majority of the trolleys we saw during the inspection were locked, however we did see two trolleys unlocked which meant these notes were not always secure. Electronic notes were only accessible by staff with a log-in and we saw that these were locked when not in use.

Medicines

Staff followed systems and processes to prescribe and administer medicines safely.

The trust had an electronic prescribing and administration (EPMA) system for medicines which had inbuilt safeguards and reports were run routinely to ensure safe prescribing. There were some issues that had been identified that were due to be addressed on the next upgrade. However, we saw incidents of medicines not being administered and staff not being able to confirm administration. On AMU, paper charts were still being used and 4 separate operating systems were used to process a discharge where medicines were needed to be dispensed for a patient going home.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. During the inspection we were told by staff there was no opportunity given to patients to self-administer their own medicines. The EPMA system had alerts set up to warn staff when patients had been on intravenous antibiotics for 3 or 7 days consecutively. The nursing staff then flag this to the prescribing doctor.

Staff stored and managed all medicines and prescribing documents safely but did not dispose of Controlled Drugs in line with national guidance. Controlled medicines were stored securely and we saw that checks of these were completed daily. If patients had brought their own controlled medicines with them, these were recorded in a separate register. However, we found a light sensitive medicine stored on open shelving and in glass fronted cabinets across multiple locations. When raised with staff the product of concern was removed from stock and replaced.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Although staff did not follow the discharge policy and keep a copy of the two-nurse signed discharge letter within the clinical notes.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff told us they knew how to report incidents and near misses and the electronic system was accessible and easy to use.

Medical care (including older people's care)

Staff reported serious incidents clearly and in line with trust policy. The trust told us that there had been 7 serious incidents for the division between August 2022 and August 2023. Of these incidents, 3 resulted in moderate harm, 2 in major harm, 1 in catastrophic harm and 1 in death. The most commonly reported incident (3 out of 7) was a diagnostic incident including delay meeting serious incident criteria.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Where incidents met the duty of candour criteria, the trust gave an apology and an explanation of where things went wrong.

Staff received feedback from investigation of incidents. We spoke with staff who told us they had feedback from the 'incident reviewer' on the electronic incident reporting system.

Staff met to discuss the feedback and look at improvements to patient care. Staff told us that incidents were discussed at daily huddles and improvement huddles. We saw divisional governance meetings where incidents and serious incidents were discussed.

There was evidence that changes had been made as a result of feedback. Staff we spoke with gave examples of changes that had been made as a result of incidents such as a patient's property list that had been initiated after an incident where patient's belongings went missing.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Not all services were operating in line with national guidance.

The trust aligned their practice and policies with the National Institute for Clinical Excellence (NICE) guidelines. It had a governance structure in place to oversee and monitor the implementation of relevant NICE guidance. The Clinical Outcomes and Effectiveness Group (COEG) provided assurance that arrangements were in place for continuous improvement of clinical outcomes across the organisation in line with best practice. However data provided to us showed that out of 37 publications, there were only 4 NICE quality standards that the trust were fully compliant with, 30 publications did not have a completed baseline assessment, and 3 publications are newly published and within a 3 month grace period. The trust told us that since the merger, integration of staff and teams across sites has been challenging due to the reduced number of staff in the clinical outcomes and effectiveness team. The trust told us that there was further re-structure and recruiting that was underway.

National guidance for stroke services states that speech and language therapy (SALT) should be available for patients 7 days a week, however staff told us that currently they only had SALT cover 6 days a week.

There was a specific care pathway for dementia patients called the Emerald pathway. We saw flow diagrams detailing actions required for patients that fit the criteria for the pathway including consideration of mental capacity act principles and completion of the 'this is me' document. A 'this is me' document is a document used to record details about someone such as their family and background, important people or places in their life and their preferences and routines. The dementia team audited the use of 'this is me' documents and we saw that compliance had varied between September 2022 and May 2023 between 26% and 100%. However there had been a general trend of improvement apart from one month in April 2023.

Nutrition and hydration

Staff did not have a system to make sure patients had enough to eat and drink to meet their needs and improve their health. However, staff used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff did not have a system to make sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. On all wards we visited we saw that patients had access to jugs of water that were in reach. In the elderly care wards, patients were encouraged to eat in the dayroom so they could be with other patients and communicate. A patient told us that: "food is very good with lots of choice".

