Western Sussex Hospitals NHS Foundation Trust

Worthing Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection visit from 9 to 11 December 2015. We held focus groups with a range of hospital staff including; nurses of all grades, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and volunteers. We also spoke with staff individually.

We talked with patients and staff from all ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members and reviewed patient records of personal care and treatment.

We carried out an unannounced inspection on 21 December 2015 at Worthing Hospital.

Overall we found that Western Sussex Hospitals Foundation NHS Trust was providing outstanding care and treatment from Worthing Hospital. We saw many examples of very good practice across all areas of the hospital. Where we identified shortcomings, the trust was aware of them and was already addressing the issues. The trust is one of the 16 members of NHS Quest, a member-convened network for Foundation Trusts who wish to focus on improving quality and safety within their organisations and across the wider NHS. NHS Quest members work together, share challenges and design innovative solutions to provide the best care possible for patients. The trust was also a winner of a Dr Foster Better Safer Care at Weekends award.

Our key findings were –

- The executive team provided an exemplar of good team working and leadership. They had a real grasp of how their hospital was performing and knew their strengths and areas for improvement. They were able to motivate and enthuse the overwhelming majority of staff to 'buy in' to their vision and strategy for service development. Middle managers adopted the senior manager's example in creating a culture of respect and enthusiasm for continuous improvement.
- Innovation was encouraged and supported. We saw examples that when raised directly with the Chief Executive and her team, had been allowed to flourish and spread across the services.
- We saw respectful and warm relationships internally amongst staff teams, the wider hospital team and outwards to external stakeholders and the local community.
- Across the hospital there was an embedded culture of learning from incidents. Staff were encouraged to have an open and honest attitude towards reporting mistakes and incidents that were then thoroughly investigated. There was strong evidence of learning from incidents both locally and across the organisation.
- The hospital was performing better, and sometimes much better than comparable trusts across England on many measures. Where this was not the case, the trust had clear action plans and investigations on-going to bring about improvements.
- An example of this was the 4 hour Emergency Department target, where new and innovative approaches coupled with strong monitoring systems had resulted in the trust meeting the target over 95% of the time. They were amongst only a handful of trusts to meet the quarter four target.
- In 2014/15 the trust improved their infection control ratings for the sixth successive year.
- There was good management of deteriorating patients and systems in place to allow early identification and additional support when a patient's condition became unexpectedly worse.

Summary of findings

- Monitoring by the Care Quality Commission had not identified any areas where medical care would be considered a statistical outlier when compared with other hospitals. The trust reported data for mortality indicators, the summary hospital-level mortality indicator (SHMI) and hospital standardised mortality ratio (HSMR). These indicate if more patients were dying than would be expected given the characteristics of the patients treated there. The figures for the trust were as expected and the figures for HSMR places the trust in the top 20% of hospitals.
- Information regarding patient outcomes was monitored. The trust participated in all national audits it was eligible for. Where improvements were identified, the trust was responding and was making progress implementing its action plans in order to improve the quality of care they were providing.
- Across all disciplines and in all core services we found a good knowledge and understanding of the policies and guidance relating to safeguarding vulnerable adults and children. Trust staff were involved in local initiatives, working with other key agencies to improve outcomes for babies and children from challenging or vulnerable families.
- Staff of all grades and from all disciplines at Worthing Hospital contacted us to tell us about their belief that Worthing Hospital was a very good hospital. They talked with great pride about the services they provided and all agreed they would be happy for their family members to be treated there. They talked of their commitment to making sure they did their very best to provide optimal care for patients. They talked about initiatives to improve patient care they had been involved in.
- Medical, nursing and midwifery staffing levels were safe and allowed staff to provide good care. Staffing acuity tools were in routine use and staffing was reviewed frequently – in some areas such as ED this was done four hourly. However, there were areas where the trust did not meet the recommendations of professional bodies such as the royal colleges. This included medical staffing in the critical care unit and the number of Supervisor of Midwives. In both these cases the trust was already taking action.
- An overwhelming majority of consultants from Worthing Hospital contacted us and were very positive about how the trust provided service from this site. The majority of consultants employed at Worthing responded to our invitation to submit written comments or to meet with us. They told us the executive team and medical director in particular were supportive, encouraging of new ideas and approachable. They told us about the work that had been done to improve the mortality figures overall and in specific areas. This included the changes to the pathways for patients who suffered a fractured neck of femur where changes to the care and treatment of this condition had reduced the number of elderly patients who died as a result of this.
- One small group of consultants from one speciality were less favourable about their engagement with the trust. They were led by a doctor who did not work at the trust and who had spread their allegations widely outside the organisation, without using the trust incident reporting and governance structures. We interviewed the protagonist prior to the inspection and also spent a whole day interviewing consultants regarding potential bullying and harassment. We found no indication of corporate bullying – in fact quite the opposite. Consultants told us the executive team were open and approachable and they felt valued and listened to. The main issues of concern appeared to stem from two things – the appointment of an external rather than a favoured internal candidate and some issues of standardising practice across the two sites.
- The trust has had an external review of the service where concerns had been raised. The report of the review gave no indication that patient safety issues were hidden or ignored. Patient safety had a very high focus amongst trust staff and outcomes were generally very favourable compared to other trusts.
- Volunteers from across the hospital were also keen to tell us about how much they enjoyed working at the hospital. They told us they were supported and accepted as a part of the hospital team. Those working in clinical areas described a sense of belonging and felt their work helping people to eat and drink or occupying elderly patients was valued.

Summary of findings

- We received an unprecedented number of letters and emails from people who used the service prior to, during and after the inspection visit. The overwhelming majority of these were very positive and told stories of staff going above and beyond the expected level of care. Staff we spoke with were exceptionally compassionate when talking about patients and we observed kindness not only towards patients but towards each other whilst on site.
- The results of the Friends and Family Test supported the view of the many patients who contacted us. In most areas the hospital consistently scored above the national average.
- The commitment of staff to providing good care coupled with good strategic and operational planning led to a service that was responsive to the needs of individuals. We saw flexibility and a willingness to make local changes to improve how people were cared for. There were numerous initiatives that improved patient experiences and allowed them equal access to care. These included Learning Disability nurses visiting the ED, interagency joint working in the hospital and community and the 'Harvey's Gang' project.
- The trust has introduced a ward accreditation scheme that was being rolled out to all wards. This scheme focussed on promotion of the trust Vision and Values through monthly monitoring of key metrics.

Outstanding practice

We saw much that impressed us but of particular note was –

The level of 'buy in' from all staff to the trust vision and value base was exceptional. We were flooded with requests from staff wanting to tell us about specific pieces of work they were doing, how much they liked working for the trust and how supportive the trust executive team were of innovative ideas and further learning as a tool for improvements in patient care. The trust ambassadors worked to promote the positive work that the trust was doing to other staff and visitors. Specific areas and staff groups of particular note included the whole neonatal team and children's services team, the emergency floor team, the Specialist Palliative Care Team, the volunteers across the hospital and the cleaning team.

Multidisciplinary working was a very strong feature across the hospital that resulted in better patient care and outcomes. There was clear professional respect between all levels and disciplines of staff. We saw real warmth amongst teams and an open and trusting culture. Exceptional examples of this included how 'Harvey's Gang' was growing and developing as more staff became involved a local initiatives such as the joint working 'Five to Thrive' protect and Family Nurse Partnership which improved outcomes for the children of young and vulnerable parents.

The trust had won a Dr Foster Better, Safer Care at Weekends award.

The level of feedback from patients and their families was exceptional. We received many letters and emails before, during and after the inspection visit. It was overwhelmingly and almost exclusively positive. Amongst the hundreds of people who contacted us to say how good the hospital was, there were just a few who felt unhappy with the care they had received.

The staff knowledge of safeguarding vulnerable adults and children and how they should proceed if concerns arose was a significant strength. There was very good joint and interagency working. The transfer of responsibility for the management of 'at risk' babies from maternity (during the antenatal period) to paediatrics (following delivery) was seamless.

The culture of safety and learning from incidents and complaints was well embedded. All staff felt responsibility for reporting mistakes and incidents and there was good dissemination of learning following investigation or review.

Worthing Hospital was the first hospital in the country to provide visitors with the opportunity to use a hand scanner that detected abnormal heart rhythms and offer immediate clinical assessment. The 'Scan Station' in outpatients gave

Summary of findings

directions of how to get to the cardiac department when an abnormality was detected where the result was discussed and an ECG performed to exclude or identify Atrial Fibrillation, if necessary. Staff told us the idea of widening the self-testing was being considered with potential for early identification and management advice for conditions such as hypertension.

Worthing Hospital had won three catering awards. These included an 'Eat Out Well Award' (Gold) issued by West Sussex Environmental Health Service. The 'Eat Out Eat Well Award' had been developed to reward caterers who make it easier for their customers to make healthy choices when eating out. A 'Food for Thought Award' was won by both the main kitchen (Silver) and the Education Centre (Gold).

The trust wide work on the care of people living with dementia was notable. The trust maintained a dashboard that was used as a tool for monitoring the implementation of the dementia strategy. Direct feedback from relatives and observation showed people with dementia received very good care. A hospital administration manager talked to us about the initiative to get staff/visitors and other people to make and donate 'Twiddle muffs' to occupy and calm patients with dementia. The really outstanding part of this was not the activities but the 'whole hospital' approach that involved non-clinical staff, volunteers, executive team members as well as clinical staff from all settings including the operating theatres and outpatients department.

The introduction of a ward accreditation scheme based on values, the trust vision and a safety focus was beginning to demonstrate how the monitoring of key performance indicators at local level and comparing these to similar wards could be used as an effective tool for improving the quality of services.

The hospital was involved in the trust wide NHS Quest initiative which focused on improving quality and safety. This involved the trust taking part in collaborative improvement projects for sepsis and cardiac arrest. Work was in progress on these initiatives at the time of our inspection.

The local leadership of services was very good. Staff told us they were approachable and open and they valued staff input. We saw particularly good examples in the ED where the hospital had continued to meet the four hour target despite a threefold increase in demand. Local leaders had worked with staff in the department and across the hospital to ensure flow through the department was maintained.

The chaplains were repeatedly mentioned as 'going the extra mile'. Staff and patients told us about the level of kindness and support shown by the team.

The improvements in the stroke service had resulted in significant and demonstrable improved outcomes for patients. In the preceding two years the SSNAP rating had moved up from a 'D' to a 'B'. This was particularly impressive given the scores were benchmarked nationally and were not adjusted to take account of the high admission rate from a population of greater age and complexity than the national average.

Welcome home packs were a really nice idea. The hospital worked with local supermarkets to provide frail and isolated patients with hampers that meant they did not have to worry about food for the first 24 hours. Packs included basics such as milk, bread, fruit and cheese.

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

The most notable issue was the referral to treatment times where the trust was not meeting the 18 week target in some specialities.

The trust should continue develop strategies to recruit and retain sufficient medical and nursing staff to meet the needs of the service.

The trust should ensure all staff have completed mandatory training and they receive an annual appraisal to ensure their continuous professional development needs are met.

Summary of findings

The trust should ensure all staff are aware of the duty of candour requirements.

Senior staff should establish active processes for compliance with the European Waste Frame Directive (2008/98/EC) and the HSE Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 with regards to the storage and disposal of sharps bins and chemical storage on the critical care unit.

Senior staff must establish active processes to ensure compliance with the trust medicines policy in relation to stock rotation and the disposal of expired products.

The trust should consider ways of ensuring they meet the RTT admitted pathway targets.

The trust should review the discharge arrangements from the critical care unit to ensure patients are cared for in an appropriate environment.

The trust must ensure they have sufficient Supervisor of Midwives.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Outstanding ☆	Overall, we rated the emergency department as 'Outstanding'. It wasn't perfect but the staff and trust executive knew where any shortfalls and risks were and were constantly reviewing the provision to ensure it was meeting the needs of the people using the service. Departmental leaders and staff had implemented systems to maintain flow and escalate problems as soon as there were indications of delays in patient flow. The trust had programmes of work to improve patient flow through the hospital. The hospital met the national target of seeing, treating, admitting or discharging 95% of patients within four hours, ending the year in the top 20 trusts in the country. We saw examples of a service that responded in an extremely compassionate way to meet the needs of a patient whose spouse had died the previous day in the same department. The service was very busy but the patient and their relatives were made to feel as though staff had all the time in the world to support and care for them. Patients were asked about their wishes and were supported to make decisions about their care and treatment. We saw staff consistently offered care that was kind, respectful and considerate whilst promoting their privacy and dignity at all times. Staff supported patients promptly in managing pain and anxiety and we observed staff discussing treatment and pain management with patients in ways they could understand. The ED had a strongly embedded culture of learning from incidents. There were clear and effective processes for incident reporting, investigation and learning from incidents. Staff we spoke with knew how to escalate concerns in relation to patient safety and safeguarding. They were aware of Duty of Candour and could describe how they met this requirement. The leaders of the service were well respected by the staff. Staff of all grades and disciplines talked positively about working in the department and for the trust.

Summary of findings

Medical care (including older people's care)

Outstanding ☆

Patients at risk of deteriorating were monitored and systems were in place to ensure a doctor or specialist nurse was called to provide additional support. The trust had an open culture and was prepared to learn from clinical incidents.

Across the Medicines Division there were enough medical and nursing staff to keep patients safe. However, on the day of our inspection, the number of chemotherapy qualified staff on the Medical Day Care Unit was less than the established amount. The trust found it difficult to recruit new nursing staff; but was able to effectively fill gaps across the division using bank and agency staff.

Staff across the Medicines Division reported problems with the trust's electronic prescribing system when prescribing and transcribing. Actions to mitigate the risks posed by e-prescribing were not recorded on the divisions risk register.

The environment at the Medical Day Care unit had led to a four week wait for patients requiring chemotherapy.

Attendance at mandatory training, as well as staff receiving an annual appraisal was below the 90% trust target. We found care was provided in line with national and local best practice guidelines. Clinical audit was undertaken and there was good participation in national and local audit that demonstrated good outcomes for patients. We observed good clinical practice by clinicians during our inspection. Patient morbidity and mortality outcomes were broadly within what would be expected for a hospital of this size and complexity and no mortality outliers had been identified. There was a good knowledge of the issues around capacity and consent among staff. We found two deprivation of liberty safeguard (DoLS) assessment applications did not contain capacity assessments.

Patients received compassionate care and were treated with dignity and respect. Most patients and relatives we spoke with said they felt involved in their care and were complimentary about staff. One person told us: "The staff have been very nice and have always responded when I have called them."

The Medicines division had good results in patient surveys with results indicating an improvement in the views of patients over the last 12 months.

Summary of findings

The Medicines Division were effective at responding to the needs of the community. The trust's performance management team understood the status of the hospital at any given time. Bed availability was well managed. Elderly care pathways had been well designed to ensure that elderly patients were assessed and supported with all their medical and social needs. Patients living with dementia were accommodated on two specific department of elderly medicine (DOME) wards. The AMU provided effective alternate pathways for GP's and other referrers.
Medical services were well led; divisional senior managers had a clear understanding of key risks and issues in their area. The medical areas had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day to day basis. The hospital had a risk register which covered most key risks. Staff spoke positively about the high quality care and services they provided for patients. They described the hospital as a good place to work and as having an open culture. The most consistent comment we received was that the hospital was a "nice" place to work and staff enjoyed working in their teams.

Surgery

Good

Overall we found that surgical services at Worthing Hospital were 'Good'. This was because;
Patients were protected from avoidable harm because there were robust systems to report, monitor, investigate and take action on any incident that occurred. There were effective governance arrangements to facilitate monitoring, evaluation and reporting and learning. Risks were identified and acknowledged and action plans were put into place to address them.
We saw patients' care needs were assessed, planned and delivered in a way that protected their rights and maintained their safety. Surgical care was evidence based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The trust was able to

Summary of findings

demonstrate it continuously met the majority of national quality indicators. Patient surgical outcomes were monitored and reviewed through formal national and local audits.

There was clear leadership and staff knew their reporting responsibilities and took ownership of their areas of influence. All staff spoke with passion and pride about working at Worthing Hospital and spoke enthusiastically about their role and responsibilities. We found staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable patients.

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

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

The trust did not meet the referral to treatment (RTT) times for a number of surgical specialties. The ophthalmology, musculo-skeletal and ENT specialties were of particular concern at the current time.

We found there were some environmental challenges where lack of facilities such as adequate storage presented a potential risk to patients and impacted on their care and treatment.

Staff were not monitoring ambient room temperatures in rooms where drugs were stored. There is a risk that certain medicines become less effective if stored at incorrect temperatures.

The availability of junior doctors out of hours was raised as a concern as inexperienced medical staff were often working unsupported.

There was a lack of surgical beds with the admissions ward, day care ward and theatre recovery frequently used to accommodate overnight stays because of bed shortages. This affected patients being admitted for surgery. Patients were sometimes recovered from

anaesthesia in the operating theatre because the recovery bays were full of patients waiting to be discharged home or to a ward. Surgery was sometimes cancelled because there were often no beds for them to be admitted to.

Critical care

Requires improvement

Overall we rated the CCU at Worthing Hospital as 'Good'.

This rating reflects the areas of good practice we found through our review of staff training, patient notes and patient outcomes as well as other performance indicators such as rates of unplanned readmissions and strategies to reduce discharge delays. Leadership in the unit was coherent, robust and well respected by the staff we spoke with.

We saw examples of innovation in improving patient safety and good practice, particularly in relation to the successful pilot of a new electronic patient records system that combined patient tracking software with observation charts and electronic prescribing. Significant challenges relating to infection control and capacity were clearly understood by the matron and lead consultant, who had undertaken scoping exercises to address them, such as a business plan to upgrade the enhanced surgical care unit to a level two care facility for HDU patients.

Staff practised in line with the clinical guidance of national organisations such as the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians (RCP) and the Intensive Care Society (ICS). Such guidance was embedded into the work culture and used to evaluate and improve practice, through the sharing of learning and use of audits to update policies and procedures. Staff contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC).

The CCU team had access to multidisciplinary specialists who routinely contributed to decision-making and ward rounds in the best interests of patients. An established critical care outreach team (CCOT) supported patients across the hospital seven days a week.

The CCU was well maintained however, there was room for improvement in infection control practices, particularly relating to the correct use of

aseptic non touch practices and more vigilant removal of dirty consumables. The unit was also not compliant with Health and Safety Executive or European Commission regulations relating to the safe storage and disposal of hazardous waste and equipment. We found some areas of non-compliance with the trust's medicine management policy, particularly relating to stock rotation and the disposal of expired medicines.
A robust incident reporting system was in place that staff used confidently to investigate incidents and errors. There was evidence that learning from investigations had taken place with an effective system in place to ensure all staff were aware of updates to practice. Overall this contributed to an environment in which safety was prioritised and patients received individualised care from staff who had a good understanding of their personal needs. Relatives spoke highly of the care they had encountered and said they had found the senior nursing team to be responsive when they had been concerned about something.
The unit met the standards benchmarked by the ICS, the Royal College of Nursing (RCN) and the Faculty of Intensive Care Medicine (FICM) in relation to staffing levels. There was a consultant intensivist on-call 24-hours a day, seven days a week and patients were always seen by a consultant within 12 hours of admission. Nurse to patient ratios of 1:2 or 1:1 were consistently met and ICS core standards guidance that a supernumerary senior nurse coordinator be present 24-hours, seven-days, was always complied with.

Maternity and gynaecology

Outstanding 

Overall we rated maternity and gynaecology services as 'Outstanding'.
This was because of the excellent work being done to engage with women and their partners through innovative and award winning use of social media and other routes. The trust was actively working to engage with harder to reach groups and had adapted services to the needs of a changing local community.

Summary of findings

Multi-disciplinary work internally at the trust and with external partners had resulted in improved outcomes for woman and babies, particularly the most vulnerable or those in challenging circumstances.
The service provided effective care in accordance with recommended practices. Outcomes for women in the service were continuously monitored and incidents and complaints were used as opportunities for learning and for the improvement of services.
The service at one of the main sites was sometimes unable to cope with the demand and this resulted in the closure and women were diverted to the other site. This also resulted in some delay for women waiting for the induction of their labour and for elective caesarean sections.
Compliance with training was good and staff were offered additional opportunities for learning and development. The care was compassionate and supportive and women and their families were treated with respect and dignity.

Services for children and young people

Outstanding 

The children and young people's service was rated 'Outstanding' because it had a strong, open culture of safety developed through the reporting and learning from incidents and complaints. Strong governance and an effective assurance framework resulted in a cycle of monitoring and improvement.
The children and young people who used the serviced experienced good care that resulted in outcomes generally above national benchmarks. Where there was underperformance, it was recognised and addressed through robust action.
Staff knew how the service was performing in specific areas and were motivated to make improvements.
Innovation and ownership of the service was strongly encouraged. There was a culture of joint working and learning from others. This worked across the trust with examples such as 'Harvey's Gang' (which the trust is justifiably proud of) and with other local providers and children's agencies. The result of this was children and families had a seamless journey through separate services, both internally and externally.

Summary of findings

Outcomes for very young children living in challenging circumstances benefited from this joint working. Most importantly staff and leaders of the service were self-aware, knew the limits of care they could provide safely, understood areas they needed to improve on and were working on these. They were very proud of their work and felt sufficiently comfortable in their position to share their pride widely and loudly to build on their strengths.

End of life care

Outstanding ☆

Staff provided an end-of-life care service that was outstanding. The specialist palliative care team, mortuary and chaplaincy team worked effectively and cohesively to provide a seamless service. Most audits performed by Worthing Hospital scored above England averages, which underpinned the rating given for this service.
The management structure, staff involvement and culture of the service were good. Patient and staff feedback was consistently positive throughout the inspection. There was a positive vision for the future sustainability of the service.

Outpatients and diagnostic imaging

Good

Overall we found outpatients and diagnostic imaging to be 'Good'.
Staff contributed positively towards patient care and were proud of the services they provided. They treated patients with kindness, dignity and respect. Medical record management enabled clinicians in outpatients to have access to patients' records more than 99% of the time. The outpatient and radiology departments followed best practise guidelines and there were regular audits undertaken to maintain quality.
All areas we visited were clean, tidy and uncluttered. Infection control practises were generally within guidelines, however some cleaning checklists were incomplete.
Staff felt managers were approachable and kept them informed of developments within the trust. However, the trust had consistently not met government targets in relation to referral to treatment times since 2013 for adults and from March 2015 for children's services.

Worthing Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Worthing Hospital

Western Sussex Hospitals NHS Foundation Trust became a foundation trust on 1 July 2013, just over four years after the organisation was created by a merger of the Royal West Sussex and Worthing and Southlands Hospitals NHS trusts. Worthing Hospital is one of three hospitals provided by the trust.

The hospitals provide 953 inpatient beds which include 77 maternity beds and 32 critical care beds. The trust employs over 5,600 staff (Whole Time Equivalent at end of August 2015). In the year 2013-14, there were more than 127,000 inpatient admissions and 533,000 outpatient attendances; over 135,000 patients attended the accident and emergency department.

The trust has an annual income of around £403 million. The trust has made a surplus every year up to 2014/15 since it was merged in 2009 and has paid back £21M of legacy debt.

Worthing Hospital provides a full range of general acute hospital services including A&E, maternity, outpatients, day surgery and intensive care. It is also home to the West Sussex Breast Screening service.

We inspected this trust as part of our comprehensive hospital inspection programme. Our inspection was carried out in two parts: the announced visit, which took place on the 9, 10, 11 December 2015 and the unannounced visit which took place on 21 December 2015.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop,

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The team of 63 included CQC inspection managers, inspectors and a variety of specialists; medical consultants, surgical consultants, a consultant obstetrician, a consultant paediatrician, and emergency medicine consultant, consultant midwives, junior doctors, board-level nurses, modern matrons, clinical nurse specialists in emergency medicine, critical care, oncology and sexual health, a student nurse, a physiotherapist, a radiographer, an occupational therapist, a pharmacist, a dietician and an expert by experience.

Detailed findings

How we carried out this inspection

To get to the heart of the patient care experience, we always ask the following five questions of every service and provider:

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

Before visiting we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the Clinical Commissioning Group, Monitor, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch. We held two public listening events (one in Chichester and one in Worthing). We also wrote to consultants working at the trust and offered consultants the opportunity to meet with us.

Facts and data about Worthing Hospital

The trust serves a population of around 450,00 across a catchment area covering most of West Sussex.

The three hospitals are situated in the local authorities of Worthing, Chichester and Adur. These areas have a higher proportion of over 65's (between 21.8% and 25.8%) compared to the England average (17.3%).

The three local authorities have a lower proportion of ethnic minority populations compared to the England average with 93.7% and 96.7% of the population being white, compared to an England average of 85.3%

Deprivation:

Adur and Worthing fall within the third quintile on the index of multiple deprivation, signifying that they are in the middle 20% in England for deprivation. Chichester lies in the second quintile, meaning it is in the top 40% of least deprived areas in the country.

The excess winter deaths in the Adur district is amongst England's worst performing districts.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Medical care	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Surgery	Good	Good	☆ Outstanding	Requires improvement	Good	Good
Critical care	Requires improvement	Good	☆ Outstanding	Requires improvement	Good	Requires improvement
Maternity and gynaecology	☆ Outstanding	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Services for children and young people	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
End of life care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good
Overall	Good	☆ Outstanding	☆ Outstanding	Requires improvement	☆ Outstanding	☆ Outstanding

Urgent and emergency services

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

Information about the service

The urgent and emergency services at Worthing Hospital comprises of the Emergency Department, the Clinical Decisions Unit (CDU) and Paediatric Emergency Department.

Worthing had 104,815 attendances between April 2015 and August 2015 to their emergency department, 20,641 attendees were aged under 17 years, and 84,174 were over 17 years of age. During 2014/15, attendances at the emergency departments at the trust increased by almost 1,000 cases on the previous year. The Trust Annual Report 2014/15 states it admitted a greater proportion of elderly patients with greater acuity, requiring longer stays in hospital, a trend that continued from the previous year. The hospital met the national target of seeing, treating, admitting or discharging 95% of patients within four hours, ending the year in the top 20 trusts in the country.

The emergency department provides a consultant-led emergency care and treatment service. It is divided into different areas, providing care for patients with minor injuries to major trauma. The emergency department has an integrated system of working with GP's. The GP service was streamed into two areas, a 'One Call' system offering primary care and the Minor Injury Assessment & Minor Illness (MIAMI) initiative.

The major area of the department has 11 beds and two cubicles where patients can be isolated for the treatment and support of patients with possible infectious diseases. There is an isolation room on entry to the emergency department. The clinical decisions unit has nine beds close to the main emergency department providing segregated accommodation for both sexes. The minor injury area has six consultation areas equipped to manage patients with minor injuries.

We used a variety of methods to help gather evidence in order to assess and judge the urgent and emergency services at Worthing Hospital. We spoke with 25 staff, nine adult patients and relatives. We examined 25 patient records, 15 of which related to children.

We interviewed the Chief of Medicine and Consultants and we spoke with professionally qualified and support staff. We observed the environment and care of patients and we looked at patient care records. We also looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments, and audit results.

Urgent and emergency services

Summary of findings

Overall, we rated the emergency department as 'Outstanding'. It wasn't perfect but the staff and trust executive knew where any shortfalls and risks were and were constantly reviewing the provision to ensure it was meeting the needs of the people using the service.

Departmental leaders and staff had implemented systems to maintain flow and escalate problems as soon as there were indications of delays in patient flow. The trust had programmes of work to improve patient flow through the hospital. The hospital met the national target of seeing, treating, admitting or discharging 95% of patients within four hours, ending the year in the top 20 trusts in the country.

We saw examples of a service that responded in an extremely compassionate way to meet the needs of a patient whose spouse had died the previous day in the same department. The service was very busy but the patient and their relatives were made to feel as though staff had all the time in the world to support and care for them.

Patients were asked about their wishes and were supported to make decisions about their care and treatment. We saw staff consistently offered care that was kind, respectful and considerate whilst promoting privacy and dignity at all times. Staff supported patients promptly in managing pain and anxiety and we observed staff discussing treatment and pain management with patients in ways they could understand.

The ED had a strongly embedded culture of learning from incidents. There were clear and effective processes for incident reporting, investigation and learning from incidents. Staff we spoke with knew how to escalate concerns in relation to patient safety and safeguarding. They were aware of Duty of Candour and could describe how they met this requirement.

The leaders of the service were well respected by staff. Staff of all grades and disciplines talked positively about working in the department and for the trust.

Are urgent and emergency services safe?

Good

We rated safety at Worthing Hospital emergency department as 'Good'. This was because there were clear and effective processes for incident reporting, investigation and learning from incidents. Staff we spoke with knew how to escalate concerns in relation to patient safety, and safeguarding. They were aware of Duty of Candour and could describe how they meet this requirement.

There were established processes to improve clinical practice and the service to patients. There was good practice evident in infection prevention and control. Cleanliness and maintenance of equipment was effective.

Staff ensured safe management of medicines. There were systems to respond to emergencies and any deterioration in a patient's health. The department was divided into different areas and staff were allocated to meet patients' needs depending on activity at different times of the day. There were plans and training for staff to deal with major emergencies.

Incidents

- There were clear processes for incident reporting, investigation and learning from incidents. Staff we spoke with knew how to escalate concerns in relation to patient safety and safeguarding.
- We spoke to the Director of Operations who told us there have been no 'Never Events' or 'Serious Incidents' recorded in the emergency and urgent care departments. Data provided by the trust confirmed this.
- Staff reported incidents using an electronic reporting system and we observed records where staff had used the system. All staff we spoke with were aware of the reporting system and knew how to raise issues and escalate concerns.
- We reviewed records of team meetings held within the department area. The records clearly showed where learning from the incidents was recorded, along with agreed actions. Staff were briefed on incidents including what had happened, why the incident had happened and how learning from incidents was fed back to the wider staff team.

- Mortality and morbidity meetings were held covering general, paediatric, mental health, and trauma cases. Staff we spoke with told us they were advised of learning from such analysis through team briefings, team meetings, board rounds, emails to all staff and regular displays of latest information around notice boards.
- All staff we spoke to were aware of Duty of Candour regulations. The trust had ensured wide awareness of this through staff emails and team briefings. We spoke with staff who could outline when this may be instigated and why. The Head of Clinical Governance had held sessions with around 30 large and small groups of staff about Duty of Candour since October 2015 including a wide cross-section of staff.
- We were given several examples of where the Duty of Candour was used in the ED. This included apologising to a patient that had been kept nil by mouth where there had been no need for this to happen and was the result of miscommunication with an HCA.
- We saw a 'SAFETY' newsletter and monthly patient stories that were used to share experience and disseminate learning from complaints and incidents to staff teams.

Cleanliness, infection control and hygiene

- The department appeared visibly clean and hand washing facilities and alcohol gel and hand conditioner was available throughout the department. There was clear signage informing people to clean their hands when entering the department.
- We saw staff following hand hygiene, 'Bare below the Elbow' guidance, and wearing personal protective equipment such as gloves and aprons whilst delivering care in line with the trust's policy.
- We saw hand hygiene audits of the emergency department showing 100% compliance in November 2015. We saw staff washing their hands in line with the World Health Organisation's guidance 'Five Moments of Hand Hygiene'.
- Patient trolleys, equipment, and curtains providing privacy were visibly clean throughout the department and we observed staff routinely cleaning equipment between use.
- Staff we spoke with could explain the protocol for patients with possible infectious disease. We saw three cubicles specifically used to support patients who may pose risks to others unless their condition was manged in a separate area. We observed patients arriving by ambulance were asked specific questions to identify any possible risk of serious infection or other conditions likely to cause risks to the staff or public.
- Domestic staff were visible in the department throughout our inspection and continually engaged in cleaning activities. We spoke with a member of domestic staff who explained the domestic regime and saw the cleaning schedule displayed on walls across the department. Cleaning audits dated November 2015 showed 100%. We saw waste bins were emptied frequently during the course of the day.
- Guidelines for infection prevention were accessible to staff via the hospital intranet and on notice boards and domestic staff told us they could access these easily from a hospital computer.

Environment and equipment

- We saw medical engineering staff routinely checked equipment and equipment was clearly labelled with stickers showing checked and renewal dates.
- The x-ray and CT facilities were within close proximity of the emergency department, enabling good patient access.
- The emergency equipment check list for November 2015 showed an 80% compliance, daily oxygen and suction equipment checks were at 83%. This meant staff were carrying out routine checks on equipment to ensure they were fit for purpose. However, we saw records that showed daily checks of the resuscitation equipment in the paediatric area were inconsistently carried out.
- We saw a room within the emergency department designated for providing dedicated mental health support. This area was not safe for patients to use; the chairs were heavy, metal framed and moveable, there were ligature points that were useable by patients in crisis and a large metal waste bin that could be used as

a weapon and that posed a potential risk to patients and staff. We discussed this with senior staff from the trust who assured us that immediate action would be taken to make the room safer.

- Subsequent to the inspection, the trust advised us that they have had a review of the ED provision for people with mental illness by an NHS mental health trust.

Medicines

- We saw records and stock levels of controlled drugs in the paediatric area, resuscitation, and the emergency department were accurate, showing the correct amount of stock stored at the time of inspection. Controlled drugs in the paediatrics area were secure and cabinets locked. The emergency department controlled drugs checking calendar for November 2015 showed 100% compliance against targets.
- All medication was stored securely except the fridge in the adult resuscitation area, which was unlocked. We saw a detailed risk assessment to support this practice and staff told us this enabled them to reach medication quickly at very busy times when patients required urgent medicines
- The fridge temperature checks were up to date and records showed the temperatures were within the requirements for safe storage of medicines.

Records

- The emergency team used a large wall mounted white board to record patient details within the emergency department. The team used the board effectively to identify team activities. Details on the board were appropriate and did not identify people through any particular characteristics. The board was discreetly placed within the department to restrict viewing by patients or visitors.

Safeguarding

- We found there were clear processes and procedures in place for safeguarding children and adults in the emergency department. Policies and procedures on managing concerns or the risk of abuse were available to staff via the internal intranet and staff knew how to raise concerns about adults and children at risk of abuse.
- Senior staff told us about an incident where a patient had attended the department due to illness and during routine investigations, Female Genital Mutilation was identified. The staff followed the trust policy on safeguarding adults, an incident report was completed and follow up with external agencies took place.
- The review of children's records showed all children presenting with injuries were assessed for the risks of safeguarding or any additional support that may be required to promote wellbeing. Staff provided us with examples of incidents they had raised relating to safeguarding children and showed us the incident form which corroborated what we were told.
- We saw the staff used a smart tool to follow up safeguarding issues following a serious incident that had happened on site. This tool identified adults who may be at risk of abuse as part of the patient triage process in order to manage risks to the patient whilst in the care of the emergency department.

Mandatory training

- Staff received training in key issues related to the emergency department. Staff we interviewed said there was good support for professional development and access to training programmes to develop their knowledge and skills.
- The medical staff had achieved 100% compliance with child protection training and 86.2% had successfully completed safeguarding adults training, 86.7% had completed infection control and 86.2% had completed equality and diversity training. These rates were slightly worse than the trust target for completion of 90%.

Assessing and responding to patient risk

- We saw staff undertake rapid assessment of patient conditions on patients admitted to the department both by ambulance and by other means. We saw the patient treatment bays were close to the ambulance entrance and were staffed by senior nurses and medical staff to undertake assessments and ensure diagnostic tests were done quickly.
- Triage times during our inspection ranged between zero minutes and 39 minutes for patients entering the department by ambulance. The trust had a median time of under four minutes from arrival by ambulance to initial assessment.

- All patients received a MEWS (Modified Early Warning Score) assessment as part of the triage process. Patient allergies were routinely checked and recorded where necessary and patient pain scores were routinely recorded, these were accurate legible and dated.
- The trust initial assessment to treatment times were broadly in line with the England average for all trusts.
- We reviewed the notes of 15 children in relation to Paediatric Early Warning Scores (PEWS); all had been triaged within fifteen minutes, complying with the standards for children and young people in emergency care settings set by the Royal College of Paediatrics and Child Health (RCPCH 2012).
- All patients under a year old and all patients returning for a subsequent visit with the same presenting symptoms were reviewed by a senior doctor prior to discharge.
- Staff routinely carried a set of small information cards on their lanyards. These included how to refer safeguarding concerns, MCA advice, safe medicine management, mental health advice and referral.
- A National Early Warning Scoring (NEWS) system was in use to assist staff in identifying patients at risk of a sudden deterioration in their condition. The use of the tool was regularly audited with demonstrable good levels of compliance.
- The trust had participated in the NHS Quest Sepsis week during September 2015.
- Buffalo stickers were stuck to the front of the ED card where there was a possible diagnosis of sepsis. This sticker reminded staff of the necessary steps to take as part of the 'sepsis bundle'. Using bundles in health care simplifies the complex processes of the care of patients with severe sepsis. A bundle is a selected set of elements of care distilled from evidence-based practice guidelines that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.
- The emergency department have introduced 'SPORT' (Staffing Patient Factors Expected Time of Arrival Reception Plan & Treatments & Tests Prepare) which follows the WHO guidance on best practice for critical handovers. This is used for all 'ASHICE' (Age, Sex, History, Injury, Condition & Expected Time of Arrival) calls and transfer of critically unwell patients to other areas.

Nursing staffing

- At all times during our visit we found a suitable staff skill mix, with experienced and senior nurse staff available for the different areas of the department. We found staff rotated through different areas and covered each other appropriately for breaks. There are several different clinical areas within the emergency department and we saw that patients were always appropriately monitored and supported.
- The department had a band 7 registered nurse who specifically addressed issues around flow through the department. We checked the staffing rota for the day of our inspection and found two registered nurses and two health care assistants in majors, two registered nurses in resus, one in triage, two registered nurses in CDU with two health care assistants and one registered nurse in minors, matching the staffing requirements for the department.
- We saw the staffing levels reflected the requirement to protect patient safety in all areas of the department and at different times of day. Staff had ward huddles routinely throughout the day where staffing levels were a key feature and action would be taken to ensure safe staffing levels, for example calling in bank or agency staff to cover any shortfall.
- During our inspection, we found the emergency department had no vacancies within its paediatric teams and the vacancy rate in the emergency department was at 2.8% against departmental requirements and seven band five nurses were due to join the department as a result of recent recruitment activity.
- We observed the staffing rota and saw the majority of staffing shortfalls were covered via the use of an internal hospital bank staff system and that agency staff were only used if the hospitals bank staff were unavailable. Bank staff were effectively inducted into the department and we saw records of agency staff induction including the induction topics covered by the staff team.

Urgent and emergency services

- The emergency department staffing rota had a staggered start time to the shift pattern to correspond with peak activity times in the department. The department had one registered nurse to one cubicle in triage, one registered nurse to four cubicles in minors and majors, and one registered nurse to two cubicles in resuscitation at the time of our visit.
- We observed that patients on emergency trolleys always had the safety sides elevated when required. This meant that elderly, frail patients or those with lowered levels of consciousness were cared for safely and protected from falls.

Medical staffing

- We saw there was consultant cover in the emergency department throughout the day. Consultant medical staff were available to manage care throughout the department as needed. One person was allocated as the emergency physician in charge so there was clear leadership at all times internally and in dealing with other departments or services.
- Staff roles and areas of work were clearly identified and during interviews, staff confirmed they were aware of their roles and responsibilities within the department.
- We observed a staff huddle at 9am. Issues regarding nursing and medical staffing were discussed, departmental issues and learning from recent incidents and effective actions taken to ensure safe staff cover at all times across the department.
- We saw the departmental staffing rotas that showed two middle grade Doctors starting at 8am. Doctors told us shifts were matched overall to the department based on activity. There are another two middle grades that start between 2-4pm working until 11-12pm.
- At night across both St Richard's Hospital and Worthing Hospital there were two middle grade Senior House Officers between 2–4am. Staff told us there is a Consultant on call on each site, who attended when required for patient and departmental safety concerns. We reviewed staffing rotas which reflected this.
- The trust employed more consultant grade medical staff and less junior doctors than the England average of all trusts.
- The consultant cover was under review at the time of inspection as the trust couldn't offer 16 hour consultant coverage. We saw a business case developed by the trust to increase consultant numbers from six to ten across both sites.

Major incident awareness and training

- We saw the department had major incident plans as part of the hospital and community-wide arrangements for dealing with a major emergency. Staff told us they had received training. Staff gave examples of when the emergency department had carried out mock emergency events and how this had helped them effectively plan for future major events.
- We observed the major incident equipment within the department and saw it was ready for use.
- There were clear protocols for dealing with patients suspected of having Ebola virus infection and staff told us they had training so they were aware of best practice.

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

The emergency services at Worthing Hospital were effective. We found assessment and treatment of patients was provided in line with national guidance and outcomes for patients were generally favourable.

In the Royal College of Emergency Medicine audits for Worthing Hospital, the majority of indicators were in the mid range for England. Worthing Hospital scored generally better in the Severe Sepsis and Septic Shock Audit, the Older Persons Audit, and the Adult Mental Health Audit.

There was strong multidisciplinary working within and outside the emergency department including mental health liaison, Children and Adolescents Mental Health Services (CAMHS), occupational therapy, and physiotherapy. There was an emphasis on utilising the Rapid Assessment and Treatment teams to support patients in transition to their respective homes and reduce admission.

Urgent and emergency services

Staff worked collaboratively in order to maintain high standards of care and efficient working.

Evidence-based care and treatment

- Initial assessment of patients with different conditions were undertaken against standard checklists adapted from Royal College of Emergency Medicine (RCEM) guidelines. This included the care for patients with head injury, suspected stroke, chest and abdominal pain and SEPSIS. For each condition there was clear guidance of the time by which assessment should be made and under which criteria a senior Doctor should be informed.
- We examined audit reports provided by the trust and saw that recommendations for improvement and re-audit had been identified and that audits were being carried out. Staff told us that audit reports were communicated via meetings, displays, board rounds, emails and staff team briefings.
- We saw that the department had Sepsis and deteriorating patient pathways in place that met the Royal College Emergency Medicine Standards in Emergency Departments (2014).

Pain relief

- We reviewed the notes of 15 children in relation to Paediatric Early Warning Scores (PEWS); all were triaged within 15 minutes, complying with the standards for children and young people in emergency care settings set by the Royal College of Paediatrics and Child Health (RCPCH 2012).
- We saw examples of staff asking patients if they were comfortable, checking pain levels and ensuring timely analgesia was administered.
- The national A&E survey 2014 showed results from questions relating to pain assessment and management were in line with the England average for all trusts.
- We spoke with staff who told us the peer audit of Neck of Femur (NoF) treatment had led to staff in the department having extra training to ensure all patients who met the criteria had a fascia iliaca block to improve pain management. A fascia iliaca is a low-tech alternative to a femoral nerve or a lumbar plexus block, a specific regional anaesthetic technique used by doctors in emergency medicine to provide anaesthesia and analgesia of the affected leg, to allow relief of pain from the fracture and facilitate movement of the injured limb into a splint.
- The physiotherapist showed us records of how they supported patients that were consistently attending the emergency department with pain, following physiotherapy intervention and advice, visits were minimised and guidance regarding condition management had been effective in reducing patient pain.

Nutrition and hydration

- We observed staff offering patients drinks if clinically safe and they had been in the department for some time.
- We spoke to a patient who said, “Staff bought me food and a drink, when they could, they explained things to me and I would recommend the trust.”

Patient outcomes

- The department took part in Royal College of Emergency Medicine (RCEM) audits to bench mark performance against best practice.
- In all RCEM audits for Worthing Hospital the majority of indicators were in the mid range of all England quartiles and Worthing Hospital scored generally better in the Severe Sepsis and Septic Shock Audit.
- Eighty-four percent of patients with potential sepsis had antibiotics administered within the emergency department, but only 14% of these were within an hour of arrival.
- Eighty percent of patients had serum lactate measured in the emergency department.
- The trust Quality Strategy Highlight Report dated August 2015 showed the organisation had a lead clinician for oversight of the implementation of the action plan from the Severe Sepsis and Septic Shock Audit. The report confirmed that implementation of a sepsis care bundle had taken place across the trust. There was dashboard monitoring via the Quest Operational Board.
- In the adult Mental Health Audit, Worthing Hospital scored better than the England average for 3 standards and was in line with the average for the rest.

Urgent and emergency services

- The hospital scored well in the Older Persons Audit on all indicators except the recording of a cognitive assessment where it fell below the benchmark.
- The percentage of patients leaving the emergency department before they are seen was approximately 3.3% in September 2015 which was slightly higher than England average of around 2.7%.
- The unplanned re-attendance rate within seven days for the emergency department showed the trust was performing at 2.6%, which was consistently better than the England average of 7% and better than the trusts own target of 5% in September 2015.
- The emergency department had developed a pneumothorax referral pathway to the respiratory department to provide patients with safe and timely referral to specialist services and improve patient outcomes. A pneumothorax is a collection of free air in the chest cavity (thoracic cavity) that causes the lung to collapse.
- In the last published national data (October to December 2014) both trust sites were graded 'C' (an improvement from 'D' in the case of Worthing Hospital at the beginning of the year). For context, of the 204 trust sites in England and Wales 86 (42%) were graded 'C' or above, 89 (44%) were graded 'D' and the remaining 29 (14%) were graded 'E'.
- Six month data from the Worthing Hospital Emergency Floor showed a reduction in length of stay in both medicine and surgery: an improvement in 0-1 day length of stay in 7% of elderly care patients; a 4% reduction in mortality and 5% in readmission rates. There was a reduction in patients waiting in ED for longer than four hours by 11%.

Competent staff

- Staff told us that teaching and induction was available for all new staff entering the emergency department. We saw the staff training matrix and staff confirmed during interviews they had opportunities to attend training relevant to their roles.
- We observed staff Continuing Professional Development (CPD) folders and there was evidence of staff attending training appropriate to their roles including feedback on their performance.
- We saw clear processes for the mentorship of new staff and students within the department, these followed the Nursing and Midwifery Council standards for Supporting learning and Assessment in Practice (SLAIP 2008).
- All new staff completed a core set of competencies held within a competency booklet specifically designed for use in the emergency department. A mentor signed off all new staff to ensure competence. We saw the booklet was used and staff we spoke with confirmed this.
- Staff told us that study days were routinely available and we saw in staff CPD folders that staff had attended training on specific study topics for example Advanced Life Support, Sepsis, and Infection Control & Prevention.
- Of the 1002 nursing and midwifery registered staff appraisals required at Worthing 805 had been completed, giving an 80.3% achievement rate. We observed staff CPD folders we saw records of appraisals and supervision were completed and up to date. Staff we spoke with told us the appraisal process was a positive experience for them and supervision enabled them to reflect on practice.
- We spoke to a senior nurse who explained how they had performance managed a member of staff that was performing tasks outside their scope of practice. The senior nurse showed us records of meetings and guidance offered to the staff member, how they had sought to improve their practice in cooperation with the staff member, managers and human resources team. This showed staff had an understanding of the staff performance procedures and how to implement these if there are concerns on staff performance.
- We saw in staff records that they routinely attended training in their own time prior to and following shift endings to update and improve their skills, knowledge, and competencies. We saw comprehensive records of staff support, training, and supervision including peer support and feedback. Staff told us that the Senior Nurses and the Matron were influential in raising their morale, acting as a positive role models, and encouraging staff to achieve best practice.
- The department held specific paediatric study days every two months for adult trained nurses in order to raise their awareness of paediatric care and treatment.

Multidisciplinary working

Urgent and emergency services

- We judged there was outstanding multidisciplinary team working and integration with the rest of the hospital. The model of the service was that all admissions were assessed in the emergency department and seen by the emergency department or medical staff interchangeably. This meant high flexibility in the team to manage different profiles of patients attending at any time, either general medical or emergency conditions (for example in between specialities and with Advanced Health Practitioners).
- We found there was outstanding internal multidisciplinary team working within the emergency department. We saw that occupational therapists and their assistants worked effectively as part of the team. They integrated their work well to enable patients to be safely discharged from the department according to their required discharge pathway.
- The physiotherapy provision enabled patients access to qualified therapists to manage their condition and minimise further admissions to the hospital. The service was available three days per week, 8am to 8pm and an on call service was available for respiratory support if necessary.
- Staff told us they could access multidisciplinary staff and that the occupational therapy team were available seven days a week. We saw the staff rota and the service was available from 8am to 6pm daily.
- The emergency department had access to mental health workers that covered seven days a week to support adults. There was also a part time children mental health worker as part of a pilot scheme offering support Monday to Friday 9am to 5pm. Staff told us that this had been instrumental in supporting them in their roles, either from direct contact with patients or via advice on the phone or email, giving access to early intervention to support patients' mental health.
- The Children and Adolescents Mental Health Services (CAMHS) service were available 12am to 8pm four days per week, there was a bleep system to support urgent requirements out of hours.

Seven-day services

- The emergency department at Worthing hospital was open at all times and medical staff were available to provide patient care and advice at all times. They also provided on-call cover for major trauma cases, providing advice to other trauma units and attending the emergency department as needed when patients are admitted. Nursing staff told us that consultants are often in the department through the night attending trauma cases or supporting the team at time of high activity.
- Occupational therapy and mental health services were available seven days a week, staff told us this had a positive impact on patients who would be able to see a professional for guidance on their wellbeing or condition that may enable them to return home more quickly or avoid hospital admission.
- The emergency department has an innovative integrated system of working with GP's and the service was streamed into two areas. 'One Call' system offers GP access from 10am to 6pm seven days a week and the Minor Injury Assessment & Minor Illness (MIAMI) initiative that runs 3pm to 9pm seven days a week.
- There were two CT scanners available and a radiographer available 24 hours per day.

Access to information

- Individual medical record files were requested on arrival in the department and were available for medical and nursing staff caring for the patient**.**ED cards were subsequently filed with the notes on transfer or discharge.
- Staff could view scan, x-ray and test results online.
- Trust policy and clinical guidelines were available on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act 2005 (MCA) and how to implement this within their roles. We saw the trust's policy on MCA and staff could access this via the hospital intranet.
- We saw during our observations that staff sought consent from patients before undertaking treatments and that mental capacity could be recorded on the patient notes when appropriate**.**

Urgent and emergency services

- We observed staff discussing care and treatment with patients and their relatives. Detailed explanation was a feature of discussions to support patients in making informed choices and to clarify consent.

Are urgent and emergency services caring?

Good

We found the Emergency Department provided a service that we rated 'Good' for caring.

Feedback from people who used the service and their families was continually positive about the way staff treated people. People thought staff went the extra mile and that the care they receive exceeded their expectations. We received very much higher than normal levels of feedback made direct to CQC before, during and after the inspection visit. The overwhelming majority of the feedback was very positive, with just a few people who were less happy with the service they received.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were very strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders. One particular example was from an elderly woman whose husband had died the previous day in the ED. The woman was herself a patient when we spoke with her and her family. The emergency floor staff had enabled the woman to be moved to be beside her husband in his last hours and they had resisted any attempt to move her from the floor because they wanted to allow her to remain physically close to where she was last together with her husband. The woman acknowledged this as being particularly important and told us she could not believe the kindness and compassion of staff when she could see they were so very busy.

Staff recognised and respected the totality of people's needs and took people's personal, cultural, social and religious needs into account.

We observed staff within the emergency department at Worthing Hospital provided care that was consistently caring and respectful. Patients and their relatives gave us positive views about the care they had received. There were good levels of privacy in the department and we observed staff promoting patient dignity and offering choices to promote their wellbeing.

Staff included patients and their relatives in decisions about their care. Staff supported patients promptly in managing any distress or anxiety.

Compassionate care

- Staff interaction with patients was good and we observed staff communicating with patients in compassionate and timely fashions.
- In October 2015, the Friends and Family Trust scores for patients recommending the emergency services at Worthing Hospital were 73.5% extremely likely and 18.9% likely to recommend the service to friends and family.
- We observed the elderly relative of a terminally ill patient supported by staff. Staff were compassionate and caring in their responses to the relative, made them refreshments, and found a private area for them to sit and wait. This demonstrated staff empathy and compassion for the relative at a significant time of emotional need.
- One relative wrote, "A positive experience of the A and E ward for my mother. Prompt, efficient care and an overnight stay enabled her to go home after one night. We would like to commend the Nurse in charge and the O.T for very good communication and care."
- A new mother said, "Having been admittted with acute appendicitis 4 weeks after having my son, the ED staff could not have been more compassionate or professional, supporting me to keep him with me overnight and expressing milk when he couldn't be with me. I can't thank every professional I have come into contact with enough. Such thorough continuity of care and truly respecting the holistic needs of my care."
- A parent said, "My child was admitted to ED and then the children's ward after coming in via ambulance. I cannot convey just how fantastic every member of staff was along what was a quite traumatic event. All staff were reassuring, took time to speak to me, keep me informed, encouraged me to ask questions, check that I had understood things and provide emotional support too."

Urgent and emergency services

- Another patient, "I was admitted to A & E and I was pleasantly surprised by the wonderful service I received after reading negative things in the newspaper about A & E 's up and down the country the staff treated my wife and myself with courtesy and dignity and made us feel safe and relaxed what was quite a frightening experience, thanks again."

Understanding and involvement of patients and those close to them

- We observed staff being caring and respectful with patients and relatives. Staff informed patients of the plan of care and about any procedures or tests that were proposed in a way that they could understand and gave time for questions and reassurance.
- We saw an occupational therapist supporting a patient. There was a clear and full explanation of treatment and detailed feedback given to the patient to reassure them of what actions would follow next.

Emotional support

- Bereavement counselling services were available in the emergency department including for parents of children that may die in the department. Support was also available for staff involved in caring for families where there was severe trauma or a sudden infant death. The department had a specific room set aside for this purpose.
- The department offered referral to the WORTH Services, an independent domestic violence service to support people affected by domestic abuse in West Sussex. The service is available seven days a week from 9am until 7pm and we saw information, leaflets, and posters were prominent across the emergency department.
- We spoke with two patients who said they felt safe when entering the department and that they had prompt assessment of their needs and that explanations in relation to their conditions was done in a timely fashion and in a way they could understand.

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

Outstanding ☆

Overall, the emergency department at Worthing Hospital provided a service that was 'Outstanding' in its responsiveness. The hospital performed as well or better than most other trusts in England on most performance indicators. The service had adapted to ensure good patient flow as this was considered key to ensuring optimal care for all. The departmental leaders and staff had implemented systems to maintain flow and escalate problems as soon as there were indications of delays in care and patient flow. The department met the government's four hour waiting time target for emergency departments despite a very significant increase in demand.

Simple strategies to support this work included negotiation for community care contracts to continue for up to 48 hours post admission to ensure that services were still in place and patients could be discharged without waiting for a new care package to be created.

The newly opened Emergency Floor had enhanced the work being done on patient flow and improved the overall experience for patients. It also showed significant improvement over a six month period for several key performance indicators such as length of stay and time spent waiting in the ED.

The Emergency Department had been developed to deliver services to meet the changing demography of the local community and recognised the needs of the local population. Consideration had been given to meeting the specific needs of people with learning disabilities; innovative approaches to their care in the ED had been initiated. There was a high number of elderly people with dementia in the local community and their needs were considered with adaptations and clear identification of their needs.

The trust worked with local stakeholders and other hospital staff to reduce emergency admissions and to provide a rapid discharge to community services, when appropriate.

Effective arrangements were in place to support patients and relatives following complaints, to learn lessons, and to improve the service when required.

Service planning and delivery to meet the needs of local people

- Patient flow through the emergency department was recognised as a key issue. We observed this being discussed at team meetings and handovers with the intention to improve the flow and experience of patients whilst promoting safe care.
- The newly opened Emergency Floor supported the efficient movement and oversight of patients through the department. It provided additional short term beds for use by patients awaiting test results and review by specialists, thus freeing up space in the ED for newly arrived patients. Patients could be referred directly to the assessment wards to reducing the flow through the ED and allowing patients (particularly elderly patients) to be cared for in a calmer and more comfortable environment.
- The Emergency Floor combined acute medicine, medicine for the elderly and the surgical assessment unit into one operational unit which removed the traditional boundaries between hospital, community and primary care. Patients received care from a multidisciplinary team, led by one consultant in a single setting.
- The increased use of Ambulatory Care Pathways reduced the need for hospital admission.
- The department has developed strong and effective relationships with external stakeholders, for example, the local clinic commissioning team, in order to provide innovative ways of working to achieve positive patient outcomes.
- The emergency department senior team recognises the population it serves. They showed us the trust annual review 2014-15 which gave details of the local population and needs analysis, they explained how the services are planned accordingly utilising multidisciplinary teams to meet individual needs.
- An Edit team was responsible for making sure newly admitted patients had initial tests and observations completed and were helped to put on a gown, where necessary to ensure blood test results and ECG results were available when patients were assessed by the medical team. This reduced the time spent waiting in the ED and improved flow.
- The emergency department senior team recognised the population it served. They showed us the trust annual review 2014-15 which gave details of a local population and needs analysis. They explained how the services were planned accordingly utilising multidisciplinary teams to meet individual needs.
- The trust has a contract and worked collaboratively with the local commissioners to provide GP services within the emergency department to provide condition management and to reduce the number of patient admissions whilst maintaining flow through the hospital.
- As part of the trust Quality Strategy 2015-2018 the hospital was implementing care bundles to improve the recognition and care of physiologically deteriorating patients including sepsis, acute kidney injury and preventing cardiac arrest. Sepsis bundles were already introduced.

Meeting people's individual needs

- The emergency department had access to translation services. We saw leaflets and information in relation to these services within the department. Staff we spoke with told us that the translation services were used especially to support the local Polish community.
- We saw that the emergency department had a specific room identified to support family and relatives at times of bereavement.
- There were two Whole Time Equivalent (WTE) learning disabilities nurses available at the trust, one based at St Richard's Hospital, the other at Worthing hospital. They are employed by Sussex Community NHS Trust but worked under a service level agreement within Western Sussex Hospitals NHS Foundation Trust. We saw that the nurses ran a report each day which allowed them to check the patients who have been admitted with a learning disability. They could discuss these with the clinical team and provide appropriate support.
- The electronic patient administration system allowed patients with learning disabilities to be flagged and the learning disabilities nurses could add new flags to the system as required to ensure staff are aware of any specific needs. This IT system could be viewed by all clinical teams.
- The department utilised an IT system that allowed them to flag all patients with a confirmed diagnosis of dementia.

- The trust had implemented an electronic assessment using the Patient Track/Assessment Pack system to demonstrate compliance with the national dementia CQUIN. In line with national guidance, patients who have memory loss or delirium on admission have further investigations including the Abbreviated Mental Test Scores (AMTS). The system automatically alerts the GP of the need to follow up patients with suspected dementia.
- Patients were screened for dementia in line with national guidance. We reviewed records showing the daily audit of identifying a dementia patient within 72 hours was completed.
- There was a dementia nurse on both sites of the trust and a dementia champion. They received a daily inpatient report for all the patients admitted with dementia and patients are given a dementia flag on the IT system to ensure staff could identify specific needs associated with the condition in order to meet individual needs.
- We saw that patients who may be living with dementia were screened using a standard tool and where possible the department utilised the 'Knowing Me' document to guide staff on patient care and treatment. We found that the 'Knowing Me' document had been used effectively to guide staff on the care and treatment of patients with dementia and to provide more patient centred care. We saw completed copies of the document in patient's notes and staff we spoke with told us that this enabled them to meet individual needs effectively.
- There was a weekly audit of the 'Knowing Me' documentation which showed that the staff were ensuring that the documentation was being used in order to meet individual needs.
- There was a 'Knowing Me Magnet', the trust's recognised symbol for dementia on show at the top of the patients bed, so that all staff can immediately see that a person may have difficulty with communication and a 'Do Not Move' sign for people with dementia.
- We witnessed handover between ambulance crews and emergency department staff which included a detailed assessment of individual needs to promote patient wellbeing.
- The emergency department worked with the Department of Medicine for the Elderly (DoME) when supporting elderly patients who presented in the department with the acute onset of poor mobility, falls, confusion, inability to cope or a specific condition requiring rehabilitation. This pathway for frail patients enabled the identification of patients fitting the DoME criteria. Staff told us this ensured a smooth transition and admission into the hospital and the effective coordination of services to meet their individual needs.
- We saw that there was an area dedicated for mothers and babies breast feeding to promote privacy and dignity.
- The department did not have a dedicated play specialist. Staff told us that they were accessible from the main children's wards if it was necessary to support individual children.
- We viewed examples of immediate action taken based on of feedback from the Friends and Family Test during 2014/15 which included, making newspapers available in the emergency department, providing clocks in areas so people are aware of the time, additional information leaflets, and refreshments in areas where people are waiting.

