

# Surrey and Sussex Healthcare NHS Trust

## East Surrey Hospital

### Quality Report

Redhill  
Surrey  
RH1 5RH

Tel: 01737 768511

Website: [www.surreyandsussex.nhs.uk](http://www.surreyandsussex.nhs.uk)

Date of inspection visit: 20-22 May 2014

Date of publication: 08/06/2014

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

**Good**



Accident and emergency

**Good**



Medical care

**Good**



Surgery

**Good**



Critical care

**Good**



Maternity and family planning

**Good**



Services for children and young people

**Good**



End of life care

**Good**



Outpatients

**Requires improvement**



# Summary of findings

## Letter from the Chief Inspector of Hospitals

East Surrey Hospital is the only hospital that forms Surrey and Sussex Healthcare NHS Trust. This hospital was an acute hospital and provided accident and emergency (A&E), medical care, surgery, critical care, maternity, children and young people's service, end of life care and outpatients services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

East Surrey Hospital had 650 beds and provided a wide range of inpatients medical, surgical and specialist services as well as 24-hour A&E, maternity and outpatients services.

We carried out this comprehensive inspection to Surrey and Sussex Healthcare NHS Trust as an example of a low-risk trust as determined by CQC's intelligent monitoring system. The inspection took place between 20 and 22 May 2014 and an unannounced inspection visit took place between 6pm and 10.30pm on 6 June 2014.

Overall, this hospital is good but the outpatients service required improvement.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- The hospital was clean and well maintained. The trust's infection rates for *Clostridium difficile* and MRSA were within an acceptable range, taking account of the size of the trust and the national level of infections.
- Patients whose condition might deteriorate were identified and escalated appropriately and the mortality rates for the hospital were within the expected range.
- The vast majority of patients reported a positive experience to us during our visits. The NHS Friends and Family Test showed the trust performed above the England average between November to February 2014. The A&E friends and family test was above the England average.
- We found patients were supported to eat and drink, but we found a small number of patients on one ward who had dry mouths and did not have the appropriate documentation completed to indicate they had received mouth care.
- Nurse staffing levels on the wards were generally satisfactory and staff, although busy, could meet the needs of their patients. There was some reliance on bank/agency or locum staff but this was very well managed and did not have any adverse effects on the delivery of care. The trust was actively recruiting more doctors but faced the same challenges that many trusts in England faced.
- The maternity service was very busy but was providing good care to women with excellent facilities.
- The trust consistently met the four-hour waiting time target in the A&E department. The flow of patients within the department was good and we did not witness any patient who had waited in excess of four hours before a decision was made to admit them.
- We found patients who were placed in beds on wards that were not their specialism were given safe care. There were good processes in place to track these patients and ensure they received the appropriate care and treatment.
- Critical care services provided safe and effective care. The caring and emotional support, as well as the leadership on the unit, was exceptionally good.
- Children received safe and effective care but the environment limited the ability to provide care to adolescents that was individualised to their specific needs. Staffing levels for children were safe and there was good leadership in place.
- Patients received good quality end of life care. Staff were supported by a specialist palliative care team. Patient care was well managed and we found some excellent examples of care being delivered.
- Outpatient services required improvement. Patients were treated with compassion, but many appointments were cancelled at short notice; and because clinics were so busy, patients often had to wait a long time to be seen. Medical records were often incomplete because notes could not be obtained in time for clinic appointments.
- Mortality rates were within expected ranges and there were no indicators flagged as being a risk or an elevated risk.

# Summary of findings

- Medical records, medical secretaries and ward clerks felt they had not been listened to as much as they could have been and expressed concern about some of the changes that were taking place.
- Without exception, clinical staff were proud to work for the trust and spoke very positively about the effective leadership within the trust. Staff recognised the significant progress the trust had made, particularly in the past two years. The commitment to the trust was exceptionally good.
- The work the trust had done on major incident preparedness was good.
- The trust was focusing on the performance of complaint handling and extra resources had been put into place within some of the divisions. We saw performance was improving and both clinical staff and the executive team were committed to this.

We saw several areas of outstanding practice including:

- There was very poor mobile signal at the Crawley Hospital site. Relatives were given a bleep that meant they could be contacted if they left the clinical areas. This meant that people were not restricted to stay in one place for long periods and could be effectively contacted by staff.
- The pre-assessment clinic at Crawley Hospital had been extended into the evening in a response to feedback and local demand.
- We visited one surgical ward where a patient who had a dementia diagnosis was being cared for. The circumstances around the admission meant that the patient's spouse was also admitted to hospital at the same time. This caused anxiety for both patients, especially for the patient with dementia. This ward identified a two bedded side room and ensured that both patients were kept together to alleviate the anxiety and distress of the rest of their admission.
- We saw staff wearing "ask me anything" badges. These badges encouraged patients and their loved ones to engage with staff to improve communication.
- Staff (including the chaplain, catering and ward staff) had arranged for a patient near the end of life to have a "wedding" with a small party afterwards. The catering staff provided a wedding cake for the celebration. Although there wasn't time for this to be an official marriage ceremony it was an example of staff working together to meet the individual needs of their patients.
- The facilities provided for women in the midwife-led birthing unit were outstanding.
- The care on the neonatal intensive care unit was outstanding. The staff team were committed to ensuring best practice and optimal care for the babies admitted to the unit.
- We visited Woodland ward within the surgical directorate, where we judged the leadership to be outstanding. We saw a very effective multidisciplinary approach to care delivery and consistent commitment to ensuring patients' individual needs were met.
- The trust has recognised that their location, close to a major international airport, increased the likelihood of girls presenting in the A&E department with complications of female genital mutilation. The safeguarding implications of this had been incorporated into the training programme.