Staff told us snacks were available for patients throughout the day, and a drinks trolley attended the wards twice a day. A patient gave us an example of where staff ensured the patient was able to eat the food they wanted: "they go to so much trouble – I really fancied an orange for breakfast but there wasn't one available so staff went to the kitchen to get me one." There was a help desk available 24 hours, 7 days a week, that could take any extra requirements and orders for the catering team.

However, we observed a ward (MAU) preparing a lunch service. Catering staff prepare the meals and bring them to the ward, and then deliver them meals to patients with the help of volunteers. Staff told us that they had lots of patients with swallow difficulties, but did not use a 'red tray' system or equivalent to identify these patients at a glance. Red trays or mugs are used to help staff identify patients who need extra support whilst eating or drinking. Staff told us it was "down to the nursing staff to identify this and offer support with feeding". This did not provide assurance that patients with eating difficulties or swallow problems got the support they required on a busy ward, there was also a potential risk of choking if a patient was to receive the wrong meal.

Nutritional preferences such as vegetarian, halal or vegan could be catered for by the service. However we spoke to a patient who was vegan but was given tea with dairy milk. They told us they did not want to make a fuss and that the staff "do try with my veganism". This meant that staff could not be assured that all patients had their nutritional preferences met.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. We reviewed notes for a patient receiving nasogastric (NG) tube feeding. We observed that nursing staff escalated appropriately to medical staff when the PH level went above the set parameters. However we reviewed a patient's notes in MAU whose food intake was being monitored. We saw that the records had not been updated for the patients evening meal the night before or their breakfast in the morning. When we escalated this to staff, they went to fill this in retrospectively, however they were reliant on the patient telling them accurately what they had consumed, which was not an effective way of monitoring food intake.

We observed in patient notes staff responding to patients who reported their bowels weren't being opened. We saw that staff were responsive with medications for this which reportedly improved but we noticed the bowel chart was not being used.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed patient records and saw that the malnutrition universal screening tool (MUST) was recorded for patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists (SALT) was available for patients who needed it, but not 7 days a week. The stroke service had access to the SALT team and dieticians and we observed that they were an integral part of the MDT. The SALT team told us that they had been working with the MAU to try and improve joint working as there were many patients admitted to MAU who had either swallow difficulties or specific dietary needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We reviewed records which showed patients pain scores were checked regularly, however on one patient record this had been missed. The service did not audit pain scores documentation but told us this was planned for the future.

Staff used a recognised pain assessment tool called the Bolton Pain Assessment Tool, which considered cues such as facial expression, body language, and physiological changes. This tool had been integrated onto the digital observation system that staff used.

Patients received pain relief soon after requesting it. Patients we spoke with told us their pain was managed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. We saw that for the 2023 – 2024 year, the service was participating in 11 out of possible 12 national clinical audits including the national lung cancer audit and adult respiratory support audit. Participation in national audits was overseen by the Clinical Effectiveness and Outcome Committee.

Outcomes for patients from national audits were not always positive. The service participated in the Sentinel Stroke National Audit Programme (SSNAP) which measured how well stroke care was delivered across the NHS. Nationally providers had struggled to meet key stroke care recommendations, such as admission to a stroke unit within 4 hours, which has also been a challenge for the hospital, admitting just 4% of patients to the stroke unit within 4 hours between October and December 2022. The average time between clock start and arrival on the stroke unit was over 20 hours. Timely thrombolysis was also a challenge at the site achieving a Band E, which was the lowest scoring category. The stroke team were aware of the drop in the audit compliance. The service participated in the Royal College of Physicians - National Lung Cancer audit and we saw that the service was much worse than national average for the case-mix adjusted percentage of patients with non-small cell lung cancer receiving curative treatment.

However we did see some positive outcomes, for example the hospital were better than the national average for emergency readmissions for acute and unspecified renal failure as reported by Hospital Episode Statistics.

The service was accredited by a clinical accreditation scheme. The endoscopy service was accredited by the Joint Advisory Group on gastrointestinal endoscopy. The service was due re-inspection by the JAG in 2024.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were not always experienced, qualified, or had the right skills and knowledge to meet the needs of patients.

The majority of staff we met with during our inspection were experienced, qualified and had the right skills to meet the needs of their patients. We spoke with staff members who were accessing additional training modules to become a specialist in their department. We also saw dedicated members of staff such as dementia nurses who could assist and support staff across the medicine service when required.