Access and flow

- We found there were arrangements to manage the flow of patients through the emergency department and to assess, treat and if necessary admit patients in a timely way.
- The hospital met the national target of seeing, treating, admitting or discharging 95% of patients within four hours, ending the year in the top 20 trusts in the country. The year to date figure for the four hour target was 97.2% on 23 September 2015.
- The senior nurse and the emergency physician in charge on each shift proactively manage delays or problems transferring to departments or other departments and monitored the flow of patients and activity levels in the emergency department.
- The percentage of emergency admissions via the ED waiting between 4 and 12 hours from the decision to admit to the actual admission was consistently better than the England average. There was a spike in December 2014 and January 2015 where the hospital

had a sudden increase in the numbers waiting longer, but this was true nationwide. Between 31 March 2014 and 28 June 2015 there were 1,554 people waiting 4-12 hours and one person waiting over 12 hours from decision to admit to admission, which was better than the England average.

- Since February 2015, less than 5% of patients had waited more than four hours from the decision to admit to the time of admission which was better than the England average of over 10%.
- Between April 2015 and September 2015, around 3.8% of patients left the department without being seen. This was worse than the England average performance for this indicator which is 2.7%.
- Between November 2014 and October 2015, 97% of ambulance handover times were recorded by the trust as being under 35 minutes. The ambulance trust target is 35 minutes to hand over care of a patient from ambulance staff to hospital staff. We witnessed timely handovers between ambulance crews and ED staff which included a detailed assessment of individual needs.
- The patients experiencing under a four-hour maximum wait from arrival to admission, transfer, or discharge was at 97.28% in August 2015 and the average year to date 2015-16 was 97.48% which was better than the trust target of 95%.
- Between 31 March 2014 and 28 June 2015 there were 1,554 people waiting 4 to 12 hours and one person waiting over 12 hours from decision to admit to admission which was generally better than the England average.
- Staff we spoke to were aware of procedures to promote safe working and guide staff through escalation procedures when the department is full or the hospital bed state may be causing a backlog to the emergency department.
- The emergency department monitors the time taken from a patient's arrival in the department to their initial assessment. We saw that a nurse at the main entrance or ambulance bay saw patients on arrival, that ambulance handover times were timely and within the national standard, which is 15 minutes.
- The ability to access the Rapid Assessment and Treatment Team had a positive impact on patient outcomes through accessing appropriate services and equipment to return people to their own homes and avoid hospital admission where possible.
- We observed regular handovers between medical staff about the overall status of the department at shift changes and clear clinical handovers when transferring or referring patients. When patients were held up because other teams were unavailable from other parts of the hospital decisions were made about diagnostic tests and admission to department areas by the senior medical staff in the emergency department to prevent delays.

Learning from complaints and concerns

- Between October 2014 and September 2015, the emergency department at Worthing received fifty-one complaints regarding the service. Aspects of clinical treatment was the highest category of complaint, with staff attitude and communication forming the second and third highest categories.
- We examined the team meeting and governance meeting minutes. All of them detailed feedback and learning by staff from complaints which had been received.
- We spoke with twenty-five members of staff during our inspection and we specifically asked them about any feedback or learning they were aware of following complaints. All were able to provide examples of where information had been shared through meetings, during handovers, on information boards and in during supervision with managers. We were assured that feedback to staff and lessons learnt from complaints were being provided
- We saw an example of a complaint and how this was managed following the unexpected death of a patient. The complaint outcomes led to staff sending a sensitive follow up letter to the patient's next of kin, offering them the opportunity to meet with key staff involved in the patients' care. This allowed them opportunity to discuss the death, access advice and guidance from the hospital during their time of bereavement.

Urgent and emergency services

- The department utilised notice boards and waiting areas to display information to patients and relatives on how to make a complaint or raise a concern with the staff.

Are urgent and emergency services well-led?

Outstanding ☆

We rated leadership and management of the emergency department at Worthing Hospital as 'Outstanding'. The strong leadership, highly effective governance and culture were used to drive and improve the delivery of high quality person-centred care. The local leadership team had managed to maintain performance through increasing demand. In the five months from April 2015 - August 2015, the ED treated 57,868 patients against a year end target of 60,490. This meant the ED had treated 96% of the expected patient numbers for the year in less than half that time but had managed to also maintain the level of service, as reflected in the performance figures. The level of patient satisfaction had continued to improve through the period of increased demand, as reflected in the FFT results.

Senior staff told us they were engaged with strategic planning and options being investigated to improve the service. There were high levels of staff satisfaction in the ED. Staff were proud of the organisation as a place to work. There were high levels of constructive engagement with staff through meetings for all grades of staff and hospital wide initiatives. Staff at all levels were actively encouraged to raise concerns and we were told that senior staff were approachable.

The trust worked with local stakeholders and other hospital staff to reduce emergency admissions and to provide a rapid discharge to community services, when appropriate. The 'One Call, One Team' initiative based at the hospital had involved many local stakeholders in primary and community care services to reduce hospital admissions and allow people to receive care in their own homes rather than in the ED. The initiative was the first prize winner in the NHS Kent, Sussex and Surrey Leadership Recognition Awards 2014.

There were established systems to ensure good clinical governance and monitor performance. The department held a risk register which identified current risks and the mitigating actions.

There was strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences. All staff were focussed on providing high quality urgent care for patients and maintaining efficient flow through the service. There was a positive culture with a strong team ethos and good relationships across all professionals, managers, and local partners.

Senior staff took a proactive stance on identifying potential problems and finding solutions. There was a sense that problems were minimised by early recognition and shared responsibility for finding the best way to address any concerns.

Staff told us that consultants and senior nurses were inspirational and led the department towards achieving high standards of care and treatment for patients.

All staff were focussed on providing high quality urgent care for patients and maintaining efficient flow through the service. There was a positive culture with a strong team ethos and good relationships across all professionals, managers, and local partners.

Vision and strategy for this service

- There was a clear strategy for the service and improvement goals set out in the trust Quality Strategy 2015 - 2018. This was known to staff locally and there was evidence of local leaders working towards these goals. For example, as part of the operational introduction of care bundles for specific high risk conditions. Consultants attended the Operational Senior Nurses meeting to highlight the new Sepsis Screening Tool which was to be introduced shortly. Copies of new tool were circulated at the meeting together with copies of the new Buffalo stickers which needed to be placed in the patients ED card, where sepsis is suspected.
- The emergency department senior team recognised the population it served. They showed us the trust annual

review 2014 -15 which gave details of a local population and needs analysis. They explained how the services were planned accordingly utilising multidisciplinary teams to meet individual needs.

- The senior emergency department staff had been involved in planning future service configuration. This had included discussion and planning about short, medium and long term plans for the future in the context of the NHS finances and local opportunities with a specific reference to the trust's own vision.
- Staffing and service configurations for the medium and long term were being developed at the time of our inspection.
- Staff we spoke with were aware of the plans for the department and the vision of the trust. All of the staff we spoke with were positive about the department's current position and looking forward to the department's future plans being implemented.
- The newly opened Emergency Floor at Worthing Hospital was one tangible result of the vision for the service that was based on the 'Patient First' strategy. Staff had worked collaboratively with the executive team to deliver a service that had good patient care at the heart but which also showed financial and flow service improvements.
- Working with other stakeholders was seen as key to providing effective and sustainable emergency services. The 'One Call, One Team' initiative was a multi-agency service based at Worthing Hospital that allowed are to be delivered in the community or through primary care services rather than at the ED. It reduced the demand on ED by keeping patients (particularly the frail elderly or those with complex co-morbidities) at home whenever possible.

Governance, risk management and quality measurement

- There were several established systems to ensure good governance and monitor performance.
- The board ensured scrutiny of the impact of efficiency programmes through the Quality and Risk Committee and the Audit Committee. The Quality and Risk Committee scrutinised three key documents at each meeting: the Monitoring of Quality Impact Assessments, the trust's Risk Register and the quarterly updated Board Assurance Framework. In addition, the Committee also received the outputs from Clinical Governance Reviews together with feedback from those Committees looking at Patient Experience and Feedback.
- The Quality and Risk Committee was able to draw this information together to highlight areas where quality may be of concern and to ensure that the root cause is identified and risks mitigated. We saw records of board meetings and audit committees during our inspection.
- Quality and audit meetings generated action points. We saw that these were communicated to teams in flexible ways. For example, by email, team meetings and staff supervision which promoted continual improvement to the quality of the service.
- Quality boards reported into the trust board to enable oversight and learning across departments. We saw records of monthly quality meetings during our inspection.
- We saw that the department held a risk register which identified current risks and the mitigating actions taken to minimise risks to patients and the staff team.
- There was a Divisional Clinical Governance Committee (DCGC) half-day monthly with a standing agenda which included mortality trends, incidents and SIRIs and lessons learned from RCA reports.
- There was also a bi-annual multi-disciplinary speciality meeting of ED staff for discussion of the standing agenda items from the DCGC meetings that applied specifically to the ED.
- A cross directorate meeting took place twice yearly to review pathways that crossed over between areas of care such as ED and the critical care unit.
- Learning from incidents led to changes in practice. A senior staff member explained how they had recognised a difference in practice between sites regarding the use of sedation. This led to a patient receiving the wrong dose of sedative. We saw how the incident had been managed, and the development of a new flow chart to support staff decision making and consistency was implemented across the staff team.
- The 2014 NHS Staff Survey showed the percentage of staff experiencing physical violence from patients,

relatives or the public was 18% during 2014, which is higher than the national average score for acute trusts of 14%. Staff told us of incidents in the department where patients had become violent and aggressive towards them and this was escalated by senior leaders to The Trust Board. In discussion with senior managers this appeared to be related to the high numbers of elderly people with dementia who attended the department and who might become agitated and aggressive in the unfamiliar surroundings of an emergency department.

- Divisional Governance Meeting minutes showed that the trust had taken action in response to this finding. Staff focus groups had been held supported by divisional managers and the Human Resources Department. There had been an increased presence of security staff in the ED. A 'No tolerance letter' had been written for staff to hand to patients, family and visitors when unacceptable behaviour was identified. Staff had been offered training in conflict resolution.
- The national clinical audit programme for the division was reviewed quarterly to ascertain progress made with the annual programme. Progress with each of the projects was assessed and monitored using a traffic light system. All audits led by the ED team were rated green, demonstrating good leadership and oversight of audit programmes within the department.

Leadership of service

- There was good leadership of the emergency department. Senior staff were visible as clinical and managerial leads, with clear levels of accountability and control over operations within the department.
- There were identified roles allocated on each shift and displayed on a large board in the department. This meant that staff could be quickly deployed to various work areas and that all staff were aware of respective roles and responsibilities within the department.
- Staff told us they felt the department management was outstanding. They cited the support offered opportunities for professional development, and the service was focused on improvements for the patients as their reasons for this.
- Staff told us they felt valued by colleagues and senior staff and there was a whole team ethos towards meeting the patients' needs.
- There was good leadership of the emergency department. Senior staff were visible as clinical and managerial leads, with clear levels of accountability and control over operations within the department. There were identified roles allocated on each shift and displayed on a large board in the department.
- Nursing teams were established with experienced staff supporting and appraising junior members of staff. Staff told us they felt that the management of the department was supportive, offered opportunities for professional development and that the service was focused on improvements for the patients.
- All of the Clinical Standards for ED were discussed at joint consultant meeting in September 2015 and leads allocated. The teams had ownership of the standard and decided how to audit/ monitor the standard within the trust. The progress of the implementation of the standards was discussed on a monthly basis with a dashboard to monitor maintenance of the quality standard.
- Local leaders had been instrumental in working with colleagues across the service to raise the grading of the stroke provision from an E at the beginning of the year to a B at last assessment in published national data. There were clear goals put in place to improve the service further during 2014/2015. These included, "All CT scans for patients admitted to hospital with a likely diagnosis of acute stroke will be undertaken within 12 hours of admission and all patients that may benefit from stroke thrombolytic treatment will be scanned immediately and treated within 60 minutes of hospital arrival." This target was achieved and demonstrated a rapid improvement in the stroke service brought about by strong local leadership.
- Local leadership had set a culture of good service that was reflected in Friends and Family tests that consistently rated the service well above the national averages provided a response rate that was above the national average.
- Local leadership of elderly patients admitted to the Emergency Floor resulted in improved outcomes for patients and more efficient use of the ED.

Urgent and emergency services

Culture within the service

- Nursing staff told us they felt it was a supportive department to work in; they said staff worked exceptionally well together across the professional disciplines. We saw staff interacted in a supportive way to ensure safety and efficiency for patient care and staff particularly noted the leadership of the consultants and senior nurses, they described them as extremely approachable and supportive.
- Focus groups held during the inspection attracted much larger numbers of staff of all grades and all disciplines. They were virtually unanimous in their praise of the trust, the hospital and their department. There was good representation from the ED.
- Junior doctors told us it was a good place to work, in particular, the attitude of all staff with each other was seen as supportive, and a good place to develop skills and experience.
- Domestic staff reported that the emergency department was a good place to work, that they were seen as part of the department team and felt pride in maintaining clean areas for patient care.
- Ambulance crews visiting the emergency department told us that staff in the emergency department were particularly supportive of new and student paramedics. We spoke with paramedics who told us that staff in the department were always willing to engage and involve them in patient care, treatment and support. One paramedic said, "The staff here are good. They work together well and we are welcomed as part of the team."

Public and staff engagement

- Patients were invited to provide feedback and comments using comment cards. Comment cards were analysed within the department, and reviewed in order to provide regular feedback to staff on areas they needed to improve. The team were able to give an example of a change to the waiting room environment that had occurred as a result of feedback.
- Feedback from complaints and the Patient Advice and Liaison Service (PALS) enquiries and comments were placed on social media and the NHS choices website. Feedback from patients' and relatives could be accessed via Healthwatch, West Sussex. This meant that the trust were transparent with the local population, sharing feedback on complaints and concerns to raise awareness of the trusts performance.
- The Board Highlight Report dated August 2015 showed an ED patient experience group had been convened to garner feedback from patients and relatives who had used the ED and urgent care services.
- Staff told us they are informed and included in developments of the service. There were daily team briefings and weekly notices with useful information and latest important changes and learning from incidents or complaints.
- Staff were engaged in innovative ways across the hospital but with impact on the ED. The 'Sit and See' report for St Richard's Hospital was carried out by a ward clerk from Worthing Hospital. They completed an observation that was shared with the ED managers and through them to staff. There were many positive comments about named staff.
- Meetings took place between service managers and all grades of staff. There were minutes available from the Emergency Nursing Assistants (ENA) Forum, Housekeepers meetings and meetings of Band 5s, Band 6s and Band 7s. These were all held separately to allow all grades of staff to have a voice
- Staff from all areas of the hospital, including the ED, could apply to be Ambassadors that represented the trust to patients, visitors and other staff. These staff felt particularly strongly about the quality of the care provided, the working environment and 'their' hospital. We met several who were keen to promote the work they were doing and tell us how proud they were of the service they provided.

Innovation

- The department had created a pathway for offering a meeting with families whose loved ones have experienced sudden death, (approximately six weeks after the event), to talk about what actually happened and answer any questions they may have going forward. This was introduced in recognition that families may have difficulties understanding what happened and have a number of unanswered questions.

Urgent and emergency services

- The emergency department had introduced "SPORT" (Staffing Patient Factors Expected Time of Arrival Reception Plan & Treatments & Tests Prepare) which followed the WHO guidance on best practice for critical handovers. This was used for all “ASHICE” (Age Sex History Injury Condition & Expected Time of Arrival) calls and transfer of critically unwell patients’ to other areas.
- Staff told us about the “One Call One Team”, a single point of access for urgent care referrals. The service facilitates rapid assessment and access to urgent care management options to prevent avoidable hospital admissions for adults. Care packages available included medical care, therapy, and personal care. The principles were to improve patient experience and choice, reducing unplanned admissions and A&E attendances from both home and residential settings. There was a single point of access for community services, GPs, ambulance crews, nursing homes and social care professionals available at all times
- The multiagency Rapid Assessment and Treatment Team led by community geriatricians provided fast-response home visits followed by up to 72 hours of intensive support to prevent hospital admissions.
- Clinicians at the trust had developed a scoring system - the Acute Kidney injury Prediction Score (APS) utilising physiological measurements, biochemical parameters and known co-morbidities to identify patients at risk of developing AKI following hospital admission before markers of kidney deterioration appear. This work will support the acute kidney injury bundle being rolled out as part of the Quality Strategy.

Medical care (including older people's care)

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

Information about the service

The Division of Medicine provides care for a wide variety of medical conditions including specialist medicine, cardiology and respiratory, elderly care, stroke, rehabilitation, endoscopy, neurology and gastroentrology. Emergency interventions such as stroke thrombolysis and primary percutaneous coronary intervention are available at all times and provided on site by a consultant led service. A medical acute dependency unit (AMU) provides care for medical patients who require short term increased support or monitoring.

Worthing Hospital had 29,928 admissions between January 2014 and December 2014 with 42% emergency admissions and 56% day cases. The most common specialities for these admissions were general medicine (35%), medical oncology (18%) and clinical haematology (13%).

During our inspection, we visited a number of medical wards and day assessment areas. We also visited medical patients accommodated on surgical wards.

To help us understand and judge the quality of medical care services we reviewed performance information from and about the trust before our inspection. At Worthing Hospital we looked at the quality of the medical ward environments and observed staff caring for patients, including the care of eight patients in detail. We reviewed more than 30 patient care and treatment records.

We spoke with more than 20 staff including, managers, medical staff, nursing staff, allied health professionals, and auxiliary staff and attended two multi-disciplinary meetings. We carried out a check of the hospital's medicines management arrangements. We spoke with eight patients who were using the service and a visiting relative.

We looked at a range of policies, procedures and other documents relating to the running of the service including: audits, for example the sentinel stroke national audit programme (SSNAP), staffing rotas, divisional quality performance dashboards, and governance meeting records.

Medical care (including older people's care)

Summary of findings

Overall we rated medical care services as 'Outstanding'.

The reason it was outstanding overall was because responsiveness of the service in the care of individual patients. For example, there was exemplary provision made for patients living with dementia across the whole hospital. We received very high levels of very positive feedback from patients and relatives of patients who had used Worthing Hospital. The 'Sit and See Scheme' allowed staff to experience the hospital from a patient perspective.

Patients who were at risk of deteriorating were monitored and systems were in place to ensure that a doctor or specialist nurse was called to provide additional support. The trust had an open culture and was prepared to learn from clinical incidents. Across the Division of Medicine there were enough medical and nursing staff to keep patients safe. The trust found it difficult to recruit new nursing staff; but was able to effectively fill gaps across the division by using bank and agency staff.

We found that care was provided in line with national and local best practice guidelines. Clinical audit was undertaken and there was good participation in national and local audit that demonstrated good outcomes for patients. Patient morbidity and mortality outcomes were within expectations for a hospital of this size and complexity and no mortality outliers had been identified. The improvements in the care of patients with strokes was notable.

There was a good knowledge of issues around capacity and consent among staff. However, we found two deprivation of liberty safeguard (DoLS) assessment applications did not contain capacity assessments.

Patients received compassionate care and were treated with dignity and respect. Most patients and relatives we spoke with said they felt involved in their care and were complimentary about staff. One person told us: "The staff have been very nice and have always responded when I have called them." The Medicines division had good results in patient surveys with results indicating an improvement in patient views over the last 12 months.

The Medicines Division were effective at responding to the needs of the community. The trust's performance management team understood the status of the hospital at any given time. Bed availability was well managed. Elderly care pathways had been well designed to ensure elderly patients were assessed and supported with their medical and social needs.

The medical services were well led. Divisional senior managers had a clear understanding of the key risks and issues in their area. The medical areas had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day to day basis. The hospital had a risk register which covered most key risks. Staff spoke positively about the high quality care and services they provided for patients. They described the hospital as a good place to work with an open culture. The most consistent comment we received was that the hospital was a "nice" place to work and staff enjoyed working in their teams.

Medical care (including older people's care)

Are medical care services safe?

Good

Medical care provided at Worthing Hospital was rated as 'Good' for safety.

Staff reported incidents when things went wrong. The trust had effective processes in place for reporting, investigating and learning from incidents.

Staff demonstrated an understanding of safeguarding and knew how to respond to any signs or allegations of abuse.

Attendance of mandatory training, as well as staff receiving an annual appraisal was worse than the 90% trust target.

The environment was visibly clean and staff demonstrated good infection prevention and control practices, although we did see some exceptions. Equipment was appropriately maintained and checked.

Medical and nursing staffing levels were set and reviewed to keep people safe. Risks to individuals were effectively assessed and managed including clinical and health risks. We found effective emergency preparedness and incident plans were in place.

Incidents

- There were 18 serious incidents (SI's) at Worthing Hospital reported through the NHS strategic executive information system (StEIS) between November 2014 and October 2015. The most commonly reported incidents were; slips, trips, and falls.
- Staff understood their responsibilities in raising concerns and recording safety incidents and near misses. The electronic incident reporting system sent feedback on the outcome of incident investigations automatically to the original reporter if this was requested on the electronic form at the time of reporting. Staff told us they were encouraged by senior staff at the hospital to do this.
- The trust's electronic incident reporting system prompted staff to categorise the level of harm of all incidents. Where 'moderate' or 'permanent long-term harm' was reported the trust clinical leadership was automatically notified. The patient safety team contacted the ward to follow up. The patient safety team then monitored the investigation process until the investigation was complete. Events causing moderate or severe permanent or long term harm were assessed by the divisional leads.
- We viewed two root cause analyses (RCA) investigations. We found these to be thorough and robust. Relevant staff were involved in investigations and reports included a chronology of events prior to and following the serious incident. RCA's we viewed showed patients were involved in investigations and informed of any actions taken as a result. Lessons learnt were recorded on the RCA investigation reports.
- We saw minutes from divisional meetings where incident reports were discussed and learning disseminated. These included quality and safety board meetings, clinical governance half days, sisters' meetings, and ward meetings. A divisional dashboard was updated monthly and circulated to all consultants and senior nursing staff to highlight any recent concerns.
- Staff received monthly divisional newsletters relating to their care group via email. For example, we viewed the 'Elderly care group monthly newsletter' dated October 2015. The newsletter reported that there had been increased reporting of all grades of pressure injury on the electronic incident reporting system. The newsletter further identified themes from RCA's, for example, a lack of documentation on admission, use the body maps, lack of documentation on the 'intentional rounding' forms and heels. The newsletter provided a reminder to staff to check patients heels daily as well as their other pressure areas and to ensure this was documented. This meant staff were regularly provided with information in regards to learning from incidents.
- Ancillary staff at a focus group told us there was some confusion as to how themes from incidents were reported back to them and although the very serious incidents appeared to filter down to staff; this did not appear to be consistent in terms of less serious incidents.

- The education department reviewed all new entries on the trust's electronic incident reporting system monthly and reported these to the education executive. This enabled the trust to monitor staff in training and for them to be supported and educated.
- Recent RCA investigations were discussed at quarterly clinical governance half days. This encouraged wider participation and greater dissemination of learning from incidents across the hospital. These meetings were chaired by a clinical lead consultant. The quarterly meetings were well established in the division and seen as a priority in terms of learning and improving patient care.
- Mortality and morbidity were also discussed at the governance meetings. All patient deaths were routinely reviewed by the consultant responsible for their care to ensure the death certification was accurate, and identify whether the death was avoidable. Within the Division of Medicine, there were no specific meetings held for mortality and morbidity. However, significant issues were presented and discussed at the monthly clinical governance half days. Notes of the meetings were taken but not formal minutes. A senior manager informed us an official agenda would be issued with formal minutes taken with immediate effect.
- A list of diagnosis groups where the trust was an outlier, was provided to clinical leaders and the trust's Quality Board Monthly. Outliers are patients who require an unusually long hospital stay or whose stay generates unusually high costs. At the time of our inspection there were two diagnosis groups where the trust was an outlier. These were 'acute and unspecified renal failure' and 'cardiac arrest and ventricular fibrillation'. These were new outliers, triggered by the trust's decision to move to a new monthly base level measure. Investigations into these were in progress at the time of our inspection.
- The summary hospital level mortality indicator (SHMI) was reported by the hospital to the trust board on a monthly basis. The most recent performance figures for January 2014 to December 2014 found that the SHMI was 'as expected' for a hospital for this size and configuration.
- The trust conducted a mortality review in July 2015 to assess the trusts new mortality form. As a result of the review the mortality form was redesigned to ensure the accuracy and clinical confidence of staff in using the form when undertaking reviews.
- The hospital had template letters as a framework for any staff writing to patients. There was also a close working relationship between the complaints and medico-legal department to ensure, that where an incident had occurred, which may not have been previously reported, that duty of candour was considered.
- The Head of Clinical Governance was the operational lead for candour within the trust with information available to staff on 'Duty of Candour' (DoC) on the trusts intranet site. The Head of Clinical Governance had presented to around 30 large and small groups of staff about DoC since October 2014. The Medicine division were in the process of developing an independent approach to candour as their understanding and experience of the DoC requirements developed.
- A band 7 nurse told us, "We are really good with duty of candour. It's the nurses who are pro-active. We make sure that any letters we send to families following an incident are attached to the RCA, if there is one." However, some staff we spoke with told us they were still unsure about the DoC requirements. This meant the trust could not be sure DoC was applied appropriately by all staff.

Safety thermometer

- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Performance against four possible harms (falls, pressure ulcers, VTE and catheter associated UTI's) were monitored across the Medicine division on a monthly basis using the safety thermometer tool. Overall the division was regularly meeting the trusts 95% target.
- The trust had a harm free care improvement nurse who monitored Safety Thermometer results and

identified themes and trends. We viewed the Safety Thermometer report for December 2015. All new harms were identified, lapses in care were identified, and the actions taken to address these were recorded.

- We found the prevalence rate of pressure ulcers reported in the Safety Thermometer had varied over time with no real decrease or increase in the rate from July 2014 to July 2015.
- The divisional dashboard indicated the division was meeting National Institute for Health and Care (NICE) guidance on the assessment of risk of venous thromboembolism (VTE). The dashboard recorded the division had met the 95% compliance target from August 2014 to March 2015. However, the rate had fallen to 94% between April 2015 and August 2015.
- Safety Thermometer information indicated that between July 2014 and July 2015 there were 33 pressure ulcers reported. The prevalence rate, number per 100 surveyed, ranged between 0 and 1.1 in this time period. We did not identify a trend in the pressure ulcer safety thermometer information.
- Safety Thermometer information indicated there was a higher rate of falls in October 2014, November 2014, February 2015 and April 2015. However, we did not identify any trends.

Cleanliness, infection control and hygiene

- We saw staff adhering to the hospital's 'bare below the elbow' policies. The importance of all visitors cleaning their hands was publicised and we observed visitors using hand gels and washing their hands. The trusts infection prevention and control team's patient information leaflet on hand washing was available across the wards and explained good hand washing technique as well as when patients should clean their hands.
- We saw gloves, aprons, and other personal protective equipment (PPE) were readily available to staff.
- We saw staff regularly cleaning their hands between treating patients. Hand washing facilities and hand sanitising gels were readily available. We found that the Division of Medicine at Worthing Hospital regularly achieved 99% compliance with hand hygiene. However, we noted poor hand hygiene practice amongst some staff on Barrow ward.
- The ward areas appeared visibly clean. We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- The infection rates for Clostridium difficile (C.Diff) from November 2014 to November 2015 was 0.4 per 1,000 admissions, the rate for hospital acquired methicillin-resistant Staphylococcus aureus (MRSA) was 0, rate for methicillin-susceptible Staphylococcus aureus (MSSA) was 1.2, and the E-coli rate was 4.3. We noted that infection rates were not clearly displayed across all medical wards and departments.
- Patients were screened for MRSA bacteria. The high impact interventions audit summaries recorded between March 2015 and August 2015 show the hospital achieved between 96% and 98% compliance of patients being screened.
- We viewed the divisional spreadsheet for patients who had received MRSA carriage screening. The division regularly achieved 100% of patients seen between June 2015 and December 2015, with the average being 98%. This ensured patients with MRSA carriage were identified and action taken in a timely way to address MRSA risks to patients.
- We saw the hospital had protocols in place for: MRSA decolonisation and 'Bactroban', this is an ointment used for the treatment of bacterial infections of the skin; and 'Hibitane', an antibacterial soap, via prescription.
- Overall the hospital's monitoring of C.diff meant there were systems in place to prevent and protect people from healthcare-associated infections. The hospital monitored patient's for C.diff pre 72 hours of admission and post 72 hours of admission. The high impact interventions audit summaries identified when cases were care related. For example, we noted in the May 2015 summary there had been one C.diff post 72 hours on the Emergency Floor, this was deemed avoidable due to a poor infection control score regarding environment. The June 2015 summary identified one post 72 hours C.diff on Ditchling ward, which again was deemed avoidable due to poor infection control score regarding the environment.
- We viewed the medicines division infection control audits dated between May and July 2015. Infection control audits were followed up with a report that

identified areas of non-compliance and made recommendations for improvements, which were followed up in subsequent infection control audits. Most audits we viewed for Worthing Hospital indicated the medicines division were meeting the hospital's 85% performance target for infection prevention and control.

- Equipment shared between patients was cleaned after each use and labelled with a green 'I am clean' label and dated. We saw equipment across the wards labelled with the stickers.
- 89.3% of staff had up to date training in infection control in line with a trust target of 90%.

Environment and equipment

- The environment of the Medical Day Care unit was cramped. The unit was configured with two areas split by a corridor, this meant the unit required two separate teams to care for patients. The unit would have worked more effectively if it were merged.
- Records showed all equipment, including resuscitation equipment was checked on a daily basis with a report given to senior staff. The trust ran a 'bay buddy' scheme whereby an allocated member of staff was allocated the role and completed daily checks on resuscitation trolleys and individual cubicles.
- We viewed the medicine divisions high impact interventions audit summaries from March 2015 to August 2015. Ward environments had been audited in accordance with hospital standards, where deficiencies had been identified, recommendations and action plans were put in place. For example, the hospital regularly scored 99% for the decontamination of equipment.
- The division had average patient-led assessments of the care environment (PLACE). The PLACE assessment score from November 2014 to November 2015 was 92%, which was better than the trust target of 85%. PLACE assessments focused on the environment in which care was provided, as well as supporting non-clinical services such as cleanliness, food, hydration, privacy and dignity.
- The hospital had undertaken a full review of asbestos in the hospital buildings fabric in 2014. Asbestos risks had been assessed by a health and safety consultancy and an action plan was in place for removal and monitoring.
- Staff on Barrow ward highlighted the ward had been reconfigured from two wards; and there was insufficient space and seating for nursing staff to complete documentation. Staff told us the ward layout also posed problems in observing patients.
- Staff at a focus group said space at the hospital was limited and this sometimes posed a problem if patients or carers needed a private space for discussions with staff. For example, staff on the Medical Day Case unit told us there was a lack of space on the unit. This had led to chemotherapy being delivered in two separate rooms, which meant two staff teams were required. Staff told us a new unit was planned, but they had not been informed of any details.

Medicines

- Some staff we spoke with raised concerns about the electronic prescribing system and discharge prescribing. We met the lead for electronic prescribing and medicines administration (EPMA) who confirmed that access to the electronic prescribing system was via a pass card or log in and that anyone on the medical register for the hospital could have access except for doctors in the A&E department. There were plans to introduce EPMA to A&E in 2016.
- We were told that locums could have access to EPMA if their placement was planned, but sometimes this could not be organised at short notice. We were shown a separate training record for the electronic prescribing system and noted some gaps at consultant level.
- We discussed the EPMA electronic prescribing system with a nurse manager, pharmacist prescriber and consultant on the medicines admissions unit (MAU). Concerns were highlighted with regards to risk following changes in prescribing 'as required' (PRN) medicine to a regular dose, when the as required dose had already been given. Not all staff had made a separate note of the change.

- There were also concerns regarding errors around transcribing of prescriptions by junior doctors. There were further concerns about being locked out of computers, when more than one person was trying to access a prescription.
- Staff on Clapham ward told us prescribers sometimes experienced difficulty in selecting some medicines in the right category with e-prescribing.
- We discussed the electronic prescribing of chemotherapy with three pharmacy staff and were told of the differing systems in place, which were linked to the area cancer network. We found that not all protocols had been uploaded the chemotherapy prescribing system, and the deadline for the end of the year had slipped because of changes in networks.
- We discussed with a consultant problems with the transfer of patients from ED with a paper chart and the need to re-enter all the medicines information on the EPMA. However, the consultant showed us the summary care record for a patient which the trust accessed. The consultant also explained procedures if the computer was inaccessible to ensure patients were not placed at risk.
- Staff at the Discharge Lounge raised concerns about discharge information provided to patients. We viewed emails between the Discharge Lounge and the pharmacy raising concerns. Staff at the Discharge Lounge told us discharge summaries for medicines were not always completed accurately, with start and stop dates. Staff also raised concerns with discharge summaries not clarifying whether medicines needed to be reviewed by patients' GPs. Staff said they were awaiting a response from the company who provided the computer software, as concerns and queries had been raised by GPs. However, we did not find any patients who were waiting for their medicines.
- We discussed the electronic discharge system where concerns had been raised about the accurate completion of discharge letters with three hospital pharmacists. We were told that a 'new look' system was being developed and a meeting was planned in December 2015 to discuss problems with discharge letters, ensuring GPs knew whether to continue medicines and to clarify changes in medicines. We were also told about work in progress to link into community hospitals and provide individual patients with a medicines administration record (MAR) to aid compliance.
- A doctor and a pharmacist we spoke with on Clapham ward said that they had not identified concerns with the clinical information on the electronic system. We spoke with three pharmacists who explained how the prescribing system was linked to the trust formulary and clinical protocols such as those for thrombo-prophylaxis and sliding scale insulin. This was designed to improve safety in prescribing and reduce the risk of error. We were told the clinical and pharmacy team were holding weekly meetings with the implementation team to resolve issues arising from the recent rollout of the electronic prescribing system.
- We were told of the advantages of EPMA, as staff were able to print out a prescription and a medicines profile. Staff told us a 24 hour helpline was available to resolve EPMA problems and that issues were always resolved.
- Medicines were securely stored. We looked at storage and noted all cupboards were locked. Fluids were unlocked but were stored behind a keypad locked door.
- Medicines requiring refrigeration were stored correctly. We viewed the records for two fridges. On Clapham ward there were regular records of fridge temperatures. However, we noted the room temperature was too warm for the storage of medicines. A thermometer had been provided by the pharmacy to check temperature. However, we did not see any records of room temperature and noted there was no air conditioning to regulate room temperature. This meant there was a theoretical risk of medicines being stored at the incorrect temperature and being rendered less effective.
- We found individual patients' drugs were stored appropriately in lockable bedside cupboards. The hospital operated the "green bag" scheme. This scheme used an easily identifiable bag for transporting medicines around a patients care setting. The purpose was to keep all medicines belonging to a patient together in a readily identifiable container.

- Overall, we noted significant pharmacist presence on all the wards. There were two pharmacists and two pharmacist assistants involved in supplying medicines, undertaking medicines reconciliation, and dispensing and screening for 'to take away' (TTA) medicines. Pharmacists worked from a designated area in the middle of the MAU ward and there were white boards to aid communication.
- The pre-assessment unit TTA packs for oral bowel cleansing agents were stored securely and there was a logging book that was completed and witnessed appropriately. Bowel preparation was only issued on prescription. However, work was in progress to write a patient group directive (PGD).
- Staff on Clapham ward told us there was daily pharmacist input; but sometimes delays occurred with discharge medicines. However, staff on other wards advised us they did not receive this input and that they sometimes had visits from a locum pharmacist. Wards had a top up service for stock once a week; and wrote requisitions for stock in between. Wards kept a handover book to aid medicines communication, which meant staff could not be sure of the regularity of the pharmacy service.
- We were told that there was a limited pharmacy weekend service; but as a result of EPMA pharmacists could produce a daily report and dispense medicines according to risk, for example, chemotherapy.
- All nursing staff we spoke with knew how to locate medicines out of hours.
- Medicines labelling enabled near patient dispensing. However, pharmacy staff told us there was sometimes duplication of discharge medicines because nursing staff did not always look in patients Pod lockers and would reorder discharge medicines.
- Clapham ward was involved in a self-administration of insulin pilot project. This enabled nursing staff to assess and support patients' ability to self-administer their own insulin. This demonstrated there were initiatives designed to increase patient participation in care in relation to medicines.

Records

- There was a combination of both electronic and paper based patient records. Paper based records were used on the wards. However, staff told us the hospital was looking to move towards a minimal use of paper records.
- We attended a divisional multi-disciplinary meeting on the Emergency Floor. We saw staff discussing patients' records on the electronic database. The database contained medical information on each individual patient. We saw patients' records being updated at the meeting. The recording doctor had a personal identifier code and entered this on each individual patient's record when recording information. This showed staff were updating information in a timely way, and the recorder could be identified if any clarification was required.
- Overall, nursing records were noted to be comprehensive and well completed in accordance with the Nursing and midwifery council (NMC) guidance on record keeping. Medical notes were found to be legible and well completed in accordance with the General medical council (GMC) guidance 'Keeping Records.'
- The division had good rates of staff with up to date information governance with 95.7% of staff having completed training, which was better than the target of 90%.

Safeguarding

- Level 2 Safeguarding adults training had been provided for nursing staff of band 5 and above. 87.3% of staff had completed appropriate level 2 safeguarding training and 95.7% of eligible staff had completed level 3, which was better than the trust target of 90%. Directly delivered Level 1 safeguarding adults training was undertaken by groups of staff who were not clinical but had contact with patients, for example porters.
- Staff demonstrated a good understanding of the types of abuse people may experience. We saw information on how to report safeguarding was available on all wards we visited.
- Staff told us if there were safeguarding concerns, they would liaise with local authority social workers. Staff

said safeguarding care management plans would be in place where safeguarding concerns were identified. Staff were able to show us the contact details for the local authority safeguarding team.

- Staff we spoke with were aware of the trust's safeguarding guidance and multi-agency procedures. Staff told us this was readily accessible on the trust's intranet. However, the ward manager on Burlington ward was unable to access safeguarding information on the trusts intranet at the time of our inspection due to the web page being inaccessible. The ward manager reported this to the trust's IT department immediately.

Mandatory training

- Staff mandatory training was monitored by the Medicines division dashboard. Mandatory training covered a range of topics including, fire awareness, infection control, basic life support, safeguarding and role specific training including manual handling. The divisional dashboard showed staff consistently met the trust's 90% target for role specific training. However, overall the division was not meeting the trust's 90% target for staff having completed all required mandatory training, with 78.8% of staff having completed mandatory training from August 2014 to August 2015.
- We viewed the trust's training spreadsheet for basic life support. Over 80% of staff had up to date training in basic life support in all wards and departments, with the exception of Erringham ward where 76.9% of staff had completed the training.
- There was a corporate induction programme for all new staff. All new staff we spoke with said they had attended the induction programme and felt it met their needs.

Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS). The NEWS is based on a simple scoring system in which a score is allocated to physiological measurements when patients are being monitored in hospital to identify patients at risk of deterioration in their condition, and ensure appropriate escalation in their care.
- Staff were aware of appropriate action to take if NEWS scores were higher than expected. We found NEWS record scores had been totalled correctly, and where a high score had raised concerns, the issue had been escalated. This meant people who were admitted acutely were continually assessed using the NEWS.
- The hospital was in the process of developing a metric measure on the divisional dashboard to monitor the use of NEWS. This would provide up to date information on the use of NEWS and aid managers in monitoring its use.
- Staff told us they felt supported by doctors when a patient's deterioration resulted in an emergency. Medical staff we spoke with told us they were called appropriately by nursing staff when patients had deteriorated.
- We viewed the NHS 'Quest' deteriorating patient operational group' strategic dashboard and action plan. This provided evidence of comprehensive risk assessments being introduced across the division, as well as risk management plans being developed in line with national guidance. For example, on 30 November 2015 the trust had agreed to participate in the 'Quest - Making Safety Visible' initiative and a new electronic sepsis assessment was being introduced, along with a Sepsis education and training package.
- We viewed the divisional annual work plan which included the implementation of care bundles to improve the recognition and care of deteriorating patients. The bundles included sepsis, acute kidney injury (AKI), preventing cardiac arrest, and stroke or high risk transient ischaemic attack (TIA).
- Staff on the Emergency Floor demonstrated the e-observation platform. The hospital used the platform for paperless capture of vital signs and clinical data to use with patients NEWS, AKI and sepsis. Staff told us the system was used to identity deteriorating patients and support intervention before patients suffered adverse events. This meant there was a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response.
- The divisional quality scorecard showed between 1 June 2015 and 1 November 2015, 88% of eligible patients had received a falls assessment within 24

hours of admission, which is better than the trust target of 80%. The trust's 'falls collaborative' met every six weeks to review the hospital's performance in regards to falls reduction. Falls reduction was also part of the trust's Quest improvement programme.

Nursing staffing

- Nursing staffing levels had been reviewed and assessed using the National Safer Nursing Care Tool. Staff felt that senior managers would listen to their concerns about staffing levels. Managers and staff told us when there were nursing shortages on the roster, these would usually be made up from bank or agency staff. Managers told us they were trying to reduce the number of agency staff needed by increasing recruitment.
- Overall, we found there were sufficient nursing staff to meet patients' needs. We viewed the trust's figures for planned and actual nurse staffing levels from May to August 2015. For medical wards in May 2015 the whole time equivalent (WTE) number of nurses budgeted for was 719.72, the actual number of nursing staff on duty including bank and agency was 697. Factoring in allowances for annual leave and other staff absence, this shows that hours worked was in line with what was required. We noted the division used more than the WTE planned number of health care assistants (HCA) between May and August 2015. For example, in June 2015 the planned number of HCA's and support staff was 420.43, the actual number of HCA's and support staff on duty was 463. This meant that there were more staff available to do non-clinical tasks, enabling qualified nursing staff to concentrate on clinical work.
- The divisional dashboard for staffing rates of actual numbers of staff against planned numbers recorded staffing from August 2014 to August 2015. For example, qualified nursing staffing rates varied from the highest rate for qualified nursing staff during the day as 96.8% in August 2014 to the lowest rate of 93.5% in February 2015. The average rate per month was over 96%.
- The dashboard for staffing also recorded the staffing rates for qualified nursing staff at night. The lowest rate was 95.8% in February 2015 to the highest rate of 97.9% in July 2015. The average night time qualified nursing staffing rate was 97%.
- The divisional risk register recorded qualified nursing staffing shortages as a risk to patient safety. The risk register recorded that staffing shortages should be recorded as an incident. It also showed actions the trust was taking to mitigate the risks posed by staffing shortages, including daily reviews of staffing by all wards and departments to ensure the allocation of staff ensured each clinical area was safe.
- Staff on Burlington ward told us providing chemotherapy competent nurses could be problematic, especially out of hours. The trust provided chemotherapy at the Medical Day Care unit. At the time of our inspection Burlington ward had one trained chemotherapy nurse on duty instead of two. The division informed us this was due to staff sickness at short notice. The trust said the unit was also covered by a chemotherapy learning facilitator and unit manager; and the lack of one chemotherapy trained nurse on the day of our inspection had not affected patient care. However, staff told us the chemotherapy learning facilitator was not full-time and was not always available.
- Staff told us there was a lack of haematology trained nurses to meet the needs of complex patients.
- Staff across the division told us they would record staffing shortages as an incident if they thought they could not provide safe care. This demonstrated the trust could monitor staffing capacity and risks this may pose to patient care.
- Staff on the Emergency Floor told us agency nurses did not provide care for patients with complex care needs. Staff told us there were 15 WTE qualified nursing staff and four vacancies. Staff told us there were a number of new staff and limited numbers of staff with over two years' experience.
- During our unannounced visit we saw that a bay on one of the DOME wards was closed due to the hospital being unable to find sufficient staff to work that particular shift on the ward. We discussed this with the ward sister who acknowledged that staffing could be "tight" and in December recruitment of agency and bank staff could be difficult. The ward sister told us the trust would rather close a bay and provide safe care than overstretch staff.

Medical care (including older people's care)

- We spoke with the Director of Medical Services. They told us nursing recruitment was on-going and the trust had recently had a drive to recruit nursing staff from overseas. We saw nursing vacancies advertised on the trust's website and the British Medical Journal website.

Medical staffing

- The hospital had a lower percentage of consultants and a similar percentage of junior doctors compared to the England average. For example, 27% of medical staff were consultant level, this was worse than the England average of 34%. Middle career doctors made up 4% of medical staff, worse than an England average of 6%. Medical staffing percentages for registrars was 44%, higher than an England average of 39% and junior doctors made up 25% of medical staff compared to an England average of 22%. This meant compared to other trusts, the medical workforce was more reliant on junior staff.
- There was a divisional on-call rota for out of hours (OOHs) medical staffing cover included evenings and weekends. For example, the general medicine consultants worked the day shift from 9.00am to 5.00pm. There was an OOH's consultant on-call outside these hours. The on-call rota carried the name of all the division's on-call consultants, with details on how they could be contacted. The rota also carried the details of on-call registrars, doctors and junior doctors, as well as their bleep contact details when on shift.
- The Acute Medical Unit AMU had consultant cover from 8am to 5pm Monday to Friday and was covered by on-call medical consultants at weekends. There was a duty cardiologist throughout the day and an off-duty cardiologist was on-call between the hours of 5pm and 9am and at weekends.
- The Emergency Floor had on-call consultants for all new patients. As well as on-call consultants for elderly care, thrombolysis, and cardiology. There were separate medicine teams and elderly care teams on duty by day and an on-call rota for medical staff OOH's, this included a medical registrar, three senior house officers, and a junior doctor. Most doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and out of hours and that consultants were supportive when present and contactable by phone if they were needed for support out of hours.
- We viewed medical staffing rotas on the Emergency Floor and saw that actual medical staffing levels were congruent with the established number of medical staff required to staff the department. Some staff across the division told us staff were coping, but felt stretched. For example, staff on one (DOME) wards told us the ward was 0.5 WTE consultant short. However, interviews to fill the post were arranged for January 2016.
- The Medicines division had handover arrangements whereby the incoming consultant met with the outgoing junior medical team at 8.00am. New patients were discussed in detail. Incoming junior doctors attended the consultants' morning ward rounds. There were daily consultant board rounds at 3.00pm. Newly admitted patients up to 7.00pm were reviewed by the duty on-call consultant. There were 'hospital at night' meetings at 8.30pm. These were attended by the on-call doctors and staff from the ward based teams.
- There were medical consultants working seven days a week in the trust. At weekends, consultant cover in the hospital was eight hours a day. Most medical admissions were seen by a consultant within 12 hours of admissions. The AMU had dedicated consultant cover seven days a week. At other times, a consultant was always available for advice or to attend the hospital in an emergency.
- The General Medical Council (GMC) visited Worthing Hospital in May 2015. The GMC report found that junior doctors reported handovers as being comprehensive.

Major incident awareness and training

- Emergency plans and evacuation procedures were in place. However, staff we spoke with told us they had not had not received recent training in major incident preparation.

Are medical care services effective?

Medical care (including older people's care)

Good

We rated medical care services at Worthing Hospital as 'Good' in delivering effective care. This was because the Division of Medicine provided evidence based care that followed guidelines and legislation.

Care and treatment achieved positive outcomes for patients and the division used audit and other data to understand and improve the quality of services.

There was a multi-disciplinary and collaborative approach to providing care and treatment with staff appropriately qualified and competent to carry out their jobs.

Staff could access the information they needed to assess, plan and deliver care to people in a timely way. Staff understood the importance of obtaining consent and were compliant with the requirements of the Mental Capacity Act (2005).

Evidence-based care and treatment

- The Division of Medicine adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. The trust had an effective process for monitoring the implementation of NICE and Royal College guidelines. For example, we viewed a selection of the division's monthly clinical governance board meeting minutes and saw these had reviews of NICE guidance as a standard agenda item. This ensured patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation, and ensured consistency of practice.
- Guidance and guidelines from the trust and NICE were available to staff on the trust intranet. Staff told us guidance was easy to access, comprehensive and clear. We viewed a selection of the trust's policies and procedures and saw these referred to the guidance and legislation that underpinned the policy. For example, the 'behaviour management policy' contained hyperlinks to relevant guidance and legislation on the DoH website.
- However, we noted that a number of the trust's paper based chemotherapy policies and procedures on Burlington ward were out of date. We asked staff if we could view the policy on the trust's intranet. Staff were unable to access the policies on the intranet due to the electronic system being inaccessible at the time. Staff told us the policies were in the process of being updated.
- We viewed the trust's 2016 audit planner. We saw an audit of NICE quality standards and guidelines was a 'priority 2, non-compulsory, audit' on the audit planner. This meant the trust was taking steps to ensure staff followed appropriate guidance and guidelines.
- The division reviewed the national clinical audit programme to ascertain the progress of the trust's annual audit programme. Progress was assessed and monitored using a traffic light, red, amber, green, (RAG) system. All national audits that were scheduled for 2015 were green rated; this indicated that evidence had been seen by the divisional leads that the audits were progressing to schedule. The only exception was inflammatory bowel disease audit (IBD) audit which was amber rated. This audit had been assessed as delayed in March 2015. However, an action plan had been implemented to get the audit back on track.
- The trust had a clinical audit programme in place for 2016. There was a '4-step' model for prioritising audits. Audits classified as 'priority 1' were external 'must do' audits. These were national projects taken from the healthcare quality improvement partnership (HQIP) programme, February 2015, for example, the national bowel cancer audit. The trust also had 'priority 2' audits, which were non-compulsory, and were covered in the Department of Health (DoH) quality accounts. 'Priority 3' audits were divisional priority audits and were signed off by the chief of service as and when the priorities arose. 'Priority 4' audits were ad hoc clinical interest audits and were not part of the annual audit planner, and were based on ideas from clinicians that could provide local changes in clinical practice and education. This meant a system of audit was in place to monitor the effectiveness of patient care.
- The electronic prescribing system allowed for close monitoring of antibiotic usage across the hospital.

This allowed the pharmacy team to see where the trust prescribing policy and national guidance was not being adhered to and to intervene with advice, when necessary.

Pain relief

- The hospital had a pain management service available for patients on referral from medical clinicians, which was staffed by a small team of nurses. Staff from the pain management team told us at a focus group they were well supported by the anaesthetic department.
- Patients told us that their pain was well managed and staff would respond promptly if they needed pain relief.
- We observed staff monitoring the pain levels of five patients and recording the information. Pain scores were recorded in patients' notes we examined. On the DOME wards people's pain had been assessed hourly in most cases.
- The carers survey for the 1 March 2015 to 23 August 2015 found 62% of carers thought staff did everything they could to help the patients pain; 14 % thought patients pain was managed sometime.; and 0% thought staff had not done everything they could to manage the patients pain.

Nutrition and hydration

- The trust used a nationally recognised tool to assess patients' nutrition and hydration. All nutrition assessments and fluid balance charts were complete and up to date with documented dietician reviews where appropriate.
- We saw nutrition and fluid plans were followed with fluid balances had been scored, and acted upon where appropriate.
- A dietician was available on referral to the hospital's diabetic service.
- Staff told us patients were offered seven hot drinks a day, and in addition there were regular water rounds.
- Patients were offered three main meals and three snacks each day. We observed the trust used a 'red tray' system to identify patients who may require support with eating. Patients were positive about the quantity and quality of the food they received.
- On Ditchling ward there was a nutrition board that identified patients' diets and eating preferences. For example, people who needed soft diets and gluten free diets were identified, as were people who required red trays. This meant people's nutritional needs were given appropriate consideration.
- The hospital operated a protected mealtimes policy. This meant patients would not be interrupted during mealtimes, visitors were not admitted onto wards during mealtimes, unless this had been pre-arranged. Staff told us relatives were actively encouraged to provide assistance during mealtimes as patients preferred their relatives to assist rather than staff.
- The trust ran a 'Lets do Lunch' initiative which paired staff who do not normally work on wards with some of the more elderly patients. They were, in effect, dining companions who provided both company and assistance. Volunteers also participated in the scheme. Staff taking up the opportunity were very positive about it and included PAs, secretaries and other non clinical staff.
- Welcome home packs had been introduced to provide frail and isolated patients with enough food and drink to ensure they do not have to worry about their first 24 hours at home. Local supermarkets were providing the goods which contained essentials such as milk, bread, fruit and cheese,
- A dietician from the trust had co-authored two books with recipes and practical tips for people with cancer or who had swallowing difficulties, to make eating easier.

Patient outcomes

- We viewed Worthing Hospital's most recent hospital episode statistics (HES) covering the period December 2013 to November 2014. The statistics for standardised relative risk of re-admission in medicine was an overall score of 95 for all elective admissions, which is better than the England average of 100. A score below 100 is interpreted as a positive finding, as this means there were less observed re-admissions than expected. For example, elective gastroenterology scored 94. However, there were outliers, with medical oncology scoring 107 and clinical haematology scoring 104.

Medical care (including older people's care)

- The HES statistics for standardised relative risk of re-admission in medicine was an overall score of 91 for non-elective re-admissions. For example, general medicine scored 90, geriatric medicine scored 98; and clinical haematology scored 80, worse than the England average of 100. However, given the very elderly population the trust saw this was a neutral finding.
- We viewed the 'Myocardial Ischaemia National Audit Project', (MINAP) audit for 2013-2014 and the trust performed better than England averages. Unstable angina is a type of recurring chest pain, and NSTEMI (which stands for non-ST-segment-elevation myocardial infarction) is a type of heart attack. 96.2% of 235 NSTEMI patients were seen by a cardiologist or a member of the cardiology team, better than the England average of 94.3%. 76.6% of NSTEMI patients were admitted to a cardiac unit or ward, better than the England average of 55.6% and 97.5% of NSTEMI patients were referred for or had angiography, either as either inpatients or following discharge. This was better than the England average of 80.3%.
- Worthing hospital performed better than the England average in all key standards measured in the National Heart Failure Audit. The report for 2012/2013 showed that input from a specialist occurred for 92% of patients compared to the average of 785. The percentage of patients who had an echocardiogram was 95% compared to an average of 91%. Discharge standards were also better than the national averages with 96% of patients prescribed Beta-blocker drugs compared to the average of 82%. Seventy percent of patients were referred to a heart failure liaison service compared to 59% nationally.
- The mortality rate from heart failure had fallen year on year from 20.9% in 2011/12 to 14.9% in 2013/14.
- The hospital participated in the Joint Advisory Group on GI Endoscopy (JAG), including accreditation level. This involved the hospital demonstrating they were meeting agreed levels for domains of the Endoscopy Global Rating Scale (GRS) in clinical quality, quality of the patient experience, workforce; training, ensuring there was a safe environment for patients and staff; and meeting the requirements for decontamination. We viewed the GRS ratings for October 2015 and found the hospital had an 'A' rating across all the domains.
- The national diabetes inpatient audit (NaDIA) from September 2013, published in October 2014, found out of 21 outcomes, 11 were better than the England average and 10 were worse than the England average. Better than the England average results included patients being visited by a specialist diabetes team, being seen by the multi-disciplinary foot care team, and the level of staff awareness of diabetes. Outcomes that were worse than the England average included: medication and insulin errors, and foot risk assessments.
- The hospital demonstrated continued improvement in the Sentinel Stroke National Audit Programme (SSNAP). Worthing Hospital's overall SSNAP score from January 2015 to July 2015 was level B for both patient centred and team centred key indicators (KI). The physiotherapy team SSNAP results for November 2015 achieved a level A.

Competent staff

- Staff told us the trust's initial induction programme was detailed and comprehensive.
- Induction was identified in the 2014 National Training Survey (NTS) as an area for improvement. The trust employed an induction manager and had made over 50 induction videos to help doctors in training to orientate themselves.
- The medical division had consistently not met the trust target of 90% of staff receiving an annual appraisal in the previous 12 months. The figures between August 2014 and August 2015 varied between 72% and 78%. This meant over 20% of staff had not received a review of their continuing professional development needs in the previous 12 months.
- We viewed the general medical council visit report from May 2015. The visit reviewed medical staff access to education, training and supervision opportunities. The report found doctors in training had access to supervision, but where junior doctors covered gaps in the staffing rota meant that occasionally they missed teaching sessions.
- The nursing staff had access to a programme of in-house training. For example, training included patient group directions (PGD), (these are written instruction for the sale, supply and/or administration

of medicines to groups of patients), and medicines management, and VTE assessment and anti-coagulation, (medicines to prevent high risk patients from developing blood clots).

- Pharmacy staff told us all band 6 pharmacy staff were given the opportunity to undertake further training.
- Some staff told us they had access to a range of education and training opportunities as an aspect of the trust's involvement with the NHS Quest initiative. This included site visits from staff at other hospitals providing peer reviews, leadership days and conferences.
- Registered nursing staff told us they were supported with preparing their revalidation. A number of staff told us that a record was kept of when staff needed to update their professional registration and reminders would be sent via email by the trust's human resources team.
- Physiotherapy and OT staff told us they had regular team meetings and were supported with their continuous professional development.
- Locum staff received an induction pack; this included a DVD introduction to the hospital. The hospital had also introduced smartcards for locum staff to address previous issues of locums not being able to access the electronic recording systems. This included a specific pack produced for the department of medicine for the elderly (DOME). Locum staff confirmed they had received an induction and felt this had prepared them to work at the hospital.
- The trust informed us all junior doctors undertook a prescribing assessment when first employed. Junior doctors with a lower score were directed towards additional e-learning relevant to their assessment outcome, and were offered support and supervision from their clinical supervisor. The plan and outcome of this was communicated to their local faculty group lead and their local academic board.
- Junior medical staff reported good access to teaching opportunities and said they were encouraged to attend education events. Junior doctors told us they received good educational supervision and that consultant staff took an active interest in their teaching.

Multidisciplinary working

- When patients received care from a range of different staff, teams or services, this was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering patients care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Throughout our inspection, we saw evidence of effective multidisciplinary team (MDT) working in the ward areas. We observed good communication at an MDT meeting on Brooklands ward. Clinical staff told us nurses and doctors worked well together within the medical speciality. There were daily multidisciplinary board rounds which included, doctors, nurses, and either an OT or physiotherapist.
- Physiotherapists, OT's, and pharmacists all told us that MDT working was generally effective. Most allied healthcare professionals we spoke with told us they felt part of the team. Staff told us there was effective working with other providers. An OT told us, "We work very closely with social workers."
- We viewed the emergency admission pathway algorithm for frail elderly patients. This gave clear guidance to staff on the steps to be followed in the event of a frail older person presenting at the A&E. This included guidance for staff on the referral pathways for the hospital's speciality teams as well as the department of medicine for the elderly (DOME). This meant patients had specific routes to specialist services which would speed up their access to appropriate care and treatment.

Seven-day services

- Staff told us enhancing seven day services was a trust priority and work was progressing towards meeting the NHS improving quality agenda. This meant the hospital was taking steps to make services more accessible and avoid compromising safety and patients' experience.
- The hospital had a Band 7 pharmacist who was rotational and multiskilling with a view to seven day working.
- Hospital in-patients had scheduled seven day access to diagnostic services. Consultant directed diagnostic tests and their reporting were available seven days a

week: They were available within one hour for critical patients and 12 hours for urgent patients. However, urgent access to interventional radiology was weekdays only. Outside these hours patients would be transferred to a dedicated hub. Patients had urgent access to endoscopy 24 hours of the day, including weekends.

- An OOH's emergency physiotherapy service was available across all inpatient areas for patients experiencing or at risk of respiratory deterioration. The service operated 365 days of the year, this was staffed by an on call physiotherapist who was available to attend on-site. The service was accessible through a pager via the main switchboard and operated 4.30pm to 8.30am on weekdays and for 24 hours at weekends.