However, we saw several examples of where managers had assigned healthcare assistants (HCAs) to one to one care or supporting patients with mental health needs or under section. This was typically happening when there was no registered mental health nurse availability. We did not see any evidence of HCAs having additional training in order to support them in these circumstances, and we saw one example where a HCA was providing one to one care to a patient that was confused and was showing signs of aggression. This was not safe for the patient or the staff member, as should something happen, the staff member did not have the appropriate training to be able to manage or de-escalate the situation.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with described a thorough induction programme involving hospital-wide mandatory and statutory training, alongside additional orientation and training when on the ward.

We spoke to overseas nurses who described the additional support they had received to help them settle into the new roles.

We saw examples of induction checklists for new starters that included orientation and information regarding the day to day running of the ward. It also listed competencies such as cannulation and intravenous therapy that needed to be completed and signed off by a mentor.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Data from the trust showed that appraisal rates across the division and the trust was consistently below the trust target of 90%. As of July 2023 the compliance rate was 77%. The trust acknowledged this and had an action plan in place to help recover the position, identifying lack of protected management time, staffing and not recording appraisals correctly as some issues to address.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All nursing staff in endoscopy had access to complete a 'breaking bad news' course.

Managers made sure staff received any specialist training for their role.

Managers recruited, trained and supported volunteers to support patients in the service. We saw a vast number of volunteers supporting the clinical teams during our inspection. One patient had a volunteer come to regularly read to them and they told us that it helped them not to feel as isolated.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. We observed effective MDT meetings happened throughout the medical directorate. We observed an MDT meeting during our inspection consisting of therapists, ward clerk, medical team, and social workers. The stroke service MDT team had additional input from psychologists, dietician and speech and language therapists (SALT).

However staff told us that provision of a full multidisciplinary team such as therapy staff, physiotherapists and occupational therapists had stopped over the weekend on some departments such as MAU.

Staff worked across health care disciplines and with other agencies when required to care for patients. We observed staff from various disciplines working together for the benefit of the patient. We also observed staff working well with in-reach teams from external organisations such as the mental health liaison team, community-based services and the homelessness team. However, some of the meetings and forums set up to link in the mental health liaison team (MHLT) and the trust had been stopped pre-COVID, and not re-started. Due to the increase in the number of patients presenting with mental health symptoms and the need for MHLT staff, it was felt that it would be beneficial to re-start these meetings.

The homelessness team were funded by the local integrated care system and provide support for patients in hospital with finding housing, linking to community support including drug and alcohol services and navigating support services. There was also a community-based service that can support with recreational drug and alcohol abuse. Staff could refer easily online or over the phone and staff told us that there was always someone who was able to offer support and visit in hospital.

We spoke with the SALT teams who told us that they were working with staff on AMU to recognise the need for SALT input from admission and to refer patients early. They said this was in the early stages and were working towards better joined up working.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The mental health liaison service was well integrated in the hospital and staff worked alongside the MH liaison team. Staff told us it was easy to get support from the MH team.

Patients had their care pathway reviewed by relevant consultants. Staff on AMU told us they had no issue with getting speciality medical staff to review their patients on AMU and that they were always seen. However on some of the other wards where there were outlying patients, staff told us it was harder to get them seen by their speciality team promptly.

Seven-day services

Key services were available seven days a week to support timely patient care.

Medical care (including older people's care)

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. We saw consultant rotas and that there were consultants on site Monday to Friday 8am until 5pm, and 8am until 4pm at weekends. Consultant board rounds occurred daily in addition to MDT meetings.

Staff could call for support from doctors and some disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However some therapy services were not available during weekends.

The mental health liaison team was provided by the local NHS mental health trust and was available 24 hours a day, 7 days a week.

There was access to routine imaging services such as x-ray, ultrasound and CT from 9am – 5pm however staff told us that they regularly work outside of these hours to meet the needs of inpatient scans. Interventional radiologists were available 24 hours a day, 7 days a week and staff told us there were no issues in accessing scans.

Some additional services such as rehabilitation services, were not available seven days a week to all patients. We spoke to members of the rehabilitation team who told us that the service in MAU was now only available on week days and that there was frustration that this had happened. The service was also not available during bank holidays which staff told us would be difficult with two Christmas bank holidays approaching. “Speech and Language Therapy services were Monday to Friday with no service available at the weekend. The stroke service had rehabilitation support seven days a week as per national guidance.

Access to endoscopy was Monday to Friday with a 24 hours a day, 7 days a week on call service.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Relevant information was displayed on the wards, for example on the elderly care wards there were leaflets related to the care of patients with dementia.

On endoscopy, there were ‘what happens next’ leaflets available for patients who had received bad news.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff could refer patients to a community based service that could offer support with drug and alcohol use and we saw an example in a patient record where an alcohol withdrawal assessment had been completed prior to onwards referral.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We spoke to staff who spoke to us about assessing capacity and using an MDT approach, including dementia specialists where appropriate. We saw a 'Do not attempt cardiopulmonary resuscitation' form that had been completed thoroughly with documented capacity and discussion with a patient on admission.

Medical care (including older people's care)

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed consent documented in the notes that we reviewed and observed staff asking for verbal consent when carrying out treatment or care. However the service did not currently audit that consent was documented in patients notes. The trust told us that a trust-wide review of consent forms, documentation and policy was being undertaken and would be monitored by the clinical outcomes and effectiveness teams.

We were not assured of how clinical staff kept up to day with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This data was not included in the mandatory training data that we requested.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could tell us how many patients were currently on a DoLS on their ward.

Is the service caring?

Good  

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff followed policy to keep patient care and treatment confidential. On most wards where there were bay areas, we observed staff pulling curtains around the bed area when giving care or treatment. Patient notes were kept in trolleys when not in use.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed staff taking into account the individual needs of patients. We observed a patient who liked to walk being regularly accompanied by a HCA so that they could still achieve this whilst in the hospital setting.

Patients generally said staff treated them well and with kindness. Friends and Family Test (FFT) data provided to us from the trust between February and July 2023 showed that 94% of patients rated their care as good or very good. The trust told us that this was based on 1238 responses, but did not provide an overall response rate.

Staff were generally discreet when caring for patients. When able, staff took time to interact with patients and those close to them, they did so in a respectful and considerate way. We spoke with patients who told us that staff did not always have time to assist them to the bathroom or their commode, meaning they felt they had to relieve themselves in the bed/bay around other patients which was not always dignified.

The bay area in MAU had curtains which could be pulled round to protect patients privacy and dignity, however we did not always observe this happening and we observed a patient being directed from their bed to the toilet by a member of staff who was in a state of undress.

Staff told us that MAU used to have a procedure room that was converted into a side room during the COVID pandemic and has never turned back. Staff felt this was not good for the patient experience who now either had to have procedures done at the bedside or at a different part of the hospital.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed endoscopy procedures and noted that staff were kind and tried to reassure patients during their procedure.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. The trust did not provide chaperone training. The trust told us that this was because all registered staff such as nurses, would have the skills to chaperone as part of their professional training. The trust told us that non-registered staff such as healthcare assistants would be given instruction on this during induction, however we did not see evidence of this in any of the induction packs or checklists shared by the trust.

Some staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. All nursing staff in endoscopy had access to complete a 'breaking bad news' course but this was not mandatory. Staff could attend advanced communication skills training which incorporated topics such as breaking bad news and initiating end of life care conversations. We asked the trust for a percentage of staff that had completed this training but they were unable to provide this.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke with relatives of patients undergoing procedures who told us that staff had kept them informed of progress and outcomes. Another relative of a patient told us that "staff are training me brilliantly on how to care for my partner".

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to communication aids should they be required for patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. During our inspection we did not see any posters or leaflets detailing how to feedback or make a complaint about the service. However, the trust website contained thorough information and guidance about how to feedback or complain.

Staff supported patients to make advanced decisions about their care. We reviewed two sets of notes from patients who had a do not attempt cardiopulmonary resuscitation (DNACPR) in place. We found that only one of these had the 'discussion with patient' section completed. This meant it was not clear whether there had been a discussion with the patient.