Access to information

- Staff could access the information they needed to assess, plan and deliver care to patients in a timely way. When there were different systems to hold or manage care records, these were coordinated organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- The hospital used an e-observations platform for paperless capture of patients' vital signs and clinical data. This meant staff had access to up to date clinical information on patients.
- The trust had introduced an electronic handover in 2015. Staff across the Medicines division were positive about the e-handover system.
- Overall discharge letters were clear and comprehensive and were sent to GPs on a daily basis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. People were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. When people aged 16 and over lacked the mental capacity to make a decision, 'best interests' decisions were made in accordance with legislation. For example, we saw a best interest meeting had been convened on Clapham ward to discuss discharge arrangements for a patient with dementia.
- Staff had a good understanding of capacity and consent issues and were able to describe the correct process for establishing capacity and obtaining consent and knew where they would get further advice and support if needed. For example, some staff told us they could contact the trust's safeguarding lead or the local authority social services for advice.
- Deprivation of liberty was recognised and only occurred when it was in a person's best interests, was a proportionate response to the risk and seriousness of harm to the person, and there was no less restrictive option that could be used to ensure the person got the necessary care and treatment. Nurses were clear about the processes they would follow to initiate 'deprivation of liberty safeguards' (DoLS). Staff told us this was covered during their safeguarding training. However, on Becket ward in two patients' notes we found neither DoLS applications demonstrated how the person met the 'acid test' criteria for DoLS.
- The trust were meeting the 85% 'commissioning for quality and innovation' (CQUIN) target for 'staff identified in the training plan to receive mental capacity act training'. The trust were also meeting the targets for 'monitoring of DoLS / IMCA consultations', by reviewing 10 applications a month. This meant vulnerable patients who required DoLS could be sure the trust monitored the quality of their applications and ensured they had appropriate access to independent advocacy services to support them through the DoLS process.

Are medical care services caring?

Good

We rated the medical care services as 'Good' for caring.

Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people.
People thought that the care they received exceeded their expectations. This was because feedback from

patients and those close to them was positive about the way staff treated them. Staff demonstrated caring, compassionate attitudes and built positive relationships with patients. The level of positive feedback was exceptional before, during and after the inspection. There were very few negative comments received about the service.

People's emotional and social needs were highly valued by staff and were embedded in their care and treatment. Staff involved patients and partners in their care and supported them to make decisions. Staff were encouraged to take part in 'Sit and See Observations' to enable them to see care through the eyes of the patients. The ward accreditation scheme included metrics based on compassionate care.

Compassionate care

- Feedback from stakeholders, patients and those close to them was positive about the way staff treated people. People were treated with dignity, respect and kindness during all interactions staff and relationships with staff were positive.
- We received very large numbers of people contact with positive feedback prior to, during and after the inspection. Very few people contacted us about poor experiences. Most people were exceptionally happy with the care they received.
- The Medicine division's response rate to the 'Friends and Family Test' (FTT) was better than the national average rate at 37%.
- During the period from November 2014 to November 2015 between 91% and 94% of respondents said they were likely or very likely to recommend the hospital.
- We observed patients being treated with compassion, dignity and respect. The patients and families were positive about the care provided. Patients told us doctors, nurses and other staff were caring, compassionate, and responded quickly to their needs. A patient told us, "They are always polite."
- We saw numerous Thank you cards and patient feedback on display across the Medical wards. For example, a patient's relative had written, "Thank you for your kindness to my relative. We were comforted to know that they were in such good hands."
- Eastbrook ward was a runner up in the trust's annual 'Patient First' star awards. The award recognised a team who had gone beyond the normal expectations in caring for patients with exceptional kindness, dignity and respect, and epitomised the trust value of "we care."
- The trust's carers survey for 1 March 2015 to 23 August 2015 found that 90% of carers thought patients had always been treated with respect and dignity by the doctors, nurses and other staff; nobody thought patients had not been treated with respect and dignity.
- The trust carried out 'Sit and See Observations' to observe the care and compassion of staff towards patients. The principles of the tool were to safeguard people through recognising that the absence of compassion was one of the first indicators of a failing environment. The scheme also celebrated and spread good practice that was observed and enabled staff to see care through the eyes of a patient.

Understanding and involvement of patients and those close to them

- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their families about the care and treatment options.
- Most patients and relatives told us that they had been kept informed regarding the care that they were receiving and that both the medical and nursing staff were approachable if they wished to discuss their care. For example, a relative who was visiting a patient on Durrington ward told us, "They are really fantastic. They've allowed me to stay. They have quite a few patients with dementia. They are so good with them. The doctor comes around every day and tells me about my parent's blood pressure, as I like to keep an eye on it."
- We also spoke to patients about the support they had received from allied health professionals such as physiotherapists and occupational therapists. They reported that they had been encouraged to learn to do exercises when on their own and the way that these had been explained to them had empowered them to feel more in control of their condition.

Medical care (including older people's care)

- We viewed the analysis and comments from the trust carer questionnaire dated 1 March 2015 to August 2015. To the question, 'during this admission, have the staff talked to you about your needs as a carer': 33% responded 'yes, fully'; 24% responded 'yes to some extent'.
- Electronic ward screens were being introduced across both hospitals to provide 'real-time' communication and information for patients and visitors. The displayed information included the safety thermometer results, FFT results, a staff uniform guide and actual staffing versus planned staffing levels.

Emotional support

- We observed patients receiving good emotional support from staff.
- Chaplaincy details were advertised in the patient guide that was available at patients' bedsides and chaplains visited regularly.
- The hospital had a Macmillan Information and Support Service which was open three days per week. It provided

  counselling, self-help and support to anyone affected by cancer.
- The hospital employed a number of clinical nurse specialists who could offer patients with specific conditions such as cancers or COPD on-going emotional support.
- We viewed the ward level 'Care, kindness and compassion' observation results. Overall across the division the results were positive for 'Demonstrable care and compassion when patient appears anxious or distressed'. For example, the emergency floor scored 100% for June 2015.
- We did not see any patients or families receiving bad news on the announced visits. However, nurses told us that if a patient was going to receive bad news from a consultant then they would always make sure that there was a nurse present to provide additional support.

Are medical care services responsive?

Outstanding ☆

Medical care provided at Worthing Hospital was outstandingly responsive to patient's needs.

The proactive involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. Good examples of this included 'One call, One team' project where the trust worked with other stakeholders to reduce the number of frail elderly people being admitted to hospital and the involvement of people with learning disabilities and carers in the development of services for patients with learning disabilities.

This was because the service understood the different needs of the people it served and designed and delivered services to meet those needs. Patients were able to access care at the right time. The trust was exceeding the referral to treatment targets in medical specialities.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that mets these needs and promotes equality. This included people who are in vulnerable circumstances or who had complex needs. The services for people living with dementia were of particular note with adaptation and consideration at both local and strategic level to meeting the wider needs of this cohort of patients. The local population was demographically very elderly and so there were large number of patients across the service who were living with dementia. The strategic planning addressed the needs of this cohort. We saw staff who were willing to be flexible and consider the needs of individuals and who were willing to try and meet each persons preferences, whenever possible.

There was active review of complaints and how they were managed and responded to, and improvements were made as a result across the services. People who used services were involved in the review by attending board meetings to tell their stories, for example. Staff were able to tell us about specific examples of learning from complaints.

Medical care (including older people's care)

Service planning and delivery to meet the needs of local people

- We reviewed the divisional work plan for 2015 to 2016. The plan outlined the key deliverable service initiatives for the medicines division. The plan was RAG rated to enable senior managers and the trust board to easily monitor the division's progress. For example, the trust had introduced ward accreditation assessments, with two wards being assessed every week.
- Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to A&E or if they did, making sure their medical and social care needs were quickly assessed. This meant elderly patients spent less time in the A&E and were either admitted to the ward or supported in going home.
- The hospital provided two rapid access cardiology clinics every week. These were led by consultant cardiologists and provided early assessment for patients experiencing chest pain.
- The hospital had a level 2 chemotherapy and haematology service. Both services were linked with Brighton University Hospitals NHS Trust and had been peer reviewed as an aspect of MDT between the services. Chemotherapy was delivered locally to patients where possible.
- The 'Coastal Cabinet' was an initiative with the local clinical commissioning group (CCG) to redesign the 'front door' of hospital services. This involved improvements in the way the hospital, community health services and the local authority worked together. Staff told us the hospital was also working with the CCG on stroke care reconfiguration in West Sussex; and the redesign of musculoskeletal (MSK) services.
- The division had two escalation wards for busy periods. Both of these wards were in use at the time of our inspection.
- The 'One Call, One Team' initiative base at the hospital was a multi-agency scheme set up to prevent elderly people being admitted to hospital unnecessarily by ensuring closely co-ordinated services in the hospital and community worked together to provide care at the person's home.
- The Emergency Floor admitted elderly patients under the care of a consultant who led a multidisciplinary team. There was ready access to diagnostic tests and support services to deliver enhanced care pathways.The performance data showed a 7% reduction in the length of stay for elderly patients and a 4% reduction in mortality.

Access and flow

- The division was exceeding the operational standards whereby 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. Individual medical speciality performance ranged from 100% for neurology and geriatric medicine to 92% for cardiology. This ensured patients had timely access to initial assessment, diagnosis and urgent treatment.
- Worthing Hospital had a longer length of stay for non-elective stays, between January and December 2014, at 7.7 days; compared to the England average of 6.8 days. All medical specialities had length of stays greater than England averages. Given the local demography, this should be considered a neutral finding.
- The average length of stay at Worthing Hospital for all elective stays in medicine between January and December 2014 was 1.9 days, which was better than the England average of 4.5.
- Performance for individual medical specialities was consistently better than England averages and ranged from an average length of stay of 1.5 days in cardiology against an England average of 1.9 days. However, gastroenterology was longer than the England average with an average length of stay of 4.4 days against an England average of 3.1 days, and clinical haematology.
- The Medicines division was effective at managing the flow of patients through the hospital. The division had developed pathways that reduced the need for

patients to access services through the A&E department. For example, the Emergency Floor ambulatory unit saw patients who would have previously been seen in the A&E department.

- Emergency Floor data found between September 2015 and November 2015 there were 4,141 admissions, 43.6% of these were timed admissions. 1,799 of these were seen and assessed by a doctor within 30 minutes, 66.8% were seen within 60 minutes, and 79.8% within 90 minutes. 78.5% of patients were reviewed by a relevant consultant within 12 hours of arrival. This meant most patients received timely assessments from a doctor.
- There was a trust wide discharge planning and bed management team who were responsible for the co-ordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new patients to be admitted and ensured patient discharges were timely.
- The trust was able to distinguish between moves based on clinical need and those for whom the move was not clinically necessary. Patients with dementia and those needing end of life care were protected from non clinical moves, whenever possible.
- Between September 2014 and August 2015 3% of patients were moved four or more times in this time period. This was better than the England average of 12% suggested by the Kings Fund. There is a correlation between bed moves and length of stay.
- The Medicines division risk register identified there was a lack of medical and DOME bed capacity at the hospital resulting in patients outlying in surgical beds and opening of escalation areas. This caused additional staffing problems for nursing and medical teams. There was a risk of patients not being in appropriate placement, causing the risk of delays in assessments, treatments and pathways with resulting increased length of stay.
- The hospital addressed this via regular operational site meetings at 8am, 12 noon, 4pm and 8pm to review bed capacity and agree decisions between divisions as to the most appropriate plans for patient placements. For example, patients were zoned in the hospital to consultant paired wards. The site team tracked outliers on daily basis to review progress, treatment plans, and expected date of discharge and ensure consultants were aware of patients being moved. Where possible outlying patients were placed in to surgical capacity rather than escalation areas. Discharge co-ordinators supported wards in processing discharge arrangements. There were extra DOME junior doctors on duty to oversee outliers, and extra bank or agency nursing staff would be requested to assist staff on the wards. The number of patient moves and patient outliers were escalated to the chief nurse on a weekly basis.
- We viewed the Medicines Division outliers, patients who are placed in other departments due to a lack of beds, figures from June 2015 to November 2015. There were five in June with a steady increase to November when there were 23. Medical staff told us when there were a number of patients in outlying wards it placed extra stress on staff seeing outlying patients. This was recognised and being addressed by the trust executive.
- The trust was meeting their Commissioning for Quality and Innovation (CQUIN) target for the 'percentage of discharge summaries with four key items of information, as assessed by audit of 25 notes per month'. The target was 23, the division was achieving better performance at 27 per month.
- A Band 7 nurse told us the average decision to treatment (DTT) waiting time for chemotherapy was four weeks. The trust informed us waiting times at the time of inspection was four weeks, but this would include an information and advice session before the start of the first chemotherapy cycle and time to allow surgery to heal. Urgent referrals would be accommodated more quickly, provided all diagnostics and staging had been completed. This was in accordance with the maximum 31 day wait from the date a DTT is made to the first definitive treatment for all cancers, as recommended in the NHS good practice guidance 'Delivering cancer waiting times.'
- The trust's cancer waiting times showed the trust met the 96% standard in every month from April 2015 to November 2015. We also found the trust were consistently meeting the 85% standard for a two

month wait from a GP urgent referral to a first treatment with the exception of June 2015 when the figure was 84.7%. This meant cancer patients could be sure they would receive timely treatment.

Meeting people's individual needs

- Appropriate information was available in English as a matter of routine. Information in other languages could be provided on request. Staff told us interpreters were available both in person and via the telephone and gave examples of when they had used these services.
- The hospital provided 'Hospital passports' scheme for patients living with a learning disability, which allowed them to identify to staff their likes and dislikes in a pictorial format. There was also an 'Easy Read' menu available for patients. The hospital also had a learning disability liaison nurse to support patients with their care and treatment.
- The trust undertook and annual review of the care people with learning disabilities received using a peer review that included input from people with learning disabilities and their carers.
- On the DOME wards we found patients had completed 'Knowing me' forms in place. These had been completed in consultation with the person who knew the patient the best and allowed staff caring for people with delirium to understand what was important to each patient.
- The hospital had 'knowing me' volunteers who spend time with older patients, talking and listening and helping with activities. Ward staff felt that volunteers enabled a more person centred delivery of care and offered reassurance, stimulation and comfort to patients.
- Patients with a diagnosis of dementia were flagged on the electronic record system. This allowed the dementia nurse specialists to keep track of patients and to visit to offer support and advice to areas where patients were being cared for.
- The trust had dementia champions in both hospitals on wards and other clinical areas. They had received additional training to enable them to support carers and other staff.
- Staff told us about the 'Twiddlemuff' scheme where staff, visitors and the local community made activity muffs and blankets for people living with dementia, to help reduce agitation.
- Ward lavatories had signs that followed the dementia design principles of prominent colours and images to convey messages.
- Patients we spoke with were generally positive about the quantity and quality of food they received. We saw a patient's records showed the patient as "Only liking chips" rather than any other form of potato. This mirrored their 'Knowing me' form. The patients' food intake charts showed they were frequently given chips as this was one of the few things the patient could be persuaded to eat.
- We saw DOME wards had activity boxes available to patients; these contained an assortment of aids to improve the care provided to patients living with dementia.
- The League of Friends had funded Rempods for use on wards to help recreate a positive environment for patients who found it hard to adjust to unfamiliar hospital surroundings.
- The trust had a carer support service for relatives of people living with dementia. Details were available from wards and the PALS office.
- We spoke with a hospital OT who told us staff occasionally struggled if the OT team recommended one to one care for dementia patients, due to staffing ratios; and staff being unable to provide one to one care.
- Individualised care plans were used throughout the hospital. The hospital also used a variety of care pathways and care bundles to assess and monitor the nursing care provided. This meant patients had records that took account of their individual needs and preference regularly recorded the outcomes of their care.
- The trust had a 'baywatch' scheme. This involved a member of staff remaining on a ward where there was a patient who needed to be supervised due to

dementia or challenging behaviour. We saw a HCA acting in this role on Ditchling ward. A band 7 nurse told us, "All HCA's and qualified nurses' do dementia training."

- 'Intentional rounding' was recorded in each patient's record. This is a structured approach demonstrating that nurses had conducted checks on patients at set times to assess and manage their fundamental care needs. Patients records demonstrated nursing staff regularly helped people change their position; offered drinks; and assisted patients in going to the lavatory.
- Patients' skin integrity was also regularly assessed, patients at risk of pressure ulcers had access to pressure-relieving mattresses and cushions in accordance with the Royal College of Nursing (RCN) management of pressure ulcers guidance.
- Hospital staff worked in partnership with a local charitable trust to provide patients with a cardiac buddy service. Cardiac rehab staff work alongside the buddies providing education and support to people with long term heart conditions. Buddies work on the wards and in the exercise classes. The scheme was developed several years ago as a result of patient feedback.

Learning from complaints and concerns

- Complaints were managed in accordance with trust policy and lessons were learnt. Staff and managers told us they preferred to resolve minor concerns locally, at ward level. Staff said these were not recorded, but if they could not deal with the concern immediately patients would be directed to make a formal complaint. This was in accordance with the trust's policy on complaints. There were clear procedures and staff responsibilities for managing and responding to complaints.
- We viewed the complaints procedure, which included a flowchart to guide staff on the procedure to follow. Complaints were dealt with by the divisional office with the matron and governance leads being notified of a complaint. The matron would be given a timescale for investigating the complaint and sending a response. The governance lead would review the matron's investigation. The response would be forwarded to the divisional office who would respond to the person who had raised the complaint in writing. The governance lead would be sent any changes to practice for approval.
- All the patients we asked said that they had not raised any complaints with the service, and they found staff approachable if they wished to raise issues.
- Information regarding complaints and concerns was available on all the wards and in the patient bedside information packs. We only saw information packs in English. Staff told us information in all languages could be requested from the hospitals accessible communications team. We saw that information leaflets provided the contact details of the patient advice and liaison service (PALS) and explained that people could receive support from PALS in making a complaint. The leaflets also advised that support for non-English speakers and people who needed support with communication was available via the advocacy service.
- We saw that complaints and concerns were discussed at the monthly quality and safety board meetings. The minutes of these meetings showed that complaints to the service were a standing agenda item and discussed at the meetings to ensure the quality of services improved. Learning from complaints was shared at team meetings and across services, where applicable.

Are medical care services well-led?

Outstanding ☆

We rated medical care services as 'Outstanding' in terms of being well led. This was because the leadership, governance and culture was used to drive and improve the delivery of high quality person-centred care.

There was good interagency working and initiatives created in conjunction with other providers in the local community to enable the hospital to maintain the flow of patients by collaborative admission avoidance strategies. Leadership stepped outside the hospital when looking for solutions to the increased demand for care of the frail elderly population serviced by the hospital.

Medical care (including older people's care)

There was a really clear vision and strategy for the service, which was well developed and well understood throughout the division. Staff went out of their way to talk to us about the care they provided, new initiatives that had been developed from staff ideas and their sense of belonging and ownership of 'their' hospital. This was true of staff of all grades and all disciplines and included volunteers.

Leaders had an inspiring shared purpose, strived to deliver and motivated staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. There was transparency in decision making with consistently high levels of constructive staff engagement. Staff believed in the leadership and were exceptionally proud of their achievements.

Governance and performance management arrangements were robust and proactively reviewed. There was a clear and proactive approach to seeking out new and sustainable models of working.

Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.

Vision and strategy for this service

- The trust 'vision and values' were included in information guides at patients' bedsides. Some staff were able to articulate the trust's values as 'PEOPLE'. This was an acronym for patients at the heart of all we do; excellence in all we deliver; openness and honesty at every level; promises delivered; listen and learn; equal treatment, equal access and equality of opportunity.
- HCA's told us the trust's vision and strategy were displayed around the hospital. One HCA said, "The vision is Patient First. It's hard not to be aware of it."
- Clinical areas had a clear vision for how they would develop their specific services in the future. For example, the Emergency Floor had a vision of how they would expand ambulatory care in the future.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the trust's strategy and good quality care. This included daily ward level safety huddles, monthly quality and safety board meetings, and clinical governance half-days that were led by senior medical staff, monthly care group meetings, and quarterly joint ward sisters meetings which were attended by matrons and senior nursing staff from across the medicines division.
- The reporting requirements for the divisions four care groups had been standardised for each care group that fed in to both the divisional board meeting and quality and safety board meeting.
- The medicines division management team structure flow chart clearly set out the sequential order of the division's management structure and how information from clinical staff and the four care groups was fed into the trust board.
- Staff were clear about their roles and understood what they were accountable for. For example, physiotherapy staff showed us their job descriptions and were able to tell us about their lines of accountability within the service.
- The hospital had introduced a balanced scorecard. This is a strategic management and planning instrument to monitor the effectiveness of services and showed they were taking appropriate steps to monitor and manage quality and performance with accurate, valid, reliable, timely and relevant information.
- A ward accreditation programme was being rolled out across both sites with metrics that focussed on the trust vision and values as well as patient safety. Progress against the metrics was measured and used by ward managers to identify goals and areas for improvement.
- The division had reviewed the governance structure and had carried out the appropriate changes to meet CQC requirements. For example, clinical governance rolling half days had been introduced with a standard agenda. The half days examined mortality trends, adverse incidents, serious complaints, serious errors (including prescribing errors), lessons learnt from RCA's and feedback from staff on safety or quality concerns.

Medical care (including older people's care)

- The Division of Medicine used a divisional dashboard, this gave senior staff and the board a comprehensive understanding of the divisions performance, with integrated information on safety, quality, activity and finances. The divisional dashboard used RAG rating and graphs as well as data to give senior staff and the board a quick way of understanding the division's performance. The RAG ratings and graphs indicated that between August 2014 and August 2015 the division had either a green rating for the 'quality' domain; and amber ratings for the 'performance' and 'workforce' domains; the 'finance' domain had received a red rating for all of the previous 12 months, with the exception of September 2014 and May 2015, indicating that the division was struggling to meet its financial targets in most of the previous 12 months.
- The trust board looked at risk, finance and key performance indicators on the divisional dashboard. Ward level board meetings were then held to disseminate information at ward level. We observed that there was a good focus on clinical risk and performance.
- The division also used a 'board highlights' report dashboard. This was a comprehensive assurance system and service performance measure that was monitored, and any actions the hospital had taken to improve performance were recorded on the dashboard. For example, in August 2015 the dashboard recorded that the referral to treatment times (RTT) in respiratory medicine had not met the trust targets of 90% due to a locum leaving at short notice. The hospital had engaged a new locum to improve the RTT.
- The trust had a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. The progress of external and internal audits were regularly monitored, and action plans put in place to ensure audits were completed within published timescales.
- The division had a risk register in place. This was used for identifying, recording and managing risks and mitigating actions. However, we noted in regards to e-prescribing there was no alignment between the recorded risks on the register and what medical staff said was on their worry list, as across the division a some junior medical staff raised concerns in regards to problems with the e-prescribing system.
- The divisional risk register recorded there was inappropriate prescribing of inpatient oral chemotherapy by junior doctors. The risk register stated that doctors were not aware of procedure to be followed for inpatients on oral anticancer medicines. There were also concerns about the system for identifying inpatients that were on chemotherapy. The risk register stated that the cancer services pharmacist saw all referred chemotherapy inpatients, and the trust's chemotherapy policy had been updated to clarify procedures. A shared network folder was also set up to allow different disciplines access to a list of chemotherapy inpatients. The risk register recorded that the problem would be resolved with the introduction of electronic prescribing in 2015. However, medical staff told us there had been some problems implementing e-prescribing. Actions the trust was taking to mitigate this risk had not been identified on the risk register.
- Themes from the assessments were fed into the divisions' existing governance structures and highlighted at the division's weekly 'CQC meetings', these were weekly meetings where the divisional leaders reviewed the divisions performance in regards to the CQC fundamental standards.
- Work was in progress for a draft standard operating procedure (SOP) for clinical safety huddles.

Leadership of service

- We viewed the Medicine Division management team structure. The senior management structure consisted of divisional level matrons and clinical management teams feeding into the interim head of nursing, and four care group managers, who had direct access to the trust board. The head of nursing was an interim and there was also a vacant care group manager post for specialist medicine.
- Ward managers told us that they felt well supported in their roles and understood their governance responsibilities. The director of operations told us they liaised frequently with the chief of medicine and clinical directors. Staff we spoke with told us the chief

executive and senior management team were visible and the director of operations frequently visited the wards. Staff we spoke with said the senior management team were approachable.

- Staff told us communication between the divisional teams was good. The division had daily board meetings. We observed a board meeting and saw there was good communication between nursing and medical staff in terms of the leadership of the service.
- Junior doctors told us the hospitals' consultants provided effective leadership. Junior and middle grade doctors felt supported by their consultants and other senior colleagues. Overall, staff felt supported by the medical leadership in the division and the trust.
- We observed good leadership skills during medical and nursing handovers. Senior staff were visible in leading these meetings and gave clear direction and support to junior colleagues.

Culture within the service

- Staff morale appeared to be high across the division. Most staff told us they felt respected and valued. We saw multiple examples of staff working collaboratively and sharing responsibility to ensure patients received good quality care. Staff at a focus group told us the hospital was a "nice" place to work.
- Staff and managers we spoke with told us there had been significant improvements in the past 12 months. Staff morale was high and this was attributed to the service's change initiative. Some staff also attributed this to the Chief Executive driving initiatives forward. An OT told us, "The trust is doing well and knows what needs to be improved on."
- Staff were motivated to move the division forward and committed to ensuring patients received high quality care. Staff told us the culture in the service encouraged openness and honesty.

Public engagement

- Patients were engaged through feedback from the NHS Friends and Family test and complaints and concerns raised from PALS. Clinical governance meetings showed patient experience data was reviewed and monitored via the quality scorecard. However, we did not see evidence of any action plans to address issues raised by the public.
- The trust conducted a carers' survey in the form of a questionnaire. Carers' comments were analysed and the response from the hospital recorded.

Staff engagement

- The trust had a 'You said, we did' staff survey. Staff were able to tell us about changes because of the survey. For example, hospital security measures for staff had been improved as a result.
- Staff received a monthly trust newsletter 'Headlines' via email. The newsletter kept staff informed of developments within the trust and gave information on learning events.
- Staff told us the Chief Executive held regular staff open meetings where staff were free to raise any issue they liked. We spoke with a number of staff who had been to these meetings and they told us they felt able to raise issues and that the Chief Executive had been open and transparent in their approach.
- The trust had an award scheme that recognised exceptional staff members or teams. The Medical Day Case unit, chemotherapy unit, had won the 'Chairman's Award' in 2015. The stroke service had won the trust's 'Award for Excellence' for exceeding the quality objectives for continuous improvement in patient outcomes. The physiotherapy DOME team lead had been runner up in this award.

Innovation, improvement and sustainability

- We viewed the division cost improvement dashboard. We saw that there were a number of cost improvement plans for the Medicines division, including a roll over scheme to ensure consistency in staff recruitment and retention payments, value stream mapping of the non-elective pathway improvement opportunities included increasing ambulatory care pathways, realignment of beds and capacity, standardisation of senior daily reviews; criteria led discharge and improved discharge planning and processes. This meant the division were looking strategically at ways to provide best value.

Medical care (including older people's care)

- The Medicines division was involved in a trust wide NHS Quest initiative which focused on improving quality and safety. This involved the trust taking part in collaborative improvement projects for Sepsis and cardiac arrest. Work was in progress on these initiatives at the time of our inspection.

Surgery

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

Information about the service

Worthing Hospital provides a range of surgical services, including trauma, general surgery, orthopaedics, urology, ear, nose and throat (ENT), ophthalmology, gastrointestinal breast and vascular surgery.

There are approximately 125 beds for surgical patients including a five bedded mixed sex enhanced recovery ward and a nine bedded private patient unit. There are nine main operating theatres with 12 recovery beds.

The majority of surgical activities undertaken at Worthing Hospital were day case procedures, which contributed 59% of activity between January 2014 and January 2015. Elective surgery made up 14% of the work, and emergencies contributed 28% to activity. The main speciality was general surgery, which made up 31% of surgical procedures, with trauma and orthopaedics taking 12%, ophthalmology 26% and the rest 31%.

During our inspection, we reviewed information from a wide range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, visited the inpatient wards, operating theatre department, pre-assessment and the day surgery unit. We also observed care being delivered by staff.

The CQC held a number of focus groups and drop-in sessions where staff could talk to inspectors and share their experiences of working at the hospital. We spoke with over 40 members of staff working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, ward clerks, and housekeeping and domestic staff. We spoke with five patients and their relatives. We reviewed nine patients' records as well as other documentation. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection.

Surgery

Summary of findings

Overall we found that surgical services at Worthing Hospital were 'Good'. This was because;

Patients were protected from avoidable harm because there were robust systems to report, monitor, investigate and take action on any incident that occurred. There were effective governance arrangements to facilitate monitoring, evaluation and reporting and learning. Risks were identified and acknowledged and action plans were put into place to address them.

We saw that patients' care needs were assessed, planned and delivered in a way that protected their rights and maintained their safety. Surgical care was evidenced based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The trust was able to demonstrate that it continuously met the majority of national quality indicators. Patient surgical outcomes were monitored and reviewed through formal national and local audits.

There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas of influence. All staff spoke with passion and pride about working at Worthing Hospital and spoke enthusiastically about their role and responsibilities. We found that staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable patients.

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

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

The trust did not meet the referral to treatment (RTT) times for a number of surgical specialties. The ophthalmology, musculo-skeletal and ENT specialties were of particular concern at the current time.

We found there were some environmental challenges where lack of facilities such as adequate storage presented a potential risk to patients and impacted on their care and treatment.

The availability of junior doctors out of hours was raised as a concern as inexperienced medical staff were often working unsupported.

There was a lack of surgical beds within the admissions ward, day care ward and theatre recovery frequently used to accommodate overnight stays because of bed shortages. This affected patients being admitted for surgery. Patients were sometimes recovered from anaesthesia in the operating theatre because the recovery bays were full of patients waiting to be discharged home or to a ward. Surgery was sometimes cancelled because there were often no beds for them to be admitted to.

Surgery

Are surgery services safe?

Good

We rated Worthing Hospital 'Good' for safe because:

There were robust systems in place to monitor safety throughout the service. This included clinical aspects such as the five steps to safer surgery and the World Health Organization's (WHO) procedures for safely managing each stage of a patient's journey from ward through to anaesthetic, operating room and recovery. Environmental safety was assured through regular monitoring and on-going checking of issues such as infection control, equipment and facilities. Surgical services used the NHS Safety Thermometer to assess the quality of care provided by measuring, monitoring and analysing common causes of harm to patients.

We found that patients were protected from avoidable harm because there were systems to report, monitor, investigate and take action on any incident that occurred. Identified concerns were closely monitored and actions taken to mitigate the risks to patients.

We saw that patients' care needs were assessed, planned and delivered in a way that protected their rights and maintained their safety. The hospital had systems to identify when patients' condition deteriorated and were becoming increasingly unwell. This enabled staff to provide increased support. Recognised tools were used for assessing and responding to patient risks.

We found that staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable patients.

The general environment was visibly clean and a safe place to care for surgical patients. There were robust systems and processes to ensure that a high standard of infection prevention and control was maintained. There was sufficient emergency resuscitation equipment available, appropriately checked and ready for use in suitable locations throughout the surgical services.

However:

There was a lack of adequate storage arrangements on the wards. This led to equipment being stored in corridors which is a hazard and infection control risk.

The availability of junior doctors out of hours was raised as a concern as inexperienced medical staff felt they were often working unsupported.

There was little electronic clinical information used in the ophthalmic department which would reasonably be expected in a unit of that size and structure. This meant that all records and reviews were completed manually and comparative and quality data collection was not available.

Incidents

- It is mandatory for NHS trusts to monitor and report all patient safety incidents through the National Reporting and Learning System (NRLS). If an incident is assessed as a serious incident it is also reported using StEIS (Strategic Executive Information System). Serious incidents can include but are not limited to patient safety incidents for example loss of confidential information. Any serious incident which meets the definition of a patient safety incident should be reported to both STEIS and NRLS.
- All incidents at Worthing Hospital were reported appropriately through the trust's electronic reporting system. There was an incident reporting policy and procedure in place that was readily available to all staff on the trust's intranet. The staff we spoke with were aware of the policy and were confident in using the system to report incidents.
- There had been no never events reported in the previous 12 months. (Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are implemented).
- Trust wide ten serious incidents were reported on STEIS between August 2014 and July 2015.
- All the staff we spoke with knew how to report incidents using the electronic reporting system. On Coombes ward they told us the main incidents reported were falls and low staffing levels. On the Downland Suite staff told us they would report any issue that adversely affected the patient such as bed moves at night.
- Learning from incidents across the trust was fed back to staff and had led to changes in practice to ensure patient safety. Learning from incidents was shared at the bi-monthly ward meeting and the daily ward

'Huddle'. Wider learning was disseminated through the trust through surgical division meetings and sister's meetings. Ward staff were kept informed by feedback from the ward sister, staff notices and briefings.

- On the ophthalmic ward staff told us how the ward sister was the designated 'incident handler' and fed back to staff in person on the outcome of any reported incident.
- All information relating to audits, complaints, incident investigations and never events were kept on the hospitals computer system where staff could access to review issues and identify any learning.
- The divisional matrons oversaw this process to ensure learning took place. Staff gave us examples where changes in practice had occurred following learning from incidents. For example, changes in practices and additional training and supervision following a medication administration error on Clapham ward.
- The main themes of the recorded incidents were staff shortages and slips, trips and falls. We saw that action was taken to reduce the risk of further incidents such as falls risk assessments, and stickers to remind staff of those patients at risk of falling.
- We saw that staff, patients and relatives were supported and informed of the outcome in accordance with the trust's Duty of Candour. The Duty of Candour requires healthcare providers to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- The trust kept appropriate records of incidents that had triggered a Duty of Candour response. The trust's policy included recording communication with the patient and any other relevant information on the electronic reporting system.
- We spoke with consultants and senior managers, who told us about the clinical governance, risk and mortality and morbidity (M&M) meetings, which were held monthly by directorate and were used to discuss any learning from incidents. Minutes of the M&M meetings were available for inspection. These demonstrated learning from recent incidents had occurred. Managers told us that the details of each unexpected, preventable or unexplained death were reviewed by the corporate governance team.
- There was a robust process in place to monitor the mortality and morbidity findings on a monthly basis. All deaths within the hospital were subject to a two stage review process. All consultants with in-patient beds were required to review eight sets of care notes to determine if an incident was avoidable. Then an in-depth review took place by the mortality steering group. Reports were then fed into the quality groups and onto the board. We were told that there was robust challenge at every stage. For example, why one hospital had a lower HSMR (Hospital standardised mortality rate) than the other. The medical director was required to explain in detail the reasons behind this.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism. We found that the NHS Safety Thermometer information was available on all of the surgical wards we inspected.
- We saw evidence that safety thermometer data was being routinely used to improve the quality of care. For example, the number of 'Harm Free Days' was available in each area. The staff we spoke with were proud of the results in their area.
- Consultants were aware of the safety thermometer data and told us that the information was included in their half day clinical governance training.
- We noted that the Patient Safety Thermometer data was discussed at the monthly ward meetings and in the weekly ward communications. The matron compiled a monthly report from the safety thermometer findings which were presented to the surgical board.
- The available information indicated that the17 pressure ulcers occurred between August 2014 and July 2015. This rate was similar throughout the time period with no changes in the numbers reported. The rate of catheter acquired urinary tract infections (13) remained the same over the same time frame. All pressure ulcers and incidents of venous thromboembolism were reviewed using a root cause analysis. The results were reviewed at a review panel held jointly with community staff.

- The safety thermometer data recorded that 90.7% of patients received a falls assessment within 24hrs of admission. The number of falls that were identified as 'avoidable' was 0.77%, with nine falls reported with a level of harm identified as three to six.
- The August 2015 Quality Scorecard indicated that the VTE (Venous Thromboembolism) assessment compliance was 94.1% against a target of 95%.

Cleanliness, infection control and hygiene

- There were infection prevention and control policies and procedures in place that were readily available to all staff on the trust's intranet. We found the surgical wards and theatre department to be adhering to national infection control guidance. We saw a very high standard of cleanliness in all the areas that we visited.
- We noted that the hospital's infection rates were consistent with the national average for bacterial infections such as MRSA (meticillin-resistant staphylococcus aureus) and C. difficile during 2013/2014. There were no particular issues noted with infection in the surgical wards or theatres. The trust recorded less than the target number of hospital infections for the year to date. The Quality Scorecard to August 2015 indicated that there were no hospital acquired MRSA cases; 13 cases of hospital C. difficile; 29 reportable MSSA (meticillin sensitive staphylococcus aureus) bacteraemia cases and 125 reportable E. coli cases.
- We spoke with matrons who told us that MRSA screening took place for elective patients before they were admitted for surgery. This was confirmed in the clinical notes we reviewed which demonstrated patients were MRSA screened prior to admission if possible and on admission if they did not go through the pre-assessment pathway.
- Patient-Led Assessments of the Care Environment (PLACE) are environmental and non-clinical self-assessments undertaken by teams of NHS staff and include at least 50 per cent members of the public. We saw the results for the most recent PLACE assessments and noted a generally high compliance rate. For example on Clapham ward the August 2015 PLACE audit scored 95% with most scores obtaining 100%.
- We noted although the trust participated in mandatory surgical site infection surveillance service that occurred during the inpatient stay, on readmission and post discharge for hip and knee replacements and fractured neck of femur patients the most recent results were not available. A Surgical Site Surveillance committee met monthly and the results fed into the surgical division clinical governance report.
- High impact interventions such as central line insertion, urinary catheter continuing care and the decontamination of infected equipment were also audited regularly. For Worthing Hospital the results were consistently scored 100% for the period May to July 2015.
- There were designated staff with infection control responsibilities. The hospital had a dedicated infection control team, which together with link nurses provided support to staff.
- We saw that regular infection prevention and control audits took place in order to make sure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE). We noted that the most recent hand hygiene audits scored above 97%.
- All surgical areas we inspected where patients were seen and treated were visibly clean and tidy. However, storage was a problem with medical supplies and physiotherapy equipment kept on the floor. Storing equipment and supplies on the floor means that in practice, these areas were difficult to clean thoroughly.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected. We found that staff were generally aware of the principles of the prevention and control of infection (IPC). We observed staff regularly use hand gel on entering clinical areas and between patients. The 'bare below the elbows' policy was adhered to and personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas.
- Equipment was marked with a sticker when it had been cleaned and was ready for use. Disinfection wipes were available for cleaning hard surfaces in between patients.
- Decontamination and sterilisation of instruments was managed by an in-house accredited sterile services

department that was compliant with the EU Sterile Services Medical Devices Directive. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, wards, clinics and departments. Bi-annual audits took place to monitor compliance with the decontamination standards. The last audit took place in September 2015 and demonstrated 96% compliance. An action plan was in place to address the outstanding areas.

- The trust had a waste management policy, which was monitored through regular environmental audits. We saw that waste was appropriately segregated, with clinical and domestic waste bins clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely.
- The cleaning of the hospital and theatres was undertaken by an in-house domestic service. Cleaning equipment was colour-coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately by the domestics which were checked and audited by a manager.
- Environmental audits took place quarterly, the last one in September 2015. Recent theatre infection control audits indicated a compliance rate of 84%. We looked at the minutes from the infection control meetings and noted that theatre cleaning issues were discussed.
- Infection prevention and control was included in the trust's mandatory training programme. The trust provided training data which confirmed that the majority of staff had attended infection prevention and control training. Those staff we spoke with all confirmed they had completed this training. Training completion rates ran between 90% and 100% for the surgical directorate with examples being the Enhanced Surgical Care Unit, the anaesthetic department and several wards all scoring 100%.

Environment and equipment

- The general environment where patients were seen and treated was generally well maintained. We noted access corridors were light, airy with good signage. Emergency call bells were in place in each room and by each bed.
- We saw there was a wide range of equipment available and the staff we spoke with confirmed they had access to the equipment they needed. We noted that in the surgical division governance meeting held on in September 2015 £40k of equipment had been identified as needing prioritising for replacement. We were told that equipment in the radiology department was also due for replacement.
- There were no local asset registers available. The equipment library managed the servicing and maintenance of all equipment through an outside contractor. This included both medical and estates equipment such as the lifts, air handling, water safety and generators.
- We saw there were systems in place to monitor, check and maintain equipment. All the equipment we saw had been labelled to verify it had been electrically tested within the past year.
- Emergency resuscitation equipment, oxygen and suction equipment was available in each area and we saw it was routinely checked. Theatres had emergency intubation equipment held in the main theatre corridor, recovery, the treatment centre and the day care unit. All were appropriately checked and signed off. There were tamper proof seals in place on the majority of the emergency equipment trolleys apart from in the main theatre.
- We were told that there had not been a devices trainer in post for a number of months but there were now training dates planned. Although we did not see the equipment training records on the wards, the staff we spoke with told us they had received relevant training on how to use equipment and felt confident and competent to use it. Staff in theatre had recorded equipment training on file.
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate log books being kept. For example the fluid warming cabinets were regularly temperature checked and recorded.
- Single use equipment such as syringes; needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner.

- We noted that the theatres were had good signage and were well organised with clear access and adequate storage arrangements.
- In the rest of the surgical facilities there was a general lack of space throughout the areas we inspected. For example, due to bed reconfiguration wards had been moved and there was a marked lack of storage facilities. Equipment was stored along corridors and on the floor which was not best practice. For example, on Coombes ward intravenous fluids were stored under a table in the clean utility room; new chairs and other furniture were stacked in a day room at the end of a patient bay. Medical equipment and supplies stored in corridors reduces the width of the corridors so that emergency access is restricted; cleaning is made more difficult and less likely to be undertaken thoroughly and the equipment itself may present a fire or health and safety hazard.
- There was also a lack of space in the Downland Suite (Private patient unit). For example, diagnostic tests such as ECG's were carried out in the nurses' administration office due to lack of clinical space.
- The pre-assessment clinic was very compact and in need of refurbishment.

Medicines

- There were medicine management policies and procedures in place that were readily available to all staff on the trust's intranet. The staff were aware of the policies and protocols and knew how to access information regarding medicines management.
- Electronic prescribing was being introduced across the trust. Competencies for undertaking this were being undertaken for roll out in January 2016. Junior doctors voiced their concerns about the risks associated with how the new system had been introduced. They particularly had concerns about prescribing on a sliding scale which was difficult in the new system.
- We observed that medicines on the wards were stored securely in locked cupboards within rooms with keypad access.
- In theatre the controlled drugs were stored in appropriate lockable cupboards. We reviewed the controlled drug registers in the theatres and noted they were checked twice daily by two members of staff. We found controlled drugs on the wards were regularly checked with entries double signed.
- We noted that the drugs fridges were checked daily to ensure drugs were kept at the correct temperature; however the ambient room temperature was not checked in any location we inspected. Many drugs need to be kept within certain temperatures for them to remain effective. For example, two types of antibiotics we checked stated they were not to be stored at temperatures over 25°. It could not be verified that the drugs were stored below this temperature and they remained effective.
- The trust was about to start a Medication Safety Thermometer, which collected data relating to appropriate prescriptions and the administration of medicines.
- The Quality Scorecard indicated that there were 465 incidents involving drug or prescribing errors. This was less than expected for the year to date.
- There were 18 moderate or above medication incidents occurring in August 2015 against a benchmark of 13. These incidents were being investigated. However there were no themes identified as they were not related to a single area or staff group.
- We carried out random medicine checks in some of the ward areas and found all stock drugs to be stored appropriately and in date.

Records

- The hospital used a combination of electronic and paper records. A new IT system was in the process of being set up but this was not fully in use or embedded at the time of our inspection.
- We looked at samples of medical and nursing records on the surgical wards and in theatre. In general, both nursing and medical records were accurate, fit for purpose, stored securely and completed to a good standard. They contained evaluation, progress and risk assessment updates. There was also information in respect to discharge planning. Discharge letters and requests for diagnostic procedures were undertaken via an electronic database.

- We noted that each nurse had a stamp with their name and registration number on to make completing the care records appropriately much easier.
- The care records included multidisciplinary input where required, for example, entries made by dieticians, physiotherapy and occupational therapists with referral to specialist advice, such as the dietician and tissue viability nurses. We reviewed a sample of care records on each of the areas we inspected and found they were well completed with good use of assessments and outcome measures.
- Surgical patients followed standardised pathways, which were personalised through individual risk assessments and the notes made in the care plans. The surgical care pathways included pre-operative assessment such as previous medical and surgical history, allergies together with baseline observations. Anaesthetic risk scores were used to ensure that only those patients suitable for day surgery were admitted as such.
- However there was no electronic clinical information used in the ophthalmic department which would reasonably be expected in a unit of that size and structure. This meant that all records and reviews were completed manually and comparative and quality data collection was not available.
- We observed clear and precise demonstrations of the WHO (World Health Organisation) checklist for each of the elective and emergency surgical procedures undertaken. Evidence of staff completing WHO checklist documentation were seen in all patient notes that we reviewed.
- The theatre register which recorded details of all surgical operations for each individual theatre was well completed with few gaps or omissions. The implant register was completed as required by the National Joint Registry.
- Nurses used laptops for recording patients' observations and for electronic drug administration.
- We were told that a new electronic system for recording patients admission and handover was in place and although there were some initial 'glitches' with the system they were aware of this and the system was improving.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy and guidelines were readily available to staff on its intranet.
- There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
- Safeguarding training was included in the trust's mandatory training programme. We saw that the majority of staff were up to date with their safeguarding training.
- We were told that all staff undertook basic safeguarding training. Those staff with additional responsibilities undertook level two and three training. The trust provided data that indicated 88% of staff at Worthing Hospital had completed safeguarding training.
- All the staff we spoke with had a good understanding of safeguarding issues and confirmed they had received safeguarding training as part of mandatory training. They told us they would report their concerns to the nurse in charge and contact the safeguarding lead if needed. They were aware of the safeguarding policy and how to access it.

Mandatory training

- Staff told us the trust provided good training and development opportunities. Mandatory training was monitored and all staff expected to attend on an annual basis. Training was provided through mainly on-line means supplemented by face to face where appropriate.
- We looked at the staff mandatory training records and identified there was generally a good uptake of training for the surgical ward, however it took some time to update the electronic training records.
- In theatres, a practice development nurse helped to coordinate staff training with mandatory training levels at 89%. Staff told us there were no problems in accessing the training; the non-completers were staff on sick leave or maternity leave.
- A weekly workforce report was produced which included staff training and appraisals. Ward sisters received monthly reports of staff compliance with

mandatory training. We saw that training was managed electronically with the ward sister booking staff onto e-learning modules and noting this on the wards duty rota.

- Included in the mandatory training were safeguarding, infection prevention and control, information governance, health and safety, resuscitation, equality and diversity and fire safety.
- The hospital tried to use the same agency staff that were familiar with the trust. We saw the new orientation and induction sheets available to support new temporary staff to the trust.

Assessing and responding to patient risk

- The trust had various systems in place to assess record and respond to patient risks.
- The WHO checklist is a system to safely record and manage each stage of a patient's journey from the ward through the anaesthetic and operating room to recovery and discharge from the theatre. The WHO checklist had been adapted to add additional checks at stage six.
- We were told that regular and routine compliance was monitored through audits, peer review and mock inspections. We noted that compliance with the checklist was closely monitored at every surgical intervention and audits of compliance took place on a routine and regular basis. The audits confirmed there were now very few incidents where the checklist had not been fully completed and each incident was followed up and discussed with the theatre staff.
- We followed a patient's journey from preoperative checking and consent to the theatre and discharge from the recovery suite. We observed good compliance with theatre safety and the WHO Surgical Safety Checklist and saw that risks to the patient were well managed at each stage.
- We saw that pre-operative risk assessments informed the care that patients received once they were admitted. For example prophylactic stockings and boots to aid circulation; pressure relieving and warming devices were put in place where the risk assessment identified a concern.
- In theatre and recovery the theatre pathway recorded the patient's vital signs with the national early warning score (NEWS) being used on the wards. This scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support.
- On Clapham ward we saw that use of the NEWS tool was embedded in practice. Across the surgical division we saw that the care pathways demonstrated that the early warning monitoring system was being used appropriately and detailed the actions taken by staff when the patient's condition required escalation.
- The patients' data was available on handheld devices to which doctors, nurses and therapists had access.
- We saw that the needs of patients with mental health problems were risk assessed using a comprehensive tool provided by the local mental health trust.
- Recognised tools were used for assessing and responding to patients risk such as the Malnutrition Universal Screening Tool (MUST) and the venous thromboembolism (VTE) assessment tool to identify those at risk from developing blood clots. These were incorporated in the admission pack.
- Risk assessments were undertaken where indicated for example moving and handling, skin integrity, nutritional needs, use of bed rails and Venous Thromboembolism (VTE). This information was then used to manage patient care.
- We saw day surgery patients had anti-embolism stockings in place where there use was indicated. We also found patients were usually having their risk of developing a venous thromboembolism (VTE) assessed.
- We observed documentary evidence in ward areas that demonstrated good clinical risk management in relation to pressure area care delivery. Patients had risk assessments in place and where a risk was identified appropriate action was taken. For example, we saw examples where a patient's position was regularly changed and they had appropriate pressure relieving equipment in place with specialist nurse input where required.
- At shift change, a formal handover of care took place to ensure patients were appropriately cared for. Medical handover between specialities took place through formal referral and agreement.

- We saw theatre staff record that they followed the five steps to safer surgery, which included team brief, sign in, time out, sign out and de-brief. Theatre staff told us that theatre pathways were used for all patients. There was a recovery protocol in place which ensured access to anaesthetists and senior medical staff at all times.

Nursing staffing

- The hospital had set staffing levels for the wards based on an acuity tool. We reviewed staffing rotas and spoke with staff about safe staffing levels and patient acuity. We found there was usually appropriate staff numbers and skill mix in the clinical areas.
- Staff told us that since the bed reconfiguration staffing problems had increased due to additional beds but with the same number of staff. Although additional staff were due to be recruited this had increased the stress on staff in the meantime.
- Data provided by the trust showed that during the period April 2015 - August 2015, the division had 96.6% of the planned complement of registered nurses during the day and 97.6% on night shifts.
- Managers told us that agency and bank nurses were used to cover vacant shifts. We noted that the current agency usage was 6.57% against a target of 2%.
- Staff told us that understaffing would be reported on the trust's electronic incident reporting system. We did not see any recent staffing related incidents recorded.
- Theatres used The Association for Perioperative Practice (AfPP) staffing guidelines to ensure there was an adequate number of appropriately trained staff available for each theatre. Theatre managers told us that they did not use agency staff has they had only two vacancies which they were able to cover internally. We were told that staff were multi-skilled and able to cover each other.
- The trust was taking positive action to recruit and retain staff. We were told there was a rolling recruitment programme and we were given several examples of new staff that had recently started or who were on induction. The recruitment strategy included investment in advertising, social media and recruitment agencies. Some staff felt frustrated that the recruitment process could take several months from selection to the person being in post.
- The ward sisters had regular meetings with the HR department to monitor sickness and discuss recruitment. We were told actions the trust had taken to address the nursing shortages such as recruiting nurses from abroad.
- The trust told us they were building a team of surgical care practitioners. These are registered non-medical practitioners who work as part of the extended surgical team undertaking certain surgical interventions, pre and post-operative care under the direction of a consultant surgeon.There were eight surgical care practitioners in place at the time of our inspection with plans to increase this to 12 in 2016.
- Specialist nurses were available to support patients and act as a resource for staff. These included specialists in breast care, vascular surgery, colorectal conditions, tissue viability and diabetes.
- There were also numerous 'Link Nurses' who supported the staff with help and advice on subjects such as infection control, moving and handling and micturition.
- Other staffing groups such as the physiotherapists and occupational therapists told us although there had been 'Grow your own' initiatives to develop existing staff they struggled to recruit to band 6 level. Locum therapists had been appointed as an interim measurement.
- Therapy staff told us that the recent bed reconfiguration meant that more patients now required therapy intervention. Although approval had now been given to recruit additional staff they had been managing by prioritising their workload.

Surgical staffing

- The most recent information indicated that between September 2004 and September 2014, the trust employed a lower percentage of consultants (37%) when compared to the England average (41%). There were also a higher percentage of junior doctors (16%) than the England average (12%).
- Middle grade doctors have at least three years' experience as senior house officer or higher grade within their chosen speciality. Registrars made up 36% of the medical workforce, against an England average of 37%.

Surgery

- The trauma and orthopaedic consultants and middle grade doctors were non-resident at night and expected to be on site until 6pm. The middle grade doctor would then be available depending on workload until 11pm.
- The general surgery and urology consultants were expected to work until 7pm and were then non-resident on-call. A separate junior doctor was then rostered until handover at 11pm.
- We found that medical cover after 11pm was particularly fragile with a junior doctor (F2) the only doctor covering all the surgical wards until 8am usually with night nurse practitioner support. Junior doctors voiced their concerns about feeling unsupported at night as it would depend on the surgical registrar on duty as to whether they were supported or not. They told us this was a particular concern if the doctor was inexperienced.
- The cover for the hospital at night was similar at the weekends and confirmed by the medical and nursing staff we spoke with. Anaesthetic cover was provided by consultant anaesthetists on a four tier rota.
- The surgical division governance meeting held on in September 2015 noted that medical staffing continued to be an issue across theatres and anaesthesia although interviews were due to be held for an anaesthetic consultant. Another fixed term consultants was due to start in January 2016.

Major incident awareness and training

- The trust had a major incident policy and business continuity plans in place. Staff were made aware of these through both electronic and paper means. The current policy was available on the trust's intranet with hard copies on the wards.
- Although Worthing Hospital was not the nearest hospital to high risk locations such as airports, ports or the M27 motorway, any major incident there would have an impact on the day to day activities of the service.
- Staff described how the major incident policy had been instigated during a recent incident at a local airfield and another time when two generators at the hospital failed. We were told that following any incident there was a staff debrief and the process was reviewed.
- Managers told us that table top exercises also took place where the major incident policy was reviewed. This was useful as the last review it was noted that emergency contact phone numbers needed to be changed because of staff leaving or changing roles.

Are surgery services effective?

Good

We rated Worthing Hospital 'Good' for effective because:

We found surgical care was evidenced based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The trust was able to demonstrate that it continuously met national quality indicators. Patient surgical outcomes were monitored and reviewed through formal national and local audits.

Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found that training for staff was good with newly qualified staff being well supported. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure patient safety.

Nursing staff assessed the nutritional needs of patients and supported patients to eat and drink with the assistance of a red tray system and protected mealtimes. Special medical or cultural diets could be catered for.

We found that the hospital was not yet offering a full seven-day service for elective surgery. Constraints with capacity and staffing had yet to be addressed. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

Evidence-based care and treatment

- Staff were able to access national and local guidelines through the trust's intranet, which was readily available to all staff. Staff demonstrated the ease of accessing the system to look for the current trust guidelines.

Surgery

- Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations. For example, patients attending for pre-admission assessments, had pre-operative investigations and assessment carried out in accordance with NICE clinical guidelines. The bariatric pathway was delivered against NICE guidelines.
- In theatre we noted that the anaesthetic equipment was checked in accordance with AGBI guidance. We reviewed a sample of patient protocols which met Royal College of Surgeons guidance.
- Following surgery patients were nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. This included recognising and responding to the deteriorating condition of a patient, and escalating this to medical staff following the early warning alert system.
- The staff we spoke with were aware of current relevant guidance and demonstrated how they were following NICE guidance on falls prevention, the management of patients with a fractured neck of femur, pressure area care, and venous thromboembolism. For example, anti-coagulant therapy was prescribed for patients at risk and anti-embolic stockings were measured and fitted to relevant patients. This was verified in the care pathways and clinical notes we reviewed.
- Within the theatre areas, we observed that staff adhered to the (NICE) guidelines CG74 relating to surgical site infection prevention and followed recommended practice.
- The trust participated in both national and local audits which demonstrated compliance with best practice and national guidelines. For example, the orthopaedic consultants confirmed they contributed to the national joint replacement audit.
- A new nurse consultant had been appointed to the breast care team. They told us that they were looking at reviewing practice and developing pathways. This demonstrated that the hospital was looking to improve the patient experience and ensure care and treatment met current best practice guidelines.
- The physiotherapists told us of the local audits they were conducting to look at reducing the risk of falls. We saw the audit results and the action plan to address the issues identified.
- The cross site maxillofacial unit had a high volume of complex skin cancer patients. Audit results showed a low rate of incomplete excision of skin tumours. At less that 4% this was much better than expected, particularly given the complexity of the cases.

Pain relief

- The trust had a nurse led pain management service in place. The Pain Team worked in collaboration with the surgical teams to help manage the patients' experience. They received referrals directly from the surgical teams, physiotherapists or from the patient or a relative. They also supported staff and patients with any pain issues through information and education.
- There were protocols and guidance on pain management for staff including little prompt cards staff could keep on them as a reminder for post-operative analgesic medication.
- The hospital used a pain scoring tool to assess adult pain levels. In the records we reviewed we noted these were completed appropriately and pain relief was given when needed.
- The pain team told us that their lead anaesthetist had received national recognition for the work they had done.
- We were told that the pain nurses visited the wards weekly looking for patients in pain and supported staff to manage their pain better. Staff could access the on call anaesthetist for advice on pain management out of hours. We noted there were few complaints about pain management within the trust over the past year.
- On the enhanced recovery ward we spoke with the nurse specialist from the acute pain service. They told us they undertook daily rounds to see all the patients they were looking after. They told us how they automatically saw all patients using patient controlled analgesia (PCA), and patients who had had an epidural and any new referral. They told us they were well supported by a consultant anaesthetist. One of the nurse specialists was a nurse prescriber who could prescribe analgesia for patients when indicated.

- In the 2015 adult inpatient experience survey 92.8% of patients' feedback that they felt staff did all they could to manage their pain.

Nutrition and hydration

- Prior to surgery patients had nutritional assessments undertaken as part of their general pre-operative assessment. A nationally recognised tool was used the 'Malnutrition Universal Screening Tool' ('MUST'). The MUST assessment resulted in a final score which then influenced the patients care and treatment. For example ensuring they were adequately hydrated before surgery. In the care records we reviewed we saw examples of appropriately completed nutritional assessment forms.
- Staff compliance with completing the form was monitored monthly and reported on the Quality Score Card. We reviewed this and noted that to August 2015 compliance with the MUST tool after 24 hours was 79.6% but this had increased within seven days to 93.8%. This indicated that the majority of patients had their nutritional needs assessed within a week of admission.
- Staff had access to dietician services weekdays between 8am to 4pm. Staff advised us there was a quick response rate from dieticians and speech and language therapists (SALT) who usually saw patients the same day. A SALT completed the initial swallow assessments on new patients who had swallowing difficulties and then provided feeding instructions to the nursing staff.
- We saw an example of the ward menu, which detailed vegetarian options, allergies and so on using a code system. The menu also detailed whether a meal was of soft consistency for patients with swallow difficulties.
- Staff confirmed that meal times were protected and that staff assisted patients with feeding when necessary.
- The hospital used a red tray system to identified patients who required assistance at meal times.

Patient outcomes

- The trust routinely reviewed the effectiveness of care and treatment through the use of performance dashboards, local and national audits.
- Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) and CRAB (Copeland's Risk Adjusted Barometer) scores. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues.
- Multidisciplinary meetings and morbidity and mortality meetings took place trust-wide. Any learning that was identified was recorded in monthly updates and reported to the trust's Quality Committee and then to the board.
- The trust had taken action to implement the findings of national recommendations. For example, there had been a significant reduction in the fractured neck of femur mortality results over the past two years following action taken to address previous poor performance. A new pathway had been introduced with a subsequent and on-going reduction in mortality.
- The trust benchmarked their performance in comparisons with other NHS Trusts such as the national hip fracture database and the national joint registry.
- We spoke with staff in the ophthalmic service. They told us that because their records were not electronic there was no outcome data readily available.
- We looked at how patient outcomes compared nationally and found that the trust performed better than the England average in the average in the majority of indicators in the hip fracture audit, bowel cancer audit and the lung cancer audit.
- In the 2014 organisational laparotomy audit 19 out of 28 resources were not available at Worthing Hospital.
- In the 2015 inpatient laparotomy audit at least 80% of patients had appropriate care in all five indicators for Worthing Hospital, which was better than the England average.
- The relative risk of readmission for elective admissions was similar to the England average at trust level and for the majority of on-site specialties. The standardised relative risk of readmission was slightly higher than the England average overall for elective surgery at 105 compared to 100; however for non-elective surgery it was lower than the England average.
- Information on patient reported outcome measures (PROMs) for patients who had groin hernia surgery, hip

or knee replacements, or varicose vein surgery indicated that the trust generally scored in line with the England average. However the PROMs outcomes for knee replacements were worse than the England average.