Medical care (including older people's care)

Patients gave positive feedback about the service. Patients we spoke with during the inspection gave positive feedback about their stay on wards in the Louisa Martindale building: “It’s a lovely hospital”, “I can’t believe it’s an NHS hospital, feels like a private one” and “you are not just a number here”.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. Staff we spoke with told us that the number of patients with mental health conditions and dementia was increasing on the wards. Data provided by the trust showed that in one month (August) in 2022, 87 patients were admitted to the hospital with either suspected or confirmed dementia. There were dedicated dementia nurses in the hospital that staff could access for support and advice.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Staff on MAU were aware of the mixed sex breaches. Due to the nature of the ward which was very busy, it was commonplace for mixed sex breaches to occur and we saw this during our inspection. It is not clear whether breaches on AMU were declared. We also saw mixed sex breaches on Albion and Lewes ward, with one female on a bay with four males. Staff were aware and had escalated but the breach was due to bed pressures.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The mental health liaison service was available 24 hours a day, 7 days a week. Staff knew how to access and request reviews from this service.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems received the necessary care to meet all their needs. The hospital had a 24 hours a day 7 days a week mental health service and dementia nurses available to provide specialist support to patients who needed it. However, patients with mental health requirements were often left on non-specialist wards such as MAU for long periods of time. There was no system for staff to identify at a glance patients who may have mental health needs, dementia or learning disabilities such as a symbol above the bed or a sticker on the patient records. This meant that staff new to the ward or shift, may not recognise these needs immediately.

Wards were designed to meet the needs of patients living with dementia. The hospital was part of the dementia-friendly hospitals charter which was an initiative to improve the care patients with dementia receive. The elderly care wards had

been designed to help patients with dementia. The ward had different coloured walls outside patients rooms to help them recognise and identify their rooms. The colours were chosen specifically for their calming affect with support from the dementia nurses. A patient we spoke with commented on the calming feeling of the ward: “Everything (is) very calm up here and I really enjoy looking at the view”. We also observed dementia friendly signage and clocks which helped to orientate dementia patients to time and place.

The ward had a photo board of staff that worked on the unit to aid patients in recognising the people caring for them. We also saw teddy bears and dolls being used to help calm patients with dementia.

Environments were designed to meet the needs of patients living with dementia. We saw dementia friendly signage in MAU shower and toilet. Dementia-friendly signage can help a person living with dementia to find their way round a new area and allow them to stay independent.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. A ‘This is me’ document is a document used to record details about someone such as their family and background, important people or places in their life and their preferences and routines. The dementia team audited the use of ‘This is me’ documents and we saw that compliance had varied between September 2022 and May 2023 between 26% and 100%. However there had been a general trend of improvement apart from one month in April 2023.

Within the elderly care wards we saw that there were whiteboards with patients likes, what matters to me and other information. One board had a type of music that the patient liked and we heard music being played in different areas of the ward.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to interpreters and translators when needed. British sign language (BSL) support was available in-person, online or using digital flashcards.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Most patients who were admitted to the medical wards came via the emergency department (ED). During our inspection we visited the ED and saw on one day there were 9 patients awaiting transfer to medical beds within the hospital. Some had been waiting in the emergency department from the night before and data on the ED flow system showed the longest waiter had been on ED for 1.1 days at that point. Flow co-ordinators worked hard to try and manage the flow of patients through the hospital but this was dependant on beds becoming available and on the day of inspection the site was minus 66 beds. Patients either went from ED to AMU or directly to the medical wards, depending on the issue and availability of beds.

Data from the trust showed that between May and July 2023, the average length of stay for a patient on MAU was between 50 and 63 hours. The number of patients that stayed in MAU for over 72 hours was 412 in this time period, the reasons for the stay were not recorded as part of this data but staff told us that the number of patients with mental health needs that couldn’t be moved to suitable beds had contributed to this.

Medical care (including older people's care)

Patients often stayed longer than they needed to. The service monitored patients that were medically ready for discharge (MRD), data provided by the trust showed that between May and July 2023, patients who were MRD stayed between 11 and 12 days before they could be discharged. There had been a lot of work around improving the discharge process and the process in-hospital was nearly all digital and was embedding well. Staff told us the biggest issue was the availability of suitable discharge locations and care packages in the wider care system.

The service moved patients only when there was a clear medical reason or it was in their best interest. Data provided to us by the trust showed that there was an average of 1.14 bed moves at the hospital between May and July 2023. Further information provided to us by the trust outlined that bed moves were decided based on the clinical needs of the patient. They also informed us that an audit was starting from September to understand and rationalise bed moves as part of a workstream to support the reduction in length of stay.

Staff did sometimes move patients between wards at night. Data provided to us by the trust showed that between May and July 2023 there were 87 bed moves between 10pm and 6am. Moving patients at night is not considered best practice as it disturbs their sleep and can be confusing or disorientating for some patients.

Managers and staff started planning each patient's discharge as early as possible but sometimes patients were discharged out of hours. We observed in the elderly care wards that discharge planners were completed on a patient's admission to the ward. Data provided by the trust showed that between May and July 2023, 28 patients were discharged between 10pm and 8am. Discharging patients at unsocial hours can be confusing and disorientating for patients and mean that they may not have the right support available when they return home.

Staff from the dementia wards actively visited ED and AMU to see if there were any patients with dementia that would benefit from being moved to the ward quickly.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. The trust provided data for delayed discharges at one of the other trust hospital sites, and therefore we were unable to ascertain whether they monitored reasons for delayed discharges at this site.

Managers worked to minimise the number of medical patients on non-medical wards. Staff told us that outliers put a strain on their staffing as staff had to leave their ward to assess the outlying patients on a different ward. Staff on medical wards told us it was often a challenge to get outlying patients reviewed promptly by their consultant. Data provided by the trust showed that between May and July 2023, there were 155 medical outliers across the service.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they knew how to make a complaint or who to speak to if they had a concern.

The service did not clearly display information about how to raise a concern in patient areas. There was no information displayed on how to make a complaint on the wards we visited, however, there was information available on the trust website for anyone who wished to make a complaint, including where people could go to obtain independent advice and support from local organisations.

Medical care (including older people's care)

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with understood the role of the patient advice and liaison team and how to refer patients or visitors to them.

Managers investigated complaints and identified themes. The service had received 63 complaints in the six months prior to inspection. We asked for themes and trends of these complaints but did not receive this.

At the time of the inspection there were 20 complaints open and in progress and there were seven complaints that had been referred to the Parliamentary Health Service Ombudsman for consideration. The trust confirmed that in the previous 12 months (1 Aug 2022 – July 31 2023), no complaints that were referred to the PHSO were considered for investigation or upheld.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Hospital services at the trust were grouped into eight clinician-led divisions. The divisions were separated into 2 areas: Unscheduled Care and Planned Care, each led by a Managing Director. Every division is led by a Chief of Service, Divisional Director of Operations and Divisional Director of Nursing. For the purpose of this report, the medical core service we inspected covered more than one of the trust divisions, including medicine and the clinical support service under unscheduled care, and cancer and specialist under planned care.

Not all staff felt that the executive team were visible or approachable. There was variability amongst staff opinions of how visible the executive team were. Some staff expressed disappointment that they had never seen senior management in their department and we heard this in several ward areas across the site.

Some staff felt they would not be able to recognise executive team leaders if they were to come onto their ward or department.

Leaders at a local level had the skills and ability to run the service. Staff we spoke with felt that local level leadership was good and they felt did their best for the service. We heard examples of how teams and leaders had come together to work through challenging times and incidents. Other staff we spoke with said they had felt supported and recognised by the senior leadership team.

There were opportunities for some staff to develop their skills. The trust told us about the development of band 3 healthcare assistants and the opportunities offered to train for a registered nurse post. We also heard examples of student nurses that trained with the trust being offered guaranteed posts to encourage staff to stay within the trust.

Medical care (including older people's care)

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

The service did not have a vision or strategy. We spoke to the senior leadership team who told us that whilst there was not a vision or strategy for the medical directorate, and that they were part of the wider clinical strategy. The clinical strategy had been newly released and the trust told us that the divisional leaders were due to meet in December to discuss how the medicine team would meet the trust objectives.

The trust had a set of values that included compassion, communication, teamwork, respect, professionalism and inclusion.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff at a local level felt respected, supported and valued. They were focused on the needs of the patients receiving care. We spoke to staff who felt well supported at a local level and felt confident to raise concerns with local managers. All staff we spoke with told us that the patient was at the centre of their care and they worked in often challenging circumstances to ensure patient safety and wellbeing. However we did hear examples of staff who felt they were not recognised for the work they did, and staff that had never had a thankyou or been told they were doing a good job.

The service promoted equality and diversity in their work. The trust had started to incorporate pronouns onto staff name badges to help staff and patients understand a persons gender and identity.