- In the 2014 Hip Fracture audit, based on 479 cases, the percentage of patients admitted to orthopaedic care within 4 hours was 61.15%. This was better than England average of 48.3%.
- Surgery on the day of or after day of admission 76.4%, which was better than the England average of 73.8%.
- Patients with a fractured neck of femur who were had a pre-operative assessment by geriatrician was 75.4%; better than the England average of 51.6%.
- The percentage of patients who developed pressure ulcers was 2.8%. This was slightly better than the England average of 3%.
- Patients who had a fall assessment following fracturing their hip was 100% once again better than the England average of 96.8%. The mean total length of stay was 21.9 days. This was longer than the England average of 19 days.
- The 2014 lung cancer audit results demonstrated that 92.1% of patients received a CT (computed tomography) scan before bronchoscopy, this was better than the England average of 91.2%. 90.1% of cases were discussed in multidisciplinary meetings, which was slightly lower than the England average.
- Performance in the 2014 national bowel cancer audit was either similar of better than the England average. 100%of cases were discussed in multidisciplinary team meetings. There was 98% data completeness for patients having major surgery, with 93.1% of CT Scans reported. 73.6% of patients were seen by a clinical nurse specialist. This was worse than the England average of 87.8%.
- In the 2014 organisational laparotomy audit Worthing Hospital provided only nine out of the 28 identified resources. In the 2015 laparotomy audit 2015, at least 80% of patients had appropriate care in five of the eleven indicators. The remaining indicators scored less than 79%.
- Participating hospitals collect data relating to surgical site infections (SSI) for different kinds of surgical procedures over a minimum period of three months. We looked at samples of the SSI data for Worthing Hospital and noted that for knee and hip surgery the trust performed better than other similar trusts for the same period.

Competent staff

- The trust had in place appropriate recruitment and employment policies and procedures together with job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post. On-going checks took place to ensure continuing registration with professional bodies.
- New employees undertook both corporate and local induction with additional support and training when required.
- Newly qualified nurses and those returning to practice were supported through a six to 12 month preceptorship programme designed to advance their clinical and management skills.
- There were checklists in place for agency and bank staff.
- Learning and development needs were identified during the appraisal process. The trust collected data on this and used this to inform managers.
- There were practice development nurses in post to support both student and trained nurses, however the nurses we spoke with on the wards told us they were rarely seen on the wards.
- Staff told us they felt supported in their role, and were able to access training via e-learning, which they completed mostly in their own time. Nursing and therapy staff told us they had access to outside training and development if relevant and agreed.
- Both theatre and ward staff told us they were supported and funded to complete various courses to enhance their practice such as degree courses and courses in leadership and mentoring.
- Nurses working for the ophthalmic services told us how training and development was now promoted and encouraged. The ward sister told us that the majority of the nurses working in the department now had specialist ophthalmic training.

- There was a competency framework in place for new starters which included competency sign off sheets. We reviewed a sample of the sheets and found they were well documented.
- We saw from the minutes of meetings that the junior medical staff were not compliant with their mandatory training despite numerous requests. This was being addressed through their medical supervisors.
- The junior doctors we spoke with told us that their training was good and they had been well supported by the consultants at the hospital. They told us they would recommend working at the trust to other colleagues.

Multidisciplinary working

- Throughout most of the surgical specialities there was effective multidisciplinary working. Considerable work had been undertaken on this since the merger of the three hospitals within the trust. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and GP's. Medical and nursing staff, and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care. The consultants focus group told us that although there were still challenges everyone was working hard behind the scenes to address the remaining issues. For example, there was close cross site working with bed meetings and safety 'huddles'.
- We heard from the breast care team who told us that half day multidisciplinary meetings took place where each screening case was discussed. The breast care nurse was an integral part of this team and there was oncology and radiology representation from the neighbouring trust who were partners in the patients' care.
- The therapists confirmed there was good communication between all the therapy services at each of the hospital's in the trust. They gave examples of sharing development initiatives and collaborative working cross site.
- The ophthalmic team told us that the service was integrated across the three hospital sites. They were working well together to improve the ophthalmic service.
- We observed positive and proactive engagement between all members of the multidisciplinary team (MDT). For example, we observed the ward pharmacist liaising with the community pharmacist regarding obtaining blister packs to meet the patients' specific needs and facilitate their discharge.
- We were told that the MDT work had improved outcomes for elderly patients who were admitted with fractured neck of femur.
- Hand over in theatres happened twice a day at 7:30am and 8pm where day and night staff handed over any surgical cases and overnight patients in recovery.
- On the wards and in theatre there were daily morning 'huddles' which involved the whole surgical team to discuss operational and individual team work and any relevant communications.
- There was good ward to theatre handover with colour coded lists used to aid the safety checks.
- We heard how the surgical division was working with the community services to ensure patients with stomas received their stoma products in good time.

Seven-day services

- The hospital did not yet offer a full seven day service across all surgical specialities and services. There were challenges related to capacity, staffing and the financial implications of providing additional seven day services.
- Although there were trauma lists each day of the week including weekends there was difficulty in getting the support services such as radiography to provide a seven day service. We were given the example where a patient had undergone an emergency stent operation at the weekend but there was no radiology support available.
- However the therapists told us there was an on call rota which worked well.
- Consultant cover was available every day including weekends, with on-call arrangements for out of hours and ad-hoc cover on bank holidays. The consultants told us that there were problems in maintaining a twenty four hour service over seven days for the two main hospitals twenty miles apart. They told us to achieve this involved a lot of locum consultants.

- The hospital was holding additional clinics and operating sessions in order to reduce waiting list pressures. For example, additional pre-assessment clinics were being held on Saturdays as there was currently a backlog of over 400 patients waiting to be seen.
- The ophthalmic department operated weekdays to 7:30pm with out of hours provision of an on all doctor and nurse.

Access to information

- The hospital used a combination of paper and electronic records. We were told that there were some problems with the electronic records system which were being addressed before whole system roll out in January 2016.
- Both ward and theatre staff told us they attended the morning safety 'huddle' where any issues for discussion and urgent communications took place.
- There were notice boards around the hospitals which gave information for staff about training opportunities, staff meetings minutes, and the results from audits and incidents.
- Departmental meetings took place at every level throughout the surgical division and both staff and managers told us there was good dissemination of relevant information both relating to patients and operational issues.
- Staff told us that most clinical information and guidance was available on the intranet. They also reported having access to information and guidance from specialist nurses, such as the diabetic, stoma and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.
- We found in theatre there was an issue in accessing electronic data in theatre as not everyone was IT literate.
- The junior doctors told us there was an issue with the number of different IT systems in place and access to the various systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- We reviewed the consent form in use which complied with department of health guidelines. Two patient records were reviewed at random. These contained appropriately completed consent forms with all risks identified and in date.
- Patients that we spoke to told us that they had been given information about the benefits and risks of their surgery prior to signing the consent form in a clear manner. They had been able to ask questions if they were not clear on something.
- Training on consent and the Mental Capacity Act 2005 was available and staff reported there was no problem with accessing the training.
- We were told that best interest decisions and deprivation of liberty decisions were taken where indicated and these were formally documented. Staff on the Clapham Ward gave a recent example of a vulnerable patient requiring a deprivation of liberty application.

Are surgery services caring?

Outstanding ☆

We rated Worthing Hospital as 'Outstanding' for caring.

The main reason for this rating was not the behaviour of individual staff - although that was observed to be consistently kind and compassionate - but the team ethos that encouraged caring behaviour from staff of all grades and disciplines, towards patients, relatives and each other. The Patient First programme recognised the value patients placed on a caring attitude of staff and built this into the Quality Strategy 2015-2018 and the ward accreditation scheme. It was an explicit expectation that staff would 'go the extra mile'.

People were truly respected and valued as individuals and were empowered as partners in their care. Patients told us that they received excellent care and treatment at Worthing Hospital. The majority of patients told us the nurses were

kind, friendly and compassionate even when they were very busy. The patients we spoke with during the inspection told us that they were treated with dignity and respect. We also received a lot of very positive feedback from patients who had received care at Worthing Hospital over the past few months. This positive feedback was reflected in the Family and Friends feedback and patient survey results.

Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account. During our inspection we observed patients being treated in a professional and considerate manner by staff. We observed staff treating patients with kindness, respect, professionalism and courtesy.

People who used services were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered people who use the service to have a voice. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs are always reflected in how care is delivered. We looked at the results from various audits and surveys and found that patients usually were fully involved in their care and treatment and although communication was sometimes an issue the trust put a high value on delivering good-quality compassionate care.

There was access to counselling and other services, where patients required additional emotional and psychological support, including a number of specialist nurses who provided emotional support to patients and made referrals to external services for support if necessary.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. We saw that Friends and Family information was displayed on notice boards around the wards and departments.
- Each ward and department collected the feedback monthly and this was displayed for staff, patients and visitors to view. We saw that across the surgical division the feedback was consistently positive with between 88% and 100% of patients happy to recommend the hospital to their family and friends in 2015.
- The response rate for Worthing Hospital in the friends and family test was lower than the England average at 28.4% for the 2,165 patients that completed the questionnaire.
- In the 2015 adult inpatient experience survey 94.8% of patients rated the welcome and kindness they received as good to excellent.
- We saw that the trust analyses all the comments that are reported back through the inpatients and carers surveys. We noted that a lot of the comments concerned the noise at night, lack of communication and staff being exceptionally busy.
- The hospital also undertook 'Sit and See Observations' which recorded the type of interactions staff had with patients. For example, the 'Sit and See observations' on Coombes ward identified that certain nurses were quiet, with no verbal communication with patients at bedside, they smiled but appeared 'shy'. This was fed back to the staff members. Other staff were noted to be very kind with a good manner with all patients in the bay. The pharmacist was observed to give positive communication with a friendly manner and thoughtful approach, although they did not introduce the student who was accompanying them. They identified a member of staff who showed exceptional kindness to a lady who was confused. A volunteer and a doctor looked at a photo album with a patient in their spare time. This demonstrated that the trust placed a high value on the interactions between staff and patients and took steps to monitor interactions and address instances were care and kindness could be improved.
- We spoke with five patients currently receiving care, and some of their relatives, who all told us of their positive experiences. Patients told us the "Everyone is so kind" and had nothing but praise for how they had been looked after.
- All the interactions we observed between patients, visitors and staff were relaxed, courteous and friendly.
- Patients' told us how well they had been looked after in recovery and we saw many letters of compliments praising individual staff members and the team for their kindness, care and treatment.
- One patient said, "I have recently attended Worthing Hospital for two separate procedures on both my legs

and at all stages from initial consultation through the initial assessment, pre op information and discussion, post op care and subsequent review it has been conducted very professionally, with an excellent one to one relationship.The supporting nursing and non nursing staff polite, humorous when needed, and informative. Great asset to the hospital and the trust."

- We noted that feedback on the wards indicated that staff were always patient, polite and sensitive to patient's needs.
- We spoke with five patients currently receiving care, and some of their relatives, who all told us of their positive experiences. Patients told us the "Everyone is so kind" and had nothing but praise for how they had been looked after.
- We observed care being delivered in a kind and thoughtful manner. We saw that staff were sensitive to the needs of patients and were mindful of their privacy and dignity. They demonstrated this by knocking on doors, asking before entering behind curtains and obtaining consent from the patients before undertaking any task.

Understanding and involvement of patients and those close to them

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- In the 2015 adult inpatient experience survey 92.8% of patients rated the welcome and kindness they received as good to excellent.
- There were sight care advisors based on the ophthalmic ward to assist and advise patients who were sight impaired.
- We spoke with staff from the enhanced recovery ward who told us how they visited patients preoperatively and spent 30 – 45 minutes with each patient explaining the process and answering any questions. They provided each patient with an information booklet that was linked with the care pathway. They told us that they made sure patients understood the procedure and what to expect for the first few days postoperatively.
- In the 2015 adult inpatient experience survey 89% of patients' feedback that they felt involved in their care and 89.57% said their medications had been explained to them.
- The patients we spoke with told us they were given all the necessary information about the specific surgical procedure that applied to them. They told us the risks, benefits and alternatives were explained to them. One told us, "The consultant included me in all decisions and is obviously an expert in their field. I consider myself fortunate to have had them to perform my operation
- The results from patient surveys and questionnaires indicated that although staff spent time explaining procedures and likely outcomes, sometimes communication was a problem. For example where English was not a member of staff's first language this was sometimes a barrier to good communication. We noted that staff talking amongst themselves in non-English languages featured as a concern in a small minority of the feedback we received. A few patients and carers reported that they found this uncomfortable and sometimes annoying.
- We saw that the trust analyses all the comments that are reported back through the inpatients and carers surveys. We noted that a lot of the comments concerned the noise at night, lack of communication and staff being exceptionally busy.
- One patient said, "Have to say that the staff and service at Worthing was first class. The nurses were so kind and nothing was to much trouble for them. The theatre staff were kind and very informative, with a show that put me at my ease about the operation."
- One relative described the "Exemplary care" of his mother who had been an inpatient for several months and was due to be discharged the next day. They told the ward staff that the ward had been "Brilliant."

Emotional Support

Surgery

- The hospital provided a chaplaincy service which provided spiritual, pastoral and religious support for patients, relatives, carers and staff. Chaplains together with volunteer ward visitors visited all the wards regularly throughout the week. They were available 24 hours throughout the week and were contactable by staff, relatives or carers through the hospital switchboard.
- Worthing Hospital had arrangements in place to provide emotional support to patients and their families when needed. This included support from clinical nurse specialists, such as the enhanced recovery team, breast and stoma care nurses, as well as the colorectal nurse and tissue viability nurses who all provided emotional support and practical help where needed.
- We spoke with the specialist nurses who told us about the care and support offered to patients. This included the vascular, oncology and breast care nursing staff who provided a counselling service. They told us they ensured patients were involved in the decision making about their treatment options and how they worked closely with the McMillan support workers.

Are surgery services responsive?

Requires improvement

We rated Worthing Hospital 'Requires improvement' for responsiveness because.

There was a lack of surgical beds with the admissions ward, day care ward and theatre recovery frequently used to accommodate overnight stays because of the bed shortages. This affected patients being admitted for surgery. Surgery was sometimes cancelled because there were often no beds for them to be admitted to. Patients were sometimes recovered from anaesthesia in the operating theatre because the recovery bays were full of patients waiting to be discharged home or to a ward.

The pressures on beds in the hospital meant that there were times when non-surgical patients were admitted to surgical beds and specialist surgical patients were admitted to general surgical beds. However, this was closely monitored and did not impact on the care that these patients received.

Patients across the trust did not always have consistency of treatment due to different historical and geographical links with other specialist hospitals.

The trust did not meet the referral to treatment (RTT) times for a number of surgical specialties. The ophthalmology, musculo-skeletal and ENT specialties were of particular concern at the current time.

The needs of local people, commissioners and stakeholders were taken into consideration when planning services. The majority of specialties within the surgical division consistently performed well. The trust was aware of those specialties which were performing below the England average and was taking steps to address the issues.

There were established surgical pathways of care from admission to discharge. The enhanced recovery programme was reducing the length of stay and improving patients' outcomes by reducing the length of stay and the need for blood transfusions and urinary catheters. The overall trust average length of stay was lower than the England average for elective admissions and similar to the England average for non-elective admissions.

The percentage of patients whose operation were cancelled and were not treated within 28 days was generally lower than the England average.

The hospital was able to meet the specialist individual needs of patients. There was sufficient suitable equipment available for example bariatric beds and wheelchairs. There were very good arrangements in place to support patients with disabilities and cognitive impairments, such as dementia. There was access to patient information literature on the wards and in the clinics. The wards had access to a telephone translation service and information in alternative languages could be provided on request.

The complaints process was understood by staff, and patients had access to information to support them in raising concerns. Where complaints were raised, these were investigated and responded to, and where improvements were identified, these were communicated to staff.

Service planning and delivery to meet the needs of local people

Surgery

- The trust had arrangements in place to discuss the planning and delivery of local services with commissioners. Meetings took place where feedback and discussion of current issues took place.
- Surgical services were configured to provide good access for patients where possible. There was a wide range of surgical activity, both general and specialised to meet the needs of the local population. This included colorectal, breast surgery and joint replacement.
- However there were trust wide challenges in providing a consistent responsive service, as each of the two hospitals had different historical and geographical links with other specialist hospitals. Worthing Hospital had closer links to hospitals in East Sussex for diagnostic and specialist treatment options, with St. Richard's Hospital in Chichester linking with Hampshire hospitals. This meant that within the same trust patients did not always have consistency of treatment. For example urology patients were referred to another NHS trust nearly 60 miles away for diagnostic tests.
- We spoke with consultants regarding cancer services. They told us that the way the service was delivered was variable across the specialities and across the two main hospital sites. This was due to historical and geographical multidisciplinary partners and stakeholders.
- There had been significant capital investment in the breast services at Worthing and the hospital was the centre for breast screening services.
- The trust was aware of this and taking action where possible. For example by forging new links with other trust's in Surrey and providing as much treatment and diagnostic treatment locally as possible.
- The trust monitored performance on a daily basis for emergencies, weekly at executive level and monthly at corporate level. We were told that additional resources were in place for periods of high demand. The information was used to inform service provision for example the recent reconfiguration of surgical beds.

Meeting people's individual needs

- We heard that the hospital was able to meet patients' individual needs. For example theatre equipment was able to take bariatric patients and had access to hoists and other safe moving and handling equipment.
- Where elective patients were known to be living with dementia the pre-operative clinics, wards and theatres were notified in advance. The 'Knowing Me' booklet was used to help identify the patients' preferences and help to settle them.
- All patients living with dementia had 'This Is Me' forms completed which included preferences and basic information such as how they took their tea and details of the people closest to them.
- Staff in theatre told us how they supported patients living with dementia and learning disabilities by having their carer come into theatre with them to allay their fears and help them to relax.
- A learning disabilities nurse worked with staff to ensure the needs of people with learning difficulties who needed surgery were met.
- Staff in theatre told us how they supported patients living with dementia and learning disabilities by having their carer come into theatre with them to allay their fears and help them to relax.
- We spoke with the staff involved in the enhanced recovery programme who explained the information booklet that was given to patients. The booklet explained who to contact after discharge if they were concerned. The hospital contact was the surgical registrar out of hours.
- There was access to patient information literature on the wards and in the clinics. For example we saw comprehensive booklets on hip and knee replacements. Patients we spoke with confirmed they had been given sufficient information about their treatment and care by the surgeon. However there was not information readily available on the wards or in clinics in any language other than English. The wards and theatres had access to a telephone translation service.
- The hospital's website also provided information, and signposted to further sources of information and helpful advice.

Access and flow

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Surgery

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- The trust monitored performance on a daily basis for emergencies, weekly at executive level and monthly at corporate level. We were told that additional resources were in place for periods of high demand. The information was used to inform service provision for example the recent reconfiguration of surgical beds.
- Consultants praised the enhanced recovery unit. They told us that the team was now well embedded and part of normal practice.
- We spoke with the staff involved in the enhanced recovery programme who explained the information booklet that was given to patients. The booklet explained who to contact after discharge if they were concerned. The hospital contact was the surgical registrar out of hours
- The hospital offered an integrated ophthalmic outpatient and day care service. Staff told us that typically patients waited six to eight weeks for their first appointment and then a further six to eight weeks for their surgery. However, there wasn't the electronic data available to confirm this.
- The hospital held nurse led pre-assessment clinics where routine tests and pre-operative assessments were undertaken. The pre-assessment clinic was not operating as a 'One stop shop' as patients had to return for an outpatient appointment to see an anaesthetist rather than be seen in the pre-assessment clinic. The anaesthetist held twice weekly clinics in the outpatient department.
- We found that the admissions ward and the day care ward were frequently used to accommodate overnight stays because of bed shortages. This affected patients being admitted for surgery as there were often no beds for them. However, staff told us that they only occasionally had to cancel these patients.
- The day care unit was staffed until 8pm. The ward was often open at night due to patients being 'escalated' into these beds when there was a lack of space elsewhere in the hospital. On the day of our inspection four of the eight escalation beds were being used for overnight patients. Staff told us this was not unusual. We were told that since the reconfiguration this had got worse as although there were more beds in some areas there were not enough staff so the escalation beds were used. We were told that the theatre readiness group which started in September 2015 were looking into the issue.
- We were told that when there was a lack of surgical beds in the hospital patients were held in the recovery ward. On are occasions they were kept there over night and were discharged home from the recovery ward. This was not ideal as the facilities were not configured to care for patients who had recovered from their anaesthetic.
- We were told that patients had their surgery cancelled on a regular basis. Theatre staff told us that approximately two patients a day were cancelled due to lack of beds to admit them to. Staff told us that approximately 20 patients a month were cancelled. This happened for a variety of reasons but it was acknowledged that lack of beds accounted for some of the cancellations.
- The trust Quality Scorecard showed that cancellations on the day of surgery were better than the year to date target with 96 people having operations cancelled over the preceding eight months compared to a YTD target of 116.

Surgery

- Theatre staff told us how patients were recovered in theatre as theatre recovery was full due to no beds being available on the wards.
- Although there were nine theatres we were told that the hospital usually only used eight so there was always one available for emergencies.
- The percentage of patients whose operation were cancelled and were not treated within 28 days was better than the England average.
- There was a lower percentage of cancelled operations as a percentage of elective admissions when compared to the England average.
- There was a higher percentage of people not treated within 28 days in 2014/2015 compared to 2013/2014.
- Operational standards were that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. Admitted pathways are waiting times (time waited) for patients whose treatment started during the month and involved admission to hospital (adjustments are made to admitted pathways for clock pauses, where a patient had declined reasonable offers of admission and chosen to wait longer).
- Figures published by NHS England in December 2015 showed that the trust consistently performed similar to the England average but below the standard for admitted adjusted referral to treatment (RTT) wait times. In general surgery the average wait time was 7 weeks with 89.4% of patients being seen within this timeframe. Over half of patients were seen within 7 weeks. For urology the average wait was 5 weeks. Oral surgery performed above the standard with 95.5% of patients being seen within the 18 week slot.
- For non admitted pathways, the average waits were 1.9 week for general surgery, 8.5 weeks for urology and 17 weeks for trauma and orthopaedic.
- We were told that ophthalmology and ENT specialties were of particular concern at the current time.
- Divisional managers told us that weekly RTT meetings were held where engagement with the commissioning CCGs, current backlogs and waiting lists were discussed. They told us that there were system wide issues with geographical location, increased capacity and the number of independent healthcare providers. These issues were under discussion with the CCG and they were working with local GPs to educate them in alternative pathways.
- We were told that additional pre-assessment clinics and surgical lists were undertaken on Saturdays with the aim of reducing the waiting lists.
- The overall trust average length of stay (LOS) was better than the England average for elective admissions but similar than the England average for non-elective admissions.
- Staff explained that discharge had become an increasing problem since the bed reconfiguration with the closure of rehabilitation beds at Southlands Hospital.
- The hospital used a discharge lounge where patients waiting for transport home could wait. The staff from the discharge lounge phoned the wards each morning and then sent staff to help with collecting patients and packing them up.
- We spoke with patients who confirmed that their discharge arrangements had been discussed and their individual situation taken into account. However, in the 2015 adult inpatient experience survey only 57.9% of patients reported that discharge was discussed with them.
- In the Downland Suite, staff told us that discharge was delayed by waiting for medication – they told us "This is the same for private patients as it is for NHS patients." However follow up appointments were undertaken at a nearby private hospital which improved the discharge process.
- The care of any surgical outliers was overseen by speciality consultants, and such patients were identified at ward level and within bed management meetings.
- We were told that there were also a number of medical outliers on the surgical wards. Managers told us that the medical outliers were always a challenge to arrange their discharge effectively. They told us that they had to be really proactive in managing their packages of care but unless there was funding available medical discharges were a challenge. They told us they met weekly with the social workers to discuss those patients with complex discharge needs.

Surgery

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected with access to the Patient Advice and Liaison Service.
- Complaints were monitored and discussed at departmental clinical governance meetings. There were mechanisms in place for shared learning from complaints through the daily ward 'Huddles', staff bulletins and the briefings given to junior doctors and the nursing staff. Information about recent complaints was displayed on the wards and any changes in practice highlighted.
- We heard that the majority of complaints involved communication issues and the wait for discharge medication.
- We heard of examples where complaints had led to a change in practice. For example, staff told us how communication was highlighted as a concern and they were all now aware of the importance of encouraging good communication.
- Where complaints were raised, these were investigated and responded to, and where improvements were identified, these were communicated to staff. Staff were aware of the reporting process for complaints, and confirmed they had received feedback where it related to the ward or their practice.

Are surgery services well-led?

Good

We rated Worthing Hospital as 'Good' for well-led because.

The trust operated effective governance arrangements to facilitate monitoring, evaluation and reporting back to staff, and upwards to the trust board. Risks were identified and acknowledged and action plans were put into place to address them. Care was evidence based and action plans were constantly reviewed.

There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas of influence. All staff spoke with passion and pride about working at Worthing Hospital and spoke enthusiastically about their role and responsibilities. Staff reported effective leadership, of feeling valued and respected. There was an open culture with sharing and participative engagement with staff.

Managers spoke enthusiastically about their ward or department and were proud of the teams they had working with them. The trust actively engaged with the public and staff through meetings, surveys and communications. Patients and the public were encouraged to contribute to the running of the service, by feeding back through on their experiences and sharing ideas. We saw the trust encouraged local initiatives to improve patient experience, care and treatment.

Vision and strategy for this service

- The trust undertook an annual planning and reporting cycle, and had developed a two-year operational plan and a five-year strategic plan.
- The Operational Plan set out the trust's immediate objectives and identified the levels of activity, the type of facilities and the bed and staffing numbers required to achieve these.
- The Strategic Plan set out the trust's longer-term term aims to improve standards of care and ensure sustainability.
- We reviewed the trusts Quality Report for 2015/16. This gave the achievements the trust had made over the past year and set out the priorities for providing a service that met the current and future needs of the local population.
- We noted that the first priority was to reduce mortality and improve outcomes with the goal to be in the top 20% of NHS organisations with lowest risk adjusted mortality.
- The second goal was to improve patient safety so that all patients received safe, harm-free care.
- The third goal was to ensure that 95% of patients received reliable care. This included ensuring equity in care for patients regardless of the day of the week in line with national developments in providing a seven day service.
- The fourth goal was to be in the top 20% of trusts nationally for patient and staff experience surveys.

- We reviewed the trusts Quality Strategy for 2015–2018 which set out the trusts strategic priorities for the next three years and identified improvement targets. The report stated that the trust's long term transformation strategy was driven by the Patient First agenda. This was led by front-line staff who were empowered to initiate and lead the change programme.
- We spoke with staff about the vision and strategy for the trust. They told us they had been informed about the reconfiguration plans and though they might not have agreed with them, they felt consulted.
- We did not see a separate surgical service plan but the overarching trust plan encompassed goals and priorities for the surgical services.
- We saw that the trust's vision and values were available on the trusts website for patients, visitors and staff to comment and understand.

Governance, risk management and quality measurement

- The trust had in place clinical and corporate governance structures with board level quality assurance oversight. The surgical division met monthly with business partners such as human resources and finance to discuss governance issues. Monthly integrated performance meetings were held where areas of concern were highlighted and discussed. Minutes were available from these meetings and we saw that issues such as incidents, complaints and risks were standing agenda items.
- The surgical division was divided into five care groups with a matron associated with each of the care groups. Each of the care groups reported at the weekly care groups meeting. Every other week the meetings were held cross site. We were told that the weekly surgical departmental meeting was an educational and learning forum to which nurses were invited.
- Strategic operational planning meetings took place monthly with attendance from each of the clinical directorates. This took into account local site initiatives such as bed reconfiguration. Quality dashboards were used as a multidisciplinary tool for performance monitoring across the surgical division.
- In theatre safety meetings took place monthly to discuss governance and risk. We reviewed three sets of minutes and noted that various safety matters were discussed including incidents. Therapy staff met regularly to discuss performance, finance and clinical governance issues. Then monthly team meetings were held with therapy staff managers who then disseminated information to their teams.
- Clinical governance was embedded at departmental level. However there was no evidence of governance issues being discussed at a local level as governance issues were not included within the minutes of team meetings or as standing agenda items.
- We spoke with the surgical divisional team who explained that all risks were routinely discussed; with the higher level risks being referred at trust level to the board.
- We were told that the highest risks currently being monitored by the trust were staffing, ophthalmology and referral to treatment times.
- Concerns were also raised about the ophthalmic data regarding complication and refractory errors. The data from ophthalmic services were not peer reviewed with the consultant keeping their own outcomes that was not part of the overall trust governance processes.
- Divisional risk and governance meetings took place monthly, and we reviewed minutes of such meetings, in which we saw discussion of incidents, and presentations from departments.
- The local risk registers were managed by the ward and theatre managers. These fed into the directorate risk assurance framework, which were reviewed and updated monthly. These reported to the Board via the Clinical Governance Committee.
- We reviewed the risk register and noted that actual and potential risks had been identified, along with the control measures, likelihood of risks arising, consequences, a traffic light rating, and the required action. The risk owner was identified, and the risks were reviewed at governance meetings.

Leadership of service

Surgery

- We spoke with the senior directors and senior clinicians with responsibilities for the surgical divisions. They told us that the senior management team were very visible and the chief executive was approachable. They all felt well supported.
- They gave the example of the senior management team attending the sisters meetings on occasion.
- There was dedicated leadership and management training in place for staff with individual learning needs identified at appraisal. For example staff in theatre told us of the leadership programme that the majority of band 6 and 7's had completed.
- The orthopaedic consultants told us that they were a busy team due to the age of the local population. They told us they were well supported by colleagues and would cross refer to ensure patients were seen by the most appropriate consultant. They told us they were well supported by the theatre manager.
- Other consultants told us that there had been a "Great improvement" in the last two years. They felt well supported by the senior management team and told us there was a good working relationship with the board. They told us of the monthly open meetings that were held which had helped to improve communication.
- The consultants particularly wished to praise the theatre manager, who they told us made everyone's job so much easier.

Culture within the service

- There was a good atmosphere observed throughout the hospital with many staff having worked at the trust for many years. We spoke with all grades of staff across the hospital. They all told us they enjoyed working at Worthing Hospital. All staff including the consultants told us the executive team were open and approachable and that they felt valued and listened to.
- Theatre staff told us about the open culture where they felt free to raise concerns and discuss issues.
- The trust encouraged staff members who had a genuine patient safety concern to raise this within the organisation at the earliest opportunity through the 'Speak out safely' campaign. The majority of staff we spoke with told us they would have no hesitation in raising concerns and some gave us examples where they had and action had been taken, however concerns were raised about perceived bullying of junior staff and the lack of minority group representation at senior level.
- The trust had various forums in place to support equality and diversity at work. These included a disability forum, lesbian, gay, bisexual and transgender group and a network of personal, fair and diverse champions. The role of these groups was to cascade information and opportunities as well as representing staff and patient views.
- Prior to the inspection we were made aware of concerns raised by a small group of consultants from one of the specialist surgical teams. The allegations were made by a doctor who did not work at the trust. None of the concerns raised had been reported through the trust's incident reporting or governance structures. We interviewed staff, managers, the consultant in question and consultant colleagues. We were satisfied that the issues did not affect the care and treatment that patients received and had been addressed appropriately by the trust through an external review of the service which was favourable and gave no patient safety concerns. We were assured that although there were still challenges with standardising cross site working within the speciality the situation was improving.
- We noted there were mechanisms in place for acknowledging and giving staff praise and positive feedback. Individuals had their contribution and efforts recognised. For example, an individual staff member was identified who had improved outcomes for musculoskeletal patients; several staff received awards in the 'Proud to care awards' which recognised staff who 'gone above and beyond the call of duty' to look after patients.
- The trust operated an 'Employee of the Month' award. Where patients, staff and members of the public could nominate a staff member who had gone above and beyond what was expected of them to make a difference to patients, visitors and/or their colleagues.

Public engagement

- The trust involved patients and the public in developing services by ensuring their views were integral to the planning, designing, delivering and improvement of

services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch; feedback from the 'Friends and Family Test', inpatient surveys, complaints and the 'How Are We Doing?' initiative.

- The trust's website provided quality and performance reports and links other web sites such as consultant performance, NHS Choices and NHS England consultant performance outcomes. This gave patients and the public a wide range of information about the safety and governance of the hospital.
- The importance of public engagement was also included within the Quality Strategy 2015-18. The public and stakeholders were invited to comment on the trust's draft strategy document and to give feedback highlighting their concerns and priorities.
- The trust told us that patient feedback surveys were used to drive improvement at ward and multi-disciplinary team meeting level. These discussions were included in the minutes of these meetings. Staff told us that they were proud of the improved patient feedback.
- Patient feedback was used in the 'You said – we did' initiative which we saw displayed on notice boards on the wards.
- We were told that where things may have gone wrong the chief executive and trust board met with patients and their relatives to apologise properly and take action to prevent the same thing happening again in future.

Staff engagement

- The trust had various means of engaging with staff and the 2015 annual report identified that valuing staff was a priority. The annual staff survey was used as a benchmark to identify areas for improvement. A priority over the next three years was to improve the trust's engagement score.
- For 2014/15, the trust's staff engagement score was similar to the national average of 3.74 at 3.73 within a score of 1 to 5, with 1 indicating that staff were poorly engaged and 5 indicating that staff were highly engaged.
- The trust had identified that staff engagement from the medical, dental, facilities and estates staff were staff groups to address.
- The doctors and consultants were able to raise any issues through the medical staff committee. We held focus groups for consultants where they told us that approximately 25% of all the consultants attended these meetings regularly. There were also monthly meetings held with the consultant body and the executive team. Although the timings made this difficult for some consultants to attend they told us that they were assured that the management team were aware of any issues they had. They felt that this was a "Step change" in the culture which had improved over the past two years.
- The 2014 annual staff survey indicated that 63% of staff responding would recommend the trust as a place to work with 71% who would be happy for a friend or relative to receive care at the trust. This was better than similar results for similar trust's across the country.
- The majority of staff had had an appraisal in the past year, with theatre staff appraisals currently at 96%.
- On Coombes ward managers told us their appraisals were now up to date however on Clapham ward only 72% of appraisals were up to date.
- Therapy staff told us they had regular supervision with open access via email and phone calls to their managers. There was an 'open door' policy between all grades of therapy staff.
- Medical appraisals were fluctuating between 80–85%. The trust was looking to improve upon this with a new deanery appointment and an electronic appraisal system. Medical revalidation was supported within the trust but they were looking at improving the surgical revalidation support across the directorate.
- New employees were supported through regular meetings at three, six and nine months to ensure they were settling into their post and there were no problems.
- Although there was no mechanism for formal supervision in the surgical division, all staff we spoke with felt well supported.

Surgery

- There were arrangements in place to support the health and wellbeing of staff such as arrangements with an annual flu vaccination programme, occupational health provider, and support from a counselling service, a staff physiotherapy service and mindfulness and stress management training for staff and managers.
- We spoke with one senior nurse who had worked for the hospital for over 20 years. They told us they were very well supported by the senior management team and gave examples of the hospital offering flexible work patterns to help them through a personal issue.
- There were also health and social events such as exercise sessions; yoga, Pilates and 'Zumba', try-a-bike sessions, healthy eating and lifestyle roadshows, sing-a-long stress busters and massage. Staff told us about the staff conference which happened twice a year. All grades of staff were invited and it was a daylong meeting to disseminate information, meet colleagues and undertake learning.
- Sickness and absence was generally lower than the England average. Low sickness and absence rates indicate that there is not a problem with work stress, morale and motivation in the trust. This indicates that staff were generally healthier and happier at work than other similar trusts.
- There were staff notice boards available throughout the surgical wards and theatres giving staff information about local and trust wide issues including training, development and team meeting minutes.

Innovation, improvement and sustainability

- We found that staff across the surgical division were passionate, committed to the hospital, and their role within it. From the ward clerks and porters to the consultants and senior managers, all told us how they loved working at the hospital. We saw many examples where staff had been empowered to make changes – big and small that made a difference to the patients' experience.
- We were told how improvements in the emergency care pathway had reduced surgical admissions.
- However, the consultants told us that it was difficult to develop services while clearing the backlog and improving the referral to treatment times.
- On Clapham Ward we heard about a new post that was being trialled to mitigate the readmission of older people post-surgery. The older persons nurse had been seconded from the community.
- In particular we noted the orthopaedic enhanced recovery project which demonstrated good use of data to implement changes to service delivery. We saw as a result of the project patients were experiencing better outcomes with improved hospital experiences. There were plans to widen the scope of the project to include shoulder surgery. The enhanced recovery programme was the winner of partnership working award in 2013 and the joint school for hip and knee surgery received an award in the staff recognition and achievement awards in 2014.
- There were plans in place to move all ophthalmic services from Worthing Hospital to Southlands Hospital where a purpose built unit was planned. This was due to include a 'One stop shop' for cataract surgery. However, we did not see the clinical programme that supported the new service.
- The trust had implemented a fractured neck of femur pathway which started when the patient arrived in the emergency department. The pathway documentation was multidisciplinary and followed the patient through surgery to recovery, rehabilitation and discharge. The pathway promoted early mobilisation was simple to complete and was constantly monitored and reviewed to improve patient outcomes. The outcome data for patients with fractured neck of femur was now consistently better than the national average.

Critical care

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

Information about the service

The critical care unit (CCU) at Worthing Hospital has capacity for 12 patients in 10 bed spaces and two single rooms that can be used for isolation purposes. The unit is configured and staffed for six level three patients in an intensive care unit (ICU) and six level two patients in a high dependency unit (HDU).

A critical care matron leads the unit at Worthing in addition to the CCU at St Richard's hospital. This provides consistency for nursing staff and contributes effectively to the standardisation of policies, care pathways and protocols at both sites. Consultants at the two hospitals work independently but do collaborate in cross-site governance processes. Both units share the same clinical director. Worthing Hospital has an enhanced services care unit (ESCU) that is managed by the critical care matron but is not included in critical care staffing or service provision.

The CCU cared for 663 patients between September 2014 and August 2015. There is intensivist cover seven days a week from 8am – 6pm. Outside of these hours a consultant is on call and an anaesthetic intensivist is available to assist.

Patients are admitted to the CCU from the emergency department, the surgical unit and other hospital departments. Bed spaces in the theatre recovery department can be used to treat CCU patients if the main unit is full to capacity. This is part of a business continuity plan and escalation policy that enables staff to provide continuous care during periods of high demand.

We spoke with 9 nurses, the lead consultant, three other doctors, two patients, two relatives and eight other professionals, including two pharmacists, a microbiologist, three physiotherapists, the equipment technician and a member of the housekeeping team. We also looked at twelve patient records, three incident reports and 19 other items of evidence to come to our rating.

Critical care

Summary of findings

Overall we rated the CCU at Worthing Hospital as 'Good'.

This rating reflects the areas of good practice we found through our review of staff training, patient notes and patient outcomes as well as other performance indicators such as rates of unplanned readmissions and strategies to reduce discharge delays. Leadership in the unit was coherent, robust and well respected by the staff we spoke with.

We saw examples of innovation in improving patient safety and good practice, particularly in relation to the successful pilot of a new electronic patient records system that combined patient tracking software with observation charts and electronic prescribing. Significant challenges relating to infection control and capacity were clearly understood by the matron and lead consultant, who had undertaken scoping exercises to address them, such as a business plan to upgrade the enhanced surgical care unit to a level two care facility for HDU patients.

Staff practised in line with the clinical guidance of national organisations such as the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians (RCP) and the Intensive Care Society (ICS). Such guidance was embedded into the work culture and used to evaluate and improve practice, through the sharing of learning and use of audits to update policies and procedures. Staff contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC).

The CCU team had access to multidisciplinary specialists who routinely contributed to decision-making and ward rounds in the best interests of patients. An established critical care outreach team (CCOT) supported patients across the hospital seven days a week.

The CCU was well maintained, however there was room for improvement in infection control practices, particularly relating to the correct use of aseptic non touch practices and more vigilant removal of dirty consumables. The unit was also not compliant with Health and Safety Executive or European Commission regulations relating to the safe storage and disposal of hazardous waste and equipment. We found some areas of non-compliance with the trust's medicine management policy, particularly relating to stock rotation and the disposal of expired medicines.

A robust incident reporting system was in place that staff used confidently to investigate incidents and errors. There was evidence that learning from investigations had taken place with an effective system in place to ensure all staff were aware of updates to practice. Overall this contributed to an environment in which safety was prioritised and patients received individualised care from staff who had a good understanding of their personal needs. Relatives spoke highly of the care they had encountered and said they had found the senior nursing team to be responsive when they had been concerned about something.

The unit met the standards benchmarked by the ICS, the Royal College of Nursing (RCN) and the Faculty of Intensive Care Medicine (FICM) in relation to staffing levels. There was a consultant intensivist on-call 24-hours a day, seven days a week and patients were always seen by a consultant within 12 hours of admission. Nurse to patient ratios of 1:2 or 1:1 were consistently met and ICS core standards guidance that a supernumerary senior nurse coordinator be present 24-hours, seven-days, was always complied with.

Critical care

Are critical care services safe?

Requires improvement

We found critical care services to 'Require Improvement' in the safe domain. This rating relates to areas we identified as presenting a risk to patients, staff and visitors:

We found chemicals, a sharps bin and hazardous waste awaiting collection in a cupboard that was unlocked and readily accessible. Two other sharps bins were in use and had not been properly stored or labelled. This contravened the European Waste Frame Directive (2008/98/EC) and the HSE Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and meant that staff had not adhered to established safety requirements.

Medicines management was not always in line with the trust's policy. We found some expired medicines, insulin that had not been labelled and the medicines of previous patients in the unit had not been disposed of.

We found some dirt on a pendulum above a bed space and a dirty container of water and cloths that was left in a bed space for over six hours.

Bed spaces in the high dependency unit (HDU) did not comply with Department of Health building space requirements, however senior staff were planning an increase in capacity to mitigate this.

We found areas of good practice in the unit. Staffing levels met the standards set by the Intensive Care Society (ICS) and nurse to patient ratios met the standards set by the Royal College of Nursing (RCN). There was an open culture of incident reporting and a multidisciplinary team conducted root cause analyses that were used to learn from incidents and share learning.

Patients received care and treatment from an established team that demonstrated practice based on robust risk assessments and an understanding of the principles of safeguarding in the critical care environment.

Incidents

- 72 incidents were reported between May 2015 and August 2015 at and Worthing and St Richard's Hospital. In most cases it was clear that action had been taken to mitigate the risk of future incidents. For example, a transfusion specialist practitioner had been contacted following a patient experiencing an untoward reaction to a blood transfusion. Improved training for staff on the insertion of central venous catheters had also been provided as a result of incident investigations. The incidents were reported on a trust level instead of on an individual basis as the matron and clinical director, who were responsible for both sites, investigated them.
- Staff discussed incidents during a daily morning safety huddle. For example, we saw that a doctor discussed an issue with the use of an item of equipment and reminded staff of its correct use. This ensured staff were aware of risks while incidents were being investigated.
- Clinical leads had established a culture of cross-site learning from incidents in order to standardise practices at Worthing Hospital and St Richard's Hospital. For example, a standardised glycaemic control policy had been implemented simultaneously at both sites following a review of how staff used nasogastric tubes.
- Monthly mortality and morbidity (M & M) meetings took place and were used to review every patient death and unforeseen circumstance. We saw that a multidisciplinary team attended the meetings, which meant that learning could take place between services, specialties and other hospitals in the trust. Staff from another specialty service presented learning from incident or mortality investigations every two months as part of a cross-site education and development strategy.
- Multidisciplinary staff contributed to the root cause analyses of incidents and to the learning disseminated to staff as a result. For instance, an antimicrobial pharmacist had contributed to an investigation that found a lapse of care in an antibiotic prescription had resulted in a case of Clostridium Difficile (C.Diff). The results of the investigation had been shared with CCU physicians and the pharmacy team at both Worthing Hospital and St Richard's Hospital.
- There have been no Never Events at this unit. Never Events are serious, wholly preventable incidents involving patient safety that can be avoided through adequate safety systems.

Safety thermometer

- NHS Safety Thermometer data was recorded and displayed in the unit. In the 12 months prior to our

inspection, there had been no new harm to patients in 100% of cases with the exception of one month when the no new harm rate was 90%. A senior member of staff had displayed educational material for staff in response to this.

- One unit-acquired urinary tract infection had been reported in the 12 months prior to our inspection.
- There were no recorded unit-acquired pressure ulcers in the twelve months prior to our inspection. Staff demonstrated an awareness of pressure areas during patient reviews on ward rounds.
- We saw staff had prescribed Venous Thromboembolism (VTE) prophylaxis in accordance with appropriate care bundles but VTE risk assessments were not consistently completed. In two of the twelve patient records we looked at staff had not completed a VTE risk assessment.

Cleanliness, infection control and hygiene

- The unit was visibly clean and free from dust on most high and all low surfaces and equipment. We found evidence of dust on one high pendulum above a bed space. All soft furnishings were wipeable and in a good state of repair.
- Staff used 'I'm Clean' stickers to indicate when an item had been cleaned and disinfected. We saw staff used this procedure consistently, and all of the equipment that was ready for use was labelled appropriately. Nurses usually cleaned equipment initially and then the unit's equipment technician completed a secondary clean.
- It was not clear that staff adhered to cleanliness policies at all times in relation to dirty disposable materials. For example, we saw that a disposable vomit bowl containing dirty water and cloths and had been left under a washbasin in a bed space. This remained in place for over six hours without a member of staff removing it.
- Staff conducted monthly observational audits of hand hygiene and found 97.6% compliance from July 2015 to August 2015. We saw evidence that doctors and nurses who failed to wash their hands at appropriate intervals were reminded of the trust policy by colleagues.
- Monthly audit results of the prevention and control of infection were consistently good, with 100% compliance found in July 2015 and August 2015.
- MRSA screening took place in 98.6% of patients in June 2015, 96% of patients in July 2015, 98% in August 2015 and 93% in September 2015.
- In all twelve of the patient records we looked at, staff had screened the individual for MRSA on admission.
- Staff told us they used the aseptic non-touch technique (ANTT) for administering intravenous injections. However we observed a nurse during this procedure twice and found they did not correctly follow ANTT practices because they did not clean the re-useable tray before drawing up drugs.
- The trust Infection Control Committee Surveillance Report dated September 2015 showed 0 cases of MRSA at Worthing Hospital for the preceding six months.
- There were two cases of MSSA infection across the hospital that were not attributable to lapses in care and which had predated the admission of the patients.
- There were Four cases of C Diff infection across the Worthing site in the preceding six months that were fully investigated. Two were shown to have some lapses of care but neither of these were on the intensive care unit.

Environment and equipment

- The CCU was well maintained and hand wash basins in bed spaces conformed to the requirements of Department of Health Health Building Note (HBN) 00-09. All floors were compliant with HBN 00-10 however bed spaces in the HDU did not comply with HBN 04-01, which applies minimum dimensions to bed spaces for adult inpatients. The senior critical care team were aware of this and had submitted a business plan to the executive team regarding an increase in capacity.
- The unit was not compliant with the European Waste Framework Directive (2008/98/EC) or the HSE Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 because sharps bins were not always stored appropriately. For example, we found a sharps bin in a bed space that was unlabelled with the aperture on the lid open. We found a sharps bin was stored in an

unlocked dirty utility room awaiting collection. Another sharps bin was stored by a blood gas analyser by the reception desk with the lid aperture open and no labels on the bin with regards to a patient name or date of use.

- The dirty utility room was unlocked and could be accessed by anyone in the unit. Chemicals were stored in this room, which contravened the Health and Safety Executive (HSE) Control of Substances Hazardous to Health (COSHH) regulations.
- A dedicated equipment technician worked on the unit and was responsible for the maintenance and availability of equipment. We saw that this member of staff provided educational support to staff as needed, such as during daily safety huddles. The equipment technician also supported staff in the submission of electronic incident reports where these related to equipment problems or failure.
- Staff had not always documented checks on equipment in accordance with trust policy. For example, a glucometer had not been quality control checked for two periods in the three months prior to our inspection; between 25 November 2015 and 29 November 2015 and between 5 December 2015 and 8 December 2015. This meant that it was not clear if the glucometer was in full working order during those dates. A nurse told us that a healthcare assistant or registered nurse was responsible for documenting the checks each shift
- The HDU environment was cramped and busy, which also meant that it was sometimes noisy. Staff told us that although patient safety was never compromised, it was sometimes difficult to maintain their comfort and provide a calm environment. One nurse said, “It is very cramped. We’re having to squeeze past and stretch over equipment and each other.”
- Out of date chemicals were stored in the unit. Seven bottles of hard surface cleaner had expired in May 2015 and two bottles had expired in September 2014. The products could not be used and it was not clear why they had not been disposed of.
- Staff documented checks of the resuscitation trolley on a daily basis, including it’s equipment and readiness for use.

Medicines

- A dedicated critical care pharmacist worked between both hospital sites and was available at Worthing Hospital two days a week. Staff told us the pharmacist had been very supportive of them in developing information accessible through the ICIP system, including the addition of a medicine library and formulary. The pharmacist offered training to critical care staff to help avoid medication errors and to discuss contributing factors when an error did occur.
- An antimicrobial pharmacist was available to support CCU staff between the hours of 8:30am and 5pm Monday to Friday.
- Staff adhered to the unit’s antibiotic policy that ensured antibiotics were only prescribed when approved by a microbiologist or in discussion with the antimicrobial pharmacist.
- Controlled drugs were stored in a locked cupboard and staff had conducted and recorded daily stock checks. We found that the quantity of drugs matched the records.
- Medicines were not always stored in accordance with the trust’s policy. We found some medicines and related material had expired, including simple linctus, Tetracaine gel, a planter remover and three bags of intravenous fluid. The medicines of four patients who had previously been cared for in the CCU were stored in the unit and had expired. This included lidocane, codeine phosphate, potassium syrup and effervescent granules. Staff were not able to tell us why the expired medicine of previous patients had not been destroyed using established protocols.
- Staff had not maintained an appropriate stock rotation system for IV fluids. We found that IV fluids due to expire in December 2015 were at the bottom of a storage drawer and those due to expire in 2017 on the top of the drawer. This meant that IV fluids that were due to expire imminently might not be used immediately and could present a risk that the unit runs out of IV fluids within a useable date because the newest products were being used first.
- The temperature of the medicines fridge had not been recorded on a consistent daily basis for the three months prior to our inspection.

- We found a vial of insulin had been opened but not labelled with an opening date or expiry date. This meant it was not clear to us or to staff if the insulin could be used.

Records

- Staff had worked collaboratively with the manufacturer to pilot, test and implement the IntelliVue Clinical Information Portfolio (ICIP) in the unit, enabling the implementation of electronic records. A dedicated critical care nurse provided full time technical support to staff. The system was used in both CCUs in the trust and staff had been provided with training on the system. Nurses we spoke with were positive about ICIP and told us they had been given adequate training to use the system confidently. We corroborated this by looking at training records, which indicated that all staff on the unit had completed relevant training.
- Multidisciplinary staff used ICIP to record the outcomes of assessments and treatment planning meetings, as well as verbal orders from doctors regarding prescriptions. The electronic system included observation charts used for patients receiving neurological, tracheostomy or pressure ulcer risk monitoring.
- As this was a new system, it was not yet compatible with the main electronic patient record system in the hospital and so staff had to manually duplicate information between systems, including patients under the care of the critical care outreach team. We saw in practice this was time-consuming but staff were positive about the improvements to care that had resulted from their innovative piloting of the new software.
- When a patient was discharged from the CCU, a multidisciplinary summary of their care and treatment was prepared to send with the patient to their next department of care or GP.
- Staff used colour-coded paper for printed copies of discharge notes when a patient was moved to a ward. This meant that ward staff could immediately identify intensive care medical notes, and critical care outreach nurses could quickly locate the intensive care treatment history during their ward assessment. The discharge notes included past medical history, diagnosis on admission, allergies and a pain assessment.
- Staff completed risk assessments for falls and bed rails and we saw these were updated as a patient's condition changed.
- Critical care outreach nurses had access to both the ICIP system and the hospital-wide electronic patient records system, which ensured they could access the most up to date observations and results of the patients they were asked to assess.

Safeguarding

- The ICIP system included links to the safeguarding policies of the trust and the local authority, as well as guidance for staff on how to raise an urgent safeguarding concern. Information relating to the Deprivation of Liberty Safeguards (DoLS) was available on the staff intranet. The CCU's ICIP nurse had transferred this information to the patient records system, which meant that staff could access this readily for assistance when treating patients with a DoLS authorisation in place. We saw that if a patient's DoLS authorisation was due to expire while they were on the unit, staff worked with the trust liaison and the local authority to obtain an extension.
- Best interests assessments had taken place with appropriate multidisciplinary staff where a person's welfare was considered to be at risk or where it was not clear if their relatives could make appropriate decisions on their behalf. We saw evidence of this in patient notes.
- Staff showed us how they could readily access the trust's safeguarding policy on the intranet and were able to discuss the principles of the policy in detail.
- During a nurse handover we saw safeguarding concerns were discussed and nurses were supported by the senior and medical teams in making referrals to the local authority.

Mandatory training

- The unit's dedicated clinical nurse educator (CNE) led a nurse learning and development programme, with specialist input from link nurses and doctors who delivered training on changes in practice based on audit results.
- The CNE had contributed to joint learning projects with the Clinical Education Network to establish a critical care introductory programme for new nurses. The CNE

had based this programme on the Critical Care Network Nurse Leads Forum (CC3N) clinical leadership competency framework and NHS Leadership Academy Framework.

- All nurses in the unit had undertaken basic life support training. All nurses who were rostered to lead a shift had intermediate life support training and all band seven nurses and the matron had advanced life support training.
- The unit and the outreach team showed good levels of compliance with trust wide mandatory training . Equality and Diversity training was completed by 100% of staff, Fire safety training and information governance scored the same at 96.5% of ward staff and 100% of the outreach team.
- Nursing staff were offered specialist critical care training based on their level of experience, such as continuous veno-venous hemofiltration (CVVH), HDU coordination, the use of transoesophageal doppler, ventilation and evidence-based practice.

Assessing and responding to patient risk

- A team of senior nurses, representing 4.8 whole time equivalents, led a critical care outreach team (CCOT) seven days a week from 0800 to 2000. This team responded to calls across the hospital to assess sick and deteriorating patients, who ward staff identified using the early warning scores (EWS) system. CCOT nurses had access to ICIP and the hospital-wide electronic patient tracking system. This meant that nurses could access the notes, observations and test results recorded for patients since they were admitted. CCOT nurses also routinely conducted a follow-up assessment of patients who had been discharged from the CCU to a ward.
- Staff used a clear and robust escalation policy and CCOT referral protocol to involve this team appropriately.
- CCOT nurses had an educational remit in the hospital and were able to offer training sessions on request and where they saw an opportunity to improve practice in certain specialties or wards.
- On the unit care was delivered and monitored to reduce risk to patients through the auditing of High Impact Actions including the care of ventilated patients, the care of central lines and regular observations. The audit results showed on-going compliance rates of 100%.

Nursing staffing

- Nurse staffing levels met the requirements of the RCN and ICS. Level three patients were provided with 1:1 nursing care and level two patients were provided with 1:2 nursing care. There was always a supernumerary senior nurse coordinator on shift in both the ICU and the HDU. During daytimes, seven days a week, a team of up to four healthcare assistants provide support to the nursing team.
- We saw from observing a nurse handover and from speaking with staff that nurses were allocated to patients on each shift based on their skills and competencies. For example, senior nurses considered skills in hemofiltration and non invasive ventilation before finalising the shift plan.
- Experienced nurses and doctors supported more junior colleagues by offering bedside support and mentoring, such as when a patient needed an unfamiliar or uncommon treatment technique. A band five nurse told us this was a particularly positive aspect of working in the unit.
- The supernumerary senior nurse position was protected on each shift. If an increase in clinical staffing was needed due to patient need or unplanned admissions, the senior nurse contacted off duty nurses for support. Patients were only admitted if there were enough suitably qualified nurses to care for them safely.
- The CNE led an education clinic ran for 18 hours per month, in a series of one hour slots. Nurses could attend these slots for one-to-one specialist support and guidance on specific treatment procedures.
- Agency and bank nurses undertook an induction and orientation before working in the unit and the senior nurse on shift checked evidence of competencies. We saw bank nurses were usually block-booked to ensure consistency of care and practice.

Medical staffing

- Six anaesthetic intensivists and one medical intensivist led the CCU, with consultant cover available between the hours of 8am – 6pm seven days a week. A consultant was available outside of these hours on-call and was able to reach the unit within 30 minutes. This met the

requirements for consultant staffing of the ICS Core Standards for Intensive Care regarding hours of consultant cover and the maximum consultant to patient ratio of 1:15.

- A senior registrar was based in the CCU overnight and was supported by a registrar in theatre and a registrar in maternity. A junior doctor was allocated to a twilight shift every day and saw patients in the CCU and theatres. During the day, up to three junior doctors were allocated to the assessment of patients who had been discharged to a ward. Medical cover overnight was arranged into three tiers of doctor depending on their experience. This model ensured the CCU was appropriately staffed and ensured junior doctors had access to developmental training.
- All junior doctors were anaesthetic trainees at grades ST3 – ST5 and were led in their training by a consultant intensivist and a research doctor.
- We observed a medical handover and ward round and saw staff fostered an inclusive, supportive culture focused on patient outcomes and effective multidisciplinary working. Each member of the team was given time and opportunity to input into assessment and decision-making. A multidisciplinary team attended ward rounds, including representation from pharmacy, microbiology, physiotherapy, dietetics and speech and language therapy.
- A consultant led a multidisciplinary ward round twice daily.
- Doctors received advanced training in the use of medical information technology.
- We saw a positive and proactive level of engagement between consultants and relatives. Relatives we spoke with confirmed that they saw a consultant regularly and they felt communication had been “very good.”

Major incident awareness and training

- Staff had used the major incident policy in September 2015 following a local incident with multiple critical injuries. Senior staff told us the unit had responded well and the call out system had worked as planned. This had enabled staff to test the coherence and viability of the existing major incident plan and enabled them to update their contact records for who could respond most quickly in an emergency.
- Staff we spoke with were able to explain the evacuation procedure and how a system of zones was used to keep people safe in the event of a fire. A member of staff said they thought their emergency training could be improved if the trust offered them practical fire extinguisher training.
- A hospital fire warden had delivered emergency training including a complete loss of systems and power.

Duty of Candour

- Most of the staff we spoke with were able to tell us about the duty of candour and how it applied to their work. A nurse showed us that the policy was embedded in the electronic incident reporting system, which they said helped them to be confident in talking with patients and those close to them about mistakes. They said, “This is a no blame culture and I think that has helped us all be honest about any mistakes. If there’s a [medicines] error we report it straight away and we’re candid about it, that’s how we learn and make sure it doesn’t happen again.”

Are critical care services effective?

Good

We rated the effectiveness of critical care services as 'Good'. This rating reflects the care and treatment delivered by staff that was in line with national evidence-based standards established by the National Institute for Health and Care Excellence (NICE), the Royal College of Nursing (RCN), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). Staff also led improvements in practice through active involvement with Commissioning for Quality and Innovation (CQUIN). Staff actively engaged with a critical care network to assess the standard of care and improve patient outcomes.

A multidisciplinary hospital team worked together to assess and treat patients, including pharmacists, microbiologists and dieticians. A critical care outreach team worked across the hospital with ward colleagues to assess and care for deteriorating or very sick patients.

Critical care

Contribution to national audits was variable, with several gaps in reporting data. This was identified as an area for improvement by the senior team. Local audits were used particularly in rehabilitation care to improve patient outcomes.

Evidence-based care and treatment

- Staff used outcomes from CQUIN meetings to consider improvements in the assessment of patients they were treating with complex care pathways. This included discussing the needs of high-risk patients in daily safety huddles and during weekly meetings used to establish patient treatment goals and outcomes.
- Treatment policies and guidelines were stored electronically on a clinical portal that was accessible through the IntelliVue Clinical Information Portfolio (ICIP). When a policy was six months from expiry, an alert was generated automatically and a member of staff was assigned to review and update the policy. This meant that staff worked with policies that were up to date and based on the latest available guidance, which we saw in practice.
- Treatment policies and standard operating procedures were readily available through ICIP, including a body mass index conversation chart, transfer of the critically ill patient, wound care and enteral feeding.
- Consultants led the update and implementation of policies based on their areas of interest and expertise, such as renal failure or diabetes.
- Physiotherapists used the KSS Deanery ITU pathway at both critical care hospital sites to manage weaning predictors as part of patient rehabilitation.
- Physiotherapists engaged with the Respiratory Leaders Network, which enabled them to gain support and learning from senior physiotherapists in the field.
- Consultants engaged with the Thames Valley and Wessex Adult Critical Care Operational Delivery Network. This meant that patient outcome data such as rehabilitation and readmission data were compared with other critical care units in a system of peer hospitals in order to identify areas of best practice and opportunities for improvement.
- Staff undertook audits on the completion of rehabilitation needs assessments and rehabilitation pre-discharge assessments, against the CQUIN target of 95%. The unit had variable results in this. From April 2015 to August 2015, the unit had been compliant in three months for the completion of rehabilitation needs assessments and compliant in one month for the completion of a rehabilitation pre-discharge assessment.