The culture of the service was mixed. A lot of staff we spoke with felt that the culture at a local or ward level was good, and that they felt confident to speak up locally. Examples given included supportive consultants to specialist registrars who felt cared for in their training and wellbeing. Consultants we spoke with talked of 'nurturing talent' and retaining trainee staff members. However outside of departments and ward levels, not all staff could describe how they would escalate concerns or use the speak up process.

A newly appointed freedom to speak up guardian had recently been appointed and was external to the trust. We saw a freedom to speak up guardian information poster on the back of a staff toilet door. However not all staff we spoke with knew about the speak up guardian and one member of staff who did know told us they "wouldn't dream of using the freedom to speak up guardian" for fear of it not being a safe process.

Some staff told us they felt there were "two tiers" and that "upper management don't listen to 'worker bees'". Staff gave examples of where major incidents had occurred, such as an IT outage, and no senior management attended to support.

Some staff felt that the culture had not improved since the appointment of new senior team members and feel that issues are "still brushed under the carpet". A member of staff gave an example where they had raised a concern in a meeting but was later told by colleagues to re-consider speaking up as it could be detrimental to their work.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Medical care (including older people's care)

The trust and division had effective governance processes in place. Staff at all levels were clear about their roles and accountabilities. We spoke to staff at all levels who were able to tell us about how they were involved in hospital governance, whether this was through incident reporting and feedback or attending safety and improvement huddles.

Governance processes fed from ward to board level. Outcomes and actions from divisional meetings were fed into relevant committees, which were fed into the trust board. The trust had aligned its governance processes to the patient first methodology embedded throughout the trust and we saw that issues concerns and achievements were discussed as part of the trust integrated performance report (IPR). The IPR broke various metrics down into the relevant patient first methodology domains,for example the metric '90% or more patients rating the service using FFT as good or very good' was a target under the 'patient' domain.

The division had driver and watch metrics in line with the patient first methodology that were monitored as part of a divisional performance dashboard. For example, reducing numbers of incidents taking more than 20 days to sign off and increasing the number of staff who had an up to date appraisal were driver metrics which were monitored on the performance dashboard.

We reviewed data from governance meetings and saw that the meetings followed a set agenda including patient safety, clinical outcomes and effectiveness, patient experience and engagement and risk management.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff identified and escalated relevant risks and identified actions to reduce their impact. There was a corporate and divisional level risk register. We reviewed the medicine risk register which incorporated all medicine division risks for the Royal Sussex County and the Princess Royal Hospital sites. All risks had a current and target risk rating, along with details of current controls in place. The highest level risk affecting the medicine division was the lack of mental health beds in the wider system, which affected the length of time patients with acute mental health needs stayed in the hospital, being supported by staff on the medical wards. There was acknowledgment within this risk description of the impact this would have on staff wellbeing and the lack of training in order to deal with this cohort of patients. Controls included early escalation to the mental health liaison team, however we saw examples where staff who had not been trained in looking after mental health patients were left to provide one to one care during our inspection.

On the risk register extract we saw, we could not see risk review dates, or a named owner of the risk. This meant that the trust may not have oversight of the risks and when they need reviewing or updating.

There were gaps in patient assessment and care delivery checking systems such as a lack of auditing call bell wait times and high risk pathways, a lack of documentation audits and a lack of a system to ensure patients who needed support with eating were managed well. This meant that the service may not have oversight of whether compliance in these areas was maintained.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust's website provided quality performance reports and annual reports.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had engaged a programme of personal services and activities, ranging from hairdressing to music to help patients keep a sense of dignity, social activity and wellbeing in the hospital. The programme was called Small Acts of Friendship and we saw several of these activities whilst on our inspection such as a quiz. Patients we spoke with told us about how important some of these activities had been to them, such as having someone come to a patient's bedside to read to them.

There was an active group of volunteers across the departments, some of these had been previous patients who told us they wanted to support patients going through similar treatments.

In the new LMB, there was a space called 'The Sanctuary' which was a space for patients, visitors or staff to use for quiet reflection. It was peaceful and looked out to the sea.

We spoke to staff on the elderly care wards who told us about team building days organised by the departments matron. The team building days included educational sessions, inspirational talks and team building games.