Pain relief

- Staff asked people about their pain during ward rounds and this was used alongside pain scores to assess the level of pain relief needed. During a ward round we saw that staff explained to patients what was causing the pain they talked about and what could be done to reduce it.
- Doctors had access to a chronic pain service clinic that was based in the hospital and were also able to access a community chronic pain management service through an established service level agreement. Staff were in the planning stage of a chronic pain support group for patients to access after they had been discharged.
- CCOT nurses checked patient levels of pain during ward assessments and recorded this appropriately, escalating any issues to their ward colleague.

Nutrition and hydration

- Clinical staff discussed nutrition and feeding plans during ward rounds and these were recorded on the patient's electronic record. We saw that staff discussed feeding plans with patients and their relatives where appropriate, including the outcomes patients could expect from their nutrition plan.
- Staff used the malnutrition universal scoring tool (MUST) in ICIP but this was completed inconsistently in the records we looked at. For example, one patient had not received a MUST assessment, one patient had received an assessment the same day as they were admitted and another patient had received an assessment the day after admission.
- We spoke with a dietician who was available on weekdays to assess patients in the unit. They said if a patient's MUST score was greater than two, they would begin supplements. The dietician was also able to begin enteral feeds and a total parenteral nutrition programme where appropriate. We saw that policies for both types of feeding were available on the intranet.

Critical care

Patient outcomes

- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality were benchmarked against similar units nationwide.
- From September 2014 to August 2015, 2.75% of patient admissions had been delayed by four hours or more. This was monitored by the unit's peer group in the critical care network and staff told us was attributable to capacity and flow problems.
- Critical care outreach team (CCOT) nurses planned patient assessment and reviews based on the hourly observations provided by ward staff and could also order their own tests where appropriate. Once a patient had been stabilised for 24 hours, they were discharged from the care of the outreach team.
- Senior nurses and doctors discussed treatment plans on an individual basis during ward rounds and agreed changes to the management of patients as part of a cohesive clinical team. Staff were able to change treatment plans based on the input of other specialists, such as after a patient had a weaning plan implemented and after the results of an MRI scan.
- A consultant told us a plan was being implemented to improve the timeliness of evaluating care and patient outcomes as ICNARC data was typically six months out of date. This would be used to more effectively plan the operation of the unit.
- Unplanned readmissions within 48 hours of discharge were constantly very low and the unit had met the benchmark of 1.2% set by the critical care network. From September 2014 to August 2015, the average readmission rate was 1.08% and for six months in that period was 0%.
- There were no non-clinical transfers out of the unit between September 2014 and August 2015.
- Mortality rates in the unit were in line with national expectations. From quarter four 2013/14 to quarter two 2015/16, the reported mortality rate was between 20% and 15%. Early deaths in the unit also fluctuated and there were similar gaps in the reporting of ICNARC data. In quarter two of 2015/16, the early death rate reduced from 2% to less than 1%. The clinical lead and the critical care network were aware of the gaps in reporting consistent ICNARC data and were working collaboratively to stabilise this.
- All blood results, including blood gases, and the majority of microbiology results were integrated into a results chart that could be viewed over varying timescales and filtered by result type. Abnormal results were highlighted in yellow and comments could be added to clarify when results were required.

Competent staff

- 40% of nurses had post-registration critical care training. Although this was below the 50% threshold established by the RCN, 16 nurses were on the associated development pathway and compliance would be at 52% by December 2016.
- Band seven and senior band six nurses acted as mentors to support band five colleagues who were completing core competencies in critical care nursing. Band five nurses were then offered the opportunity to progress their professional development through a nurse leadership course offered at university level.
- 49% of nurses had completed a mentorship programme and each new nurse was assigned two mentors.
- New nurses were trained, assessed and supported in the use of specialist equipment unfamiliar to them by senior nurses and the equipment technician. This ensured the safety of patients was maintained when nurses moved from a hospital or ward that used different equipment.
- Staff we spoke with told us they felt the level of training offered to them was appropriate to their roles and they were not asked to do anything beyond their capacity. Training and developing routes were not always clear to staff we spoke with. For example, one healthcare assistant had asked to be trained to take bloods and said this had been declined without a reason for it.
- New nurses were supernumerary in the unit for the first four to six weeks after joining and the CNE approved the completion of this only after a full shift competency assessment. Staff had to demonstrate competency in a series of safety awareness checks such as effective handover, the identification of patient risk, basic ventilation and recognising their own limitations. Following this, nurses began a professional

development programme that was used to set objectives and assess competency in areas such as compliance with the use of personal protective equipment and mask fit testing.

- Trainee nurses attended three study days after completing their initial competency training, including ventilation and cardiology training.
- The CNE supported nurses to progress and complete their competencies. Nurses could attend one-hour education clinic slots to have specific competencies signed off by a senior colleague.
- International nurses and those who had been out of education for more than three years attended a university-based study skills module to support them in their studying and professional development.
- 100% of the nurses in the unit had either received an appraisal in the twelve months prior to our inspection or had a confirmed date for this.

Multidisciplinary working

- A band seven clinical nurse specialist and four band six nurses led CCOT, which was available in the hospital Monday to Friday between 8am – 8pm that responded to the needs of deteriorating patients. CCOT nurses provided follow-up care for CCU patients after they had been discharged to a ward and also worked to prevent critical care admissions through effective care and treatment in other wards.
- CCOT nurses provided an educational and advisory role to colleagues in the hospital. We saw a positive and collaborative relationship between the CCOT team and ward nurses and doctors, who were able to support the outreach team in prioritising the review of patients who were most sick.
- A team of 15 respiratory physiotherapists was available, four of whom attended the CCU daily and ensured patients received 45 minutes of physiotherapy as recommended by NICE clinical guidance 83 rehabilitation after critical illness.
- Physiotherapists we spoke with told us they felt the unit's rehabilitation pathway was robust and was delivered by staff who had been assessed in their competency before they were allocated to a rota.
- Physiotherapists, a dietician, a pharmacist, speech and language therapy (SaLT) staff, consultants and nurses attended a weekly meeting to set treatment goals for patients who had been in the CCU for longer than four days.
- Outreach physiotherapists were available to support patients in the hospital who had been discharged from critical care. This ensured patients received continuity of care in line with complex rehabilitation pathways.
- We found evidence of cross-site working between staff at Worthing hospital and their colleagues at St Richards hospital. This had resulted in improved standardised working practices that improved the standard of patient care. For example, physiotherapists had spent time with their colleagues at St Richards to develop skills in weaning equipment that was more commonly used at the other site.
- Staff had access to advice and expertise for pancreatitis patients but were not able to support patients who needed a necrosectomy. Such patients would be transferred to the nearest centre, in Guildford, for more specialised treatment.
- Significant collaboration had taken place across multidisciplinary specialities to embed the ICIP system into practice. For instance, before the system was piloted, hospital IT staff, pharmacy staff, informatics specialists, CCU nurses and doctors and representatives from the manufacturer had liaised to ensure the system was appropriate for the critical care environment. The multidisciplinary approach to supporting CCU staff in the routine use of ICIP was apparent in the daily safety huddle when a nurse noted that wireless connectivity between the system and the hospital's main patient electronic records system had been disrupted. We saw that staff followed a clear protocol to escalate the issue and patient care and treatment was not affected because data was still entered and stored appropriately.
- The ward administrator facilitated a daily safety huddle used to identify any risks to the operation of the unit. During our inspection we saw the huddles were attended by the equipment technician, the duty CCOT nurse, CCU nurses, doctors and consultants, pre-registration nursing students and housekeeping staff.

Critical care

- We saw that a multidisciplinary team were involved in the discharge of patients from the unit, including physiotherapists and CCOT nurses. Staff provided information to patients on the follow-up clinic once they had been discharged.
- There was a multidisciplinary approach to staff training. For example, a critical care transfer training exercise had included registrars and paramedics as part of a live trial on an ambulance.

Seven-day services

- Out of hours and at weekends, an on-call pharmacist was available.
- Doctors began patients on supplementary feeds if they were admitted outside of the working hours of a dietician who then re-assessed the patient.
- A consultant intensivist was available on-call overnight and staff were also supported by an anaesthetic consultant in the hospital at these times.

Access to information

- Staff had access to the electronic patient notes system used elsewhere in the hospital but this had not yet been made compatible with the CCU's ICIP system, which meant that staff had to spend additional time looking for historical notes if needed.

Consent and Mental Capacity Act

- The electronic patient records system included a section to record mental capacity assessments as well as the person's resuscitation status, such as if they had a DNAR order in place. In all of the patient records we looked at, an appropriate mental capacity assessment had been recorded.
- We saw that the unit had access to an independent mental capacity assessor (IMCA) and that this service was used in patients' best interests.
- Staff we spoke with were able to explain their understanding of their responsibilities under the Mental Capacity Act (2005) and when they may need to apply for a Deprivation of Liberty Safeguards (DoLS) authorisation. We saw that a best interests assessment had been completed by appropriate multidisciplinary professionals when needed and staff had access to guidance from the local authority safeguarding team when needed.
- Staff demonstrated awareness of obtaining consent from patients based on their level of consciousness and type of treatment. For example, a nurse told us that if a patient was intubated or sedated, they still explained what they were doing and why. If a patient was conscious but drowsy, they explained what they were doing and how it was in their best interests.
- Doctors recorded best interests decisions in patient notes using evidence from observations and test results.
- The CNE and hospital's DoLS lead had delivered MCA training to all nurses in the CCU. The training had used case study examples of patients with DoLS in intensive care units investigated by the Law Society.

Are critical care services caring?

Outstanding ☆

We rated critical care services as 'Outstanding' in the caring domain.

Feedback from people who use the service, those who are close to them and stakeholders was exceptionally positive about the way staff treated people. People thought that staff went the extra mile and the care they received exceeded their expectations.We saw staff demonstrated kindness and compassion when speaking with patients and relatives, including during ward rounds and when discussing treatment. The unit had won a local award because of the positive feedback sent to a local newspaper.

People were involved and encouraged to be partners in their care and in making decisions. Staff spent time talking to patients and those close to them. They were communicated with and received information in a way that they could understand. People understood their care, treatment and condition. People and staff worked together to plan care and there was shared decision-making about care and treatment. This approach to involving patients showed us staff had developed ways to maintain patient dignity and show respect during their interactions. The feedback about the quality of communication was

exceptional with families and patients reporting that all disciplines and all grades of staff went out of their way to make sure patients understood what was happening. This included nurses lip-reading to ensure they communicated with a patient with no speech.

Relatives we spoke with were very positive about the care and treatment their family member had been shown, including during difficult conversations regarding prognosis.

During ward rounds, assessments, personal care and all other elements of staff interaction with patients, we observed an open culture of communication in which patients were the centre of staff attention and concern.

Staff went the 'extra mile' as exemplified by the ward clerk who won a trust STAR award (although we were told she was not the only member of staff who gave care that exceeded expectations).

Compassionate care

- A patient who had been cared for on a ward by a CCOT nurse gave us very positive feedback and said they had been well looked after. We saw from observing a CCOT nurse that they considered the general wellbeing of people, such as asking if they were drinking enough, in addition to assessing their essential medical needs.
- Relatives we spoke with told us they were very happy with the standard of care their relative had received. They said, "[The care] has been immaculate. It really couldn't be any better."
- We saw staff were aware of the need to protect the privacy and dignity of patients and relatives. For example, 'do not disturb' signs were used on bedside curtains during examinations and staff covered people appropriately when examining them during ward rounds. Staff were proactive in offering relatives private space to talk when needed, which we saw they did without prompting.
- We saw staff paid attention to detail when around patients and their relatives, which reduced anxiety. For example, during a ward round the doctor made sure that people who were able to drink had juice or water within reach. When a person seemed sad or upset staff noticed this and took time to sit and chat with them, which we saw was offered with genuine patience and kindness.
- The ward administrator was a trust Ambassador, representing good practice, and acted in a care and support role for patients and relatives in addition to their administrative duties. This individual had won a 'STAR Award' by the trust for their level of care and compassion shown to people. This included sitting and talking to anxious patients and relatives and demonstrating acts of kindness above and beyond the critical medical treatment people needed. This included bringing a patient a book, newspaper or an ice lolly. The administrator demonstrated a genuine and compassionate approach to providing reassurance and care for people in distress and told us, "We want to give the best experience we can."
- Nurses demonstrated consideration of compassion when planning patient care in the handover. For example, a patient who needed a central line to be inserted had refused the procedure. A nurse had explained the procedure to them and said to think about it overnight and let them know in the morning.
- We observed a nurse handover and found staff had a consistent focus on patient-centred care that included attention to detail in supporting recovery. For example, a patient who had been agitated overnight had been calmed by a nurse who offered to remove their surgical gloves.
- Two relatives told us how happy they were that staff had worked to communicate with their family member who could not speak. One relative said, "They've managed to lip read. They're so patient with him and we're reassured staff can understand what he wants. We've been in a private hospital before but this place is so much better. They really care about us as individuals and that's what's important."
- The CCU had been given a local community award from the local press in recognition of the number of patients and relatives contacting them with positive messages of their experience in the unit.

Understanding and involvement of patients and those close to them

- We spent time speaking with two relatives of a patient in the CCU. They told us at length about the kind and "gentle" approach of staff at all levels. They said, "The consultant comes to speak to us as often as we want

and they've been great at keeping us up to date with [patient's] treatment plan. It hasn't been good news but we couldn't have managed without the dedication of the staff. It's been beyond our highest expectations."

- One patient said, "I don't remember much about my admission but since I woke up staff have involved me in everything. They've told me what they're doing and why and ask me how I'm feeling a lot. My family have to travel a long way to see me and the nurses here have been really good at keeping them informed and making sure they're looked after."
- A follow-up clinic was provided for patients one month after they had been discharged as part of a rehabilitation care pathway. Staff offered this to patients who had been ventilated for four or more days or for patients who had been in the unit on a long-term basis.
- We saw staff spoke openly with patients about their treatment and the critical care environment. For example, a nurse spent time talking with a patient and told them what each piece of equipment around them was for and what the tubes attached to them were doing. We also saw a doctor explain to relatives details of a prognosis using language that avoided jargon and technical terms. We asked a nurse about this. They told us it was a standard approach to involving people and they noticed it helped to relieve anxiety. A consultant involved patients in discussions of their treatment and prognosis during a ward round, advised them what the rehabilitation plan was and asked if they had any questions.
- During a ward round we saw staff spoke to patients who were sedated and ventilated and explained what they were doing in the same way they did for patients who could communicate verbally. Staff also included them in conversations between themselves on the basis they might be able to hear and understand what was going on around them.

Emotional support

- Relatives we spoke with told us that the level of emotional support they had received "couldn't be better." They told us, "Simple things like getting us a cup of tea when we've been upset and offering to phone us a taxi. Just little things that have made us feel so much better."
- Outreach nurses provided patients with links to appropriate community support groups.

Are critical care services responsive?

Requires improvement

We rated the responsiveness of critical care services as 'Requires improvement.'

People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. Staff had developed an understanding of meeting the needs of local people who presented with significant health and social care needs related to deprivation.

There was a proactive approach to understanding the needs of different groups of people and to delivering care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs. Staff with experience in caring for patients with alcohol-related health failure had been sought out by senior staff and specialist links were actively used to ensure patients received the most appropriate care. Specialist support was available for patients with needs relating to learning difficulties and dementia.

However, the delayed discharge of patients was an on-going issue in the unit due to a lack of capacity generally in the hospital. Senior staff had established positive working relationships with bed managers and there was a robust escalation policy in place to mitigate delays where possible.

Service planning and delivery to meet the needs of local people

- Staff we spoke with had an acute understanding of the needs of the local population relating to high levels of deprivation, alcoholism, smoking and drug overdoses. The clinical director told us that the CCU tended to attract doctors interested in the unique needs of the local population, such as a consultant nephrologist. This was reflected across the hospital and staff in the CCU were able to request input from a team of new consultants who were specialists in liver failure.

Critical care

- CCOT nurses had a good understanding of the health and care needs of people after they were discharged from the hospital into the local community. For example, a study day had been arranged by nurses to deliver training to local nursing home staff on laryngectomy care.
- Staff had links with specialist nurses in organ donation and there was a clear policy in place to support staff in discussing this with patients and their relatives.
- The respiratory therapists from the trust has developed the Sussex Rehabilitations Pathway for critically ill patients. This resulted in patients receiving the same quality of care after transfer from the CCU to a ward. This gave a single point of contact and an advocate for their complex needs and helped patients feel supported and understood during the transition phase.
- A paperless critical care management software system had been introduced at Worthing in February 2015. The system was interfaced with the trusts patient administration system and allowed all patient demographics to be automatically transferred when the patient was admitted to the CCU. Important details such as allergies and next of kin were readily available, It allowed an audit trail of records made by all staff and had prompts to remind staff to entre specific key information.
- The system promoted a standardised ward round, electronically generated handover sheets, and there were specific records of discussions with relatives and discharge planning.

Meeting people's individual needs

- A relatives room was provided in the unit and people had access to a kitchen with hot and cold drinks and food preparation facilities. There was no facility for overnight accommodation for relatives.
- Staff assessed patients for their level of delirium using the Richmond Agitation Sedation Scale (RASS) and we saw this was actively reviewed during ward rounds.
- The IntelliVue Clinical Information Portfolio (ICIP) system was fully integrated to ventilation mapping equipment and other bedside monitoring equipment. This enabled staff to monitor and interrogate patient data efficiently at the bedside and resulted in automatically recorded observation data that could be audited.
- Staff told us they were aware of the risks of boredom and feelings of isolation that could be experienced by patients who were getting better in the HDU. A healthcare assistant told us portable televisions and DVD players had been donated by patients and relatives and could be used in the HDU.
- An outreach nurse raised concerns about how the hospital responded to the do not attempt resuscitation (DNR) authorisations of patients. They told us when patients were admitted with a long-standing DNR in place and needed assessment by a CCOT nurse, doctors sometimes removed the without a discussion between the patient or other staff.
- Staff had access to a learning disability link nurse and a dementia lead in the hospital, who were available on-call to assist in the CCU. The learning disability nurse saw all patients with learning disability who was admitted to the hospital.

Access and flow

- Staff discussed capacity and business continuity during the daily safety huddle, which included: a record of the number of available beds in different parts of the hospital, a discussion of any ward ready patients in the CCU, and identification of any patients elsewhere in the hospital waiting for a CCU bed. We saw that this was an effective process alongside regular communication with hospital bed managers to ensure access and flow was managed efficiently.
- An escalation plan was used for times when the unit was full to capacity. Patients could be looked after by ITU-trained nurses and an intensivist in theatre recovery provided they could be transferred safely and without the risk of infection.
- Level two patients could also be looked after appropriately in the ESCU provided nurse staffing levels and skill mix matched patient acuity.
- Staff had introduced a 'red amber green' rating to their escalation plan that hospital bed managers could access. This helped with planning bed flow as amber or red ratings indicated to bed managers that the CCU was full to capacity.
- In the twelve patient records we looked at, we saw a consultant had assessed each patient within twelve hours of their admission.

Critical care

- The South East Coast Critical Care Network (SEC CCN) Quality Report 2014/2015 showed that Worthing ITU was in best performing four hospitals in the region for the % of patients whose admissions to ITU was delayed by four hours or more as a percentage of all admissions.
- The unit was above the regional average for the percentage of patients who were readmitted following discharge from the unit.
- THE SEC CCN Quality report showed 2014/2015 78% of patient discharges were delayed for over 4 hours.
- THE SEC CCN Quality report showed that 35% of patient discharges were delayed by more than 24 hours against a QUIPP target of 20%.
- The number of transfers from the ITU for non clinical reasons was 2, which was better than the regional average.
- In the same period the unit did not meet the critical care network target of no more than 6.3% of discharges taking place overnight. In this period an average of 20.8% of patients were discharged between the hours of 10pm and 7am.
- The numbers were falling with the monthly report for SEC CCN for August 2015 showing the over 24 hour level had fallen to 30%, the number of night transfers had fallen to 16% and the number of transfers out for non clinical reasons was 0.

Learning from complaints and concerns

- A relative we spoke with told us that senior staff had responded quickly when they had raised concerns about a nurses attitude towards the mouth care of a patient. They said, “I reported this issue I had and it was dealt with very quickly. The nurse was given some extra training and now I can’t praise them enough.”
- Information was readily available for patients and relatives regarding processes to submit a complaint. This included photo identification of the person in charge of the shift who people could approach to discuss concerns.

Are critical care services well-led?

Good

We rated critical care services as 'Good' in the well-led domain.

The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. An example of this was the development of a virtual outreach ward. The organisational culture supported innovation and listened when staff had ideas.

There was a clearly structured and well established leadership team in the unit led by a clinical lead and a matron who was also responsible for the critical care unit at St Richard's Hospital. The matron led a project to increase capacity of the unit to alleviate pressure on the HDU and to bring the unit into compliance with Department of Health building requirements. Another project was being developed to consider an innovative approach to increasing the capacity of the unit for patients who needed to be treated in isolation.

The unit was led by a matron for critical care working across both sites and a Worthing based critical care lead consultant intensivist. They reported to the Head of Nursing for Surgery and Head of Surgery, respectively.

Nurses had access to a development and leadership programme developed by the clinical nurse educator. This programme was used to attract nurses to work in the unit, embed loyalty to the unit and result in a stable team of clinicians who could drive forward good clinical practice.

There were very high levels of staff satisfaction across all staff groups. Staff were very proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff. Staff at all levels were actively encouraged to raise concerns. All of the staff we spoke with were positive about the leadership and culture of the unit and were keen to tell us how happy they were working there.

Vision and strategy for this service

- Senior staff had a clear vision and strategy for the service that we found was clearly understood and supported by staff we spoke with. Priorities for the

senior leadership team were to increase the space available for equipment storage, improve infection control in the unit and increase the number of level two HDU beds.

- A business plan had been submitted and was being reviewed to upgrade the environment and equipment in the enhanced services care unit (ESCU) to accommodate HDU patients. This unit already came under the leadership remit of the matron. Under the business plan the unit would be included in the ward rounds of CCU consultants. The business plan addressed the ICS requirements for minimum levels of nursing and medical staff.
- The matron had led a business case for the purchase of Bioquell pods to be installed in the unit to increase capacity for patients who needed to be treated in isolation and to improve infection control capabilities. The pods are standalone units that can be fitted into existing space with the same equipment as current bed spaces and single rooms. The pods can be sealed to offer full isolation nursing and medical delivery.
- An expansion of CCOT provision to a twenty-four hours, seven days a week service was planned as part of the future strategy of the service
- The ward administrator was an Ambassador for the hospital and contributed to trust-wide strategies to thank staff for exceptional service and to consider ways of sharing best practice across specialties.

Governance, risk management and quality measurement

- The lack of space in the unit, particularly in relation to HDU and equipment storage, were included on the unit's risk register. The matron and lead consultant were acutely aware of the need for additional space and had conducted scoping exercises to consider how this could be achieved. It was proposed that the ESCU, located on a geographically separate ward from the CCU, could be adapted to meet the needs of level two patients and thus provide an extra HDU area. The matron already led the ESCU and the nurses on the unit, which would assist in the integration of services.
- The lack of space for equipment storage had partially been addressed with the installation of large new cupboards and a drive by staff, using protected time, to assist the unit's equipment technician to conduct a large-scale reorganisation of storage management across the whole unit.
- A general unit meeting was held every two months and a consultants meeting was held every two to three months with staff from both the St Richard's site and the Worthing site. We saw that critical care patient treatment outcomes from both sites was discussed at the meetings and used to identify areas of learning that could be standardise policies and care pathways.
- Staff had raised the security of the hospital site overnight following incidents of unauthorised people in the hospital and people threatening staff when they asked them not to smoke inside the building. It was not clear that the trust had a robust or effective security policy in place to address this and staff told us police had told them not to contact them about unauthorised people on site during the night.

Leadership of service

- All of the staff we spoke with told us they were happy with the leadership of the unit, particularly in relation to how they were supported to develop and work with specialists. A doctor said, "This is a really positive, well led place to work. The matron is outstanding."
- CCOT nurses told us they were happy that they could run the service autonomously in terms of the management and organisation of care and that they were also very much a part of the main critical care nursing team.
- The clinical nurse educators (CNEs) at both critical care hospital sites had adapted the Critical Care Network Nurse Leads Forum (CC3N) clinical leadership competency framework to the band six nurse role, to provide substantive developmental opportunities to staff. This programme included the completion of a CC3N level one workbook, an orientation period in the leadership role and a twelve month assessed competency period. This strategy was used to stabilise the staff team and to secure long-term commitments from nurses.

Culture within the service

- The ward administrator provided a complex support role to clinical staff that helped them to focus on clinical

care. For instance, this member of staff provided a reception service, prepared the off duty nurse rota, assisted with procurement, facilitated the daily safety huddle and some nurse meetings and also prepared the minutes of various meetings between staff. Staff told us that the ward administrator also organised social events for them, which one person described as "absolutely essential for keeping our morale up."

- Staff in all roles contributed actively to the safe and efficient running of the unit. We found evidence of this during our conversations with staff at all levels and during our observation of daily safety huddles. Each individual was encouraged to participate and given time to contribute, which we saw was effective in addressing issues. For example, staff sickness meant that the housekeeping team was short staffed. In the safety huddle the housekeeper advised clinical staff of this and made them aware of contingency plans.
- The approach of staff to help each other appropriately was also reflected in the role of the equipment technician. They were responsible for setting up equipment ready for a patient transfer and would accompany patients to other departments, such as for an MRI scan, when it was appropriate.
- A doctor said, "We have a really good nursing team that works well together, a strong physiotherapy team and a strong multidisciplinary approach to care, particularly with dieticians and pharmacists."

Staff engagement

- Staff were invited to annual team away days that included training sessions and opportunities to discuss the running of the unit, including support around conflict resolution.
- The CNE allocated each band six nurse a development project to lead on, such as supporting student nurses or infection control. The team of band six nurses were working with band five colleagues to develop a series of 'quick clinical guides' based on their skills and experience.

Innovation, improvement and sustainability

- Staff were planning the trial of a social media support group for patients after they were discharged. This would include links to critical care treatment information and help people to communicate with each other privately, based on a social media model that had been successfully launched in another hospital service.
- The professional development of staff was a focus of the unit's sustainability plans. This included a partnership with a university to offer a critical care nursing pathway that led to an undergraduate BSc degree followed by the opportunity to study an MSc Research programme.
- The trust was developing an electronic virtual outreach ward so that the outreach team could monitor the sickest patients on hospital wards. This would allow for a more seamless and timely admission, if and when necessary.

Maternity and gynaecology

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

Information about the service

Western Sussex Hospitals NHS Foundation Trust's maternity and gynaecology services are based over three sites, but share the same guidelines and protocols. In 2014/15, 5,194 babies were delivered in the Western Sussex Hospitals NHS Foundation Trust; that is an average of 433 babies a month.

The services are delivered from two main sites: St Richard's Hospital in Chichester and Worthing Hospital. Women can choose to give birth in either hospital irrespective of where they live. The two hospitals are 20 miles apart. Working closely with midwives based in the community, women who anticipate an uncomplicated delivery may also choose to give birth at home. There is a third site, Southlands Hospital in Shoreham, offering gynaecology day services.

In 2014/15, 2,465 babies were born at Worthing Hospital. That is 205 deliveries a month.

There is a new telephone maternity triage service covers both sites and enables women to be directed to the most appropriate support. Both St Richard's and Worthing Hospital have an early pregnancy assessment unit, ambulatory gynaecology services and there is a dedicated emergency gynaecology day unit on the Worthing site. There are no dedicated gynaecology wards on either site and so gynaecology in-patients are cared for on the general surgical wards.

Both have an antenatal day assessment services for women requiring closer monitoring during pregnancy. There are also antenatal clinics where women can have ultrasound scans and screening tests to identify any health issues that might affect their babies. There are also parent craft, physiotherapy classes and breast feeding workshops available.

Worthing Hospital has a nine-bedded delivery suite. All the rooms have ensuite facilities and two of the rooms have birthing pools. There is no midwife-led birthing centre at Worthing.

In-patient antenatal and postnatal care is available on Bramber Ward which has 27 beds, there are some individual rooms and the rest are in six bedded bays. There is one dedicated maternity operating theatre at Worthing Hospital. There is a level 1 special care baby unit at Worthing Hospital for babies who require additional monitoring and a level 2 Local Neonatal Unit, for babies requiring short-term intensive care, at St Richard's Hospital. Babies requiring greater levels of support would be transferred to a hospital with a level 3 unit.

There is some gynaecology surgery at both hospital sites and at Southlands Hospital, Colposcopy and hysteroscopy are carried out at Southlands Hospital, but oncology is referred to the cancer centre in Brighton.

Termination of pregnancy for fetal abnormality or following an intra-uterine death is carried out at Worthing Hospital. In 2013/14 there were 25 medical abortions carried out at Worthing Hospital. There are no surgical abortions at Worthing. All other terminations of pregnancy are contracted out to another provider.

We visited all areas of maternity services and spoke with 79 members of staff, some on an individual basis and others in joint meetings, handover sessions and focus groups. This

included staff of all grades including midwives, doctors, consultant obstetricians, domestics, maternity care assistants, receptionists, ward managers and members of the senior management team. We made observations in respect to the provision of care, staff interactions, the availability of equipment and the environment. We reviewed written material such as policies, guidelines and safety protocols and we reviewed formal arrangements for audit and the management of risk in order to evaluate the governance arrangements.

Summary of findings

Overall we rated maternity and gynaecology services as 'Outstanding'. This was because of the excellent work being done to engage with women and their partners through innovative and award winning use of social media and other routes. The trust was actively working to engage with harder to reach groups and had adapted services to the needs of a changing local community.

Multi-disciplinary work internally to the trust and with external partners had resulted in improved outcomes for woman and babies, particularly the most vulnerable or those in challenging circumstances.

The service provided effective care in accordance with recommended practices. Outcomes for women in the service were continuously monitored and incidents and complaints were used as opportunities for learning and for the improvement of services.

The service at one of the main sites was sometimes unable to cope with the demand and this resulted in the closure and women were diverted to the other site. This also resulted in some delay for women waiting for the induction of their labour and for elective caesarean sections.

Compliance with training was good and staff was offered additional opportunities for learning and development. The care was compassionate and supportive and women and their families were treated with respect and dignity.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Outstanding ☆

We rated the service as 'Outstanding' for safety.

This was because of the culture of learning from incidents and mistakes that pervaded the service and the focus on patient safety. All staff were open transparent, and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of quality. There was on-going, consistent progress towards safety goals reflected in a zero-harm culture. We saw evidence that incident reporting, investigation and dissemination of learning were well embedded in the culture of trust staff with incidents being seen as a tool for driving improvements.

The level of consultant obstetrician cover on the labour ward exceeded the national recommendations. The hospital had 80 hours of consultant presence across seven days. The recommendation made in the intercollegiate guidance, "Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2013)" is that there should be a consultant presence for at least 40 hours per week. The RCOG Hospital Recognition Committee suggests that less than 30% of hospitals achieve the recommended standard.

There were some midwifery staffing shortages but these had not impacted on patient safety as there was sufficiently robust mitigation in place.

Records related to the care of each woman were completed accurately and safeguarding procedures were operating well. Compliance with mandatory training was high and was monitored closely. Women reported feeling safe and confident in the skills of midwives and doctors.

There was good compliance with infection prevention and control measures and maternity services scored well against cleanliness audits. Across the trust there were low levels of hospital acquired MRSA and clostridium difficile infections. The surgical site infection rates for maternity and gynaecology patients were much better than the national averages for similar trusts.

The trust had good safeguarding arrangements that were known to all staff. Other external organisations were actively engaged in assessing and managing anticipated future risks, which could be demonstrated by the trust's proactive response to lack of information sharing around the safeguarding of children by another provider.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. Maternity and gynaecology services at Worthing Hospital were struggling with shortages in midwifery and medical staffing. The midwives were prioritising safety and the service was routinely closing one site and diverting to the other because of capacity issues, including staffing.

Incidents

- In the 12 month period between 1 November 2014 and 31 October 2015, 13 serious incidents were reported to have occurred within maternity and genecology services across the trust. We read the reports of these incidents and saw that five involved the mother only, three involved the baby only and one involved both mother and baby. Two incidents involved delays in appointments, procedures and diagnosis, one incident involved a screening issue and one involved an invasive procedure. All of the reports indicated that a multi-disciplinary independent panel had collected evidence and a transparent investigation had taken place with a view to learn lessons rather than to apportion blame.
- Staff we spoke with was aware of the incident reporting system and the importance of learning from incidents. Five of the serious incidents took place at Worthing Hospital. There were no serious incidents reported at Worthing Hospital between May and October 2015.
- We read the notes of some of the women's health integrated quality safety meetings and saw that medical staff were fully engaged in the analysis of incidents and identification of any trends.
- We spoke with the patient safety midwife who told us about the monthly patient safety meetings that were held alternately at Worthing and St Richard's hospital. In attendance at these meetings included the head of midwifery, quality governance and experience lead

midwife, a consultant obstetrician, a labour ward lead and the antenatal clinic manager. In addition, any staff, including community midwives, with information relating to a specific case on the agenda would attend.

- We saw the minutes of these meetings and noted that they discussed the monthly incident report, trends, safety alerts and the risk register. For example, we saw that ultrasound scanning had been added to the risk register because of capacity; as a result, a member of staff had consulted colleagues and produced a 'working plan'. More scanning machines had been included in the trusts bid for the use of capital and additional scanning lists were being held in antenatal clinics over weekends to clear the backlog of nuchal combined scans (a screening test for Down's Syndrome).
- One of the incidents was classified as a 'never event' and this involved a retained swab following a gynaecology procedure in outpatients at Southlands Hospital. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures have been implemented.
- Staff who spoke with us demonstrated their awareness of this 'never event' and said that, as a result of this incident, a standard operating procedure for gynaecology invasive procedures had been adopted for all surgery conducted outside of an operating theatre. In addition, the national World Health Organisation (WHO) checklist for safer surgery had been adapted for use in outpatient settings and staff training had been updated. This demonstrated to us that staff were using this incident to learn lessons and improve procedures.
- We saw the minutes of the gynaecology risk meeting of October 2015 which included an update on the actions agreed following the never event. The minutes indicated that a new colposcopy standard operating procedure had been written in line with invasive procedures safety checklist in theatre and compliance was being audited. In addition, new boards had been installed to support swab counts. This demonstrated to us that staff were using this incident to learn lessons and improve procedures.
- The ward manager on Bramber ward told us that staff on the ward were informed of incidents via text message, daily safety huddles and a discussion of all safety issues at the ward handover.
- We looked in detail at the investigation report following an incident that occurred at Worthing Hospital, where a baby's condition was not detected by ultrasound scanning. The report was thorough and considered all possible factors, such as, the normal detection rate for this particular abnormality, the quality of the images, the condition of the scanning equipment, the competence of the staff and the time allocated for each scan. The trust asked experienced sonographers, not previously involved in the case and sonographers from another trust, to review the still images of the scans to see if they could make a diagnosis. The investigation panel posed the question: 'Was the failure to diagnose unreasonable'.
- The recommendations from this investigation demonstrated that the trust had considered the details of the case and used them to identify "Systemic improvements rather than to apportion blame to individuals." The lessons learned were clearly documented, such as, the tendency within the trust to assume ultrasound imaging is consistently at a standard and that it gives a high degrees of assurance simply because the detection rate for abnormality at the trust is well above the national average. The recommendations from the investigation included both teaching and technical solutions and a divisional approach to issues of workforce capacity and competence.
- The investigation panel considered the trusts obligation resulting from the duty of candour. The parents were offered an opportunity to discuss the events and a copy of the investigation report was made available to the parents of the baby. The investigation was thorough and the process was open and transparent.
- There was another serious incident involving an unplanned home birth and an adverse outcome for the baby. This case raised questions for the trust around effective communication, especially when the service was busy, with one site closed and 'on divert' and unable to manage the demand. We saw the case was discussed in several meetings including the patient safety meeting and perinatal meeting. It was also noted that, in November 2015, the service updated the escalation and contingency plan for diverting and closing a maternity unit.
- There was a monthly newsletter to staff from the Patient Safety Midwife. We saw the Worthing Hospital editions

for September, October and November 2015. All three editions included praise and congratulations from serious incident reviews, such as, recognition of good multidisciplinary working alongside the surgical team who were involved with a complicated caesarean section. There were also reminders about guidance and practice such as adhering to a postnatal feeing plan for babies who need to gain weight.

- Other incidents were also reported and monitored across the Trust. From 1 November 2014 to 31 October 2015 there were 984 incidents reported in maternity and gynaecology services. In 81% of these incidents there was no harm to the patient. There were 18 incidents resulting in moderate harm, but there was no clear theme to these incidents. This level of reporting demonstrates an open and honest reporting culture. We spoke with the patient safety midwife who told us that information about the learning from incidents was shared via 'Maternity Matters' a monthly bulletin circulated with pay slips, face to face group meetings, individual meetings and via supervision. The patient safety midwife said that when action was taken at one site, they checked what was happening at the other site so that the learning was shared and procedures remain consistent.
- During the same period there were two maternal deaths and two babies died. These deaths were reported appropriately and fully investigated. Support was offered to the families and the staff involved. The mortality and morbidity data from maternity and gynaecology is reviewed in the patient safety section of the monthly operational departmental and governance meeting. Perinatal meetings occur fortnightly. It was noted the outcome of the investigation into these deaths showed no avoidable cause and that care had been managed appropriately.
- We asked staff for examples of the trust fulfilling its responsibilities under the Duty of Candour. Two examples were given. One involved the use of scissors that were not sufficiently sharp to perform the procedure for which they were used. In this case, the trust wrote to the woman affected and explained what had happened and offered an apology. Another example was of a screening appointment missed by the trust. Again the trust wrote to the individual with an explanation and apology. These examples demonstrate that staff at the trust are aware of and execute their responsibilities under the duty of candour.

Safety thermometer

- The NHS Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care. It also records the extent of harm associated with maternity care. It is intended for public display so that the public are informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It also records babies with an Apgar score of less than seven at five minutes and/or those who are a admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.
- Results of the safety thermometer survey were displayed on Bramber ward and we noted that there had been one incidence of venous thromboembolism in March 2015. We noted that there had been no other reported incidents of this kind since December 2014.

Cleanliness, infection control and hygiene

- We observed all areas of the hospital providing maternity services, apart from the labour theatre which was in use. We found the standard of cleanliness to be good and there was evidence that domestic staff followed guidance about the required cleaning standards, practices and frequency of cleaning. We found stickers on items of equipment indicating they were clean and ready for use. Domestic staff tended to keep their own cleaning schedules in the cleaning cupboard rather than displaying them in the rooms.
- Statistics on infection control and equipment checks were displayed on the notice board on Bramber ward.
- We spoke with a member of domestic staff on the delivery suite and they showed us the records they kept of cleaning delivery rooms, toilets and bathrooms. The

records we saw included entries for the daily flushing of the birthing pools and a record of the dates when the disposal curtains should be replaced. There were records of emptying bins, cleaning the inside of windows and mirrors and cleaning surfaces. The member of staff we spoke with took great pride in the work and was fully engaged with the ward.

- Women we spoke with said that they were pleased with the level of cleanliness. One women in a single room on Bramber ward said "The ward is always spotless."
- We saw the 'patient-led assessments of the care environment' (PLACE), for Bramber ward. This is a system for assessing the quality of the patient environment which involves local patients. The Bramber ward assessment was conducted in September 2015 and scored 92% for ward cleanliness. There was some dust and cobwebs found on ceiling vents and offensive material in the waste bin. The ward scored 70% for condition and appearance because of the poor condition of some of the flooring and chairs and the need for some redecoration. The ward scored 83% for hand hygiene, staff appearance and safety. This was because hand hygiene pumps had been left on hand basins causing an infection control issue. The ward scored 100% for privacy, dignity and wellbeing despite the challenges of the small bay areas.
- We saw an infection control audit undertaken for the antenatal clinic in April 2015. The audit found that the clinic was 79% compliant with the expected standards and made recommendations in relation to labelling sharps bins, using 'I am clean stickers' and keeping hand washing sinks clear of other items such as a urine analysis testing strips and coffee cups.
- We also saw an infection control audit undertaken for the gynaecology Day Unit in July 2015. The audit found that the Unit was 96% compliant with the expected standards. One of the recommendations was that all staff should be made aware of the symbol for items that are intended for single-use. Evidence of quality care and best practice was identified including that personal protective equipment was being used to reduce the risk of cross-infection and that waste and sharps were disposed of correctly.
- We also saw infection control reports for high impact interventions for June, July and August 2015. These reports included scores 100% for correct procedures for tasks such as central and peripheral line insertion, for urinary catheter insertion and for decontamination audits. There was 100% compliance with hand hygiene for the delivery suite and in all other areas of maternity and gynaecology. However, the antenatal clinic had three weeks missing data for hand hygiene.
- Rates of infection such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Diff) were better than the average for hospitals in England. There had been no reported cases of MRSA at Worthing Hospital from April 2014 and no surgical site infections in gynaecology since June 2014.
- We review the technical audits for the cleaning services at Worthing Hospital and found scores of 99% for the labour ward, Bramber Ward and the gynaecology day unit. All were above the target set for the assessed level of risk.
- We observed staff washing their hands between seeing patients, using gloves and the hand gels.
- The ward manager on Bramber ward informed us that infection control audits were conducted weekly. The manager said that there were spot check audits from time to time on medication, for example, and there was currently an audit on the ward of the administration of all intravenous antibiotics.

Environment and equipment

- We checked the resuscitaire in the new-born assessment room on Bramber ward. The checklist was in place and up-to-date.
- We saw from the risk register that the trust had twenty-four neonatal resuscitaires across both sites and 16 were either over ten years old and/or did not meet the specification required to follow the Resuscitation Council guidance for new-born life support. Fourteen of these 16 resuscitaires currently in use did not have the ability to deliver air of blended gas, as recommended in the guidance. There was no evidence that the elderly machines had any detrimental impact on patient safety.
- According to the risk register, a business case for new resuscitares had been prepared in September 2015 to present to the trust. We spoke to several staff about this and they said that they were being replaced and they were aware of the date for replacement.

- The scanning machines in the early pregnancy assessment centres at both sites were also on the risk register because the service felt they needed to be replaced. The risk register described the issue: "The limited resolution produced by both machines results in low quality images meaning higher rescan rates/missed diagnosis rates as sonographers have no confidence in these images." It was also felt that the need to rescan before providing a clear diagnosis caused anxiety for patients.
- There was also a risk with the colposcopes at Southlands Hospital because they over ten years old and there was a risk of breakdown. There were however, no incidents related to broken colposcopes.
- We saw the equipment maintenance log for Worthing and saw that three foetal monitors and a thermometer were on the list for repair. This demonstrated that there was an active maintenance programme for equipment.
- The noticeboard in the corridor on Bramber ward had an update displayed stating that an emergency equipment check that have been conducted in October 2015.
- One of the maternity assistants on Bramber ward told us that they had designed the daily and weekly checklists for equipment that were used as part of the normal routine.
- We checked the two CTG machines on the delivery suite. They both had 'I am clean' stickers and had been checked that day. They had been serviced and were within the review date. Similarly, we checked a defibrillator and it was also within date for the next service.

Medicines

- We checked the arrangements for the storage of medicines on the delivery suite. We found the drugs room had an entry code lock. Inside there was a locked cupboard for the medicines and inside was another locked cupboard for the controlled drugs. All the drugs we checked in the cupboard were within date. We saw that drugs were checked twice a day and audited by the pharmacy.
- We also checked the drugs storage and administration on Bramber ward and all processes were correct for the controlled and other drugs. Fridge temperatures were checked daily. Guidelines for staff were on display in the treatment room.
- We saw that there was a drugs round in progress on Bramber ward and that the midwives administering medicines wore tabards to indicate that they should not be disturbed. This meant that midwives were able to concentrate and this helped to protect from medicine administration errors. We also observed instructions for the patient group directions (PGD) on the medication trolley. After the drugs round, we asked a midwife about the PGDs and they were aware of the NICE guidance and that PGDs were reserved for limited situations and that the patient must fit the criteria set out in the PGD.

Records

- We were informed that there were green postnatal notes and buff coloured notes for babies. There was also hand held notes and the red books for babies. Red books are used nationally to track a baby's growth, vaccinations and development. There was a theatre record booklet for recording treatment and observations during surgery which stopped being used after recovery when it was absorbed into the postnatal record. There was an electronic recording system and the service was investing in laptops for community midwives to record patient details. The hand held notes for mothers contained useful information about pregnancy, screening, pain relief, choices and what to expect at the birth.
- We checked eight sets of patient notes in detail. Of the eight, all had a named midwife recorded and all had full risk and VTE assessments. In addition, all the notes contained a complete World Health Organisation checklist for safer surgery and all had a birth plan. Only two sets of notes required CTG documentation and in both the documentation was complete with stickers and two signatures. There was a list of signatures and printed names in all the notes. This demonstrated a good standard of record keeping.
- We were told by several midwives and administrative staff, in one-to-one sessions and in the focus groups, that the maternity records had been relocated to off-site

storage. This meant that the only records kept on site and easily to hand, were for women whose maternity care and treatment was completed in the previous three months. Other records could be accessed on request.

- Some reception staff voiced concerns that the move to an offsite archive would increase their workload. The issue had also been entered onto the risk register in September 2015. There was an update in October indicating that the trust had decided to employ an additional clerk for the 'retrieval and culling' of maternity medical records for one year. There was a further note following a discussion at the women's health operational meeting, advising staff to make better use to the electronic record system and that a case was being made for more computers on the wards.

Safeguarding

- We met with the named safeguarding midwife for the trust. The safeguarding midwife told us about a number of separate pathways they had developed in the service for more vulnerable women in pregnancy. There was a multi-agency pathway for teenage young parents supported by a young person's midwife, family support worker, health visitors and colleagues from social services. Together these health and social care professionals created 'the team around the family'.
- The trust also had a Family Nurse Partnership for vulnerable first time mothers facing challenging situations. In this partnership, nurses have a smaller caseload in order to work closely with a young woman throughout her pregnancy and until the child is two years old.
- We saw a local protocol for maternity services and adult drug and alcohol treatment services. This was for pregnant women and their partners who use substances. The public health midwife also told us about the work of the service with domestic violence and the NSPCC safeguarding and child protection model called 'signs of safety'.
- A community safeguarding midwife attended the staff focus group held in Worthing. She told us about the alert system and the electronic database for vulnerable women and those with a child protection plan. She said that there was an effective multiagency system and the trust had a young person's midwife.
- We saw that a consultant in community gynaecology had circulated a document to staff about female genital mutilation (FGM) and the responsibilities of individuals to report cases involving under 18s to the police and safeguarding. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patient's health record; there was a clear process in place to facilitate this reporting requirement.
- We saw an item on the risk register about a difficulty in exchanging safeguarding and child protection information with BPAS. The trust was trying to resolve this situation, was referring to the Department of Health policy for sharing information entitled 'Seven golden rules' and had raised the matter at the trust's safeguarding forum. It was reported that the issue was largely resolved.

Mandatory training

- Overall, across both sites, the service is meeting the trust target of 90% compliance in four out of ten training modules. Nursing and midwifery staff are 90% compliant with training in infection control, child and adult protection and health, safety and risk. They are just below the 90% target for completing training in fire safety, information governance, back training, equality and diversity conflict resolution and resuscitation training, Medical staff in the service are 90% compliant with modules in infection control, child and adult protection and health, safety and risk. They are below 90% compliance in fire safety, information governance, back training, conflict resolution and resuscitation training.
- A closer inspection of the mandatory training records for Southlands and Worthing Hospital show that Southlands had 100% compliance with adult and child protection and equality and diversity training. There was also 100% compliance with resuscitation training for all nursing and midwifery registered staff in the service at Southlands Hospital.
- At Worthing Hospital, there were high levels of compliance with all training modules in the gynaecology day unit and in public health.

- Staff at the focus group in Worthing said that the trust supported staff to attend mandatory training sessions. One member of staff who was working exclusively on the 'bank' said that here experience was not the same support for bank staff where access to training was limited. Colleagues in the group said that they had not been aware of this.

Assessing and responding to patient risk

- A senior midwife would conduct a risk assessment where a woman requested a home birth. This meant that there was a careful assessment of risk before any home birth and safety was part of the decision making process.
- We saw, from the postnatal patient notes and through talking to staff, that the service used the Modified Early Obstetric Warning Score (MEOWS) charts to provide graphic evidence of the health of a patient deteriorating. However, we noticed that a few charts had not been calculated to give an overall score and had not be signed by the clinician. This meant that they were not always being used to achieve the full benefit.
- 85.4% of staff in maternity and gynaecology had completed a training programme on life support. This was below the trust target of 90% but included staff who were recently recruited and who were on maternity leave and long term sickness absence.
- We asked the trust for a recent audit of the completion rate for MEOWS charts. They said that they had not completed an audit since 2013, but had plans to complete them every three years.
- The senior management team informed us of their plan to introduce telemedicine software into the service for the remote review of CTG. This would allow staff to review CTGs at a monitoring station and it would allow an opportunity for 'fresh eyes' review of CTG traces away from the woman in labour. It would also allow the on-call clinician to review the CTG from home via a safe server. We were informed that a business plan had been prepared but had been put on hold in the summer pending further research on 'safety and efficiency' of centralised monitoring. This item was also on the risk register.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy.
- There was one obstetric theatre on the labour ward at Worthing. This meant that, when it was occupied and an emergency arose, the patient and equipment would need to be transferred to the main theatres, via the lift, to the floor above. This created additional anxiety for the patient, and a delay and potential additional risk for mother and baby. It also relied on a theatre being free in main theatres and the lift being available. We saw that this issue had been identified by the trust and placed on the risk register. The mitigation was outlined, such as close liaison with main theatres and careful theatre diary management. The trust had not identified the capital to resolve this issue to make an additional theatre available solely for obstetrics.

Midwifery staffing

- The ratio of midwifery staff to births within the service, taken across both sites combined was slightly better than the England average, with one midwife to 25 births in May 2015. The England average for that month was one midwife to 27 births. The benchmark commonly used is 1 midwife to 28 births and the trusts own target was 1:30 or better.
- There had been a steady improvement in the midwife to birth ratio since March 2014.
- The most recent local supervising authority (LSA) Annual Audit Report: 'Monitoring the Standards of Supervision & Midwifery Practice' was completed in July 2013 for the period 2013/14. At that time the midwife to birth ratio was 1:29 and it was recommended by the LSA that the ratio should be maintained. We understand that the LSA completed a further audit in 2015 but the report was not available at the time of our visit.
- We asked the trust to supply vacancy numbers and they confirmed that for November 2015 there were 17.9 (whole time equivalent) vacancies in maternity and gynaecology across both sites.

- We saw the data for the numbers of staff that were planned to be working and the number of staff (including bank staff) who were actually working each month from May to August 2015. The number of actual qualified staff working appeared to be close to the numbers planned. However, there were slightly fewer numbers of maternity support assistants and support staff working, compared to the planned numbers.
- We attended a meeting with senior staff of the service and they confirmed that the staffing levels were a challenge in maternity and gynaecology. The Divisional business plan described the staffing situation for midwives as 'frail'. This was due to a combination of factors including leavers, maternity leave and an increasing sickness rate which was at 3.3% at the time of our inspection. They said that recruitment was underway for qualified staff and three had been recruited but were not yet in post.
- The trust used the intrapartum 'Birthrate plus' monitoring tool at least every four hours for monitoring activity and staffing on the delivery suite. This enabled the ward manager and midwives to assess their 'real time' workload arising from the numbers of women needing care, their condition on admission and throughout the processes of labour and delivery. This was monitored and assessed in relation to the staff on duty and the bed capacity.
- The delivery suite at Worthing was overly busy at the time of our visit and had closed to any new admissions. Staff working on the telephone triage system were aware of the situation and were diverting women to St Richard's Hospital. This divert was still in place when we had completed our visit at midday the following day.
- Staff working on Bramber ward said they were often asked to go to the labour ward because it was so busy. Staff on Bramber Ward said that it was also a problem for the staff left on Bramber Ward as they were now short staffed and unable to provide the standard of care they wanted. The ward manager on Bramber ward had introduced the idea of 'core' staff for the ward, these were staff who worked permanently on Bramber ward and could assist other staff who were not familiar with the ward and its routines. The introduction of core staff was welcomed by the midwives we spoke with.
- We were informed that midwives working at Worthing were not required to attend the obstetrics theatre to provide instrument/scrub assistance or to act as the assistant to the obstetrician. However, midwives at Worthing did attend the obstetric theatre to support the women and baby, as recommended in the consensus statement on staffing obstetric theatres agreed by the College of Operating Department Practitioners, the Royal College of Midwives and Association for Perioperative Practice, produced in May 2009.
- Staff working in the clinics said it was easier for them as staff were more constant and consistent. They said that clinics, in the main, ran to time and were adequately staffed.

Medical staffing

- The skill mix and profile of the 62 medical staff in maternity and gynaecology services at the trust was similar to the average across trusts in England. The only difference was that there were fewer registrars at Western Sussex and slightly more middle grade doctors, that is, doctors who had been working at a senior level for at least three years, compared to the England average. This meant that the medical staff were more experienced than at other trusts in England.
- There was 80 hours of consultant cover per week on the labour ward at Worthing Hospital and there was always a consultant on-call out of normal working hours, that is, 8.30am to 6.30pm. A consultant we spoke with said that providing cover was a bit of stretch because they had vacancies. Recruitment was underway, including overseas recruitment.
- The national shortage of junior doctors in obstetrics and gynaecology and the inability of the trust to fill its obstetric registrar rota was on the risk register. We were informed of the mitigation involving the use of long term locums, some consultant obstetricians were 'acting down' to cover vacancies and there was effective collaboration across the two sites.
- However, they had some long term locum cover, an overseas doctor's scheme and one consultant worked a night shift each week and some weekends on call. The divisional business plan and strategy said, 'The Division

has had to have an innovative approach to recruitment and has introduced the role of resident on call consultants (ROCs) in order to mitigate the risks surrounding the reduced number of junior doctors'.

- There was an obstetric consultant of the week on each site and there was an anaesthetist available 24 hours a day seven days a week. We found that the medical staff were fully engaged with the midwives and with other colleagues.
- We saw from a report following an incident involving ultrasound scanning that there was a shortage of sonographers at Worthing Hospital. It was reported that this shortage was caused by staff taking maternity leave or leaving the trust and an inability to recruit replacements. The trust was using locum members of staff. In addition, 25 minutes was allocated for each scan rather than the recommended 30 minutes and scans were conducted without a supporting member of staff to input the data. The report concluded that this placed 'additional pressures on Sonographers during sustained periods of heavy demand.'
- The risk register had an entry on the national shortage of ultrasonographers and the impact this may have on the women receiving timely and appropriate scans. There were some dual trained midwives and gynaecology nurses providing some additional capacity and further ultrasound sessions were being offered to women at weekends. However, the issue was on-going and a business case was to be developed in January 2016 to increase the number of dual trained staff within the service.
- Medical staff did not share the same rotas across the two sites but we were informed that they had recently covered sickness across the service. The consultant obstetrician said that they worked well as a team and put the patients' needs first.
- Weekly consultant meetings took place on each site and the labour ward consultant conducted a review of caesarean sections at the multidisciplinary handover. There was also a monthly divisional meeting.

Major incident awareness and training

- We spoke to a manager in the service who said that there was training across the trust for responding to major incidents such as floods or power failures. The manager said that they had a business continuity plan, lists of important contact numbers and practice runs were carried out. We saw a copy of the business continuity plan and the escalation plan for maternity and gynaecology.
- When we asked about major incident awareness and training the midwife leading on public health told us about the recent aircraft accident on the A27 outside shoreham airport. This incident impacted on the work of the service because the A27 was closed for almost a week and community midwives found it difficult to get to some appointments. There was also a delay for women in labour trying to reach hospital. The service responded by sharing details with neighbouring services and offering reciprocal support so that women could be seen locally.

Are maternity and gynaecology services effective?

Outstanding ☆

We rated the effectiveness of maternity services as 'outstanding'.

This was because outcomes for patients were in line with or exceeded the national averages for most indicators.The level of massive post partum haemorrhage was better than the upper limit target of 1% with no women suffering a blood loss greater than 2,500 mls.

There was further work to be done in normalising birth to reduce the higher than average caesarean section rates but the trust was aware of this and taking action to improve performance against this particular measure.

Staff working in maternity and gynaecology services had access to professional guidance to inform care and treatment. Midwives had continuing professional development that enabled them to perform effectively in their roles and mother's said that they were both competent and professional.

People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure

consistency of practice and the service was continually monitoring patient outcomes. The service was seeking to make improvements in a number of areas including in the rates of normal births.

The trust participated in local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness was shared internally and was understood by staff. It was used to improve care and treatment and people's outcomes.

Staff were well qualified and had the skills needed to carry out their roles effectively and in line with best practice. Staff were supported to maintain and further develop their professional skills and experience. Multi-disciplinary working was good both within the service and with agency partners.

Pain management was available and the service was supporting the development of new approaches such as hypnobirthing.

Evidence-based care and treatment

- There was evidence available to demonstrate women using the services of the trust were receiving care in line with the National Institute for Health and Care Excellence (NICE). For example, routine antenatal care was delivered in accordance with NICE standard 22, including screening tests for complications of pregnancy.
- We saw documentary evidence that the trust had benchmarked their guidelines against NICE guidance and that these were consistent with NICE guidance. For example, the audit found that the local guidance on ectopic pregnancy and miscarriage were compliant with NICE quality standard QS69 and the local guidance on induction of labour was compliant with NICE quality standard QS60.
- We also saw that guidance published by NICE and other organisations was used to inform good practice in relation to investigations. For example, in one root cause analysis investigation, reference was made to NICE guidance from 2014 in relation to maternal sepsis and fetal wellbeing. In another investigation report into a massive obstetric haemorrhage, reference was made to the national guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) Prevention and management of postpartum haemorrhage (2009) and the Royal College of Anaesthetists (RCOA) guidelines for the provision of anaesthetic services (2014). The ROCA guidelines were used to conclude that the anaesthetist should have remained with the patient until transfer to recovery.
- We were provided with a copy of 'Learning points of the week', a weekly bulletin written and circulated by a consultant in Obstetrics and Gynaecology. The bulletin included a reminder of the new National Institute for Health and Care Excellence (NICE) guidance on menopause. In the same bulletin a consultant attached a link to the Health Foundation's report on the continuous improvement in patient safety.
- We saw that a local audit was undertaken in October 2015 on completion of the WHO checklist in maternity theatre. In the same year there were audits for antenatal care, the gynaecology day unit in Worthing and Bramber Ward.
- There was also an audit in Worthing to investigate and identify causes for the increase in the rate of caesarean sections in September 2015. The results were inconclusive and it was decided to collect and analyse additional statistics using the Robson ten point classification of the characteristics of pregnancy and delivery. This process was on-going at the time of our inspection.
- We saw the audit programme for 2015/16 and saw that further audits were planned on caesarean sections, the outcome of multiple pregnancy and outpatient hysteroscopy as part of the ambulatory gynaecology service.
- The service was basing its strategic plans and quality strategy on the 'Better Births Initiative' which is the Royal College of Midwives programme for developing maternity services in the UK. They were also using the Trust Patients First programme to standardise and improve patient pathways.

Pain relief

- Women had hand held notes, which provided information on pain relief. There were also leaflets available in the clinics and on the website. The leaflets set out options such as using transcutaneous electrical

nerve stimulation (TENS), Entonox or pethidine. The midwives told us that an anaesthetist was always available for epidurals and we noticed that the women we spoke with found the anaesthetist helpful and reassuring.

- We spoke with a woman on Bramber ward who said she had a plan for pain relief and she was able to follow it throughout her labour. She said she had wanted to move around in the early part of labour and was able to do that.
- We saw that there were two rooms on the delivery suite that had birthing pools which meant that women could use water emersion for pain relief in labour. The midwives told us that they were popular with women for pain relief.
- We also equipment such as a birthing balls and a V shaped pillow to support women in labour.
- The trust also had a workshop and leaflet on hypnobirthing.

Nutrition and hydration

- We spoke to a woman on the Bramber ward who said the food was good. They said "There was a choice and it was all tasty". Another woman said she thought it might be difficult because she was a vegetarian, but she felt she was well catered for.
- A woman on Bramber ward said, she was surprised to find that after all the women had been fed first, her partner was also offered food. She also said that she had lots of support with feeding her baby.
- Another woman said that the food was better than a couple of years ago when she had her first baby but "it was not always that warm." She said that there were 4/5 main course choices.
- We found breastfeeding advice on noticeboards and in leaflets that formed part of the welcome pack on Bramber Ward. Leaflets included the 'Start4life' leaflet produced jointly by the Unicef and the NHS. There were other trust leaflets such as, care of you and your baby in the immediate postnatal period and a parents' guide to the breast feeding policy. These information leaflets were also on the maternity website.
- The hospital was one of the first in the country to receive the Unicef Baby Friendly Award in 1999. The midwife leading on public health, who informed us that the trust was now part of a multi-agency initiative developed in West Sussex entitled 'Five to thrive'. It was described as a programme to support parents and carers with pre-birth to 2-year old children, 'to promote positive behaviours that help build baby brains and develop loving attachments'. The public health midwife said that she was aware that the breastfeeding initiation outcomes had been pretty static for some years and so the trust had decided to try a different approach. This new programme had been launched recently and was designed to be inclusive and holistic. That is, it would involve all parents however they choose to feed their baby.
- The public health midwife also told us about a new community based weight management in pregnancy programme that had been developed with a group of six service users. The programme had been given an 'All Party Parliamentary Award'. It was designed as an alternative to just being weighed by a medical professional and advised to lose weight. It had begun with a discussion group based around the NICE guidance on weight management and the potential risks to babies.

Patient outcomes

- The trust was providing midwifery staff to complete training in manual perineal support at birth which research suggests may be protective against anal sphincter injuries.
- The rate of 3rd and 4th degree perineal tears was consistently below the projected level with 2.1% of women sustaining tears against a target upper limit of 6% in the YTD to October 2016.
- The hospital was performing better than the projected target of less than 15% of births being operative vaginal deliveries with 12.8% of births being assisted.
- The hospital had more successful vaginal births after caesarean section births than predicted with 77.5 % of opting women delivering vaginally compared to a target of 75%.
- Unexpected admissions to SCBU or NICU were much better than the upper limit target of 10%. The YTD admission rate to October 2016 was 1.8%.

Maternity and gynaecology

- The level of massive post partum haemorrhage was better than the upper limit target of 1% with 0 women suffering a blood loss greater than 2,500 mls.
- The CQC intelligent monitoring data showed that the trust was not performing significantly differently to the main body of NHS trusts in relation to maternal and neonatal readmissions, caesarean section and cases of puerperal sepsis and other puerperal infections. Where there was a deviation from the England average was in elective caesareans deliveries where, at the trust, these were 12% of all deliveries against an England average of 10.9%.
- In terms of rates for caesarean sections. The total number, including planned and unplanned, for the service was and average of 27.7% for the period from April 2015 to November 2015. This was against a target of 26% or less. The monthly rate had been increasing in recent months with 30.3% in September 2015 and 31.3% in November 2015. The increase in the caesarean rate to 32.3% in September 2015 at Worthing was investigated by the service. The conclusions of this investigation were that there was good evidence of consultant involved in both elective and emergency sections and guidelines were being followed. There was evidence that normal birth was being offered to women who had previously had a caesarean section but that there were often co-morbidities indicating a need for delivery prior to spontaneous delivery.
- The service confirmed that they were providing 1:1 care in labour for all women.
- The referral to treatment times in gynaecology were reported to be 93.1% compliant in September 2015.
- Between April and July 2015 there were 848 births in Worthing and between August and November 2015 there were 826. Of these, 60.3% were spontaneous normal deliveries which was below the trust target of 70%.
- Between April and November 2015, there were no intrapartum stillbirths and one neonatal death at Worthing Hospital. There had been one intrapartum stillbirth in 2014/15 and one in 2013/14. There had been one neonatal death at Worthing Hospital in 2013/14. This was much better than the UK norm which was 6 per 1000 births of babies over 24 weeks gestation.
- The trust was involved in some forward looking trials such as the Affirm trial that was focused on reducing the numbers of stillbirths. They were the only trust in the south of England involved in this study.
- The service was performing above its own target for women attending their first appointment within 12 weeks and six days of pregnancy. The target was to achieve this is 90% of cases and it was being achieved in 94% of cases at Worthing hospital from April to November 2015.
- We saw from the maternity dashboard for April 2015 to November 2015, that the service as a whole had never closed for new admissions. It had not closed in 2014/15 or 2013/14. Worthing Hospital maternity services had diverted 47 women to St Richard's between April 2015 to November 2015.
- There have been no maternal in-utero transfers from Worthing to a service outside of the trust network in 2015.
- The noticeboard in the corridor on Bramber ward displayed patient outcome statistics such as the number of births a month, the proportion of normal births and the rate of caesarean sections.
- We saw the outcomes from the national neonatal audit programme for 2013 for Worthing Hospital. The hospital was at or above the standard on four of the five indicators, including the retinopathy screening and breastfeeding.
- The trust had received an All Party Parliamentary Award for their Weight Management in Pregnancy Programme.
- The trust had implemented the South East Coast and South Central Network/DH National Care Bundle for reducing stillbirth.
- The trust was a pilot member of the RCOG Patterns of Maternity care in English NHS Hospitals.

Competent staff

- We looked at rates for the completed of appraisals for nursing and midwifery staff at Worthing Hospital and it was at 80.3% We saw from various meeting notes that staff were being encouraged to complete appraisals.
- The staff survey feedback for maternity and gynaecology indicated that in 2014, 3% fewer staff found that their

appraisal had helped them improve how they performed in their role, than in 2013. There was a 4% reduction in staff reporting that their appraisal left them feeling valued than in 2013. 37% of staff reported that they had not agreed clear objectives with their manager and 47% had not identified any learning and development needs at appraisal.

- We saw that the service had responded to this with further consultation with staff and a clear action plan, including refresher training on appraisal. Staff we spoke with said that appraisals were improving and becoming more useful.
- We were informed that all midwives were trained and competent to deal with preeclampsia and obstetric emergencies such as postpartum haemorrhage, shoulder dystocia and cord prolapse.
- Women we spoke with all said that they were impressed by the skills of the midwives. One woman said 'they were all so professional' and 'my midwife was so skilled and knowledgeable'.
- Senior managers and staff in the focus groups were positive about the expertise of the staff and the cooperative team working. One manager said, 'Our staff are fantastic. They embrace change, involve people and they always want to improve on what they do.'
- We spoke with a relatively new member of staff at the focus group. She said that she had only been in post for three months but had already had an appraisal and had been offered lots of training.
- There was an annual update on CTG procedures and there had also been an external masterclass. Much of the learning came from reviewing incidents and discussing how to respond in different scenarios.
- The senior midwives and doctors on duty provided CTG review known as 'fresh eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that is it was within normal parameters. The trust recognised that it was important to refresh the CTG training regularly and enable staff to attend. One of the clinicians said 'It is genuinely fresh eyes and not four eyes.'
- We were informed that there was a weekly meeting involving fetal surveillance where a case was presented and scenario's debated and discussed. The consultant said that the use of CTG monitoring, the use of 'fresh eyes' and interpretation is a matter for continuous debate and learning across the service.
- We also saw evidence of on-going learning and development. For example, we saw a programme for an Antenatal & Newborn Screening Study Day covering areas like infections in pregnancy, communication, consent and informed choice in screening and how to do sickle cell and thalassemia screening.
- The trust had received a Health Education England funding award for their Learning Zone and Mobile Learning zone Initiative (2015). This project provided easily accessible mobile clinical simulation training for multidisciplinary teams within acute and primary care environments.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) requires a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:13 and that the caseload of the supervisors to midwives was uneven (LSA Report 2013). However, the LSA adjusted the data to take account of SoMs who were on maternity leave which gave a ratio of 1:18 which confirmed that there were not enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Staff told us that the current ratio of supervisors to midwives was 1:20. We asked the trust to confirm the ratio and they provided information that demonstrated that the trust had 12 SoMs on the LSA database and two midwives were in training to become supervisors of midwives. This was below the NMC requirement. We were not able to confirm this with the 2014/15 LSA report as it had not yet been made available to the trust.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.

Maternity and gynaecology

Multidisciplinary working

- We attended a morning multi-disciplinary handover meeting on the labour ward at Worthing Hospital. It was a well-attended meeting with medical staff, midwives, nurses, anaesthetist, doctors from gynaecology, ward managers and the lead for antenatal services.
- The white board listed the women on delivery suite, on the Birth Centre, on the antenatal ward and women whose labour was due to be induced. It also listed pregnant women on other wards and any having home births. It was noted that Worthing Hospital was on divert to St Richard's.
- We saw notes of meetings where staff from other areas of work attended. This included perinatal meetings where midwives met with colleagues from paediatrics. In addition, maternity worked closely with gynaecology and with colleagues from the special care baby unit.
- We spoke with domestic staff and receptionists who said that they felt included and part of the ward and unit team.
- We also spoke with community midwives who attended meetings with each other, with hospital based midwives and specialist midwives, colleagues from social services, health visitors and consultants and GP's.
- Staff in focus groups told us inter professional working relationships were good with mutual respect and a willingness to help each other.

Seven-day services

- Consultants and anaethestists were available out of hours either in the hospital or on-call.
- We were informed that screening was available Monday to Friday but that the trust avoided screening on a Friday because support would not be available from the early pregnancy unit over the weekend.
- Outpatient scanning was usually only available Monday to Friday, but because of a shortage of staff, scans were also being offered at weekends to avoid any backlog. Ultrasound scanning was available for in-patients seven days a week.
- Gynaecology services were more limited at weekend and in the evenings. The gynaecology day unit closed at 8.00 pm. Any gynaecology emergencies had to attend ED.

Access to information

- All clinical staff had ready access to patient specific information
- The trust intranet provided ready access to policies and guidance.
- Good consultant level cover enabled junior medical staff ready access to support and advice.
- Information about situations where a mother or baby was at risk of harm from abuse was shared between all relevant staff in the hospital and in primary care services. This meant that opportunities to protect vulnerable people were optimised.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with the antenatal and newborn screening midwife in the early pregnancy assessment centre. She told us that they had designed their own consent form which is signed and checked throughout the process.
- We also saw a trust wide internal audit of compliance with consent forms being used that was conducted in 2014/15. The recommendations from this audit were that only one standardised consent form should be used across the trust and this was the one contained in the policy.
- We also saw an audit of consent forms used in gynaecology. This was conducted at St Richard’s in 2014 but learning was disseminated across all sites. The findings of this audit was that greater emphasis should be focused on documenting that the risks of surgery have been explained and consent has been obtained.
- We saw spoke with staff about the Mental Capacity Act 2005 and found they were well informed. One midwife said that there had been a useful update in the September 2015 edition of the newsletter. Staff had also been directed to an e-leaning site for a full session on the MCA.

- Midwifery and medical staff had a good understanding of their responsibilities when obtaining consent from children and young people.

Are maternity and gynaecology services caring?

Outstanding ☆

We rated caring as 'Outstanding' for maternity and gynaecology because of the unprecedented level of very positive contact made directly to CQC before, during and after the inspection visit. Specific examples are included below.

People were truly respected and valued as individuals and were empowered as partners in their care. Feedback from people who had used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. The trust used social media and other more conventional routes (such as drop in sessions at local family centres) to gather feedback from women who had used the service.

Women talked about “My midwife” and reported real warmth and rapport. Feedback made direct to CQC prior and subsequent to the inspection site visit was exceptionally positive about maternity services. Overall, we received almost exclusively positive feedback and people talked about how staff had provided support and reassurance. There were comments from people using gynaecology services as well as those using maternity services. We even received feedback direct to CQC from a couple whose baby was stillborn but who wanted to tell us about the support and kindness they were shown.

Feedback through the Friends and Family Test survey showed that women and their families had an exceptionally good experience in the maternity service. The response rate and scores were consistently above the national averages. Results of the NHS maternity Services Survey published in December 2015 show that the service was considered to be at least as good and often better than the England average results for all key indicators. No indicators were below the England average.

We witnessed behaviours from staff that indicated that they were using a caring and compassionate approach. Staff also took care to protect the dignity and privacy of women in all areas of the service.

Partners were made to feel welcome and encouraged to be involved in the pregnancy, labour and birth with facilities available for fathers to stay overnight on the postnatal ward.

Compassionate care

- Women we spoke with on Bramber Ward were very positive about their care. One woman, who had an emergency caesarean section, said that the "Care had been fantastic." She said that she had felt safe and the anaesthetist was particularly "Reassuring and kind." She said that her partner was able to stay all the time and there was no pressure on either of them.
- One new mother said: "I really like the fact that I could stay in the recovery area for four hours after the birth. It gave my husband and me time in private with our baby and was good for bonding." She said that the midwives were caring and came quickly in response to the call bell. She said all the staff were lovely: "I’m really impressed; it’s been a pleasant experience."
- Another woman on Bramber ward said: "They really care. You can tell they really want to be here, they are not just doing their job. They’re amazing."
- Many people contacted us directly to tell us how good they felt the maternity service was at Worthing Hospital. One said, “The care myself, my husband and baby received throughout my care during and after pregnancy was fantastic. We now live nearer another hospital but choose to come back as we trust it so much. This is the third child we have had at Worthing and the treatment we have received from the diabetic ante-natal team each time has been fantastic. As a high risk patient in more than one area I have received one to one care taking into account all of my needs (there are lots). We have been lucky to have the same midwife in attendance of our last two children. Our baby had to go to special care this time & they were fantastic too. The staff here really care about you and you are not just a statistic. The care I received on Bramber ward after the birth of my child was amazing.”

- Another told us, “I had a water birth. The midwife I had was absolutely fantastic! She encouraged me at times when I doubted myself and couldn't have wished for a better midwife to have! She made me feel at ease and comfortable and from that I had an amazing experience. I think she even stayed later on her shift and didn't rush me."
- We observed the staff and saw that their interactions with women were friendly and caring. They were careful to protect the privacy and dignity of women in the bays and pulled the curtains closed behind them.
- In the CQC survey of women’s experiences of maternity services conducted in 2013, the trust scored better than other trusts in relation to three areas. Those areas were about women being able to move around in labour and choose the position that made them most comfortable, having skin-to-skin contact with their baby shortly after the birth and staff introducing themselves. This demonstrates that the service was offering support and compassionate.
- The more recent data from the December 2015 Maternity Services Survey showed that the trust had improved performance and was considered to be at least as good and often better than the England average, according to the 211 respondents. In Labour and Birth the trust performed better than average for questions around moving during labour (88%) and partner involvement (96%). Staffing during labour questions resulted in a score that broadly in line with England average but better for clear communication (94%) and respect and dignity (93%).
- For care following the birth the trust scored better overall than the England average with particularly good scores for questions about the partner length of stay (96%) and cleanliness (94%).
- We saw some of the Friends and Family Test data for July 2014 to August 2015. The service was receiving feedback from mothers that was consistently very good. In the clinical governance report for August 2015, managers reported positive feedback on Friends and Family overall 93 – 95%. It was noted that this was lower than usual, which was above 95%, and this felt to be because response rates were lower than previously.
- Maternity Services had a different social media account and were able to receive feedback through '@WSHTmidwives'. It was also mentioned that there were ‘lots of plaudits’ on the twitter and Facebook accounts.
- Similarly, we saw that that in gynaecology the hysteroscopy outpatients’ satisfaction survey was very positive.
- A trust midwife was the winner of the RCM National Award in the Best Midwife category (2015).

Understanding and involvement of patients and those close to them

- Women we spoke with on Bramber ward told us that they had been fully involved in their care and treatment and were able to make informed choices. One woman said the ‘Communication from the midwives was great and another woman praised the anaesthetist who she said “Reassured her so she could relax a bit”.
- We spoke with a mother who had her second baby at Worthing by caesarean section. She said that she “Could not fault the care.” She said her partner had been included even though he had to leave to look after the other child. They said that they both felt informed about the birth and the recovery process.
- One woman said that the staff were very supportive of partners and they made sure her husband had food and drink.
- A woman recently arrived on Bramber ward said that she was taken to theatre early because of problems. She said communication with the doctors was really clear and helpful. She said ‘They have been brilliant with me.’ She also said that she was unable to walk to the toilet but when she rang her bell they responded immediately.
- One woman said that the midwives explain everything very clearly and in an understandable way.
- On the noticeboard on Bramber ward we saw details on the new maternity website and the Facebook Group offering support with weight management and diabetes.
- We saw that the trust had received an all-party parliamentary award for supporting partners to stay overnight on postnatal wards. We saw that there were sofa bed available and reclining chairs for partners.

Maternity and gynaecology

Emotional support

- We were informed that there was a three-day turnaround for counselling for fetal abnormalities at Worthing. There was a counselling midwife working across both sites at the trust. The service would make telephone contact in order to give women high-risk results promptly.
- Staff had undertaken training on how best to pass on news that might be distressing.
- The chaplaincy service offered support to parents who suffered a late miscarriage, stillbirth or neonatal death. They could provide advice on practical issues as well as emotional or spiritual support.
- Women were encouraged to have family support from partners or others close to them throughout the pregnancy and delivery. Very young mothers were encouraged to involve their own mothers for additional support.

Are maternity and gynaecology services responsive?

Good

We rated responsive as 'Good' for maternity services.

This is because the service adapted and modified services to meet the needs of individuals and groups with particular needs. People's individual needs and preferences were central to the planning and delivery of services. The services were flexible, provided choice and ensured continuity of care.

The involvement of other organisations and the local community was integral to how services were planned and ensures that services met people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers such as the young parent's pathway and access to mental health support as part of maternity services.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included people who are in vulnerable circumstances or who had complex needs. The service was responsive to the individual needs of women and their families from different communities. Exceptional specialist support was available for young pregnant women through innovative multi-agency working.

People could raise concerns and complaints and be confident this would be investigated and responded to appropriately. There was evidence the trust used complaints to improve the services.

Issues of capacity, along with peaks in activity throughout the year, resulted in the need to sometimes divert women to the other site. The staff were managing the situation by closing monitoring activity, staffing and bed capacity.

Service planning and delivery to meet the needs of local people

- We spoke with the senior maternity team about the choices available to women deciding where to have their baby. We noted that, if assessed as low risk, they could choose to have a home birth or attend the Birthing Centre at St Richard's Hospital. Women assessed as likely to have a higher risk birth, with medical or obstetric complications, would be advised to have a hospital birth and could choose between St Richard's and Worthing Hospital. We saw a leaflet on the website for women setting out these options.
- The trust was a founding partner in 'Baby Grow', a multi-agency initiative in West Sussex, for parents and carers with pre-birth to 2-year-old children, which aimed to better co-ordinate the services for early help and intervention and provide an effective pathway of support for vulnerable parents, at the earliest opportunity.
- The trust was a partner organisation in the Family Nurse Partnership (FNP) programme that provided continued support for young and vulnerable parents during the pregnancy and first two years of the child's life. West Sussex mothers supported by the FNP initiative were almost twice as likely to initiate breastfeeding as other same age mothers in West Sussex. Parents supported through the FNP programme were more likely to have their children immunised
- Hypnobirthing was available and we spoke with a woman who had been given some scripts to practice prior to her labour.

Maternity and gynaecology

- There is an early pregnancy assessment unit and a dedicated Gynaecology day unit at Worthing with four day beds. This unit sees women who have abdominal pain, hyperemesis gravidarum (extreme morning sickness) and ectopic pregnancies. This unit is open from 7.30 am to 8.00 pm and at 8.00 pm they call the bed manager if they require an admission.
- Staff in the unit expressed their regret at the lack of a dedicated ward for gynaecology patients, particularly those who lost a baby in the second trimester of pregnancy and were treated on the delivery suite. With no gynaecology in-patient beds, these patients were treated post operatively on the general surgical wards with care and treatment from general surgical nurses rather than trained gynaecology nurses. The staff said that unstable patients, those with a ruptured ectopic pregnancy for example, would stay in Accident and Emergency before going to theatre.
- We were informed that, when the delivery suite was busy and on divert, they would postpone elective caesarean sections and delay induction of labour on Bramber ward.
- We spoke to a number of people, including midwives, doctors and manager, who said that the room and facilities available at Worthing Hospital were insufficient to meet the local need. We were informed that there was insufficient space for expansion, for a dedicated bereavement room or for a Birthing Centre. One manager said that, with the developments at Southlands Hospital, colleagues at Worthing were presenting a case for some expansion of maternity services at Worthing.
- The provision of midwifery led care in a birthing centre for women giving birth at Worthing was also an entry on the risk register. It was argued that, 'Streaming high and low risk cases through the creation of a midwifery led unit would assist in the further development of specialist care for appropriate cases in the appropriate environment'. When we asked about plans to resolve this issue and they pointed to the development of Southlands as an ophthalmology centre and that would free up space at Worthing Hospital. However, we were also told that there were other services competing for any available space at Worthing.
- We spoke with staff in the early pregnancy assessment unit who told us that if an anomaly was found as a result of screening they would offer counselling to help the women decide if they wanted to proceed with the pregnancy. They said that they made sure all the information was available and that they knew about the all the options. If they decided to terminate the pregnancy, they have a choice of treatment at St Richard's or a referral to another provider. If they decided to continue with the pregnancy support was provided throughout the pregnancy and postnatal period.
- We spoke with the midwife leading on public health. She told us that there was a significant Polish community living in West Sussex and, at first, women from this community would tend to come late into the service for their first booking. The midwife said that they organised a focus group within the community and realised that there was a different understanding of the role of the midwife in that community. Now that they have improved their communication and clarified the role of the midwife the Polish women attend for a first booking much earlier. This demonstrates how the trust makes every effort to the meet people's individual needs.

Access and flow

- There was a maternity telephone triage and advice line that covered both sites. This was a relatively new initiative and it was working well for pregnancy, labour and post-natal care. Staff in the focus group said that it meant that they did not have to answer telephone enquiries on a busy ward.
- The telephone triage service worked closely with both sites and kept up-to-date with acuity and staffing levels. The service was made aware when a service was becoming busy and when it was necessary to divert to one or other of the sites. The triage service was also able to make the two sites aware of women who had called and were likely to come into the service shortly.
- One midwife on Bramber ward said that the staffing levels were not always at the required levels and would be reduced on Bramber if additional staff were needed on the delivery suite. She said that this caused delays with discharge on Bramber and then a problem with bed occupancy and the ward would be unable to take

women from delivery suite. She said it becomes a 'vicious circle'. She said that sometimes it also meant delays for women waiting for induction of labour and community midwives were brought in to help, which 'had a knock on effect on their work and on home births'.

- We were informed by the Head of Midwifery that sometimes it was necessary, for safety reasons, to close one of the trust sites due to capacity, that is, a shortage of beds or staffing, or both. We were also told that women were informed, early in their pregnancy, that they may have to be diverted from the place they had chosen to give birth if it was too busy. We were informed that the trust had never had to close both sites at the same time.
- We were given a copy of the maternity dashboard where the number of site closures and 'diverts' were recorded each month. In the year 2014/15, the total of internal diverts, was 92 from Worthing to St Richard's Hospital. The year to date figures on the frequency of diverts in 2015/16 suggest that the total number for 2015/16 will be similar. We looked at a breakdown of the numbers and saw that the reason given for all diverts in 2014/15 was 'increased activity'. We noted that, not all women that were diverted gave birth, many were viewed, discharged and gave birth at a later date at the hospital where they booked originally.
- We saw that there was an escalation and contingency plan for maternity unit diverts and closures to maintain the safety of mothers and babies when "the whole system or one constituent part of the system were unable to manage the demand being placed on it." This policy had been updated and ratified in November 2015. It was recognised in the plan that managing patients at times of increased activity and insufficient capacity would involve managing additional risk across the organisation. The senior managers acknowledged it was the result of managing two relatively small sites.
- Maternity on the two sites were sharing the same protocols and one of the senior midwives told us that integration was good and joint meetings were the norm. Perinatal, Governance and Patient Safety meetings alternated between sites. However, cross-site working was not as advanced in gynaecology.
- Data from NHS England regarding the non-admitted gynaecology pathway showed that 98.3% of patients were treated within 18 weeks of referral to the hospital. The non-admitted waiting time standard is 95%.
- The admitted pathway was 87% for gynaecology which fell just short of the standard of 90%. This featured in Governance meeting minutes and strategies were put in place to address this.

Meeting people's individual needs

- We reviewed four cases with the screening midwife. One case involved a young women with challenging social circumstances and difficult relationships. The antenatal screening had identified multiple abnormalities. The young women wanted to continue with the pregnancy and support was offered by a multi-disciplinary team of specialist midwives and doctors from two hospital trusts and staff from social services. The team included the young person's midwife, advocacy services, consultant obstetrician and paediatricians. Communication with the young women was via Facebook as this was the only way to make contact.
- In another case a women was supported to prepare for palliative care for her baby following the birth, due to severe abnormalities identified at an early ultrasound scan. The was a clear paediatric plan and close liaison with a local children's hospice. The trust dealt with the case very sensitively and involved a team of consultants, managers, supervisor of midwives, paediatricians and the GP. The family were able to visit the hospice prior to the birth.
- A third case involved a couple with a strong faith and beliefs. The trust was able to offer support from the hospital chaplaincy and the hospital chaplaincy worked jointly with the couples' own Pastor.
- The fourth case demonstrated how doctors at Worthing Hospital were able to work collaboratively to manage the individuals needs care and treatment of a women and her baby with a suspected cardiac condition with a London teaching hospital.
- The public health midwife felt there was a gap in the midwifery service for women with perinatal mental health issues. She said that, although there were consultant leads on perinatal mental health on both sites, there was no care pathway for pregnant women or

postnatal women requiring support and services for moderate to severe mental health issues. Those who are acutely mentally unwell would be seen by the Sussex Partnership Trust. She said that this issue was on the risk register and work was needed in the service to fill the gap.

- Staff we spoke with at Worthing expressed concern about the lack of bereavement facilities on the Worthing site for women sustaining stillbirth or foetal loss. We saw that this had been escalated and it was included as an item on the maternity and gynaecology risk register. This item described the issue: 'Women who experience loss are currently cared for in a delivery room on the labour ward surrounded by other women giving birth to live babies.'
- The action listed on the risk register was to maximise the resources currently available at Worthing and to continue to provide the best care in the challenging environment. The risk was last reviewed in October 2015.
- We saw information on the noticeboard on the Bramber Ward and in the day room there was a poster showing the signs/cues from a hungry baby which would precede crying.
- Information was freely available for women on the trust website. There were useful hospital tours on video for both sites on the website. There was also written information and choices and facilities and range of useful, up-to-date leaflets on all areas of pregnancy and birth.
- We saw the welcome pack for postnatal women was provided on Bramber ward at Worthing. The pack included useful information about returning to fitness after birth, caring for your baby, sleeping arrangements for your baby, breast feeding, facilities on the ward and visitors.
- We were informed that the service used 'language line' for patients whose first language was not English. There were also leaflets in different languages such as Polish.
- The trust had introduced personalised growth charts to help staff identify problems more accurately at an earlier stage in the pregnancy. Each woman had her own 'Growth Chart' that was based on her weight, height, ethnicity and parity.
- The trust had introduced bespoke maternity health care records and specialist care pathways for diabetes in pregnancy, weight management in pregnancy, multiple pregnancy, HIV, instrumental birth, manual removal of placenta, third and fourth degree tears and a tracker for foetal anomaly.

Learning from complaints and concerns

- We saw the complaints policy and we saw that details about how to make a complaint were displayed on noticeboards. Leaflets were available in clinics and on the wards. We also saw details of the how to contact the patient liaison services (PALS).
- There were 49 complaints received in maternity and gynaecology between 1 October 2014 and 30 September 2015. Twenty-six of these complaints were about services delivered from Worthing Hospital and one complaint was about gynaecology services delivered from Southlands Hospital.
- The trust separated the complaints into main themes and found that, of the 26, received at Worthing Hospital most were about 'all aspects of clinical treatment', communication and the attitude of staff.
- We looked at six complaints and the response from the trust in detail. We saw that the responses were from the Chief Executive. These complaints were about home birth, induction of labour, the closure of one site and diversion to the other site, physical and emotional support for women experiencing a miscarriage and complications following a caesarean section.
- We looked at the trust's response to each of these complaints and found that they had apologised and investigated the issues in detail. They provided a response to each of the issues raised in the complaint and used each complaint as an opportunity to learn and improve the service. For example, as a result of the complaint on home birth, the maternity leaflet and guidance on homebirth was amended to say: 'Anyone who had an induction should be advised to have a hospital birth'.
- Similarly, the complaint about the support available for women experiencing a miscarriage enabled the service

to review the care provided and make changes. We saw that this complaint was discussed anonymously and the clinical governance and quarterly meeting so that lessons could be learned and shared across the service.

Are maternity and gynaecology services well-led?

Outstanding ☆

We judge the well-led domain of maternity services to be 'Outstanding'.

This was because of the exceptional commitment the service leaders had developed in their teams to ensure the provision of the very best care for women.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. The level of 'buy in' from staff was exceptional and all were able to articulate the trust and maternity service vision for the future. Staff were positive about working in the trust and being part of a team who understood and shared the trust's vision. Staff were proud of the services they were able to deliver to women and their families.

Governance and performance management arrangements are proactively reviewed. There were well-led arrangements for assessing and monitoring the quality of the service. Information was shared in an open and honest way with staff and with stakeholders. Staff and service users were involved in shaping the future developments and improvements in the service.

An innovative and proactive approach was taken to working with other organisations to improve care outcomes for the most vulnerable of women using the service. Close working with partner organisations across West Sussex had demonstrably improved outcomes for young parents and their children.

The service had taken a very pro-active stance in engaging with service users. The innovative use of different social media, coupled with more conventional approaches, such as drop in sessions, allowed for wider feedback that was used to shape and improve services.

Vision and strategy for this service

- We spoke with a range of staff all of whom were aware of the trust's vision. When we asked the question at the focus group they all said in unison "We care." They were also able to list the strategic themes such as 'We care about quality' and 'We care about being stronger together'.
- The 'Patient First' initiative that was part of the trust wide strategy 2015-2018 was well known by staff who understood what this meant for their service.
- We saw a copy of the women's and children's Divisional Strategy and Business Plan for 2015/16. The strategy set out the risks and challenges for the year including staffing, maintaining quality standards with current staffing ratios and a capital programme already committed elsewhere.
- We were also provided with a copy of the Maternity Quality Strategy entitled 'Better Births'. This strategy placed the emphasis on person-centred care, focusing on normalising birth and reducing stillbirth and reviewing every death occurring in the hospital to ensure learning. The strategy was developed with the involvement of service users and staff. Staff were aware of it and were able to tell us about the engagement event.

Governance, risk management and quality measurement

- We spoke with the midwives leading on patient risk, governance and women's experience. We found that there were reliable risk management processes in place including systems for learning from incidents, sharing the learning and implementing change across both sites.
- We saw that action plans were developed and implementation of the recommendations was tracked at trust level.
- We saw that the division had a comprehensive register of risks and that these risks were graded and mitigation put in place where possible. The risks were dated and reviewed regularly until they were resolved and removed from the register. Highly graded risks were escalated to the trust wide risk register.
- We found that there were highly effective governance processes for maternity service. These involved good levels of incident reporting and thorough investigation

and learning from serious incidents. Clinical outcomes were being monitored and there was a rolling programme of audit and review. Complaints were used as an opportunity for leaning and service improvement.

- Maternity on the two sites were sharing the same protocols and one of the senior midwives told us that integration was good and joint meetings were the norm. Perinatal, Governance and Patient Safety meetings alternated between sites.
- The trust is a member of the South East Coast and South Central Network maternity dashboard pilot.

Leadership of service

- The senior managers in maternity and gynaecology said that, as a service, they felt 'heard' within the trust.
- Midwifery staff spoke positively about the leadership of the service at departmental level and their support in general. We saw good examples of leadership at ward level. Staff said that senior managers were visible and approachable.
- Staff told us that teamwork and collaboration was good and they felt supported and able to approach managers in the service.
- Staff in the focus groups were very positive about the local leadership of maternity and gynaecology services. Groups were very well attended and represented staff at all grades and across disciplines.
- The manager on Bramber ward spoke to us about the patient experience on the ward. The manager said that she wanted to hear directly from the women and their families on the ward and conducted a daily ward round to speak to women about their experiences.
- We heard from two consultants who wrote individually to CQC prior to the inspection to tell us that they felt the organisation was very well led at trust level and that the style of leadership was reflected locally. They talked about positive relationships between staff groups built on mutual respect and a shared commitment to providing the best possible care to patients,

Culture within the service

- The level of engagement with CQC about the trust was unprecedented and overwhelmingly positive. Staff wanted to tell us about the work they were doing and plans for the future.
- Staff said that there was an open, honest and collaborative culture. They said that there were fewer differences now across the different sites and a greater level of consistency.
- At the staff focus group a midwife said 'The culture is all about one to one care and it is women centred.' Another member of staff said; 'Policy and all things are up for discussion. Everything is negotiated and I can talk to people at all levels and they will listen'.
- The midwife leading on quality and patient experience told said: 'I am proud of our staff, they embrace change'. She referred to the strategy development day on Better births. She also said that they were now using social media and staff chat to open new channels
- One member of staff said 'It is a very happy place to work' and another praised the teamwork between midwives, doctors, domestics, receptionists, therapists, nurses and managers.
- Trust ambassadors were selected from amongst all staff groups to share their passion for 'their' trust widely. Many ambassadors were keen to speak to us about the positive culture of the organisation and what a good place to work the trust was. They felt and showed a real sense of ownership for the services they provided.

Public engagement

- We were informed that there used to be a Maternity Services Liaison Committee (MSLC) through which the trust services uses could engage with people who used the service. However, the MSLC was no longer functioning.
- The service engaged with women and their families via face-to-face drop in sessions hosted by midwives that were held at local children and family centres.
- There was also a maternity expert group made of women who have recently used the services and it included those who had a concern or had made

complaint about the service. Members of the group contributed to 'walk around reviews' of the service, providing feedback on what they saw. There was a social media page for this group.

- Service users were also involved in an engagement event around the development of the 'Better Birth' quality strategy for maternity. The event engaged over 90 key stakeholders to inform direction and emphasis for service development.
- Social media was used extensively to gather the views of women who had used or were using the service.
- The trust was the winner of the Kent, Surrey and Sussex Academic Health Sciences Network Award for Innovation in Patient, Carer and Public Engagement (2015) for the Listen and Involve project.
- The Listen and Involve project was a new initiative which improved access and support available to pregnant women, mothers and their families, particularly those from 'harder to reach groups'.

Staff engagement

- We found that staff were involved in the engagement event around the development of the there 'Better birth' quality strategy for maternity.
- The staff survey feedback for 2014 indicated that 8% staff in maternity and gynaecology felt less involved in deciding on changes that involved their work than they did in 2013. The service responded with an action and increased the number of opportunities for staff to engage such as the 'better births' programme and 'patient first'.
- Most staff in the focus groups said they felt engaged in decision making.
- We saw notices in the service with feedback from the women and children staff survey for 2014/15. The feedback included the things that made staff proud, such as, the standard of care. It also listed three improvements the staff have said they would like to see, such as, to feel confident that managers will act on the feedback provided. There were also details of how the survey information would be used to and action plan had been developed and was being implemented.
- Maternity Services had a social media group for staff members called 'Staff Chat'.

Innovation, improvement and sustainability

- We saw a poster displayed on the noticeboard asking for staff to volunteer as maternity champions. This was a new project to encourage innovation and suggestions for improvements for both staff and patients.
- Staff informed us that the maternity triage and advice service had been a great improvement for the service. Contact and communication was easier for women and the midwives did not have to deal with telephone calls on a busy ward.
- The research midwife at the focus group informed us that the trust was involved in some forward looking trials such as the Affirm trial that was focused on reducing the numbers of stillbirths. They were the only trust in the south of England that was involved.
- The interagency approach to providing an enhanced service to young parents had resulted in improved outcomes for their children.
- The extensive use of social media for women who used the service and for staff gave access to wider views and ideas for service planning and development.

Services for children and young people

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

Information about the service

Western Sussex NHS Foundation Trust provides services for children and young people including; a level two neonatal unit, Bluefin children's ward with a children's assessment unit (CAU) and day surgery provision at St Richard's Hospital.

The neonatal unit has 12 cots inclusive of one cot where a baby can be ventilated, two high dependency cots and nine special care cots.

Bluefin children's ward has 22 beds, one level 2 high dependency bed and three beds on the children's assessment unit.

The trust had 5,903 hospital child admissions between January 2014 and December 2014, of which 99% were emergencies.

During the inspection, we visited the neonatal unit, the children's assessment unit and Bluefin ward.

We spoke with 18 children and their parents or carers, 24 registered nursing staff, three support staff including health care assistants and nursery nurses, five medical staff, two play specialists and one member of management staff. We reviewed 23 sets of medical records as well data provided by the trust.

The trust governance and management is provided through a Divisional Structure which meant service leaders, clinical specialists and some operational staff worked across both sites. This is reflected in reports for both sites and therefore read very similarly because of this.

Summary of findings

The children and young people's service was rated 'Outstanding' because it had a strong, open culture of safety developed through the reporting and learning from incidents and complaints. We found evidence of strong governance and an effective assurance framework which resulted in a cycle of monitoring and improvement.

The children and young people who used the serviced experienced good care that resulted in outcomes that were generally above national benchmarks. Where there was underperformance, it was recognised and addressed through robust action. Staff knew how the service was performing in specific areas and were motivated to make improvements.

Innovation and ownership of the service was strongly encouraged. There was a culture of joint working and learning from others. This worked across the trust with examples such as 'Harvey's Gang' (which the trust is justifiably proud of) and with other local providers and children's agencies. The result of this was children and families had a seamless journey through separate services, both internally and externally.

Outcomes for very young children living in challenging circumstances benefited from this joint working. Most importantly staff and leaders of the service were self-aware, they knew the limits of care they could provide safely, they understood areas they needed to

improve on and were working on these. They were very proud of their work and felt sufficiently comfortable in their position to share their pride widely and loudly to build on their strengths.

Are services for children and young people safe?

Outstanding ☆

Children and young people's services were rated as 'Outstanding' for safe because;

There was a genuinely open culture in which all safety concerns raised by staff and people who use services were highly valued as integral to learning and improvement. Staff understood their responsibilities in raising concerns and reporting incidents and near misses and were fully supported to do so. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety. The management of incidents was robust and established amongst all staff. There was evidence of learning and communicating with staff regarding outcomes of investigations.

The trust could demonstrate a long period of 100% harm free care from September 2014.

Safeguarding children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focussed on early identification. There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.

A proactive approach to anticipating and managing risks to patients was embedded and recognised as being the responsibility of all staff. Risks to children and young people who used services were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies.

There was particularly good management of the risk of deterioration on the neonatal unit with very high levels of consultant oversight and involvement. Staff were well equipped to respond to the deterioration of patients and followed an established early warning scoring system with clear escalation processes in place. The trust took a very proactive stance on ensuring medical staff were well versed in the management of paediatric and neonatal resuscitation. Staff worked across the site providing clinical simulations within different clinical settings.

Services for children and young people

Whilst there was a shortage of permanent nursing staff, the risk of this was mitigated through the use of agency and bank nursing staff. There was no discernible impact on patient safety and recruitment was underway. The actual staffing was close to the planned staffing levels.

Incidents

- An electronic reporting system was established throughout the children and young people's service. All staff had access to this system and were aware of how to log incidents and near misses. A senior staff member recorded the outcome and feedback onto the electronic system and investigated reported incidents and near misses. This meant staff who reported incidents received feedback from the system.
- Feedback and lessons learnt from incidents took place at several forums such as at regular Integrated Paediatric Governance Meetings, communication folders set up in clinical areas for staff, weekly patient safety meetings on the wards and units and monthly feedback communications from the patient safety nurse.
- There had been no serious incidents or 'Never Events' at the trust between November 2014 and October 2015. Embedded learning had taken place after a serious incident three years prior to our inspection after the death of a young person. Lessons learnt were shared amongst all general practitioners, this trust and two other trusts in the locality.
- Morbidity and mortality (M and M) meetings took place fortnightly and all babies needing support beyond usual postnatal care were discussed at this forum.
- Each case presented at the M and M meetings was subject to a double review process to maximise the opportunity for learning. The junior doctor was required to present to their consultant initially and get feedback about the case prior to presenting to the wider group. This ensured highlighted and succinct key messages and learning points were delivered rather than being lost amidst historical or less pertinent details.
- There was access to the local neonatal network morbidity and mortality meetings. This meant knowledge, skills and learning were shared between trusts in the area.
- All retrievals where children and babies are collected and transferred to another care provider were reported onto the electronic incident reporting system for monitoring of how the retrieval was conducted.
- Duty of candour amongst medical and nursing staff was understood and opportunities for learning were actively sought. The staff involved discussed the incident with parents and listened to their concerns.
- Duty of candour was prominent in the children and young people's service. Patients and parents were often given explanations, even when incidents did not meet the threshold for duty of candour. There were three recorded cases of parents and carers being given explanations and apologies between August and October 2015.

Cleanliness, infection control and hygiene

- A range of infection control audits took place regularly throughout children's services to assess the effectiveness of cleanliness and hygiene in the clinical areas. The Infection Control Audit dated July 2015 showed Bluefin ward had achieved 98% compliance against the indicators.
- The neonatal unit also scored highly with audit results showing compliance at 98% plus.
- Technical audits, which audited the average cleanliness of areas against the National Cleaning Standards (2007), were performed approximately once every two months. These showed the children and young people's service consistently achieved higher than the NHS standard.
- Infection control audits assessed the environment, hand hygiene, decontamination, handling and disposal of linen, parent kitchen environment, handling and disposal of waste, handling and disposal of sharps and use of PPE. These audits showed areas for improvement were identified and re-audits showed progress. An example of learning from infection control audits was the commode was not regularly cleaned and recorded on Bluefin ward. Now a health care assistant on every shift has the cleaning of the commode on their checklist to complete. Subsequent audits showed this improvement to be effective.

- The monthly Women and Child Health Infection showed consistent compliance of 100% was achieved across the children's unit for a range of infection control measures such as the care of central lines, peripheral lines, urinary catheters and decontamination audits.
- The playroom had a daily cleaning schedule completed by play therapists. Toy boxes in the playroom were cleaned 3-4 times monthly. A daily wipe over was done of all surfaces in the playroom and was recorded in daily and monthly signed checklists. The cleaning of toys and the playroom was audited by the trust's walk-around audits.
- Only wipe-able and washable toys were used in the isolation side rooms for infectious patients. This prevented any soft toys harbouring infectious bacteria.
- Babies who became unwell within 10 days of birth could be admitted to an isolation room on the neonatal unit so that they received the same expert care as other babies on the unit, but did not pose an infection risk to other neonates.
- The Quality Scorecard for the Women and Children's Division showed that from October 2014 to August 2015 there were no cases of hospital attributable MRSA. The Trust Infection Control Committee Surveillance report dated September 2015 confirmed this.
- Data from the patient led assessment of the care environment (PLACE) audits looked at ward cleanliness, ward condition, appearance, hand hygiene, staff appearance and safety showed scores of 100% in October 2015 for both Bluefin ward and the neonatal unit.

Environment and equipment

- There was a retrieval room dedicated for children waiting to be transferred to other providers for more specialist care. The retrieval room was dedicated to providing intensive support to very sick children, with resuscitation equipment and emergency medicines.
- There was a trust wide policy for the management of medical devices. This stated all medical devices should be serviced and repaired in accordance with the manufacturer's instructions or recognised quality standards. Equipment service and repair request logs showed job reference numbers for servicing and repairs and was accessible to staff.
- Resuscitation equipment was located throughout the children and young people's service.
- Checks of resuscitation trolleys were not always recorded. Of the two trolleys on Bluefin ward, neither had been checked for a combined total of 18 days in September 2015; 19 days in October 2015; 14 days in November 2015 and five days from 1st December 2015 to 10th December 2015.

Medicines

- Medications were secure and kept in locked cupboards and refrigerators. Medicines were kept in a drugs room on Bluefin ward, which had access only by a swipe card.
- Controlled drugs, which are drugs controlled under the misuse of drugs legislation such as morphine, were kept in a locked cupboard within the drugs room. Only the nurse in charge had the key to the controlled drugs box and there was a two person sign off in place for any administration of controlled drugs to a patient.
- The pharmacy was open until midday each day. This meant prescribing and dispensing needed to occur in the morning.
- For patients going home in the afternoons, some discharge medications could be provided from stock on the ward.

Records

- Medical records were completed appropriately in the children's and young people's service. We reviewed 25 sets of medical records all of which had appropriate assessments and reviews documented.
- Paediatric walk round audits took place monthly and included the auditing of medical records. This included checking the completion of malnutrition assessments, observation checks, use of care plans and completion of fluid, feed and drug charts. The results were largely positive with very minor exceptions such as one nutritional assessment not being completed in August 2015.
- Paediatric plans were placed in the antenatal concerns folder where a baby with a known anomaly was due for delivery within the following two weeks. Medical records

for babies contained pertinent notes from the prenatal stage. This meant the likelihood of prenatal concerns not being transferred to the paediatric notes was minimised.

- Babies on the neonatal unit born at the trust had their medical records linked into their mother's notes. Babies had a form of their care pre-birth which then informed the start of their own medical records once they were born. Nursing records had a coloured page at the front of the notes for concerns to be clearly recorded and given prominence in the records.

Safeguarding

- The safeguarding team for this trust consisted of 15 staff including executive leads for safeguarding, named doctors and nurses and safeguarding nurses.
- Weekly safeguarding meetings were held at each site to look at all safeguarding issues and provide supervision to named nurses and midwives. There was representation from the child and adolescent mental health service (CAMHS) and from the trust's emergency department at the meeting.
- The named doctor for safeguarding children ensured there was good access to child protection supervision for medical staff.
- A multi-agency safeguarding hub (MASH) in the locality was being set up and was due to go live in January 2016. The trust's safeguarding team were involved with the setting up of the MASH.
- The trust was compliant with section 11 of the Children's Act 2004, providing an audit to ensure an organisation's functions safeguard and promote the welfare of children.
- There were weekly multidisciplinary child protection meetings and psychosocial meetings. These meetings enabled safeguarding staff to receive and share information with staff involved in looking after children with protection orders and those with psychosocial problems.
- Safeguarding nurses attended morning medical handovers. This enabled the sharing of information between the safeguarding nurses and medical staff.
- A self-harm pathway was in place for all patients attending hospital after self-harming. This ensured they received care appropriate to their needs and that relevant professionals could be involved in safeguarding them.
- Safeguarding children level three training figures were 89% for nursing staff and 86% for medical staff. The target for the training was set at 95%. There was a clear understanding of who had not completed the training and why, with plans in place to get at least 95% compliance. The local clinical commissioning group (CCG) audited the trust's safeguarding provision, including training and a full action plan was created with ownership by the chief executive.
- A plan was in place for a charity to provide sexual exploitation training to staff in children and young people's service. However, this training had not commenced at the time of our inspection.
- Domestic violence training was provided by an independent domestic violence support service. This meant staff were knowledgeable regarding signs of domestic violence in the family and how to report concerns.
- The trust was compliant with section 11 of the Children's Act 2004, which provided an audit to ensure an organisation's functions safeguard and promote the welfare of children.
- All safeguarding concerns were flagged within the fortnightly perinatal meeting. The safeguarding midwife liaised with the neonatal unit staff and provided advice where concerns were raised.
- The safeguarding team covered both sites and included a liaison health visitor and safeguarding specialist nurses. Weekly safeguarding meetings were held at each site to look at all safeguarding issues and to provide supervision. At Worthing, the safeguarding nurse attended the emergency department weekly.
- Female genital mutilation training was provided as e-learning for staff. This meant staff knew how to recognise female genital mutilation and how to report concerns.
- Staff knew the process for reporting a safeguarding concern. One sister advised us she had reported referrals to the child protection team at the council.

Services for children and young people

Mandatory training

- The practice development nurse rostered all nursing staff to attend two days each year to complete mandatory and competence training.
- Mandatory training for staff covered the areas of health, safety and risk; resuscitation; safeguarding children and vulnerable adults; conflict resolution; equality and diversity; fire safety; infection control; information governance; and back training. Overall, nursing staff mandatory training compliance was 79% and medical staff compliance was 72%. The figure was lower than the trust target because conflict resolution had recently been introduced in response to the staff survey highlighting concerns about violence towards staff. Staff who were on long term sick leave, maternity leave and new starters were also included in these figures.
- Staff received electronic alerts when there was non-compliance in their mandatory training record. This meant staff were aware of their training status.
- Out of 40 staff on Bluefin ward and 26 on the neonatal unit, 37 and 26 respectively were trained in basic paediatric and newborn life support. Accounting for staff on maternity leave and staff who had just started working at the trust, this meant most staff were up to date with life support training (92.5% and 100% respectively).
- The trust resuscitation officer provided paediatric resuscitation training and covered basic and advanced life support. The trust neonatal lead provided neonatal life support training. The trust simulation lead provided training for stabilisation and life support in accordance with advanced paediatric life support and paediatric intensive care unit guidance. This meant the training adhered to national guidance.
- The trust hosted regular British Resuscitation Council accredited courses for European Paediatric Life Support (EPLS) and Paediatric Immediate Life support (PILS). The department had an APLS qualified instructor, two EPLS instructors and two NLS instructors within the paediatric consultant team and further instructors throughout the wider consultant body within the trust, for example in the Emergency Department and Anaesthetics.
- The department aimed to adhere to the Standards for Children and Young People in Emergency Care Settings laid down in the Intercollegiate Document (2012) and endorsed by the RCPCH recommending APLS or equivalent to be undertaken at consultant and middle grade level every four years with consideration of any extended training needs at doctor's appraisals.
- Basic life support (BLS) training was provided annually and within induction and Trust Simulation Events, Clinical Governance rolling half days, with PILS as an additional adjunct for junior members of the team.
- Neonatal Life Support (NLS) was provided, as per recommendations, every four years with annual refresher updates provided in-house by NLS instructors.
- Of the 5 consultant paediatricians at Worthing Hospital, 4 were in date for APLS and the 5th was booked onto a course in March 2016. Of the middle grade doctors, 3 of the 4 who required APLS were in date and one was booked on a course in March 2016.
- All medical staff had completed current basic paediatric life support training (100%).
- All medical staff who required NLS were in date for this (100%).
- The department team prided itself on the strong use of simulation training both within the simulation suite and within the paediatric, neonatal and emergency department clinical environments. They had used this for enhancing consultant's and junior staff's individual skills and strengthening teamwork. Notable achievements included testing important emergency protocols e.g. major paediatric haemorrhage within ED and reskilling a senior consultant following a period of extended sick leave.

Assessing and responding to patient risk

- The trust had very clear policies and algorithms on the management of specific neonatal conditions such as potential sepsis, meconium aspiration, falling blood sugar levels and fitting. The management guidelines contained clear information on escalating support and treatment to the next level.
- The trust monitored the blood pressure of each baby referred to the paediatricians to identify if a baby was hypotensive but also to pick up any cases of the much rarer, neonatal hypertension.

- A paediatric early warning scoring (PEWS) system was used to assess children's observations, such as blood pressure, pulse and oxygen saturations. Escalations for higher scoring children were made using the situation, background, assessment, recommendation (SBAR) method. SBAR is a structured method for communicating critical information that requires immediate attention and action. Escalation was made first to the nurse in charge, then to medical staff. The consultant was contacted directly if required.
- Monthly paediatric walk around audits included audits of early warning scores being completed appropriately. One sample of the September 2015 audit showed early warning scores were appropriately completed 100% of the time.
- There was an escalation flowchart, which ensured staff were aware they must directly contact a consultant when a child deteriorated. This required an incident report for monitoring and assurance.
- The tertiary units were not using a scoring system and the neonatal units at the trust worked to the network agreement of individualised care planning based on consultant review and decision about on-going care and frequency of monitoring. Written plans were in place such that staff knew the requirement for monitoring and parameters for escalation for each baby they were caring for. The written plans included the triggers for consultant review.
- Nursing staff were very proactive in ensuring locum doctors understood the expectations of the ward or unit and the need to contact consultants if there were any concerns at all. Nursing staff confirmed they were encouraged to override a decision and contact a consultant directly, if they felt there was a need to do so. Paediatricians all said they supported nursing staff in making direct contact where they had any concerns at all.
- Contingency arrangements for the care of critically ill children were in place which included 24 hour availability of clinical staff with the appropriate competency in advanced paediatric life support and consultant resident on call cover.
- The environment was secure and access was limited to those who needed it. The doors to the unit were locked and only accessible by swipe card or by ringing a door bell. Staff on the neonatal who were uncertain about who was ringing the bell came to the door to check before allowing people on to the unit.
- Paediatricians were aware of children admitted anywhere in the trust. This included young mothers admitted to the maternity units, older teenagers who were occasionally cared for on the adult critical care unit and any patient on the private patient wards.

Nursing staffing

- The workforce requirements for Bluefin Ward were set according to the paediatric acuity and nurse dependency assessment tool (PANDA) and was evaluated by the Royal College of Nursing guidance (2013) – 'Defining Staffing Levels for Children's and Young Peoples Services'. This described the different nursing levels required according to age and dependency.
- Audits were completed three to four times a year to map the nursing levels against the standards required for care of children under two 2, children over two and children requiring high dependency care.
- Data provided by the trust showed actual staffing against planned staffing on the children's unit. Over the four month period May 2015 to August 2015 the average planned staffing to actual staffing for registered nurses was 113 planned to 104 actual. For health care assistants the average planned staffing was 34 compared to 33.5 actual.
- The trust acknowledged recruitment difficulties and mitigated against the risks by the use of agency and bank staff. There was no discernible impact on patient safety from lower than ideal staffing levels.
- Bank staff usage averaged at 1.33 WTE each month and agency staff usage for that period averaged at 0.3 WTE each month. There was no agency staff usage at nurse in charge level in the same period.
- There was one staff nurse vacancy on the neonatal unit, which was in the recruitment process at the time of our inspection.

Services for children and young people

- There was a 'full pack' of specialist nurses in place for long-term conditions such as asthma, diabetes, complex needs, neonatal outreach, incontinence and weight management.
- The neonatal unit at Worthing Hospital was aligned to the Department of Health neonatal toolkit standards (2012) and the British association of perinatal medicine (2011). The trust provided compliance data through the neonatal networks and measured progress through monthly workforce audits using a nationally validated tool.
- The neonatal unit exceeded the British Association of Perinatal Medicine (BAPM) standard of having at least 70% of nurses qualified in service by 5%.
- The nursing workforce was flexible in covering all four wards across both sites, in accordance with nursing contracts at this trust.
- There were no ward or neonatal unit closures. This indicated although staffing levels were lower than required, safe care was still provided and bed closures had not been required.

Medical staffing

- The paediatric team had a three tier medical rota. This included an establishment of eight consultants, six tier two (or middle-grade) doctors, and eight tier one (or junior) doctors.
- There were split rotas for neonatal care and paediatrics between the hours of 9am and 5pm and additional tier one cover in the early evening and weekend mornings. Consultants worked extended hours (until 7pm) on four or five weekdays every week.
- Four 'long day' shifts on each of the tier two rotas in a six week cycle were covered by consultants and between two and two and a half night shifts were covered by a resident on call consultant each week. This was in addition to the traditional consultant on call.
- There was a six-week rota where medical staff rotated through the service. Between the hours of 9am and 5pm there were two registrars covering the service with one registrar at night.
- There were two middle grade doctor vacancies at Worthing Hospital. There were currently six middle grade doctors in post, with the aim for nine.
- Consultant staff lead specialist services for respiratory medicine; critical care; diabetes and endocrinology; enuresis; rheumatology and chronic pain; neonatal medicine; cardiology; oncology; febrile neutropenia; neurology and epilepsy; and ambulatory care. Specialist nurses supported these services, which meant children with long term conditions were well supported and cared for.

Major incident awareness and training

- The trust had an emergency preparedness, resilience and response policy in place. This policy outlined roles and responsibilities in the event of a major incident such as an adverse weather occurrence or a transport related disaster. The policy gave clear guidelines for specific services within the trust to create emergency response plans.
- Staff had an awareness of major incident planning and knew what to expect in terms of extra duty. The play team looked after staff children.

Are services for children and young people effective?

Good

Effectiveness was rated as 'Good' for the children and young people's services. There was a comprehensive audit programme in place for both local and national audits with demonstrated implementation of learning from action points. In many areas patient outcomes were significantly better than national benchmarks and showed year on year improvement.

Staff adopted a truly holistic approach to assessing, planning and delivering care and treatment to children and young people who used the service. Nutrition and hydration had a high profile in the service with all children undergoing assessment for malnutrition until there was evidence they were not at risk. Pain was well managed with the involvement of a dedicated pain team and the hospital paediatric trained anaesthetists.

Multidisciplinary working was well established and there were very good external links to tertiary centres and specialist networks. Mutual respect was apparent at all levels and across professional boundaries.

Services for children and young people

The very close liaison between obstetricians and paediatricians was clear and this resulted in early input from the paediatricians when a neonate was likely to need additional support. Consent practices and records was actively monitored and reviewed to improve how people were involved in making decisions about their care and treatment. The legal framework and trust policy on consent was well understood by staff.

The reason the service was not rated outstanding was because of poor performance in the national paediatric diabetic audit and unremarkable scores for some other outcome data.

Evidence-based care and treatment

- The staff on the paediatric unit at Worthing Hospital followed national best practice guidance in the care of the children they treated. The hospital services met the Department of Health guidance 'Getting the right start: National Standards Framework' (2003) in that children and young people received care that was integrated and co-ordinated around their particular needs and the needs of their family.
- The neonatal unit worked closely with local tertiary provision to ensure that services worked closely to meet the national standards of care.
- The trust had a programme of current and planned audits which included both national and local audits.
- A monthly clinical audit report was produced for scrutiny and assurance at the divisional meeting which detailed the status of each local or national audit, and had outcome reports embedded. The reports included an action plan where benchmarks were not met, including expected dates of completion and dates for re-audit.
- An audit of paediatric head injury leading to hospital admission found that head injury forms were not being completed. An action was made for these forms to be introduced and junior doctors encouraged to complete them by December 2015. A re-audit was planned to check the implementation of this action.
- The neonatal unit was working towards gaining United Nations Children's Fund (UNICEF) Baby Friendly Initiative, which improved the practice of infant feeding in health care settings. This meant trained staff would be able to support the experience of parents in feeding their babies.
- The neonatal unit was also working towards accreditation to the BLISS (baby life support systems) Baby Charter, which is a scheme that ensures a family-centred approach in the care of sick and premature babies.
- The paediatric service reviewed Mortality and Morbidity (M and M) data in the patient safety section of the monthly Operational Departmental Governance meeting. There were annual meetings with tertiary critical care services and neonatal M and M data was reviewed through the perinatal meetings which took place fortnightly on the Chichester site.
- Bluefin ward participated in the 15 steps challenge as set out by the NHS Institute for Innovation and Improvement. This challenge provides a toolkit for staff from outside the unit and service user representatives to assess their setting for the impression it gives within the first 15 steps of somebody walking into it. Feedback forms were completed by reviewers with improvements identified which were used as frameworks of improvement. The fifteen steps feedback was generally positive.
- Audits were linked to the general clinical governance framework for the trust. For example, a safe prescribing audit was triggered by a prescribing incident. This showed systems were in place to share learning and promote safety were working effectively.
- Clinical audit plans and results were fed into divisional meetings where it was decided what issues needed to progress through the assurance pathway.

Pain relief

- A flexible working system was in place to ensure anaesthetic care for sick children could be provided. If the consultant anaesthetist on call was not a trained paediatric anaesthetist and a sick child required the care of an anaesthetist, then roles were swapped to prioritise the care of the child.