Some of the wards ran raffles during the year where staff and patients could purchase tickets to win a hamper. Funds from the tickets sold were then put towards something to improve the experience on the ward, such as televisions for patients.

The trust website had a vast amount of information for patients, staff and visitors. We saw that there was a section on 'patient stories' where patients could share their experience and help others that may be going through a similar journey.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had a well-established improvement system that was used throughout the organisation. Patient First is the trust's long-term approach to transforming hospital services for the better. It is a process of continuous improvement by asking frontline staff to identify opportunities for positive, sustainable change and giving the support to make change happen. All the staff we spoke with could tell us about the improvement boards and huddles, and how they used it in day to day practice to make improvements. In the new building, we saw that staff were using it to resolve teething problems on the new wards to help with the transitional period.

Medical care (including older people's care)

The Louisa Martindale building (LMB) was newly opened in June 2023 as part of the trust's Teaching, Trauma and Tertiary Care (3Ts) development project to support patients across all of Sussex. The LMB provided an additional 100 inpatient beds and we visited several of the newly opened wards. Staff told us that they were very happy to be moving to the new building and what an improvement it was on the previous areas.

The hospital had recently switched to fabric linen bags rather than plastic in an attempt to reduce their carbon footprint. Staff told us that there were not currently enough of these and so some had reverted to using plastic bags but we were told that more had been ordered. The trust had also signed up to be a partner with 'Care without Carbon' which was a programme focussed on integrating sustainability into day to day decision making in the NHS.

Staff told us about a course they had recently taken, called the Green Space for Health programme which was helping to improve the quality and use of green spaces in the NHS for patients, staff and the wider community. Staff were excited to use the new healing garden that was part of the Louisa Martindale site but we were told at the time of the inspection that they did not yet have access to this.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it not complying with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure appropriate training, in line with guidance, is in place and completed by staff to support patients with learning disabilities, dementia and autism. Regulation 12.
- The trust must ensure equipment in ward environments is moved or stored in a suitable location and avoids emergency exits being blocked. Regulation 12.
- The trust must ensure the nutritional and hydration needs of patients are met. This includes establishing an effective system for patients to be supported by staff at mealtimes in order to maintain adequate nutrition and hydration. This also includes ensuring nutritional and hydration intake of patients is monitored and recorded consistently. Regulation 14.
- The trust must ensure hazardous waste such as sharps materials are managed and disposed safely in line with current legislation and guidance. Regulation 15.
- The trust must ensure improvements are made to governance systems and processes by conducting regular audits to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. This includes auditing of the accuracy and quality of patient records, pathways and assessments. Regulation 17.
- The trust must ensure that patient record documents and systems are reviewed to ensure staff have access to patient information that is accessible, accurate and up to date across all electronic or paper-based records. Regulation 17.
- The trust must ensure that workforce data for the trust can be separated to show individual site performance. Regulation 17.
- The trust must ensure they have an out of hours discharge policy to reduce risks relating patients when discharged out of hours. Regulation 17.

Medical care (including older people's care)

- The trust must ensure that persons employed must receive appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform in relation to caring for patients with mental health illness, and dementia. Regulation 18.

Action the trust SHOULD take to improve:

- The trust should ensure they monitor call bell wait times to ensure patients are not left for long periods of time when needing support from staff.
- The trust should ensure they monitor staff compliance with high-risk pathways such as sepsis.
- The trust should consider providing chaperone training to unregistered members of staff and ensure that this is included on induction.
- The trust should work towards reducing the number of times a patient is moved during their hospital stay.

Our inspection team

The team that inspected the hospital included 4 CQC inspectors, 1 CQC operational manager, a CQC national professional advisor for surgery, 5 specialist advisors who between them had expertise in medical and surgical services and 1 expert by experience. The inspection was overseen by a CQC Deputy Director.

During the inspection we visited medical and surgical wards, the discharge lounge, 2 theatres including general and neurosurgery and recovery areas. We spoke with a range of patients, visitors and staff and conducted interviews with service managers and leaders remotely.

We observed ward handovers, daily staffing meetings, safety huddles and the day to day running of the services. We reviewed patient records, drug charts and care plans. We also reviewed information received before the inspection from patients and staff. We reviewed several documents before, during and after the inspection. These included meeting minutes, policies, guidance, staff rotas, training figures, feedback from staff and patients, complaints and investigations.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.