Services for children and young people

- There was a trust wide pain team available 9am to 5pm. There was also out of hours availability through the anaesthetic service. There was ward staff representation at the paediatric pain group who met once every three months.
- A paediatric pain policy was in place that detailed an analgesic ladder. This described three steps for pain assessment that nurses used on the ward. One child and their parent said they received pain relief quickly after an emergency admission, demonstrated this policy was effective.
- Nurses and medical staff on the paediatric unit monitored and managed pain using a variety of strategies including prescribed analgesia timed to be effective prior to any procedures.
- Play specialists were employed and used to reduce the anticipation and experience of pain through the use of alternative strategies such as distraction.
- There was a Paediatric Chronic Pain Service provided in response to very high spending on sending children with complex pain conditions to remote national tertiary specialist centres. It is one of 17 such services nationally. The success of the service was measured and showed average pain scores improved from 8/10 pre treatment to 2/10 post treatment. There was also a significant improvement in the level of disability the children and young people were experiencing with 70% having no disability on discharge.

Nutrition and hydration

- The staff on Bluefin ward were proactive in monitoring the nutrition and hydration of children and young people. All children admitted were STAMP assessed, which is a screening tool for the assessment of malnutrition in paediatrics. Patients had their STAMP assessment documented in their medical records. A bedside checklist also advised staff to check this.
- Once the assessment showed there to be no immediate risk of malnutrition then the decision to stop malnutrition monitoring was considered and discussed with parents.
- Special diets, such as gluten free or lactose free, were supplied in conjunction with the pharmacy and catering departments. A board in the ward kitchen informed the housekeeper about which children required special diets.
- The neonatal unit managed to attain high breastfeeding rates through additional support for mothers with babies in the unit.
- Facilities were available for parents of children and babies to make drinks and snacks on the ward. They were also welcome to bring in particular food for their child, if they wanted.
- There was provision of total parenteral nutrition (TPN) on the neonatal unit. This meant babies who could not tolerate nutrition in their digestive tract still had their nutritional needs met.
- Paediatric dieticians were available to work with staff, children and families when necessary.

Patient outcomes

- Performance in the National Neonatal Audit indicated an improvement to the previous year's audit of babies having their temperatures taken on admission to the unit with the most recent score being 100% against a previous score of 0%. This practice was embedded and formed part of the admission process.
- The proportion of babies being screened for retinopathy of prematurity was 100% (previous score was 80%) which was better than the average of participating trusts.
- The proportion of babies being exclusively fed breast milk at discharge was 55% (previously 65%) which was better than the average. An additional 5% of babies were partially fed with breast milk.
- Readmission rates for asthmatic children were 14.5%, which was better than the England average by 2.5%.
- Readmission rates for children with epilepsy were 19%, which was better than the England average by 8.9%.
- There were no emergency readmissions after elective admission at Worthing Hospital among patients in the under 1 age group between February 2014 and January 2015. This reflected the very low numbers of children undergoing emergency surgery at the hospital.

Services for children and young people

- There were emergency readmissions after elective admission among patients in the 1-17 age group between February 2014 and January 2015. However, no treatment specialty reported six or more readmissions. This reflected the very low numbers of children undergoing emergency surgery at the hospital.
- The trust met the paediatric best practice tariff for diabetes. This is a year of care tariff payable to paediatric diabetes units when they meet certain criteria, which cover all aspects of high quality diabetes care.
- Readmission rates for children with diabetes were 26.3%, which was worse than the England average by 11.9%. This was considered and felt to be because most care of diabetic children took place in primary care provision and there was a significant shortage of GP's in the area served by the trust.
- This trust was part of the trauma network for children. This meant the trust was able to provide emergency trauma care to children with the support of other specialist units.
- There had been a local audit to assess whether improvements had been made against the trust's performance in the 2013 national asthma audit which demonstrated ongoing monitoring of patient outcomes.
- There had been a local audit to assess improvements made against the trust's performance in the 2013 national asthma audit. Improvements were noted in the use of nebulisers (13% up from 3%); the prescribing of steroids (97% up from 56%).
- There was advanced practice for the level one neonatal unit in the provision of a cooling cot to reduce the damage caused by lack of oxygen to the brain at or immediately after birth. This meant babies with reduced oxygen had an increased likelihood of an improved outcome.

Competent staff

- All staff on Bluefin ward were qualified children's nurses. 75% of nurses on the neonatal unit were qualified in service (QIS) with 1 nurse in training. The aim was to have 75% QIS. This meant staff caring for children were able to meet the needs of children specifically.
- Both medical and nursing staff were appraised each year. Appraisal rates for nursing and nursing support staff were 92% and appraisal rates for medical staff were 98% against targets of 90%. This meant staff were developed and had their performance evaluated regularly.
- A development programme was in place for nurses to progress into more senior roles, with academic accreditation. This included leadership training, European paediatric life support training and physical assessment skills.
- All staff were given the opportunity to progress and develop their competencies further. Staff on Bluefin ward told us they had been offered the opportunity to progress. A safeguarding nurse was supported by the trust financially as well as scheduling time off to gain higher education specific to their role. This meant they would be competent to a high standard in their safeguarding role.
- A practice development nurse had a dedicated role to support nursing staff in their revalidation. This included supporting learner in practice, professional competency updates, and the building of revalidation portfolios. This meant the trust was active in supporting nurses through the process of renewing their registration.
- There was a preceptorship programme in place for new nurses. This provided a structured transition from student nurse to qualified nurse. All new nurses to the trust had a competency booklet that they were supported to complete.
- A range of competencies was available to nurses, such as patient group directive, naso-gastric feeding, and tracheostomy competence. All registered nurses on Howard ward and the neonatal unit had intravenous and central venous access competencies. 90% of staff on Howard ward had the single check competency for administering medications. Three nurses had the chemotherapy administration competence. Assessment proformas were in use so when competency training was undertaken, a clear pathway documented progress.
- Clinical nurse specialists worked with the multidisciplinary team to provide on-going management of children with long term conditions. This included the appointment of an Adolescent and

Transition Nurse in May 2015 to support adolescents moving from Children's to Adult Services. The role was patient focused but also available as a resource for families and staff.

- There was a lead nurse for children and young people with complex needs.
- There was a competency framework in place for Health Care Assistants.

Multidisciplinary working

- There was embedded multidisciplinary working throughout the children and young people's service.
- The neonatal unit had good links with the local foetal medicine service at another trust, as well as the local tertiary care provider for neonatal care. All infants born at less than 23 weeks gestation were stabilised and transferred to a specialist centre.
- Neonatal unit grand rounds (where medical problems are presented to doctors and students) had a clinical librarian present and visiting consultants were invited periodically. There were visiting grand rounds with visiting or in-house consultants with specific expertise providing specialist advice and learning opportunities. This allowed for good multidisciplinary working and clear care planning with the involvement of the wider team.
- There was a neonatal outreach service that provided home visits for babies who were able to have an early discharge. Referral into this service was birth before 36 weeks. A link nurse supported this service across both sites.
- Weekly psychosocial meetings took place that enabled staff to address situations where there were concerns about a family's ability to cope with their new baby. The liaison health visitor worked alongside neonatal unit staff and could discuss any issues with colleagues in the community. The transition nurse also attended this meeting.
- Ward rounds took place three to four times a day on the neonatal unit. This included the night staff on the postnatal ward handing over any cases where there were concerns about the condition of a baby in the late evening.
- Nursery nurses on the neonatal unit provided kangaroo care and skin-to-skin support to parents of babies. Physiotherapy support was provided to the unit for any babies requiring physiotherapy such as babies diagnosed with cerebral palsy.
- Relationships with tertiary centres were good and consultants at the trust described the ability to "Phone a friend" if they had any concerns. This meant there was ready access to specialist neonatal intensive care consultants who could advise on the best course of action in any situation. The default option for trust staff was to seek more specialist input if in any doubt at all about the best management of a sick baby or child.
- The children and young people's service was part of a wide range of clinical networks including the critical care network; diabetes network; cardiology network; oncology network; epilepsy network; and Wessex surgical network.
- There were also established links with other providers for specialties including respiratory medicine, children's intensive care, cystic fibrosis and neonatal care. This meant there was shared support and learning between multiple providers of care in the region.
- There was a community children's nurse employed by another provider who supported the trust. Their role included supporting children in the community who required nursing care, including those with long-term conditions or life limiting conditions.
- A multidisciplinary daily safety huddle took place throughout the service. This meant all staff involved in children's care were kept updated and had the opportunity to feed into updates.
- Two play specialists based on Bluefin ward helped children and their parents to cope with the experience of being in hospital. The play specialists provided distraction from unpleasant procedures such as the taking of blood. The play specialists attended the daily safety huddle.
- Services for children with long-term conditions were multidisciplinary. This meant the holistic needs of a child and their family were met. For example, the diabetes service consisted of medical staff, specialist nursed, dietician, and psychologist support. This supported the service in meeting the best practice tariff.

Services for children and young people

- A review of patients who required but did not receive a mental health bed was undertaken after joint communication between the trust and the child and adolescent mental health service (CAMHS). CAMHS were trialling the provision of a specialist nurse in the emergency department to provide an expert assessment of need, and care planning where required. The aim was for fewer admissions and additional support with care planning. This trial was still on-going at the time of inspection so we could not assess the effectiveness of this intervention.
- There were established transition pathways for long-term conditions such as diabetes, epilepsy and respiratory conditions. These pathways included the provision of multidisciplinary child and adult clinics and events. An adolescent and transition nurse was implementing the 'Ready Steady Go' programme. This programme prepared young people for the transition of their care from children's services to adult services.
- Allied health professionals supported the ward according to demand for their services. Physiotherapists attended Bluefin ward every day, occupational therapists were more involved with discharges on demand. Speech and language therapists provided an on demand provision with regular telephone contact with wards.
- The diabetes service provided by the trust consisted of a multidisciplinary team inclusive of medical staff, specialist nursing, dietetics and psychologist support. This supported the service in meeting the best practice tariff.
- The play therapy service worked cross-site. The play specialists provided observational sessions for medical staff, as well as being part of the new doctor's induction presentation. Medical handovers were open for play specialists to attend.

Seven-day services

- A consultant of the week system was in place throughout the service, this coupled with the resident consultant on call allowed for daily neonatal ward rounds.
- The on call consultant spoke with the on call registrar and with the senior nurse on duty every evening. There was a senior nurse on call every night.
- There was a resident on call paediatric consultant on the neonatal unit. This meant babies could receive urgent medical attention outside normal working hours.
- Diabetic patients on Bluefin ward had access to 24 hour specialist diabetes care due to an on call diabetes service.

Access to information

- There was a bleep system in place to allow staff to contact senior nursing staff for advice and support.
- Electronic recording systems allowed all staff to access patient specific data readily.
- Data collected on the neonatal unit was entered onto a live patient data management system that connects most neonatal units across the country, with one staff member responsible for checking data quality and consistency. This ensured the neonatal unit was able monitor its performance in line with the rest of the country.
- The paediatric neonatal leads were copied in to all scans and communications where an anomaly had been detected in pregnancy and were involved in discussions where the anomaly was likely to result in the need for longer-term paediatric involvement.
- General practitioners (GP's) were able to receive electronic discharge information. This meant information from the hospital could be readily available to GP's with no delays.

Consent

- A trust policy for consent to examination or treatment was in place. This policy had a section detailing parental responsibility and the assessment of Gillick competence for staff to reference.
- There were separate forms for young people aged 16-18 who were consenting to surgical procedures, which adhered to Gillick principals.
- We observed parents and children being informed prior to gaining verbal consent of what the intervention was and why it was needed.
- An internal audit had been commissioned to assess consent practice against trust policy. Three recommendations had been made with clear action plans to meet these recommendations.

Services for children and young people

Are services for children and young people caring?

Outstanding ☆

We rated the service as 'Outstanding' for caring.

It was the sheer volume of positive contacts to the trust and direct to CQC that showed the service was considered outstanding by those using it. There was a strong, visible person-centred culture that was evident in all grades of staff and all disciplines. Staff were highly motivated and inspired to offer care that was unfailingly kind.

Relationships between children and young people who used the service, their families and staff were strong, caring and supportive. This was particularly true of those families where the child had a long term or complex condition and on the neonatal unit. These relationships were highly valued by staff and promoted by leaders. The relationship between nurse managers and paediatricians was warm and respectful and this set the tone for all staff on the unit.

Parents told us they felt welcomed, safe and nurtured through the difficult time of having a preterm or sick baby. One of the consultant paediatricians had developed an end of life care service to support families caring for a dying child. They were not paid for this aspect of their work and it was not part of their job description. However, having identified a need, they provided a 24 hour a day seven day a week telephone advice line and undertook home visits day and night to ensure the child had good symptom control and that the family felt supported. This is reported under the children's report, as well as end of life care, as it demonstrated the relationship building and compassion for families that was demonstrated before the child required palliative care.

Children and young people were active partners in their care. Staff were fully committed to working in partnership with children and young people and promoted empowerment enabling them a voice and to realise their own potential. Individual preferences and needs were reflected in how care was delivered. Emotional and social needs were highly valued by staff and were embedded in their care and treatment. Young people were supported to develop and manage their own health. The level of positive feedback made directly to the CQC was unprecedented. We received many comments, emails and letters from parents who were fulsome in their praise of the service and how their child had been cared for.

Compassionate care

- All staff we spoke with were very passionate about their roles and dedicated to making sure children and young people received the best patient-centred care possible.
- We observed staff respecting the privacy, dignity and respect of patients. Staff closed curtains during care, lowered their voices so discussions could not be overheard and comforted patients throughout procedures. Staff took the time to interact with patients and their families. A staff member was seen enthusiastically discussing a football match with a patient, highlighting the good rapport they had established. We saw staff lowering themselves down to the child's level for discussions and using clear, non-jargon language.
- On Bluefin ward there was an 'Appreciation Board' showing thank you cards and letters from patients and their families. There was a handmade bag on display, a gift to staff with the words 'You are awesome' sewn into it.
- We reviewed the results from a number of different patient experience surveys and the feedback was very positive. All 'NHS Choices' comments for Worthing Hospital Children and Adolescent Services rated the service as 5/5. Comments from surveys included, "Staff were totally amazing and we will be eternally grateful to them" another said, "Fantastic, dedicated staff, thank you so much."
- Friends and Family tests showed a recommendation rate of nearly 100%. However, the response rate was low, especially Bluefin ward at 7.5%, such low response rates meant wards were not getting an overall picture of the experiences of friends and family, which may actually be doing them a disservice as the recommendation rate was so high.
- The trust performed broadly in line with other trusts in the National Children's Survey 2014. Where there was a variance from the average, the trust scored better than national averages. There were no questions where the trust scored worse than average.

- The service used real time local surveys to gather patient and parent views and these too were very positive.

Understanding and involvement of patients and those close to them

- The trust introduced an Adolescent and Transition Nurse in May 2015 to support adolescents moving from Children's to Adult Services. The role was patient focused but also available as a resource for families and staff, who confirmed it was a valuable resource. All adolescents received a 'Ready, Steady, Go Transition Plan' as part of their 'Transition, moving into adult care' information pack. The plan enabled adolescents to check their understanding of health issues such as, self-advocacy and managing emotions. It enabled them the opportunity to access more information or help if they did not feel confident in a particular area. This supported adolescents and enabled them to be confident in taking control of their own health when moving into adult services.
- Patients and families were also involved in the creation of their own unique 'passports', which included their full health history and background. If a child had a learning disability, the information was tailored to meet their individual need and ensure understanding.
- Parents and carers of children told us staff focussed on the needs of the child and their family. They felt involved in discussions about care and treatment options and told us they were confident asking questions.
- Staff told us they discussed goals with families and gave them advice. We heard examples of staff 'going the extra mile' to support families. One family who had received treatment at Worthing but lived in London had been told at a follow up appointment their nurse had rung in to check up on the patient. They commented, "Now that is caring in your job."
- We observed staff interacting with children and parents. Staff created a warm and caring environment, greeted children by name and in turn, patients and families spoke to staff on a first name basis. Staff were friendly and kept patients and families informed. Children advised us they felt listened to, which is reflected in data from the 'National Children's Inpatient and Day Case Survey 2014'.

Emotional support

- Staff from the trust supported children, young people and their families in the first instance. Referrals to other services such as counselling services, Child and Adolescent Mental Health Services (CAMHS) and chaplaincy could be made if further specialised support was needed. Information boards were prominent in ward areas and provided leaflets detailing where to find support services.
- Staff advised there were weekly Psychosocial Meetings with CAHMS to review psychological support. These meetings focused on the mental health of children and adolescents, as well as how to support adults with mental health issues who have children.
- Staff understood the impact the condition and treatment had on children and young people and this was embedded in their care using a multidisciplinary approach. For example, play specialists spent time with patient's siblings, providing them with attention and support when they were in the hospital environment.
- Patients had a named consultant written above the patients' beds. Consultants knew all family members present on wards. Consistency meant staff built up relationships with children and their families. These relationships meant all concerned had an enhanced experience in hospital. Something we witnessed on several occasions.

Are services for children and young people responsive?

Outstanding ☆

We have rated the responsiveness of this service as 'Outstanding'.

This is because the needs and preferences of children and young people were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.

The involvement of other organisations and the local community was integral to how services were planned and ensured services met the needs of the children and young people. There were innovative approaches to providing person-centred care that involved departments outside

those normally considered part of children and young people's services. The 'Harvey's Gang' service was a shining example of the hospital and trust wide commitment to responding to the needs of children and young people, particularly those with complex conditions. The attitude and understanding of adolescents was also good with a code of conduct and freedom pass allowing them additional privileges.

There were integrated person-centred pathways developed with other providers that ensure the holistic needs of vulnerable young children were met through shared working and information sharing. Transition arrangements from the neonatal unit to primary care services and the transition of adolescents to adult services were well developed and allowed for seamless care.

Families had access to the right care at the right time and this was managed appropriately. There was an open and transparent approach to handling complaints. Information about how to make a formal complaint was widely available however; families tended to contact the service directly when they had a concern or sought support from the Patient Advice and Liaison Service (PALS).

Service planning and delivery to meet the needs of local people

- Staff actively involved children, young people and families when planning, and delivering services. For example, wards had a 'Patient Perspective' board displaying patient questionnaire results. Answers given by parents and children and teenagers were separated. Staff gave examples of service changes as a result of the questionnaire. An example of this was patients did not regularly receive information packs on discharge, therefore handover sheets now have reminders to print information packs and a shortcut has been created on the ward computer. Parents also fedback that they did not always know where to find tea/coffee facilities; therefore a tour of the ward was introduced as part of the admission process.
- We saw evidence the trust involved and engaged with local communities in planning services for children and young people. Community nurses visited regularly to check on patient progress, which aided discharge planning and continuity of service. The 'Neonatal Outreach Service and Support Group' who provide training, such as resuscitation and assistance with obtaining equipment, supported families through the discharge process. Appointments were made after discharge on a needs basis.
- The trust staff worked with the local authority and other key stakeholders to deliver joint services such as the 'Baby Grow', a multi-agency initiative in West Sussex, for parents and carers with pre-birth to 2-year-old children, which aimed to better co-ordinate the services for early help and intervention and provide an effective pathway of support for vulnerable parents, at the earliest opportunity.
- The trust was a partner organisation in the Family Nurse Partnership programme that provided continued support for the children of young and vulnerable parents during the first two years of the child's life. The scheme showed real benefits for children. For example, parents supported through the FNP programme were more likely to have their children immunised.
- There were good links to a local children's hospice and a community hospice service that provided support and respite for children with life limiting and life threatening conditions and could also provide facilities for families in the last few days of life and after death. Families using both the children's ward and the neonatal unit were referred, when appropriate.
- There would good links with tertiary centres and specialist hospitals so that paediatricians could access expert advice about complex conditions. Care could be shared by both organisations to reduce the travelling and time away from home for the family.
- The trust recognised workforce development as key to achieving the Standards for Defining Staffing Levels for Children and Young People (RCN 2013). They had initiated a band 6 development programme to support future recruitment from amongst their senior band 5 nurses.

Access and flow

- Ward layout was effective in terms of use of space and efficiency, Bluefin ward had been opened up from two wards into one, which allowed staff to monitor patients more easily and provided less cramped

accommodation. Surgical theatres and Accident and Emergency were located nearby. Children received rapid access as all paediatric services are in one area with direct access to the Post-Natal ward and Labour ward.

- All sleeping accommodation was separated into male and female only areas, and wards were designed so no patient needed to pass through an area of the opposite sex in order to access toilets, bathrooms, or leave the ward. Staff used 'Patient Led Assessments of the Care Environment' (PLACE) assessments to monitor accommodation standards.
- Adolescent beds were separate from the rest of the ward and patients stayed in single sex rooms from the age 13 upwards, which meet National Service Framework (NSF) standards.
- There were very good networks of support for children in the community. The Advanced Nurse Practitioner was involved in looking at alternatives to hospital admission/attendance and promoting self-care by parents. Staff contacted patients several days after discharge to discuss any concerns or developments, which aided in preventing unnecessary re-admissions.
- The non-admitted RTT was generally above the required 90% standard month on month. Trust wide the performance averaged 93% from January 2015 to September 2015. There was a slight drop off in the latter two months from a high of 97% but the trust had identified this and had put mitigation in place to ensure on-going good service delivery. The measures included additional clinics, triaging referrals and making onward referrals to tertiary centres to avoid delays and a proactive stance to reduce non attendance.
- The MIAMI initiative showed collaboration with local primary care services whereby GP's could refer children with minor illness and injuries to a paediatric led community outpatient service. This reduced the need for a hospital appointment and helped maintain throughput.

Meeting people's individual needs

- The hospital supported families who were likely to spend long periods on site, by providing use of a kitchen and separate bathroom facilities. On ward bedrooms were available, as well as additional fold up beds next to patients so parents could not only be on site, but sleep next to their child. Visiting hours at Worthing Hospital were 3pm to 5pm and 6:30pm to 8pm.
- A 'Breast Feeding' room was available for mothers who wanted to express in privacy. If this was in use, the wards provided enough privacy screens for people to use in cubicles.
- The wards provided a friendly, homely environment. Adolescents were given space, there were separate playrooms for children, and young people aged 13 upwards. Both were light and airy with a good selection of toys in the children's playroom and a pool table, football table, air hockey, TV and DVD player and games consoles in the adolescents' room.
- Staff told us access to interpreting services was good. In many cases, they used the 'Language Line' telephone service; however, they had not experienced any problems when they needed to book an interpreter.
- Staff could describe the ethnic and religious diversity of the people who used their services and explained how they could make modifications to ensure they were culturally sensitive.
- Staff we spoke to recognised and understood how families could feel overwhelmed in a hospital setting where they may not have the same support network as at home, particularly those who had children with complex needs. Staff supported families by watching over children when parents needed a rest, and provided 1:1 cover when needed. A high-sided bed was available for children who were mobile, too big for cots and have little understanding of their own safety. This enabled parents to take a rest without fear of their child falling out of bed.
- Staff showed they were proactive in meeting the needs of children and young people. For example, the Chief Biomedical Scientist set up 'Harvey's Gang' after a paediatric oncology patient wanted to know what happened to his blood when it went for testing. Now any critically ill children can have a tour of the laboratory where they are given their own lab coat, which a member of staff makes in their own time. This initiative won the Patient First STAR Awards 2015 for

Compassionate Care and was being introduced by four other trusts. Staff were very enthusiastic about 'Harvey's gang' and described the positive impact it had on children and parents in promoting understanding.

- Staff used a number of initiatives to support patients and promote understanding. For example, oncology patients used the 'Bead of Courage Journal'. Patients' created a necklace and every time they required a procedure, for example a blood test, the child chose a new bead. This encouraged children to consent to a procedure and promoted understanding as families could see how many procedures were involved in treatment.
- We saw evidence the trust involved and engaged with local communities in planning services for children and young people. Community nurses visited regularly to check on patient progress, which aided discharge planning and continuity of service. The 'Neonatal Outreach Service and Support Group' who provide training, such as resuscitation and assistance with obtaining equipment, supported families through the discharge process. Appointments were made after discharge on a needs basis.
- The trust recognised workforce development as key to achieving the Standards for Defining Staffing Levels for Children and Young People (RCN 2013). They had initiated a band 6 development programme to support future recruitment from amongst their senior band 5 nurses.
- Trust staff were responsive and recognised the particular needs and challenges of adolescents. There was a Young Persons Code of Conduct for ages 14-18 years of age which made explicit acceptable and unacceptable behaviours. There was also a Freedom card which allowed young people off the ward with signed parental/guardian consent - to go to the shop or the café.

Learning from complaints and concerns

- The trust had a complaints policy and staff we spoke with knew how to access it. Staff felt the process was open and honest. Staff are aware of actions to take when concerns were raised. This included trying to resolve any problems as they were raised. Staff are proactive in working in partnership with children, young people and their families, which minimised the need for people to raise complaints. If there were complaints, staff knew what to do and how to signpost people to the complaints procedure.
- We reviewed complaints made between October 2014 and September 2015. Six complaints had been made about services for children and young people. There were no discernible themes or trends.
- Information about how to make a complaint or how to contact the Patient Advice and Liaison Service (PALS) was displayed in the wards.

Are services for children and young people well-led?

Outstanding ☆

Well-led was rated as 'Outstanding' in the children and young people's service.

This was because of the positive culture and ethos that pervaded all aspects of the service and which resulted in a motivated and enthusiastic workforce.

The encouragement of innovation, listening to families and staff and executive support for the introduction of new initiatives resulted in service improvement and better care that met the needs of people using the service. This encouragement resonated from the trust board to ward level with a member of the local youth parliamentary committee attended the Children's Board meetings along with a family member of a child with complex needs.

The public were very well engaged with the service and their opinions were actively sought. The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care by ensuring there was a clear process of assurance from 'ward to board' and more importantly, back again. Leaders had an inspiring shared purpose and motivated staff to succeed.

Staff of all grades and disciplines were proud of their service and wanted to deliver a high quality of care. Comprehensive and successful leadership strategies were in place to ensure delivery and to maintain the desired culture. The trust was committed to 'growing its own' through formal leadership education and individual

development. There was a culture of constant innovation and improvement encouraged across all staff groups. This allowed staff to 'think outside the box' and to take control of how their service was delivered.

Vision and strategy for this service

- Staff across the service at Worthing Hospital were aware of the vision and values of the trust.
- The Chief Executive referred to their 'Patient First' programme in a presentation given to the CQC. All staff knew details of the programme in detail.
- Knowledge of the trust's vision and values was good across staff groups. For example, one staff member told us the vision of the service was to put the patient first, referring to the new 'Patient First' Initiative as set out in the Quality Strategy 2015-2018. Another staff member told us further detail about the vision of 'We care', as set out in the strategy.
- The trust had a very good sense of direction and firm commitment to improvements in the safety and quality of patient care. This vision was well publicised and we found staff from across the service 'bought in' to the vision and values.

Governance, risk management and quality measurement

- A Paediatric Integrated Governance meeting was held monthly. A clear pathway was in place for the escalation of assurance and concern from this meeting, firstly into a monthly Women and Children's Governance meeting, then to the Trust Quarterly Governance Meetings and then to the Children's Board which the chief operating officer chaired.
- Staff told us the risk register was completed at senior level but they were confident that senior staff members escalated issues appropriately.
- Staff were aware of the service's risk register. One staff member told us although they did not directly input into the risk register, they were informed of what was on there and actions being taken. For example, piloting a child and adolescent mental health nurse in the emergency department to reduce admissions and further support care planning.
- The WSHFT Children's Board was executive led with non-executive representation and involvement of parents and young people. It was established to drive safety and quality across children's services.
- A paediatric pathway for management of case reviews was in place, which fed into the divisional governance report meetings. This meant there was a structured and standardised pathway for assurance and learning from case reviews.
- Weekly and monthly meetings were established for heads of nursing, clinical directors, and heads of service. This ensured that any governance issues were acknowledged and actioned between formal governance meetings if the need arose.
- Staff were aware of themes on the risk register. This meant that staff were informed by their managers of the general governance of the service they work in.
- Monitoring of infection prevention and control provided an accurate and up to date overview of how well the service was reducing the risk of cross infection.
- A regular planned programme of audits monitored patient outcomes.

Leadership of service

- Staff told us they felt they were supported to progress with good access to further training and development.
- Leaders were proactive in managing the service as a team. There was a weekly nurse in charge meeting where the service was discussed and levels of action required were agreed. Staff felt valued by their leaders. One staff member told us that, "There was good management support, especially at busy times."
- Staff felt their senior colleagues lead them well, were supportive and were approachable. One staff member told us "the chain of management" was strong.
- Staff were assured their senior colleagues represented the service well within the executive team and the board. Two staff members referenced the chief of service representing the service.
- Staff who attended focus groups were very positive about the leadership of the service. There were so many staff who wanted to come and tell us about their work that we had to split the group in two.

Services for children and young people

- We observed relationships between the neonatal nurses and the paediatricians who led on neonatal care. There was clear mutual respect and evidence that this had a positive impact on patient care as the nurse felt comfortable raising any concerns with the consultants directly and knew they would be listened to.
- One of the paediatricians was the Chair of the Wessex Paediatric Critical Care Network where clinical leaders from across the region shared information and reviewed cases to share good practice and learn from mistakes.
- Innovation was encouraged (Harvey's Gang being one example). We saw other examples of where staff or parents had made suggestions and managers had listened and made changes. For example, access to child and adolescent mental health service (CAMHS) at the weekends not being sufficient. This was escalated to a senior nurse, now there is weekend access to CAMHS via another provider in the locality.
- There was a Board level lead for children's services.
- The diabetes service was in the planning stage for further development to reduce the glycated haemoglobin (HbA1C) level of the children in the service. This development was incorporated into a consultant's personal development plan (PDP) to ensure leadership of the development, with visits to other trusts planned.
- Senior paediatric medical staff and nursing staff had led roles in the PICU network, the Wessex Paediatric Involvement Group and the Neonatal Network which promoted collaborative working and standardisation across the South East.

Culture within the service

- There was a collaborative culture across both sites with staff supporting each other by being flexible and working cross-site when required.
- Staff felt valued and respected by their colleagues. A new member of the medical staff said they felt well looked after throughout their induction period at the trust. A health care assistant told us they felt integrated with medical and nursing staff and advised they were on first name terms with senior medical staff.
- All staff were proud and happy to work at the trust. The workforce was willing to be flexible to provide the best possible care. This demonstrated commitment and ownership of the service by the staff.
- Teamwork was a trend with most staff referencing teamwork as a good thing about working in this service.
- We heard from several consultant paediatricians who told us about an approachable and supportive executive team. They felt the trust encouraged openness and respect.
- Trust Champions asked to speak to us and tell us about how highly they valued the trust and how they were motivated to talk to as many people as possible about this.

Public engagement

- The public was actively engaged in the governance of the children and young people's service. A member of the local youth parliamentary committee attended the children's board meetings, as did a family member of a child with complex needs.
- The public were invited to participate in fundraising events for the service. Fundraising events held in both a local racecourse and the trust's medical education centre had enabled the purchase of five parent beds on Howard ward at St Richard's Hospital.
- Young people and staff from outside the unit were engaged in the 15 steps challenge where the children and young people's provision was reviewed. The report of one visit showed they thought it was good the doctors had written funny things on a playroom whiteboard but they would like free Wi-Fi.

Staff engagement

- Staff felt engaged and were enthusiastic about the service they worked in. Updates and feedback were circulated on what was happening in the service.
- A staff and parent facilitated group for children with complex needs requiring inpatient care had resulted in specialist equipment being purchased. For example, an interactive picture communication system which allows children to use images and symbols as well as a personal passport system which allows important information to be accessible to teams wherever the child goes.

- Staff could apply to the ambassador scheme. A nurse on Bluefin ward was a newly appointed ambassador who advised the role enabled her to share good practice with the rest of the trust.
- There was a staff award ceremony where the trust celebrated the contribution staff made.

Innovation, improvement and sustainability

- Trust paediatric staff, with the local paediatric intensive care forum had introduced and implemented a regional tool for the recognition and management of paediatric sepsis.
- A bespoke leadership programme had been implemented for nurse in charge level nursing staff in the children and young people's service.
- A unique project was being undertaken with the local clinical commissioning group (CCG) to support families in considering self-help strategies during their child's illness and prevent hospital admission where appropriate.
- Care pathways for children were being improved by advanced paediatric nurse practitioner (APNP) roles. This responsibility had traditionally been belonged to medical staff. Using the APNP role for this purpose negated the need for over-medicalisation.
- The paediatric chronic pain service provided specialist support in avoiding long journeys and admissions to specialist hospitals.
- The clinical director for paediatrics had developed and implemented a trust-wide development programme for new consultants.
- The diabetes service was in the planning stage for further development to reduce the glycated haemoglobin (HbA1C) level of the children in the service. This development was incorporated into a consultant's personal development plan (PDP) to ensure leadership of the development, with visits to other trusts planned.
- There was a Paediatric Chronic Pain Service provided in response to very high spending on sending children with complex pain conditions to remote national tertiary specialist centres. It is one of 17 such services nationally. The success of the service was measured and showed average pain scores improved from 8/10 pre treatment to 2/10 post treatment. There was also a significant improvement in the level of disability the children and young people were experiencing with 70% having no disability on discharge.
- The neonatal outreach service offered specialist support for the transition from hospital to home. Support provided included resuscitation training for parents, discharge planning and support at home. The outreach nurses worked closely with primary care professionals to provide a safe and effective transition from one service to another. The service also reduced the length of stay and readmissions. In 2014, 472 cot days were saved with a financial benefit of £212,400.

End of life care

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

Information about the service

End of life care is one of the core services of Western Sussex Hospitals NHS Foundation Trust, catering for a population of around 450,000 people with approximately 950 beds across two sites. There are approximately 2,000 deaths per year across the 2 hospital sites approximately and half of all deaths occur in acute care settings.

The trust employed palliative care specialists to help patients with advanced progressive or life-limiting illness and those close to them to enjoy the best possible quality of life they can, and help them face problems associated with these conditions. They aim to prevent and relieve suffering by early identification and treatment of pain and other problems, and provided the physical, psychological, social and spiritual support their patients and those close to them required.

End of Life Care Services were provided across the hospital and were not seen as being the sole responsibility of the Specialist Palliative Care Team. With an increasing population of older patients with multiple co-morbidities and complex medical needs the challenge for staff to identify patients in the last days of life was growing and this was acknowledged by the trust with work being done to address this.

As part of this inspection we visited seven wards and the intensive care unit and urgent care areas looking specifically at EOLC and reviewed the medical and nursing records of 31 patients. We also visited the bereavement office. We observed care being delivered on the wards and spoke with 42 relatives and 24 patients, most of who were identified as requiring EOLC. We also spoke more generally with other patients about the overall care provided on wards and the attitude of staff. We met and spoke with numerous ward staff including healthcare support workers, junior nurses, and ward managers. We met the chaplains and the mortuary manager and were shown the resources and facilities they had available to them.

End of life care

Summary of findings

The overall rating for end of life care services for Worthing Hospital was 'Outstanding'.

Trust staff talked with enthusiasm about their proactive stance in getting people home to die if at all possible. This was supported by a very effective rapid discharge policy that was sufficiently resourced to make it workable. The first national VOICES survey of the bereaved (2012) suggested that 71% of people wanted to die at home but that only 29% of people nationally who died in hospital felt they had sufficient choice about this. At the Western Sussex Hospitals NHS Foundation Trust about 80% of people were supported to die in their preferred place of care. A strong culture of enabling rapid discharge supported people and their families in their desire to die in their home surrounded by the people they love and within a familiar environment that they retain more control over. The trust's equipment library was a very good resource that enabled the rapid discharge of patients who wanted to be cared for at home in the last few days and hours of life.

A review of the data showed that the trust had robust policies and monitoring systems in place to ensure that it delivered good end of life care. However, it was the direct observation and conversations with staff, relatives and patients that made us judge the care outstanding. Individual stories and observed interaction provided assurance that staff of all grades and disciplines were very committed to the proactive end of life care agenda set by the board.

Staff provided a service that was outstandingly caring. The specialist palliative care team (SPCT), mortuary and chaplaincy staff worked effectively and cohesively as a team to provide a seamless service. Most audits performed by Worthing hospital were scored above England averages, which underpinned the rating given for this service. We heard from several staff about the exceptional support given by the chaplaincy team, in their own time, to help a person approaching the end of their life find a 'lost' baby that was buried in an unknown location having died shortly after birth. This service had subsequently helped several other parents to find their babies many years after they had 'lost' them.

Feedback made directly to CQC, from relatives of people who had died at Worthing hospital was overwhelmingly positive. They told us that they, "Had 5 star care" and that staff in all areas of the hospital were caring, respectful and attentive. They talked about being involved and appreciated being supported to remain near their relative at all times. We spoke at length with one patient and their family, they knew and understood they were dying but were peaceful and relaxed. They told us this was because, "I am being surrounded by love and care, such that you would not get anywhere else."

The trust had prioritised the correct use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms as a tool for engaging with patients and relatives about how they would like care to be delivered should there be an unexpected or expected but significant) deterioration in the patient's condition. Consultants had oversight of the decisions made by the junior doctors in consultation with the family and we saw examples of clear challenge where a consultant was not content that sufficient thought had been given to the decision to withhold resuscitation that was requested by the relatives. We reviewed 32 DNACPR forms as part of the inspection and saw that they were all completed properly, had involved patients and their relatives where appropriate). We also saw that where patients did not want their decision discussed with family members this was respected.

End of life care services were responsive. All teams worked hard to meet the needs of patients at the end of their life. There were some delays in discharges throughout the trust but these did not affect people needing end of life care where the trust managed to ensure that 79% of people were able to die in their preferred place of care.

The management structure, staff involvement and culture of the service were also outstanding. Staff

End of life care

feedback was exclusively positive throughout the inspection with all grades of staff supporting the trust focus on providing good end of life care. There was a positive vision for the future sustainability of the service.

Are end of life care services safe?

Good

Worthing Hospital was rated 'Good' for safety. We found that patients who received end of life care were being looked after in a safe, clean environment across clinical areas by specialist trained nurses and doctors. Medicines were appropriately prescribed as per national guidelines therefore the majority of patients received adequate medicines to keep them comfortable.

The 39 (DNACPR) forms we reviewed were all completed within the Resuscitation Council UK guidelines with approximately 75% showing clear evidence patients and their families had been consulted and their wishes documented.

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported to do so by their managers. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety. Incident reporting was managed robustly and there was evidence of good dissemination of learning from incidents. Within the trust end of life (EOLC) service, there had been no never events or serious incidents reported between August 2014 and July 2015.

Safeguarding vulnerable adults was given sufficient priority. Staff were encouraged to take a proactive approach to safeguarding and focus on early identification. They took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. We saw examples of where safeguarding concerns were discussed and addressed when it was felt that relatives might be overly keen to have active treatment withdrawn from an elderly relative.

Medicines were appropriately prescribed in line with National Institute for Health and Care Excellence (NICE) guidelines. This meant the majority of patients received adequate medicines to keep them comfortable and free from pain.

Incidents

End of life care

- Across the trust's EOLC service, there were no never events or serious incidents reported between August 2014 and July 2015. Never Events are (serious,wholly preventable patient safety incidents that should not occur if the available, preventative measures have been implemented) reported for the palliative care service.
- Nursing staff told us they were confident in reporting incidents and 'near misses' on the hospital's electronic incident reporting system. We reviewed eight incident investigation forms and could see there was good dissemination of learning from incidents. Nursing staff told us they received feedback from reported incidents via e-mail, at ward meetings and weekly updates. We saw evidence of this within minutes of ward meetings.
- A few junior doctors told us that they had never used the electronic reporting system to report incidents preferring to pass information to the nursing staff to report. The reasons given for this were, "The forms are too time consuming to complete". There was a general feeling and perception amongst this small cohort of junior doctors that completion of incident reports would not lead to any changes.
- The Duty of Candour regulation is in to ensure that providers are open and transparent with people who use services and other relevant persons (people acting unlawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incidents, providing reasonable support, providing truthful information and an apology when things go wrong.
- The nursing staff on the specialist palliative care team and on the wards we visited told us they were aware of duty of candour and assured us they would use it to inform patients and relatives when a notifiable safety incident had occurred. We saw from entries in patient records that the staff held conversations and explained when management of symptoms had not been particularly effective and noted an open style of communication with patients and relatives, generally. We did not see any specific examples relating to Duty of Candour in end of life care.

Cleanliness, infection control and hygiene

- There were 21 cases of Methicillin Resistant Staphylococcus Aureus (MRSA) and 38 cases of Clostridium difficile (CDiff) over a 1000 bed day period across the trust. Both of these scores were lower than the England average and were better than the trusts own target. There was no data for MRSA or CDiff related specifically to patients receiving end of life care.
- The wards that we visited were visibly clean and tidy. We saw all staff washed their hands appropriately, making good use of hand washing facilities and hand sanitiser gels. We also saw staff observed the bare below the elbows policy in all clinical areas.
- The hospital undertook regular auditing of cleanliness in all areas of the building against the National Specification for Cleanliness in the NHS. The results showed high levels of compliance with this specification.

Environment and equipment

- The environment on the medical wards where patients were receiving end of life care was mostly clean and bright, however there were a few side rooms available due to the design of the wards. There was no separate accommodation within Worthing hospital for relatives to stay but staff made them as comfortable as possible on reclining chairs if required.
- There was sufficient equipment available to meet the needs of people on the wards at all times.
- Syringe drivers (small infusion pumps used to gradually administer small amounts of fluid, with or without medication to a patient) in use were T34 McKinley and were standardized to one type which would help minimise the risk of human or training error.
- The chapel of rest viewing room was a good size and was newly refurbished. It could easily be adapted to take two deceased members of the same family at a time where required. There was also a newly refurbished quiet room where relatives could sit before and after viewing for as long as they wished.
- The environment at the back of the mortuary was not satisfactory. The removal area was next to the clinical waste disposal area for the hospital which meant that it was often unclean. The mortuary staff had raised and had added it to their risk register.

End of life care

- The mortuary staff told us that more and more families were deciding to make their own arrangements for transporting loved ones and "do it yourself" funerals were becoming more popular. They said "It is not acceptable for families to associate collecting their loved ones with collecting rubbish".
- This issue was not raised with the executive team as part of the inspection as we were advised that the trust and estates department were already looking at plans to extend the mortuary and relocate the refuse collection area.
- Service records were available for equipment, such as the commercial instrument washer in the mortuary. These showed that equipment was being maintained and serviced in line with the manufacturers' recommendations.

Medicines

- We reviewed 39 sets of notes at Worthing Hospital and saw that anticipatory medicines for patients nearing the end of life were prescribed appropriately by medical teams who followed the national guidelines. This is medication that patients may need to make them more comfortable. Doctors were aware how to access guidance on the intranet to assist them with this. We saw clear guidelines for medical staff to follow when writing up anticipatory medicines for patients.
- The safe and effective use of medicines was audited under the National Care of the Dying Audit for Hospitals (NCDAH) 2013-14.The findings showed medicines were prescribed as required, for the five key symptoms that may develop during the dying phase. The audit showed that the care of 65% of patients across the trust achieved 5 out of 5 criteria measured against the England average of 51%. Site specific information was not available as the audit was for the cross site service.
- The trust used a new Electronic Prescribing Medicines Administration (EPMA) for three months prior to our inspection. Junior doctors and a pharmacist told us that they found it was more time consuming than the previous system. Research published in the Pharmaceutical Journal of the Royal Pharmaceutical Society showed that electronic prescribing reduced both medication errors and costs to NHS organisations, where it was used. The trust told us that they were aware there were some concerns across these groups and they were working to address these through additional support and training.
- Medicine Administration Record sheets for individual patients receiving EOLC were clearly completed and provided evidence of compliance with the trust symptom control guidance.

Records

- During our inspection of Worthing we reviewed 39 sets of patient records. All the records we looked at were legible, signed and dated, easy to follow and gave details of people's care and treatment.
- Care plans were individualised and patients identified as requiring end of life care were on pathways based on the "One chance to get it right" document 2014. This describes the five priorities of care that must be in place in the last days of life and included food, drink, symptom control and psychological, social and spiritual support.
- We reviewed 39 DNACPR forms which had been completed within the Resuscitation Council UK guidelines. In the records of 36 patients we found clear and comprehensive records of the discussions between staff and patients (where possible) and their families (where appropriate).
- We saw that DNACPR forms completed on previous admissions or in the community were reviewed by a consultant and cancelled where it was felt they no longer applied.
- In two records we saw the DNACPR had an added comment about the limitations of care that the patient consented to. This showed they wished (and it was agreed) that they wanted to be given medicines and oxygen to treat their current presenting condition, but that if their heart stopped they did not want to be resuscitated.
- We noted that one junior doctor had a discussion with relatives where the next of kin had requested withdrawal of all treatment. The junior doctor made a record of the request in the notes and discussed this by telephone with the consultant. The consultant

comment was recorded in the notes as them wanting to carry out a full review with the wider team prior to withdrawal of treatment. This MDT review had taken place within 24 hours of the request being made.

- We spoke with three family members and four patients about their conversations regarding DNACPR forms. We found that people's accounts of conversations matched what was recorded in their records.
- Of the forms seen a few had no review date on them. We were advised by a consultant this was because as the patients' condition was terminal and any future attempt to resuscitate was likely to be futile.
- When we returned to undertake an unannounced visit we saw that where a form had been completed by a junior doctor it was countersigned by a consultant following review by them. The review was documented in the patient's medical records. We still saw one exception to this but a junior doctor we spoke with explained this was in accordance with trust policy that countersigning was not necessarily immediate.

Safeguarding

- We spoke with two members of staff in the specialist palliative care team about protecting people from the risk of abuse. The specialist palliative care team knew how to contact the safeguarding team via the hospital intranet and switchboard. They also knew they could contact the local safeguarding team in and out of hours.
- The trust had a dedicated Adult Safeguarding lead nurse.
- All staff we spoke with told us they had received adult safeguarding training within the last two years. We saw training matrixes on the wards visited that confirmed this.
- The trust safeguarding policies had been reviewed and were in line with current national guidance. Staff we spoke with all had a sound understanding of their responsibility in relation to safeguarding adults.
- We saw details recorded about a multidisciplinary discussion which involved the safeguarding lead where a patient's relatives were perceived as being overly keen to withdraw active treatment. A plan had been drawn up which included speaking with the relatives to explain that the patient's current presenting condition was treatable and that with treatment they would be more comfortable. The correct processes had been followed throughout the management of this situation.

Mandatory training

- All new nursing staff were required to complete syringe driver training as part of their induction and were assessed for competency prior to using the syringe drivers. All staff we spoke to on the wards and within the SPCT told us they were trained, assessed and competent in syringe driver use. We saw data to support this claim.
- All new staff received training on end of life care within induction as a part of the trusts mandatory training.
- The SPCT delivered an education programme to nursing staff on the wards. This included how to identify patients who may be entering their end of life phase. Staff told us that it had given them the confidence to know when to contact the SPCT.
- The members of the SPCT had all completed the trust mandatory training.

Assessing and responding to patient risk

- For patients where the progression of their illness was clear the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible, at all times. Proactive, anticipatory care plans were put in place to ensure that non specialist staff were aware of the best way to manage symptoms that were likely to present as part of the disease progression.
- As part of the on-going discussion with patients and their relatives the ceiling of care was discussed and documented for patients who might respond to some treatments such as antibiotics for an acute infection but for whom it would be futile and overly invasive to offer mechanical ventilation, for example.
- The hospital used a recognised national early warning score (MEWS) to monitor patients at risk of deteriorating clinical conditions. This was monitored through the electronic records system which also provided automatic escalation where concerns identified by a heightened MEWS score were not addressed within a given timeframe.

End of life care

- Review of ward based patient records showed that the system was used effectively for patients not identified as end of life or for those who had a current treatable condition.

Nursing staffing.

- The trusts End of Life Strategy and policies made it clear that EOLC was the responsibility of all staff, and was not limited to the SPCT staff and Clinical Nurse Specialists or specifically nurses.
- The SPCT had handovers and board rounds at 9:00am every day which included attending safety huddles. These multidisciplinary meetings were also held on most wards to improve patient safety.
- The SPCT was multi-disciplinary and comprised of 3 consultants working between the trust and the two hospices. The specialist nursing team comprised of a dedicated matron 1.0 WTE (Band 8a) leading the service across all sites, 4.4 WTE Clinical Nurse Specialists (Band 7), and 2.5 WTE Clinical Nurse Specialists (Band 6). There was a Band 6 and a Band 7 vacancy within the team created in response to an increase in the referral rates over the past 12 months.
- The SPCT delivered an education programme to nursing staff on the wards. This included how to identify patients who may be entering their end of life phase. Staff told us that it had given them the confidence to know when to contact the SPCT. The trust applied the NHS England safe staffing framework which ensured the hospitals were staffed with the appropriate number and mix of clinical professionals. From November 2014 to October 2015 the trust scored 96.4% on day shifts and 97.6% on night shifts against the framework standards. This meant that wherever patients received end of life care within either hospital they would be placed in well-staffed wards where their needs could be met.
- Staff we spoke with confirmed that there were always sufficient staff to ensure that people who were very close to the end of life would have a dedicated member of staff with them at all times when their family could not be present.
- Most wards had end of life link nurses as a first point of contact for staff to go to for advice.

Medical staffing

- The SPCT included three consultants who work jointly between the trust and two local hospices. This gave the trust a total of 1.2 WTE consultants in palliative medicine. They provided an on-call service 24 hours a day, seven days a week for clinical support and advice. Patients who were known to be approaching the very end of life could be admitted directly to one of the local hospices, if that was their preference.
- The Palliative Medicine Consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.
- The Consultants worked across the acute hospital, the community and the local hospice allowing for improved continuity and management of patients using more than one of the services.

Major incident awareness and training

- Most staff we spoke with had been aware of and received training in the trust's major incident plan. There had been a recent major incident locally which had tested their knowledge of the plan and showed it to be effective.
- The mortuary had a business continuity and escalation plan available for staff to reference. Staff were aware of this plan and knew where to locate it. The mortuary manager was able to talk us through the arrangements. This meant that should there be a sudden surge in demand for refrigerated mortuary space (such as following a major incident or utility failure) that the trust had an agreement with local undertakers to provide additional facilities.
- Worthing Hospital had to use the business continuity plan for the mortuary during severe inclement weather when the basement of the hospital had flooded. The arrangements had proved satisfactory.

Are end of life care services effective?

Outstanding ☆

The trust provided outstanding, effective end of life care to patients.

End of life care

Outcomes for people who used EOLC services at Worthing hospital were consistently better than expected when compared with other similar services. Statistically, it was a high performing trust in this aspect of its work by providing care that exceeded the national guidance.

All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation were proactively pursued. It was fully compliant with the Key Performance Indicators of the National Care of the Dying Audit and achieved the National Institute for Clinical Excellence (NICE) Quality Standards for End of Life Care for Adults.

The trust overall scored higher than the England average in all ten clinical key performance indicators in the National Care of the Dying Audit Hospitals (NCDAH) 2013/14 and scored 100% in five of the indicators. The trust also achieved four out of seven of the organisation key performance indicators in the National Care of the Dying Patient audit.

There was a holistic approach to planning people's discharge, transfer or transition to other services, which was done at the earliest possible stage. The effectiveness of this was reflected in audit results which showed that 79% of patients died in their preferred place of care.

Feedback from patients and their relatives was positive about the quality of care and the resources available to them at the hospital. People we spoke with reported that their symptoms were very well managed. People who were too unwell to hold a detailed conversation appeared to be comfortable and hydrated. We observed excellent bedside care which provided comfort and reassurance to the families, as well as ensuring that people remained comfortable and peaceful in their final days.

Figures quoted are trust wide as the end of life care provision was trust rather than site based.

Evidence-based care and treatment

- The Specialist Palliative Care Team used a combination of National Institute for Health and Clinical Excellence (NICE), End of Life Quality Care Strategy and Royal Colleges' guidelines and quality standards to determine the care provided. The end of life care pathway used at Worthing is based on the five principles of care.
- The end of life care pathway used at Worthing Hospital was based on the five priorities of care, approved by the General Medical Council (GMC) and Leadership Alliance for the Care of Dying People. This is a coalition of organisations that have set clear expectations for high standards of care.
- The trust took part in the National Care of the Dying Audit (NCDAH). The results for 2013/14 showed the trust had scored 100% in five of the indicators. The trust also achieved four out of seven of the organisation key performance indicators in the National Care of the Dying Patient audit.
- The trust used evidence based end of life care and adhered to the NICE guidance relating to end of life care such as the Quality Standards 13 end of Life Care for Adults and Clinical Guidelines 140 Opioids in Palliative Care. The Trust audit plan 2015-2016 confirmed that the use of these was monitored.
- NICE Quality standard for end of life care for adults, Quality statement 6: Holistic support – spiritual and religious states that, "People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences". It suggests that there should be evidence of availability of local chaplaincy services in accordance with NHS chaplaincy: meeting the religious and spiritual needs of patients and staff (Department of Health 2003). We judge that the chaplaincy service at Worthing Hospital was particularly good at meeting the needs of the community it served.
- Nursing staff completed risk assessments to identify individual risks such as pressure damage. The use of pressure damage risk assessments was audited routinely. The absolute levels of hospital attributable pressure damage were low. The minutes of the Trust Board meeting held on 29 October 2015 showed the rate of pressure damage of grade 2 and above at 0.78 per 1000 bed days. Monthly auditing of pressure damage prevention measures was taking place.
- The trust reported the harm free score for October 2015 as 95.8% which was better than their own target which had been set based on the national average.
- All end of life care plans we looked at were personalised, reviewed, dated, acted upon and contained patients and families wishes.

End of life care

- Patients who were in their last year of life were not automatically identified when first admitted via urgent care services unless they were on an advanced directive end of life care plan or a DNACPR in place from the community. However, all departments had strong links with the palliative care team and knew how to make referrals to them when necessary.
- The trust also achieved four out of seven of the organisation key performance indicators in the National Care of the Dying Patient audit. This is being used as a benchmarking tool.
- We saw clear usage of evidence based practice which included, risk assessments such as the pressure area damage risk score, falls and safety thermometer which was audited to be 95% effective.
- All end of life care plans seen had been personalised and contained patients and families wishes. They also made it clear where patients with mental capacity did not wish their prognosis to be discussed with their families.
- Medical staff involved in the provision of end of life care were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person's life; this included the option of clinically assisted feeding.

Pain relief

- Effective pain control was an integral part of the delivery of effective EOLC across all wards of the hospital and this was supported by the SPCT. Anticipatory medicines were being prescribed and equipment to deliver subcutaneous medication such as pain relief was readily available.
- All patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly.
- We saw evidence that pain relief was being given and monitored, for example, site intensity and type of pain. The wards that we visited used the pain thermometer and a pain intensity rating scale. These had been mostly completed appropriately and showed that patients had been asked about their levels of pain. Patients we spoke to confirmed they had been asked to describe their pain and felt they had been listened to.
- Patients could expect their pain management to be looked at by a number of clinicians who would coordinate an agreed approach to controlling their symptoms of pain.
- The Audit plan 2015-2016 included a planned review of how well the trust complied with the NICE Clinical Guidance 140 'Use of Opioids in Palliative Care'.

Nutrition and hydration

- We saw that people were being adequately hydrated and nutrition was given high importance, especially within the Specialist Palliative Care Team.
- Medical staff involved in the provision of end of life care were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person's life; this included the option of clinically assisted feeding.
- The dietician was involved in the assessment of patients where palliative care support was being considered. They undertook a comprehensive assessment and completed an individual nutritional support plan. This included guidance on Refeeding Syndrome where fluids and feeding was being reintroduced after a period in the community with minimal intake.
- We saw from nursing records that people who could not take oral fluids were given fluids by alternative routes and that they received regular mouth care. Patients who were unable to drink were offered sponges with water on them, to moisten their mouths and reduce the risk of oral thrush.
- One record showed that a patient became very distressed when the moistened sponge or small sips of water were offered. The nursing staff had discussed this with the patient's family and agreed to stop offering the fluids in this way. Records showed that petroleum jelly was applied to their lips to prevent them become sore and cracked. We visited this patient and saw they were comfortable and that their lips were smooth and sore free.
- A review of the patient's hydration requirements in the NCDAH audit scored 100% against the England average of 50%.

Patient outcomes

End of life care

- The trust had participated in national clinical audits they were eligible for including the 'Care of the dying audit' in 2013/14 and were gathering statistics towards the 2015 audit.
- Anticipatory medicines for patients nearing the end of their life were prescribed appropriately by medical teams. We also saw good documentation and conversions from oral to subcutaneous medications. Doctors were aware how to access guidance on intranet where there were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. These are medications that patients may need to make them more comfortable. One patient was very restless and the consultant had suggested the use of a mild tranquilizer to reduce the risk of them hurting themselves by hitting their arms against the bed rails or trying to climb out of bed in their confusion. It was felt that this medication would also reduce the risk of skin damage from shearing.
- Rapid discharge fast track care plans were in place following several national drivers to improve patient choice surrounding place of death (including DOH End of Life Strategy 2008), this trust established a Rapid Discharge Home Pathway for End of Life Care in 2012 – aiming to improve discharge arrangements and coordination with a range of community services, to enable more patients to die at home if this is their preferred choice. This was audited from the 18 August 2014-18 September 2015. The audit showed that 79% of patients died in their preferred place of care which was much better than the national average.
- All equipment required for in-patients and for patients discharged home was accessed via the trust's equipment library. Staff told us that the equipment library took responsibility to record, clean and service every piece of equipment loaned. Nursing staff from the Specialist Palliative Care team (SPCT) told us that this was a fantastic resource which helped to minimise delays for patients on rapid discharge care pathways.
- The Quality scorecard included in the Board meeting minutes dated March 2015 showed achievement of 94.4% episodes of harm free care against a target of 92%.
- Across the trust, 98% of patients and their relatives had a discussion with a healthcare professional regarding their recognition that the patient is dying. This was better than the England average of 75%.
- The chaplaincy service was on-call 24 hours a day and provided support for people regardless of whether they had a particular faith or no faith at all. For 70% of patients, an assessment of the spiritual needs of the patient and their nominated relatives or friends had taken place. The England average is 37%.
- Western Sussex Hospitals NHS Foundation Trust was one of 16 member trusts of NHS Quest. This meant they were able to access a range of additional benchmarking and peer review activities. NHS Quest is the first member-convened network for Foundation Trusts who wish to focus relentlessly on improving quality and safety. NHS Quest members work together, share challenges and design innovative solutions to provide the best care possible for patients.

Competent staff

- The Palliative Care CNS team were all trained in specialist palliative care. The consultants had also completed higher level specialist training in Palliative Medicine. This meant that there were high levels of expertise and good understanding of current issues within the team.
- The specialist palliative care team nurses told us that they currently received end of life learning, group supervision, annual appraisals and four-weekly external supervision from a psychologist. We saw documented evidence of this. Nurses told us that although they had great support from each other within the team having access to external supervision had made a positive impact on them.
- The SPCT ran a rolling 'End of life' education programme. The trainer teaches health care assistants (HCA's), student nurses and new doctors. Training took place on specific wards which enabled more staff to attend.
- The SPCT provided a green folder on each ward which contained the 'Guidance for care of patients in the last days of life' information, and contact numbers for the

team. The rationale was to facilitate dying with dignity, comfort for patient and provide carers with support. Nurses on the wards told us they found the folders extremely useful.

- All staff had training in equality and diversity as part of their induction. Guidance was available on wards, in the chapel/ multi faith room and on the intranet to support staff in providing care in accordance with peoples religious and cultural preferences.
- Staff at the trust could and did access the specialist palliative care training programmes at the local hospices.

Multidisciplinary working

- There was good multidisciplinary working across the end of life service. The SPCT had forged strong bonds with community nursing teams, the hospice and other local hospitals. This helped when arranging fast track discharges to the patients preferred place of death.
- In the National care of the Dying Audit the trust scored 100% on the multi-disciplinary team recognising that a patient is dying against the England average of 61%. Communication regarding the patient's plan of care for the dying phase scored 100% against the England average of 59%.
- Multi-disciplinary team (MDT) working was integral to the delivery of effective EOLC at Worthing hospital. The 39 patient records we reviewed showed us that ward areas had regular multi-disciplinary meetings to discuss and agree management plans for patients. There were entries by all members of the multidisciplinary team in patients' medical records. We also saw good evidence of leadership and challenge being provided by the consultants to junior doctors on the elderly care wards.
- Medical staff from the SPCT worked sessions at the local hospice and in the community. This allowed for better continuity of care and provided a more standardised model of care across the local healthcare economy. Similarly, clinical expertise from palliative medicine consultants at the hospices allowed for more seamless care between hospital, hospice and the community services at a strategic level, the EOLC Board had representation from many disciplines including the palliative care consultants and nurses, resuscitation officers, mortuary staff, HR and finance representation, paediatric staff, the organ donation co-ordinator and non-executive directors. Support for the group was also provided by the audit team and clinical effectiveness team. We saw the minutes of several EOLC Board monthly meetings that demonstrated attendance and showed dissemination of information across the hospital.
- We observed the level of 'buy in' to the end of life agenda from members of the wider multidisciplinary team at on our unannounced inspection at Worthing hospital. A patient had died during our time on the ward and was being cared for by two nurses when the family arrived. They were greeted warmly by a physiotherapist, who introduced herself, said she had cared for the patient whilst they were on the ward and offered condolences. She then walked with the family to the bedside and offered to stay with them for a while, which the family accepted.

Seven-day services

- Inpatients at Worthing Hospital had access to specialist palliative care input around the clock for seven days a week. NICE Quality Standard for End of Life Care for Adults (2012) statement 10 states that, "Service providers ensure that systems are in place (such as shift patterns and on-call rotas), to provide timely specialist palliative care and advice at any time of day and night for people approaching the end of life who may benefit from specialist input."
- Adequate medical and specialist nursing cover was available to provide a very good service level across all areas of the trust. The current arrangement with the local hospice allowed hospital staff to have access to specialist medical advice outside of normal working hours.
- At the time of our inspection, Worthing Hospital provided a five day service with 24 hour a day consultant on call cover.
- Funding had been agreed for the staffing complement to increase by an additional 2 WTE Clinical Nurse Specialist and increased consultant hours to cope with increased demand on the service and offer better availability of the face to face service to inpatients. The decision to increase the capacity of the team was based on a 130% increase in patient referrals over the preceding twelve months.

End of life care

- The SPCT staff told us that at the time of our inspection they were seeing 85% of patients within five days of referral, which they hoped would improve when the new appointments took up post.

Access to information

- All permanent staff had access to patient's records including the SPCT.
- Policies and guidance was readily available on the intranet.
- The SPCT were known to staff across the hospital who told us they were able to contact them for advice and guidance whenever they needed to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw clear information about the Mental Capacity Act 2005 (MCA) guidance on the trust's intranet at Worthing Hospital. Training records confirmed that staff were provided with training in the Mental Capacity Act 2005. Whilst most staff were well versed and had a good understanding of their responsibilities, a few were uncertain about the act.
- We examined 39 patient records which included DNACPR forms. In all but one case there was a recording of whether the person had capacity to consent. Where the person lacked capacity there was evidence in the notes that a proper assessment had taken place.
- There were two records that showed a junior doctors decision was challenged by a consultant and a reassessment had taken place.

Are end of life care services caring?

Outstanding ☆

People were truly respected and valued as individuals and were empowered as partners in their care. Palliative and end of life care services were delivered by exceptionally caring and compassionate staff. We observed that care was planned and delivered in a way that took the wishes of people into account. It was evident throughout our inspection how staff went the 'extra mile' to provide care for patients who were nearing the end of their life. Despite limited resources in some areas, the level of dedication was commented upon by patients and those close to them who consistently told us they could not fault the caring nature of the staff.

We saw that staff were committed to providing good care to people that focussed on meeting the wider needs of the dying rather than the purely physical. There was good recognition of the importance of family and friends as life ended. We were told lots of stories that demonstrated the compassion and kindness that pervaded the hospital, including weddings and reuniting elderly mothers with their babies that had died many years earlier.

Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. People thought that staff went the extra mile and that the care they received exceeded their expectations. We spoke with thirteen patients and thirty six people close to them about the care received at the end of a patient's life. All of the people we spoke with provided very positive comments about the care received from the Specialist Palliative Care Team (SPCT), the chaplaincy, bereavement office and the mortuary service. These teams were regarded as providing a service above what was expected of them to support and include families in the care provided. It was clear that there was a strong culture of person centred care for patients and those close to them.

We received far more written feedback than usual prior to the inspection. It was also overwhelmingly positive. People told us that they had been supported very well and that their loved ones had been very well cared for. Palliative and end of life care services were delivered by caring and compassionate staff on most wards. We observed that care was planned and delivered in a way that took the wishes of people into account. We saw evidence that the majority of staff were going the extra mile to provide care for patients who were nearing the end of their life. The level of care was obvious to friends, families and patients alike. Two people stopped us in a busy corridor to tell us how good the hospital and its staff were.

On site we spoke with seventeen patients and eighteen relatives about the care they received. All provided very positive comments about the care received from the Specialist Palliative Care Team.

Compassionate care

End of life care

- We spoke with 24 patients and 42 relatives during the inspection specifically about care received at the end of life. All people we spoke with told us that members of the palliative care team were caring and compassionate and did everything they could for their patients.
- Hospital staff demonstrated a strong commitment to empathy and enhancing the environment for dying patients and their relatives in busy hospital areas. We saw that families were encouraged to participate in care if they wished (e.g. mouth care). Staff supported relatives to stay overnight, if they wished by providing folding beds in side rooms or reclining chairs and blankets.
- On the unannounced visit we were present on a ward shortly after a patient had died and could see that the staff treated the deceased patient with dignity and respect. They ensured other patients were protected from the situation.
- The bereavement and chaplaincy services were available to support staff when a patient died. The staff counselling service was available throughout the trust. The multi and non- faith chapel was open to staff, patients and relatives where the chaplaincy was also happy to offer support. In traumatic cases the lead chaplain told us they would go and offer support to any person in any area required.
- One of the consultant paediatricians had developed an end of life care service to support families caring for a dying child. They were not paid for this aspect of their work and it was not part of their job description but having identified a need they provided a 24 hour a day seven day a week telephone advice line and undertook home visits during both day and night to ensure the child had good symptom control and that the family felt supported.
- We saw many examples of end of life compassionate care. Several separate members of staff talked to us about the chaplaincy services and told us how they had helped reunite an elderly, terminally ill patient with their baby that had died many years previously. The patient had asked the Patient Liaison service to find out where their baby that had died during childbirth at the hospital many years previously was buried. Records were searched but no clue found so PALS talked to the chaplain about it. The chaplain made contact and started searching in their own time, visiting local authority records departments, the registry office, local funeral directors and eventually located where the baby was buried in an unmarked grave. The chaplain escorted the patient to the grave and then provided ongoing support as they finally came to terms with losing their baby. The story spread and the chaplains have helped several other families who have 'lost' babies to be reunited.
- The mortuary staff went above and beyond to provide compassionate support to families who had lost loved ones. For example, by setting up the chapel of rest to make it look like a bedroom to reduce the levels of stress when viewing.
- We saw another situation on the Emergency Floor where a patient whose spouse had died the preceding day was allowed to remain in the room where she had last been with her husband. Other family members were allowed to remain with her and support her through this difficult time.
- Most people and families we spoke to told us that the care and they received was "fantastic" and that the nurses went "Above and beyond the call of duty to make people feel valued and respected".
- The NHS Friends and Family Test questionnaire for inpatients results were consistently above 90%. Worthing Hospital achieved 91% in 2013/14 and 92.1% in 2014/15. This is the percentage of patients who would recommend the inpatient services overall and is not specifically related to End of Life Care Services.

Understanding and involvement of patients and those close to them

- Patients, who were able, told us they felt involved in their care and treatment. Their families and carers told us they also felt involved. Family members told us that medical staff had fully explained the care and prognosis of their loved one. A patient told us "I have had everything explained to me and I know there is nothing more they can do. I told them I wanted to go home on Monday and its happening today. I am so relieved." Their family member told us the team had arranged the care package required to transfer their loved one home to their preferred place within three days.

End of life care

- Information was available for patients on the wards, bereavement office and chaplaincy. Although all the information leaflets we saw were only printed in English. The bereavement office staff told us they had access to language line and interpreters for interviews if they had notice to arrange.
- The trust had produced a Booklet called 'The End of Life and understanding the changes that occur.' It explained what happens to an individual when they are dying and how loved ones and staff might best support them.
- We observed one consultant coming in specially, from an external event, to speak with the family of a person who was dying. The staff had been concerned that the family really didn't understand what was happening and one member of the family had become very angry with staff. The consultant took the family member to a quiet area and spent over an hour with them, explaining everything repeatedly in great detail.

Emotional support

- Emotional support was evident on most wards throughout the inspection in both hospitals. One example was where the whole SPCT team, chaplaincy, bereavement office and mortuary had worked together to bring comforting information regarding a deceased relative who had passed away many years ago. Another account was where the mortuary staff had gone above and beyond to make a viewing possible for two family members who had passed away together.
- The emotional support provided by the SPCT, chaplaincy, and bereavement office and mortuary staff was outstanding. There were many examples seen where staff were offering emotional support. For example when relatives come to collect death certificates and want to view their loved one the bereavement office staff provide a free parking ticket, accompany the family to the chapel of rest and stays with them until they wish to leave. We heard many accounts of how all teams offering end of life care had pulled together to provide a first class service.
- The pastoral team were available to provide support for families and carers, including an on-call service out of hours. The team provided a dedicated service which supported people through the end of life process and recognised that they needed to support the emotional wellbeing of families after they had left the building.

Are end of life care services responsive?

Outstanding ☆

End of life care services were rated 'Outstanding' for responsive.

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. People's individual needs and preferences were central to the planning and delivery of services. The services were flexible, provided choice and ensured continuity of care.

All teams worked exceptionally hard to meet the needs of patients at the end of their life. There were some delays in discharges throughout the trust but these did not affect people receiving end of life care where the trust managed to support 79% of people to die in their preferred place of care. This was well above the national average and demonstrated the effectiveness of both the One Call, One team, initiative and the rapid Discharge team. The responsiveness was particularly outstanding because of the way services were joined up, built on each other and worked to deliver the 'Patient First' strategy. This could be demonstrated through the Emergency Floor where the oversight of the very aged and frail was managed to avoid them being cared for in hospital: It formed an integral part of the End of Life Care provision and contributed to people dying in their preferred place of care. People who were dying were recognised, their care needs identified and there was a rapid response from across the whole local healthcare economy.

The involvement of other organisations and the local community was integral to how services at the hospital were planned and ensured that services met people's needs. We saw evidence from data that fewer people died in hospital than the national average for all trusts. We also saw that a higher proportion of people had input from the Specialist Palliative Care Team than was the norm nationally.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included people who are in vulnerable circumstances or who had complex needs.

End of life care

The trust also responded well to changes in public perception and national guidance. It was able to demonstrate a flexibility of service provision that resulted in adaptations to ensure that practice was in line with current best practice guidance.

Service planning and delivery to meet the needs of local people

- The palliative care service was widely embedded in all clinical areas of the hospital. The SPCT took referrals mostly from GPs and urgent care services and acted and responded to new referrals in a timely fashion. The SPCT saw 95% of patients within 48 hours of referral, which was much better than the England average of 56%.
- The One Call, One team initiative was an effective multiagency provision that reduced unnecessary admission to hospital. It was based in the hospital and staff supported the programme that enabled more people to remain at home to die.
- The chair of the EOLC Board was a consultant surgeon who was also the Chief of Service (Core) and Director of Medical Education at the trust. This has raised the profile of EOLC across the trust and removed responsibility for good EOLC from the SPCT alone and made it the business of all staff.
- End of life care was a core component of the 'Western Sussex Hospitals' Quality Strategy 2015-18'. The document showed a commitment to strategic and operational planning to meet the needs of people at the end of their lives.
- The SPCT goal for 'Fast track' discharge planning was 24 hours. The effectiveness of this had been audited at Worthing Hospital. Most delays in rapid discharge had been due to lack of community resources. Staff from the SPCT told us that they had close working relationships with community teams across West Sussex and were aiming for a seamless transfer between services.
- A higher than average 79% of patients died in their preferred place of care, 25% of patients were discharged within the 48 hour time frame. The remaining 75% were delayed up to six days due to requiring nursing home assessment or packages of care, which was outside the immediate control of the trust.
- The paediatric team had created and end of life care pathway that was in use at a local children's hospice and allowed for seamless transfer of care from the hospital to the hospice or vice versa.

Meeting people's individual needs

- People of all faiths and those with no faith were catered for within the purpose built chapel and counselling rooms. Religious texts were available for Christians, Jewish, Hindu, Sikh and Muslim religions. The chaplaincy was Anglican, which reflected the beliefs of the predominant population. There were visiting clergy from other religions such as Roman Catholic priests who visited wards and offered support to Catholics.
- Across the trust we found considerable respect for the cultural, religious and spiritual preferences of patients. The chaplaincy service had 70 volunteers across both sites to help visit patients and offer Holy Communion to people who could not get to the chapel. All volunteers had a full employment check including disclosure and barring Service (DBS) to check suitability to work with vulnerable people, and undertook the trust induction programme for new staff. Holy Communion was available for both Anglican and Catholic patients.
- The chapel was made available every Friday to allow Muslim patients, staff and visitors a dedicated time for prayers. The local Imam came into the chapel to lead this. There was also a separate room available for Muslim prayers. This contained prayer mats and copies of the Quran. However, there was no ablution area for Muslims to wash themselves prior to prayer within the chapel. The lead chaplain told us that this was unavoidable due to the availability of space. Muslim people were either dry washing or washing prior to using the prayer room.
- There were not many side rooms or quiet rooms on the wards for breaking bad news. Staff told us they were doing their best to promote privacy and dignity wherever they could.
- Translation services were available 24 hours per day either through a telephone service or individual translators. There were many staff at the hospital who spoke the languages that were represented in the local communities (such as the Polish and Philippine communities) who could support patients by interpreting, when necessary.

End of life care

- The trust had introduced many initiatives as part of their work to implement 'Putting People First', the National Dementia Strategy. The Dementia Strategy supported staff to provide good care to people with dementia, many of whom were approaching the end of their life. There was a dementia lead nurse and link nurses on wards and in departments as well as specific resourcing such as a activity boxes and 'Twiddlemuffs'. Staff and families had access to specialist services and nurses trained in caring for people living with dementia and people with learning disabilities. All staff were offered "Sage and Thyme" courses (communication skills training for dealing with patients and families in distress).
- The Quality Scorecard in the Board minutes dated March 2015 showed that the trust beat all their own targets related to dementia care. This included 98.7% of patients identified as having dementia being referred to a specialist service against a target of 90%.
- We saw evidence of good discharge summaries with clear information for on-going care and transfer. This meant that the specific needs of people were made known to the staff taking over their care after discharge.
- Information for people their families and carers was available. We saw leaflets and booklets explaining symptoms and treatment options. The chaplaincy and bereavement service carried an assortment of information leaflets for example 'Help when someone dies in Hospital'.
- Facilities and guidance for staff on caring for people after their death according to their religious beliefs were available on the wards and in the mortuary. Staff were aware of the content of these guidelines.

Access and flow

- The trust had won a Dr Foster award for Better Safer care at weekends in May 2014.
- There were rapid discharge protocols and processes in place that were seen to be effective in getting people to their preferred place of care prior to their death. There was a system in place to identify these patients if they were re-admitted to hospital once an advance directive or end of life care pathway had been started.
- The SPCT goal for Fast track discharge was 24 hours but could take up to 7 days to complete where there were delays caused by a lack of local authority and community resources. Staff from the SPCT told us that they had close working relationships with community teams across West Sussex and were aiming for a seamless transfer between services. The relationship with the local hospices, which provided inpatient and community services, made communication and continuity of care easier. We did not see any evidence around delayed discharges beyond seven days for end of life care.
- There was very good communication between the community and the hospital to achieve home deaths. From February 2013 to January 2014 the trust SHMI showed that for non-elective patient admissions, the percentage of deaths occurring in hospital had fallen year on year for the past four years showing the effect of this communication and the trust's EOLC strategy. In 2011/12 the Trust's HSMR of 107.5 was ranked 112 of 141acute trusts (the 79th centile), whereas for the latest data (12 months to December 2014) the trust's HSMR of 92.6 is now ranked 60 of 141 (the 43rd centile).
- In England, hospital is the most common place of death with 52% of people dying in hospital against 80% of people stating that home was their preferred place of death. The trust provided sufficient support to allow 79% of patients to die in their preferred place of care.
- Patients were identified as needing end of life care by the consultants or members of the team that they were admitted under. Sometimes this was in the emergency department but, more usually after a full assessment of their condition. End of life patients could be admitted directly to the hospice via urgent care if that was felt more appropriate and agreed with the on-call palliative care consultant.
- The mortuary capacity was around 80% full most of the time. There were formal agreements with local funeral directors to support them with storage of the deceased during times of increased activity in the hospital. Good contingency and Business continuity plans were in place for situations where there might be a significantly increased number of deaths.
- End of life patients could be admitted directly to the hospice via ED, if that was felt more appropriate and agreed with the on-call palliative care consultant.

End of life care

- Good links with the local children's hospice allowed for the rapid transfer of dying children or babies to a less overtly clinical setting with good provision for their families. This meant the parents could spend time building memories and making the last few days and hours as good as possible.

Learning from complaints and concerns

- There were no unresolved complaints relating to EOLC. All people had access to the complaints procedure which was managed in line with the trust's policy. Information about complaints was displayed throughout the hospital.
- The Complaints office representative attended every EOLC Board meeting and provided a summary of complaints related to EOLC with an action plan that had been created to address shortfalls identified. Where there were concerns people were invited to meet with trust representatives to resolve the situation locally.
- There were very few complaints relating to end of life care. The minutes of the EOLC Board showed 2 complaints in August 2015 and 0 complaints in September 2015. The complaints related to uncertainty about visiting hours when someone was not formally identified as being in receipt of end of life care. Action was taken and the learning was disseminated through safety huddles.
- We saw a very good example of learning and changing practice when concerns were raised. Staff in the bereavement office told us that junior doctors had previously expressed concerns about the process and completion of death certificates. In response the bereavement office staff had devised a flow chat which included the entire process. This was laminated and made available for all new doctors to follow. We read a thank you card from one doctor which said, "I just loved coming to your office for a natter and would like to thank you for making a dastardly deed more bearable."
- The staff within the SPCT had devised a flow chart for ward nurses to follow to help them identify patients who may be requiring end of life care. The chart also gave easy to follow criteria of when to discuss and refer the patient to the Specialist Palliative Care Team. This flow chart was devised when it was recognised that ward nurses did not always identify and refer patients quickly.

Are end of life care services well-led?

Outstanding ☆

We rated End of Life Care at Worthing Hospital as 'Outstanding'.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. The trust were aware of what they did well and areas where there were still challenges to address. We saw a flexible and adaptable service that responded effectively to national initiatives and local demand in a timely manner. It would not be possible to deliver the quality of service we observed if leadership was ineffective.

We saw local and service leadership that encouraged collaborative working and sharing of ideas and information to the benefit of dying patients and their families. All the staff we spoke with were clear that they were led by people who were approachable and supportive; they could give clear examples to demonstrate this.

There was a clear governance structure across both hospitals for end of life care. There were two non-executive directors (NED's) with an end of life care interest on the trust executive committee. This meant that end of life care had two representatives at trust level to ensure strategic oversight linked to operational effectiveness. The two NEDS were members of the EOLC Board.

The End of Life Board met monthly and took responsibility for strategic development and monitoring of end of life care. The composition of the EOLC Board ensured that EOLC was seen as the responsibility of all staff working at the trust, not purely the responsibility of the SPCT. We saw excellent 'buy in' to the end of life care philosophy across the hospital.

There were high levels of staff satisfaction across the organisation. Staff were exceptionally proud of the organisation as a place to work and spoke highly of the culture and the high quality work they were part of. There were consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns. There was clear leadership across all areas we visited providing end of

life care. Larger numbers of staff met with the inspection team and told us they had very good managerial support and felt fully involved with decision making. The culture within the hospital was transparent and caring.

Vision and strategy for this service

- The palliative care team had a clear vision and strategy for the service: To provide a seven day service, to have a roaming nurse across both sites and an embedded consultant. Consultants were based at the hospices and covered the hospital from there, as required.
- There were two non-executive directors (NEDs) with end of life care interest on the trust executive committee. This meant that there were two people with end of life care interest at board level. The ends of life board meet monthly and took responsibility for strategic development and monitoring of end of life care.
- The trust had a Quality Strategy setting out priorities for 2015-18. The key goals were around reducing mortality and improving outcomes and safe and reliable care. The trust was implementing an End of Life Care Strategy aimed at improving the quality of care for patients and their families at the end of life, focused on the following priories:
- The possibility that a person may die within the next few days or hours is recognised and communicated clearly. Decisions are then made and actions taken in accordance with the persons needs and wishes and these are regularly reviewed.
- Sensitive communication takes place between staff and the dying person, and those identified as important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
- The needs of families and others identified as important to the dying person are explored, respected and met as far as possible.
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.
- As part of the Quality Strategy the trust had identified several key work streams to ensure the successful implementation of the strategy. These included a re-admission avoidance project, an electronic end of life register, increased palliative care presence on wards/ departments, seven day a week palliative care team support and an enhanced palliative care education programme.

Governance, risk management and quality measurement

- We saw a clear governance structure from ward and department level to the Board. Ward staff were represented on the EOLC Board and could also discuss issues with individuals from the SPCT. The SPCT Board fed upwards and received information from both the Quality Board and the Divisional Boards. In turn these reported to the Trust Executive Committee and to the Board.
- The End of Life Board met monthly and took responsibility for strategic development and monitoring of EOL Care. The palliative care team took the lead on end of life care and rapid discharge home to die pathways.
- The SPCT nurses took responsibility for oversight of the service and had a real grasp of how the trust was performing, what could be improved and what the barriers to improvement were.
- There were risk registers for the mortuary and for the palliative care service. The risks of not providing seven day services, and the environment outside the mortuary were evident on the register.
- There was strong monitoring of the trust incident reporting processes. There was an embedded culture of reporting and learning from mistakes.
- The Audit Plan 2015-2016 showed that audit of EOLC issues were planned for the service, going forward and showed pro-active rather than reactive leadership of the service.
- Western Sussex Hospitals NHS Foundation Trust is one of 16 member trust of NHS Quest. NHS QUEST is a member-convened network for Foundation Trusts who wish to focus relentlessly on improving quality and safety. NHS QUEST members work together, share challenges and design innovative solutions to provide the best care possible for patients.

End of life care

- The trust had a quality strategy setting out priorities for 2015-18 'Best care every time'. The key goals are reducing mortality and improving outcomes, safe and reliable care.

Leadership of service

- We found that local leadership of the palliative care, bereavement, chaplaincy and the mortuary service to be extremely good with managerial support at all levels. We also saw good leadership for the service at divisional trust senior management level for the service.
- There was good communication between local service leadership and divisional management who acted on requests by the service to drive improvement. Staff reported positive and approachable leaders who supported them to provide the best possible care.
- The trust scored slightly better than the England average for the percentage of staff who felt there was good communication with senior managers in the most recent NHS Staff Survey. The proportion was increased from the previous survey. Staff also reported good levels of support from their immediate managers.
- The nurses from the SPCT took responsibility and felt ownership of their service. They saw it as their responsibility to share best practice and to support staff caring for dying patients. They had a good grasp of how well their service was performing and knew what they wanted to do to improve the service further.
- Ward staff felt the SCPT nurses were visible and provided good levels of education and support.
- The number of staff who volunteered to attend focus groups and to meet with the inspection team was unprecedented. The feedback was almost entirely positive about trust senior and middle managers.
- The overall staff sickness rate across the trust had been consistently better than the England average for the past four years.

Culture within the service

- There was a very positive culture across the site amongst those staff providing end of life care. Most staff spoken to told us they felt valued and supported as part of the team and their line managers who had an open door policy. Two staff members came to speak to us together and said, “Is it really odd to enjoy end of life care? We do, we think it is a real privilege to help someone at the very end of their days.”
- We noticed staff smiled a lot, at visitors, at patients, at other staff. Everywhere we went staff smiled and said hello. They offered help even when it wasn’t asked for, stopping to offer directions to lost visitors and holding door open for those less able.
- The specialist palliative care team had only been working together for three months and told us they felt enthusiastic about their new roles and about providing the best possible care to their patients.
- Locally, the passion and dedication towards delivering good care at the end of a patient’s life was clear to see throughout our inspection. The palliative care, bereavement, chaplaincy and mortuary teams were committed to delivering the best service possible within their available resources.
- The staff within the mortuary, chaplaincy service and palliative care team were very open and were happy to raise concerns and believed the culture was open and learning could take place.
- Staff at these groups and those we spoke to individually said they would be very happy to have relatives cared for at Worthing hospital. Some talked to us about having relatives who had been cared for at the end of their life. One trust ambassador said. “Mum got fantastic care, I tell everyone if you want your mum looked after like you would do yourself then here is the place. I didn’t work here then but afterwards I wanted to give something back so I changed jobs and here I am. I love it.”

Public engagement

- Relatives were wholly involved in their loved ones end of life journey and were consulted every step of the way. One relative told us “I have been here two days now; I am not made to feel in the way or told to go home. The staff just understand I haven’t got long left with dad and don’t want to waste it. It’s not that I don’t trust them it’s that I want to be able to look after him myself and they let me do that.”
- Friends and family members accessed the bereavement support service via the bereavement office at the hospital. Bereavement counselling services could be

accessed through the bereavement office or with outside agencies as preferred. One of the bereavement office staff told us they tell relatives "It's the last nice thing we can do for you before you leave this hospital." This summed up the general culture of the service.

- The trust had installed a sculpture in the reception area of the hospital, "The gift". This was a celebration and recognition of the gift given to patients by people who had donated organs and tissue for transplant. A service of thanksgiving for all organ and tissue donors and their families was held at Chichester Cathedral.
- Friends and family members can access the bereavement support service via the bereavement office, either at the hospital or outside as preferred.

Staff engagement

- There was effective engagement with the staff in the trust on decisions about end of life care. The trusts two non-executive directors (NEDs) with end of life interest who sit on the board helped raise the profile of the service at trust level.
- The organ transplant co-ordinator told us there was good communication and staff engagement at both Worthing and St Richards's Hospitals.

Innovation, improvement and sustainability

- The external specialist counselling service for the specialist palliative care team staff is an innovation because it offers a level of support to staff without delays, to provide them with the support they require.
- The palliative care team had a clear vision and strategy for the sustainability of the service. To provide a seven day service, to have a roaming nurse across both sites and an embedded consultant. Both consultants were based at the two local hospices.
- There was evidence of the trust embracing EOLC for non-malignant palliative care patients and working with a range of key stakeholders to develop excellent EOLC for all.
- The trust, in discussion with the palliative care team had developed a clear vision and strategy for the sustainability of the service. This was reflected in the Quality Strategy 2015-2018 which provided details of how the strategy was to be implemented.
- One of the consultant paediatricians had developed an end of life care service to support families caring for a dying child. They were not paid for this aspect of their work and it was not part of their job description but having identified a need they provided a 24 hour a day seven day a week telephone advice line and undertook home visits during both day and night to ensure the child had good symptom control and that the family felt supported.
- Shared end of life care pathway for children enabled seamless transfer of care between the children's hospice and the hospital.
- The trust was doing some very good work for patients living with dementia across all services.

Outpatients and diagnostic imaging

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

Information about the service

Worthing Hospital offered outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required. The hospital had medical and surgical specialty clinics, as well as paediatric and obstetric clinics. In the last year 344,036 patients attended the hospital for outpatient services.

The diagnostic imaging department carried out routine x-rays, magnetic-resonance imaging (MRI), computerised tomography (CT), mammography and ultrasound examinations.

During the inspection we spoke with 68 members of staff, who were working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, ward clerks, and housekeeping and domestic staff. We also spoke with 7 patients and their relatives. We held focus groups where staff could talk to inspectors and share their experiences of working at the hospital.

Summary of findings

Overall we found outpatients and diagnostic imaging to be 'Good'.

Staff contributed positively towards patient care and were proud of the services they provided. They treated patients with kindness, dignity and respect.

Medical record management enabled clinicians in outpatients to have access to patients' records more than 99% of the time. The outpatient and radiology departments followed best practise guidelines and there were regular audits undertaken to maintain quality.

All areas we visited were clean, tidy and uncluttered. Infection control practises were generally within guidelines, but some cleaning checklists were incomplete.

Staff felt that managers were approachable and kept them informed of developments within the trust.

However, the trust had consistently not met government targets in relation to referral to treatment times since 2013 for adults and from March 2015 for children's services.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because;

There was a good incident reporting culture throughout the hospital. Staff could give examples of changes made as a result of reporting incidents. Safety huddles discussed incidents each morning.

Medicines were managed in line with national guidance and were stored in accordance with manufacturers instructions.

The diagnostic imaging department had policies and procedures in place to protect patients from harm. The department worked within national guidelines.

On the whole, environment and equipment was clean and well maintained. However, infection control practices were not being consistently demonstrated. Although clinical areas appeared clean some cleaning checklists were incomplete.

Incidents

- Staff reported incidents using an electronic reporting system. Feedback was automatically received from this system. Staff gave us examples of feedback from a variety of incidents.
- Outpatient staff discussed incidents at communication meetings each morning. The audiology department recorded these meetings and we saw copies of these minutes. Senior staff reviewed information about reported incidents at the governance meetings. Managers passed on any lessons learned at governance meetings back to their teams.
- In the last calendar year, the diagnostic imaging department reported two incidents to the Care Quality Commission in line with ionising radiation (medical exposure) regulations (IR (ME) R 2000). Staff dealt with the incidents in an appropriate manner and gave patients an explanation of what had happened. In addition to this, diagnostic imaging staff reported a variety of incidents on a regular basis.
- Knowledge about duty of candour was part of the induction process and was included in mandatory training . Details of it appeared in the trust's newsletter, which we saw. Staff we spoke with described duty of candour with confidence.

Cleanliness, infection control and hygiene

- All areas we visited were tidy, clean and uncluttered. Disposable curtains hung around examination beds. They were clean, free of dust, and labelled and dated. The dates were within six months of the inspection. An infection control audit of five outpatient areas in the hospital in July 2015 scored above the target score of 85% for cleanliness.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and the Health and Safety at work regulations.
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed and by who. Temporary closure mechanisms were engaged.
- Hand gel was available at the main reception to the hospital but not in all outpatient waiting areas. There was a hand washing basin in every room we saw and guidance on 'Five steps to hand hygiene' was on soap dispensers. This was in line with World Health Organisation (WHO) advice. We observed a majority of staff using the WHO five steps to hand hygiene, but we did not see staff using hand gel regularly entering and leaving the department.
- We saw staff in clean uniforms and bare below the elbow. The hand hygiene audit score for the last month was 100%, which was better than the target score of 85%. We were unable to see staff hand washing between patients, as clinic room doors were shut when patients attended. Personal protective equipment was available in areas we visited and we saw staff using gloves and aprons.

Outpatients and diagnostic imaging

- Equipment was cleaned between each patient and green 'I am clean' stickers applied to indicate it had been cleaned. Equipment we looked at had 'I am clean' stickers on, indicating it was clean.
- Equipment that required sterilisation was marked with a blue sticker when sterilised with the date on. We saw blue stickers on equipment indicating it had been sterilised.
- Staff changed containers for the portable suction machine daily. Any used containers were stored in a dedicated area and returned to the outpatient department for disposal. Equipment used to examine ears was single use only, which was in line with good infection control practices.
- In the diagnostic imaging department staff cleaned equipment daily and we saw completed checklists to confirm this had been done.

Environment and equipment

- The outpatient area had separate clinic areas, with dedicated waiting areas for each clinic. Seating was made of wipe clean fabric.
- Staff and patients undertook regular assessments of the clinical and waiting areas. We saw results of these assessments and action plans arising from them. This indicated all areas were being monitored for overall appearance, privacy and dignity.
- Equipment was maintained regularly with a service contract. We saw spread sheets of equipment maintained under this contract, which was in accordance with the trust's medical devices policy.
- The resuscitation trolley in outpatients had equipment for adults and children. It was a sealed unit and checked daily by two members of staff. The resuscitation trolley in radiology had weekly checks in line with the trust's policy.
- In radiology, equipment service folders were in every room. All equipment was regularly serviced. We saw an annual quality test of diagnostic imaging equipment occurred each year. In addition to this a radiation protection committee reported annually on the quality of radiology equipment. These mandatory checks were based on the ionising regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R 2000).
- Lead aprons were available in all areas of diagnostic imaging for children and adults. Regular checks occurred of the effectiveness of their protection. We saw spreadsheets which showed checks occurred regularly and that equipment provided adequate protection.

Medicines

- We saw medicines stored in outpatients in a locked cupboard in a locked room and in line with instructions on their labels. Only qualified staff held keys to the drug cupboards. This was in line with National Institute for Health and Care Excellence NICE guidelines MPG2. Staff stored medical gases securely and we saw staff checked the oxygen cylinder daily, to ensure it was always ready for use.
- Drugs we saw were in date on the whole. However, one had expired in November 2015 and 3 were due to expire in two weeks. There were no written records of drug stocks. This indicated stocks of drugs were not being regularly monitored.
- Staff checked drug fridge temperatures daily. We saw complete checklists and all temperatures were within 3-5 degrees centigrade. This gave assurance that processes were in place to manage the appropriate storage of drugs.
- Prescription pads were checked in and out as per the trust protocol and we saw staff following the process. This demonstrated safe and secure management of prescription pads.

Records

- At Worthing (and Southlands) Hospital the medical records department had on average 32 380 requests each month. The department consistently made more than 99% of records available each month for a 12 month period. Staff told us medical records were consistently available for clinics.
- Medical records could be obtained at short notice by tracking them around the hospital. Porters delivered records to clinics the night before for morning clinics

and were stored in a locked room overnight. Records would be delivered by lunchtime for afternoon clinics. At the end of clinics, staff put records into a plastic box, which was sealed and returned to medical records.

- An electronic tracking system helped staff to see where records were in the hospital. If the location of records did not match with the tracking system an incident form was completed.
- At the time of our inspection when clinics ran, staff kept records in a corridor in outpatients under constant supervision. The trust planned to have lockable trollies available in the outpatient areas. We saw records were stored face down and a list of patients in clinic was covered to maintain patient confidentiality.

Safeguarding

- All staff we spoke to in outpatients demonstrated a good awareness of what to do if they had safeguarding concerns and who to contact. This was supported by small laminated cards which described the process of making a safeguarding alert. Staff demonstrated good knowledge of how to assess the ability of children to make judgements about their own care. They gave examples of how various forms of neglect could be identified. 99% of staff had attended children safeguarding training in the past year. 94% of staff had attended vulnerable adult training in the past year.
- In diagnostic imaging staff told us they had safeguarding children training to level one. Children attended the department for a variety of tests. This was not in line with the Safeguarding Vulnerable Groups Act 2010 or the Royal College of Paediatric Child Health guidance, 2010. This required staff interacting with children to attend level three safeguarding training.

Mandatory training

- Nursing staff told us they could access mandatory training and were supported to do so. We received data which indicated 93% of outpatient staff had attended mandatory training in the last year. This was better than the trust target score of 90%.
- Radiology staff had attended mandatory training regularly. 91.5% had attended mandatory training in the past year. This was better than the trust's target score of 90%.

Assessing and responding to patient risk

- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas we visited and signed by all members of staff. Radiology staff had a clear understanding of protocols and policies. Protocols and policies were stored in coloured folders in each room.
- We observed good radiation compliance in line with policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. We saw radiographers referring to the IR(ME)R regulations for a patient's examination. A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with IR(ME)R 2000.
- All staff in diagnostic imaging carried a 'pause and check' card at all time. This reminded them to carry out checks to ensure the right patient had the right diagnostic test.
- The CT scanner room could only be accessed with a swipe card. Only authorised staff had a swipe card to gain access. A security code was needed to gain access to the MRI department , which was only given to authorised staff.
- The booking centre had good processes and practices in place to ensure patients could not be lost in the system. Paper referrals received into the hub were scanned onto a computer system, then filed. The referral was entered onto the administrative system the same day. The computer system automatically sent a letter to patients informing them their referral had been received. Staff at the booking centre checked referrals daily and gave appointments accordingly.
- We saw warning lights and signs indicating rooms were controlled areas in the diagnostic imaging department. This prevented entry to areas where people may be at risk of radiation.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging departments in line with best practice.

Staffing

Outpatients and diagnostic imaging

- At least one trained and one untrained nurse staffed the outpatient department during clinic opening times. The department did not use agency staff. We saw records that confirmed no agency staff were used. The department used their own staff as bank if they needed additional staff. We reviewed staffing data which indicated that the appropriate number of nursing staff were available for the outpatient departments for through May, June, July and August.
- Radiologists were available between 9am to 11am in the morning and 1pm to 3pm in the afternoon to discuss patients and their results with junior doctors. A radiologist was available through the day every day to provide reports. In addition to this a radiologist was available every day until 9pm in the evening.
- An on call system operated in the diagnostic imaging department. A process was in place to change this to a shift system. Managers had given staff the opportunity to set up a working party to establish how this could be achieved.
- In phlebotomy there had been three band six vacancies for 12 months and one band six vacancy. Staff told us there was a reliance on goodwill for them to work nights and this was impacting on their welfare.

Major incident awareness and training

- Staff could describe what their role would be in the event of a major incident. This was in line with trust policy. They showed us where they could access information on what to do. Staff told us they had practised for emergencies in the past.

Are outpatient and diagnostic imaging services effective?

Evidence based care followed guidelines and legislation and staff were appropriately qualified and competent to do their jobs. We found that there was collaborative team working in clinics.

There was a programme of audit and the provider used the outcomes of audit to improve the quality of services.

Practice complied with the requirements of the Mental Capacity Act 2005.

Evidence-based care and treatment

- We saw staff completed a variety of audits regularly in outpatients and radiology. They checked environment, infection control . They demonstrated compliance with NICE quality standard (QS61), statements two and three. In diagnostic imaging assessment of the quality in diagnostic tests is a requirement of ionising regulations 1999 and the IR(ME)R 2000.
- A quality team monitored mammographer's work every month. This demonstrated the department met national standards for image quality.
- The audiology department had accreditation with the United Kingdom Accreditation Service. This provided independent assurance that standards were being met in this area.

Pain relief

- If patients required pain relief, nursing staff could give paracetomol. Patients were sent to pharmacy if anything stronger was required.

Competent staff

- Staff told us that additional staff were available during the induction process so that sufficient time was allocated to get to know the area they were working in. They were moved through different clinical areas regularly to maintain their competency in a variety of skills. We saw completed competencies for phlebotomy staff and in radiology.
- In radiology, there were several stages to gaining competencies in different skills. Competency certificates were kept in individual staff folders. We saw folders with completed competencies in.
- In radiology, in compliance with IR(ME)R regulations, certificates were held for those staff in the hospital who were able to refer patients for diagnostic imaging tests. We saw copies of these. This gave assurance that only those qualified to request a diagnostic examination were able to do so.
- We saw that all employed radiology staff were registered with the Health Care Professions Council (HCPC) . Managers checked the registration of their nursing and health care professions staff regularly. We saw electronic records to confirm this.

Outpatients and diagnostic imaging

- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the nursing and midwifery council (NMC).
- Staff felt that appraisals were a useful process and development was positively encouraged. 91% of all outpatient staff had an appraisal within the last year, this was better than the trust target of 90%.

Multidisciplinary working

- Staff told us they felt well supported by other staff groups. Learning was shared between different staff groups at regular teaching sessions. Staff from different professional groups told us they had attended and benefitted from this training.
- There was good communication between staff in the booking centre and care group managers, who could be contacted via phone or email if queries arose. We saw evidence of email communications between staff members.
- Therapy staff shared learning and had joint teaching sessions. Staff from several professions told us they had attended and benefitted from these sessions.

Seven-day services

- Radiology consultants worked seven days a week. The diagnostic imaging department provided a seven day a week, on call service.
- Some outpatient clinics ran at the weekends. In the past year 1,727 clinics ran at weekends.

Access to information

- Staff had access to full medical records more than 99% of the time in the last 12 months. We saw performance management data which confirmed this. Staff told us they had no difficulty obtaining or locating records.
- A patient archiving computer system (PACS) was used for the storage of diagnostic imaging tests. The results of radiology examinations were available on a secure computer system. Staff had individual pass codes to log on to the system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of how to gain consent from patients .
- 94% of staff attended training in the requirements of the Mental Capacity Act 2005. Staff could describe how to assess a patients understanding of their treatment and investigations. Dementia champions were available around the trust if any more assistance was required to ensure individuals patients needs were met.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as 'Good' because;

Feedback from patients and those close to them was positive about the way they were treated. Staff treated patients with kindness and respect. We saw staff had processes in place to respond to patients individual and emotional needs. They supported each other and provided individualised care to patients.

Compassionate care

- In the most recent Friends and family test (October 2915), 90% of patients would recommend the outpatients department, which is broadly in line with the national average of 92%.
- However, patients we spoke with would not go to any other hospital. They told us they could not wish for better care.
- We observed staff dealing with patients in a kind and courteous manner.
- Patients we spoke with felt they had been treated with dignity and respect. They told us staff were always friendly and professional. They reported staff went the extra mile for patients and gave examples of giving extra assistance to those who needed it. We saw copies of thank you letters to support this.
- The reception areas had barriers and signs asking patients to remain at a respectful distance, when others booked in. This allowed patients to have confidentiality when giving personal details.

Outpatients and diagnostic imaging

- In outpatients, there were individual clinic rooms, with signs on doors to provide privacy for patients. In some areas consultants told us they always had staff in attendance who could chaperone, in line with the trust's policy.
- There were no separate waiting or changing areas for male and female patients in the diagnostic imaging waiting areas. The department did not run male or female only clinics, to maintain dignity or respect.

Understanding and involvement of patients and those close to them

- The phlebotomy department team had developed 'Harvey's Gang'. This was a team approach to dealing with children diagnosed with blood disorders. The team welcomed children with blood disorders to the department. Each child was given a laboratory coat, a certificate and a goody bag and shown around the department to increase understanding of what happened when blood was taken. Improvements to the service were continually being made. For example as part of a child's ongoing treatment, blood was required to be taken regularly and this process often made them tired and listless. The phlebotomy team had discussed with families the best time to perform this procedure. The time was changed to better fit in with family life and school.
- In the audiology department staff provided patients, at the end of their life, with hearing aids. This helped these patients hear friends and relatives, when communication became difficult for them.

Emotional support

- The cardiac rehabilitation team provided emotional support to attendees from patient volunteers who had accessed the group in the past. The team operated a 'buddy' system. Patients were paired up who had experienced similar symptoms.
- The breast unit had counselling rooms and there was a separate area for men and women. Emotional support was provided by specially trained nursing staff.
- An audiology staff member won a national award for the support she provided to a family with a child suffering from tinnitus.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because;

The trust had consistently not met the referral to treatment time standard or England average for the past two years. In histopathology the length of time it took to provide a result for some tests had worsened over a five month period.

However, the trust consistently met its cancer waiting times. The diagnostic imaging department was providing access to tests and results in a timely manner. The hospital provided one stop clinics for several specialities which reduced the number of appointments a patient needed.

Service planning and delivery to meet the needs of local people

- The phlebotomy department had a walk-in ticketing system and patients were seen in order of arrival. Patients were not informed of any delays or the reasons for them. We were told that on average the wait was half an hour. There was insufficient seating for patients to wait and we saw some patients had to stand whilst waiting. There was no provision for less mobile patients. The trust had not carried out any disability access audits in this department.
- In order to meet demand 1,727 clinics ran at the weekends over the past year. In addition to this, 1,837 clinics ran after 5pm on weekdays. This enabled patients to access appointments at times suitable for them.
- In radiology there was a walk in service for patients referred from their GP requiring an x-ray. This operated between 8am and 6pm, five days a week. Reception staff advised patients of the length of wait when they booked in. We observed staff doing this.
- The audiology department was open from 8am to 6pm five days a week. Over the Christmas period staff had put a plan in place to ensure all patients who needed a hearing aid got one. We saw a copy of this plan.

Outpatients and diagnostic imaging

- In response to feedback from patients in the audiology department bought a television for the waiting area. The television showed educational programmes and we saw a program about hearing aids and balance being shown.
- We saw a variety of information leaflets on display in corridors and waiting areas which could be accessed by patients. We saw leaflets in an 'easy to read' format were readily available.
- Telephone advice was available to physiotherapy patients. Some outpatient clinics also offered telephone advice to patients following their clinic visit.
- The cardiac rehabilitation service offered advice and exercise classes for patients who had experienced heart problems. They offered attendance to their classes at either Worthing or Southlands Hospitals. If patients had difficulty attending either site a member of the team would visit them at home. A comprehensive, easy to understand booklet was given to each patient who attended. Additional advice was available via telephone. The service offered an open invite to patients up to a year after their initial referral.
- The diagnostic imaging department sent out information leaflets with patient appointments. The leaflets gave a clear explanation of what to expect at the appointment. If a special preparation was required prior to the examination, this was highlighted on the front of the leaflet. We saw many leaflets were available.

Access and flow

- Non-admitted pathways are waiting times for patients whose treatment started during the month and did not involve admission to hospital. Operational standards are that 95% of non-admitted pathways should start consultant led treatment within 18 weeks of referral. The non admitted referral to treatment times (RTT) for this hospital from December 2013 was consistently worse than the England average and the standard of 95%.
- Since March 2015 the non admitted referral to treatment times for children's services were below the standard of 95%. There was a decline in compliance and in October 2015 was at 70%.
- In the last calendar year 15% of appointments were cancelled by the hospital. This meant 51,605 patients had their appointment cancelled, on average 4,300 patients each month.
- Clinic delays were not routinely recorded or monitored. A record of a late appointment would be made in a patients medical notes. Clinic overruns were monitored internally and this information was given to an operational manager. We saw data which indicated 84% of patients were seen within 30 minutes of their clinic appointment. 12% waited between 30 minutes and hour. 4% of patients waited more than one hour for their appointment.
- Over a 12 month period the trust performed mainly above the England average of 95% and above the standard of 93% for two week urgent GP referrals. 99% of patients waited less than 31 days from referral to first treatment. This was better than the England average of around 98% and standard of 96%. 94% of patients waited less than 62 days for their first treatment for cancer. This was above the England standard of 85% and England average of 84%.
- The booking centre staff scanned all referrals the same day they came into the department. All cancer referrals received a specific code in order to identify them quickly on the computer system, which we saw in action. The waiting list team dealt with these referrals as a priority and they showed us the process in detail. Cancer patients were offered an appointment straight away in accordance with the trust's policy. All other referrals were taken daily to the different speciality teams to be graded into different levels of priority. When this had been done, the referrals were returned to the booking centre so that appointments could be offered.
- The target time for the referrals to be graded was five working days. The length of time it took to grade referrals was checked at random. In May 2015, across all specialities, out of 43 occasions, the target time was achieved twice. The longest time it took to grade referrals was 65 days. This indicated the five day target time to grade referrals was not being met and impacted on the time from referral to treatment. There was a considerable difference between the time it took different specialties to grade. Minutes of weekly meetings we reviewed indicated that delays in grading was an ongoing problem.
- Over a six month period (May to October 2015) the histopathology department on average provided results for 85% of all specimens within seven days. On average 87% of bowel screening results were available in seven

days. For specimens where a piece of tissue had been removed to provide a diagnosis, an average 70% of the results were available within seven days. Over a six month period (May to October) the amount of time taken to provide a result had reduced from 84% to 51% within seven days. The number of specimens received had increased from 601 to 1,613 during the same period.

- When we inspected the hospital there was no waiting time for an X-ray. 65% of X-rays of inpatients or from the emergency department were reported on in five days or less. 67% of x-rays of patients referred from GP's were reported on in five days or less. On average 95% of outpatient x-rays received a report within 13 days.
- At the time of inspection the waiting time for a CT scan was five weeks. 96% of scans for emergency department and inpatients were reported on the same day. The remaining 4% were reported on in a day or less. On average routine scans were reported on in seven days. This meant that patients were getting their x-rays and scans and their results in a timely manner.
- During our inspection, the waiting time for MRI scans was seven weeks. 94% of scans for patients in the hospital or emergency department were reported on in less than a day. On average 95% of routine scans were reported on in 12 days. This meant patients were receiving a result of their investigation in a timely manner.
- The waiting time for an ultrasound scan was five weeks. 99% of patients in the hospital or emergency department had their scan reported on in one day or less. 93% of routine outpatient scans were reported on in five days or less. On average 95% of scans were reported on in 10 days, which indicated patients received a result of their investigation in a timely manner.

Meeting people's individual needs

- We saw pictorial signs around the hospital. This enabled patients with dementia or learning difficulties to find their way around the hospital.
- There was a liaison nurse for patients with learning disabilities based at the hospital. They supported patients, and staff and ensured information about a patients preferences were adhered to.
- Patient information leaflets were available in formats suitable for patients with learning disabilities. We saw leaflets in 'easy to read' format were readily available. Staff told us they had visited one patient at home as the patient found attending hospital too distressing.
- Staff used 'This is me' as part of the referral process. 'This is me' is a document produced by the Alzheimer's Society and widely used nationally. It enables people with dementia to tell staff about their needs, preferences, likes, dislikes and interests.
- A lift could be used to transport disabled patients to different floors of the hospital. Staff told us if the lift broke down, they had to take patients to different levels using a service lift located in the kitchen. Patients told us they had difficulty finding disabled parking spaces at the hospital. The trust did not routinely carry out disability access audits which meant they did not regularly monitor the accessibility of the hospital for disabled patients.
- There was tea and coffee available in some patient waiting areas. Volunteers made drinks for waiting patients. Seats of different heights were available. Waiting areas suitable for children had toys available.
- We saw a variety of information leaflets on display in corridors and waiting areas which could be accessed by patients. In the breast clinic we saw information aimed at specific client groups.
- Telephone advice was available to physiotherapy patients. Some outpatient clinics also offered telephone advice to patients following their clinic visit.
- The cardiac rehabilitation service offered advice and exercise classes for patients who had experienced heart problems. They offered attendance to their classes at either Worthing or Southlands Hospitals. If patients had difficulty attending either site a member of the team would visit them at home. A comprehensive, easy to understand booklet was given to each patient who attended. Additional advice was available via telephone. The service offered an open invite to patients up to a year after their initial referral.
- The diagnostic imaging department sent out information leaflets with patient appointments. The

leaflets gave a clear explanation of what to expect at the appointment. If a special preparation was required prior to the examination, this was highlighted on the front of the leaflet.

- Staff told us patient leaflets were not available in other languages in outpatients, but they could be accessed in radiology. If required, a translation service was available on the phone via dedicated line.
- In the breast clinic we saw information aimed at specific client groups.

Learning from complaints and concerns

- Leaflets informing patients how to make complaints were available in waiting areas. Staff told us they felt able to handle complaints and preferred to do so at a local level to defuse the situation.
- Staff told us they received feedback about complaints via the computer system and their managers. The staff could not give us any examples of changes made to service delivery as a consequence of learning from complaints.
- In the last calendar year 10% of all complaints made to the trust were about the outpatient department. Of the 53 complaints made to this hospital 30% were in relation to appointment delays and clinic cancellations.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because;

Staff engagement was good across all staff levels and there was a positive culture of team working within outpatients and radiology departments.

Staff felt involved in decision making and were aware of developments throughout the trust. The senior management team were approachable to staff at all levels.

Vision and strategy for this service

- Staff had good awareness and knowledge of the vision for the hospital
- In outpatients, managers had worked with an external company to identify areas of improvement. An action plan had been developed to deliver these suggested improvements.
- The audiology department had plans in place to gain accreditation for a children's service and a balance service.

Governance, risk management and quality measurement

- Clinical staff oversaw the management of referrals to outpatients and radiology, both urgent and non-urgent. There were many failsafes in place to ensure that patients did not get lost in the system. The booking centre staff alerted care group managers if issues arose. Booking centre staff worked with care group managers to assess and deliver outpatient services.
- The diagnostic imaging department was following policies and procedures in accordance with ionising radiation (medical exposure) regulations (IR(ME)R). This was overseen by a radiation protection committee and advisor. There were twice monthly clinical governance meetings where incidents, risks and complaints were discussed. We saw minutes of these meetings.
- A divisional clinical governance review meeting occurred every three months. Minutes from these meetings were available for inspection and we noted that all risks, incidents and complaints were discussed. We saw action plans arising from these meetings.
- Meetings to discuss and manage the referral to treatment times for medical and surgical divisions occurred every week. They involved clinical oversight of long waiting patients, which included an action plan for each patient . This mitigated risk to long waiting patients. We saw minutes of these meetings and action points arising from these.
- There were a variety of audits on-going in the outpatients and diagnostic imaging departments. They continually measured the quality of reporting, environment and we saw action plans that arose from these.
- The management teams met weekly to discuss waiting times. We saw minutes of these meetings.

Outpatients and diagnostic imaging

- The recent introduction of daily safety huddles in each area was welcomed by all staff we spoke with. In diagnostic imaging they updated staff with weekly emails.

Leadership of service

- Staff felt their managers were approachable and they could discuss any issues with them. They were aware of who the senior managers were and the changes ongoing in the hospital. The senior management team were visible to staff on the floor and were contactable if issues arose.
- Regular information was shared by managers with newsletters, daily huddles and emails.
- Audiology staff reported leadership of their department was outstanding. They felt well supported in planning for the future and their own development.
- Staff felt a redesign of pathology services had been poorly managed in the initial stages and were concerned about job security. However, lessons had been learned and staff were reassured that no job was under threat. The redesign had meant that roles were to be used to support training and service development. Staff now worked across the different trust sites to ensure continuity and timely reporting.
- We were told of an example where there had been significant areas of conflict within a team. A common ground had been established and poor behaviours had not been tolerated. This showed that there was active management of challenging situations to ensure resolution.

Culture within the service

- There was a real sense everyone was working together for the same aim. Staff spoke proudly about their achievements and working at the hospital. In addition to this, they were driven in delivering further improvements to their service.
- Staff within outpatients and diagnostic imaging were proud of the team dynamics and the willingness to change their service when necessary. They gave examples of where changes had been made.
- Throughout all areas we visited there was a very positive culture of team working amongst all staff groups. There was an overwhelming pride in the work they did and a can do attitude. Supportive relationships were evident in areas we visited.
- Staff of all levels had an appreciation for what other staff members did within and between teams.
- Staff felt listened to when reporting concerns. Staff we spoke with felt valued within their teams and as part of the trust.
- In the phlebotomy department, two services were being integrated. At the time of inspection it had not been achieved. Staff told us that services were being maintained as a consequence and there was a reliance on the goodwill of staff to work nights. Stress levels were reported as high and staff engagement was suffering as a result.

Public engagement

- When considering a new service development, the physiotherapy team set up a stall in the town centre. This was to gain views from patients on how the service would best serve the local population. This led to the department offering appointment times up until six in the evening and Saturday mornings.
- The cardiac rehabilitation team held focus groups with local people prior to setting up their service. This was in order to understand what patients would want from their service. The team received regular feedback from patients using their service. Staff gave us examples of changes they had made as a result of this feedback.
- The hospital regularly gained feedback from patients using patient satisfaction surveys and the friends and family test. At the time of inspection the trust did not hold regular patient engagement meetings.

Staff engagement

- Staff felt they were able to raise any concerns or ideas with managers. They told us staff conferences were a valuable source of seeing what was going on elsewhere in the trust. All staff we spoke with felt the chief executive was visible within the trust, had an open door

policy and was approachable. Some staff felt that although the Chief Executive hadn't visited their service or department, they felt informed by the regular newsletters.

- The introduction of ambassador roles enabled some staff groups to have a greater involvement with other teams and staff groups, where prior to this they had felt isolated from other teams. Staff felt like they were working on one site rather than three.
- Allied health profession staff were encouraged to develop with band five progression training. This gave them a variety of skills to progress on to a higher band post.
- The radiology department was looking towards changing to a shift system The radiology manager encouraged staff to set up a working party to find the best solution to making this change.
- However, a few staff told us they did not always feel valued for the work they did and others had no rest areas available to them.

Innovation, improvement and sustainability

- Staff in the eye department had worked towards a paperless system. This was to come into effect when the new department in Shoreham was opened.
- A consultant in the urology department had raised considerable funds to provide a service which would reduce the time between diagnosis and treatment. This improvement enabled patients to begin treatment at the earliest opportunity.
- The audiology department had VICAS accreditation and were undertaking a skill mix review with advise from professional bodies. This would enabled the department to have the expertise necessary to provide an efficient service.

Outstanding practice and areas for improvement

Outstanding practice

We saw much that impressed us but of particular note is –

The level of 'buy in' from all staff to the trust vision and value base was exceptional. We were flooded with requests from staff wanting to tell us about specific pieces of work they were doing, how much they liked working for the trust and how supportive the trust executive team were of innovative ideas and further learning as a tool for improvements in patient care. The trust ambassadors worked to promote the positive work that the trust was doing to other staff and visitors. Specific areas and staff groups of particular note included the whole neonatal team, the children's team, the Specialist Palliative care team, the volunteers across the hospital and the cleaning team.

Multidisciplinary working was a very strong feature across the hospital that resulted in better patient care and outcomes. There was clear professional respect between all levels and disciplines of staff. We saw real warmth amongst teams and an open and trusting culture. Exceptional examples of this included how Harvey's Gang was growing and developing as more staff became involved and local initiatives such as the joint working 'Five to Thrive' protect and Family Nurse Partnership which improved outcomes for the children of young and vulnerable parents

The Trust had won a Dr Foster Better, Safer Care at Weekends award.

The level of feedback from patients and their families was exceptional. We received many letters and emails before, during and after the inspection visit. It was overwhelmingly and almost exclusively positive. Amongst the hundreds of people who contacted us to say how good the hospital was were just a few who felt unhappy with the care they had received.

The staff knowledge of vulnerable adult and safeguarding children and how they should proceed if concerns arose was a significant strength. There was very good joint and interagency working. The transfer of responsibility for the management of 'at risk' babies from maternity (during the antenatal period) to paediatrics (following delivery) was seamless.

The culture of safety and learning from incidents and complaints was well embedded. All staff felt responsibility for reporting mistakes and incidents and there was good dissemination of learning following investigation or review.

The introduction of a ward accreditation scheme based on values,the trust vision and a safety focus was beginning to demonstrate how the monitoring of key performance indicators at local level and comparing these to similar wards could be used as an effective tool for improving the quality of services.

The hospital was involved in the trust wide NHS Quest initiative which focused on improving quality and safety. This involved the trust taking part in collaborative improvement projects for Sepsis and cardiac arrest. Work was in progress on these initiatives at the time of our inspection.

The implementation of the Dementia Strategy provided very good, personalised care for patients living with dementia. The really outstanding part of this was not the activities but the 'whole hospital' approach that involved non-clinical staff, volunteers, executive team members as well as clinical staff from all settings including the operating theatres and outpatients department.

The local leadership of services was very good. Staff told us they were approachable and open and that they valued staff input. We saw particularly good examples in the ED where the hospital had continued to meet the four hour target despite a threefold increase in demand. Local leaders had worked with staff in the department and across the hospital to ensure the flow through the department was maintained.

The chaplains were repeatedly mentioned as 'going the extra mile'. Staff and patients told us about the level of kindness and support shown by the team.

Outstanding practice and areas for improvement

The improvements in the stroke service had resulted in significant and demonstrable improved outcomes for patients In the preceding two years the SSNAP rating had moved up from and 'E' to a 'B'. This was particularly impressive given that the scores were benchmarked nationally and were not adjusted to take account of the high admission rate from a population of greater age and complexity than the national average.

Welcome home packs were a really nice idea. The hospital had worked with local supermarkets to provide frail and isolated patients with hampers that meant they did not have to worry about food for the first 24 hours. Packs included basics such as milk, bread, fruit and cheese.

Areas for improvement

Action the hospital SHOULD take to improve

The trust should continue develop strategies to recruit and retain sufficient medical and nursing staff to meet the needs of the service.

The trust should ensure all staff receive an annual appraisal to ensure their continuous professional development needs are met.

Senior staff should establish active processes for compliance with the European Waste Frame Directive (2008/98/EC) and the HSE Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 with regards to the storage and disposal of sharps bins and chemical storage in the critical care unit.

Senior staff must establish active processes to ensure compliance with the trust medicines policy in relation to stock rotation and the disposal of expired products.

The trust should consider ways of ensuring they meet the RTT pathway targets

The trust should review the discharge arrangements from the critical care unit to ensure patients are cared for in an appropriate environment.

The trust must ensure they have sufficient supervisor of midwives.

The trust should review the resources available for emergency laparotomy as the national audit findings showed there were not meeting all the required standards for this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...