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

Importantly, the trust must:

- Carry out a review of the outpatients service to ensure there is adequate capacity to meet the demands of the service.
- Implement a system to monitor and improve the quality of the outpatients service that includes the number of cancelled appointments, waiting times for appointments and the number of patients that do not have their medical records available for their appointment.

In addition the trust should:

- Review the training provided to clinical staff on the Mental Capacity Act to ensure all staff understand the relevance of this in relation to their work.

# Summary of findings

- Ensure that a review of mouth care is undertaken so that staff are clear where this should be recorded in the patient's care record.
- Review the action taken to engage with medical secretaries, ward clerks and medical records staff to ensure these groups feel more included in decisions relating to their role.
- Review the working environment for the medical records staff.
- Continue to focus on improving the trust's performance on complaints handling.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Accident and emergency

### Rating

Good



### Why have we given this rating?

The emergency department was providing safe care. There were sufficient staff to meet the needs of patients. The department was clean and arrangements were in place to manage and monitor the prevention and control of infection.

Evidence-based systems were used for treating very sick patients and risks were monitored and addressed. Staff were aware of clinical guidance for patients with specific needs or diseases. Patients were confident in the staff's ability to deliver high quality care. We saw excellent team working across disciplines with therapy staff available every day in chemical decision unit (CDU) promoting effective discharge.

Patients felt they were listened to and we observed patients being cared for with compassion and kindness. The trust had performed consistently better than the A&E national target since October 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged. There were systems in place to ensure A&E responded to patients' needs appropriately and in a timely manner. Support for patients with a learning disability or mental health problem was readily available; although services for children with mental health problems were difficult to access. Complaints and concerns were dealt with appropriately but the time taken to respond was not always in accordance with the trust's own policy. The emergency department was well led and staff were proud of the work they did. Governance processes involved all disciplines of staff as well as a patient representative.

#### Medical care

Good



We saw that patients were treated with respect and that their privacy and dignity were protected. We observed care that was in line with current guidance and best practice. The medical division had robust systems for monitoring safety, quality and performance including systems for reporting accidents and incidents. Generally there were sufficient staff to provide care although not all wards were consistently meeting the staffing levels they

# Summary of findings

had deemed were necessary. We found that patient's individual care needs were met including pain relief and nutrition and hydration, although the provision of mouth care was not clearly recorded. We found one patient who had a pressure ulcer that had not been reported. Patients were adequately monitored and there were systems to manage those who condition was deteriorating. There was a focus on developing care for people living with dementia. We found staff had received training on the Mental Capacity Act and the Deprivation of Liberty safeguards (DoLs) but not all staff were able to demonstrate a clear understanding about how it related to their role. We did not find this was having an actual impact on patient care.

The division was not responding to complaints within the agreed timescales. The trust recognised the need to improve performance on complaints and extra resources for the medical division were put in place in April 2014. Performance was improving and was being closely monitored through the governance arrangements at both divisional and trust board level.

Demand for medical beds often outstripped supply. In these circumstances there were arrangements to increase capacity through the use of additional beds. There were systems to ensure that care and treatment remained safe, that it was regularly reviewed and that there were staff accountable for these areas. Staff told us they felt supported by their leaders. There were arrangements to gather patient feedback and we saw that this feedback resulted in staff taking appropriate actions.

## Surgery

Good



Patients who used the service experienced safe, effective and appropriate care and treatment and support that met their individual needs and protected their rights. The care delivered was planned and delivered in a way that promoted safety and ensured that people's individual care needs were met. We saw patients had their individual risks identified, monitored and managed and that the quality of service provided was regularly monitored. We found the clinical environments we visited and other communal areas

# Summary of findings

in the hospital meticulously cleaned. Hospital-acquired infections were monitored and rates of infection were of a statistically acceptable range for the size of the trust. Outcomes for patients were good and the department followed national guidelines. Complaints were investigated and handled in line with standard policy. We saw the trust use patient's complaints and comments used as a service improvement tool and the trust actively encourage feedback from its patients and their relatives or loved ones.

## Critical care

Good



Patients we spoke with gave us examples of the good care they had received in the unit. The leadership of the unit created a culture of reporting and learning from incidents. There was good multidisciplinary working to ensure patient needs were met. Guidance from recognised professional bodies were followed and audited to ensure their effectiveness. Patients were treated with compassion, care and dignity. The service demonstrated responsiveness to the needs of patients and the local population. Changes were being made to the management of high dependency unit (HDU) to improve patient flow through the service.

## Maternity and family planning

Good



The service was offering good, safe compassionate care for women and their partners. The refurbished facilities of the new midwife-led birthing unit provided excellent facilities for normal, uncomplicated births in a relaxed, calm, non-clinical environment. The consultant-led facilities were soon to be refurbished to the same standard and offer excellent multidisciplinary care and treatment. An active service user group had been involved in planning for and making the changes to the service. Midwife to birth staffing levels were not in accordance with recommended guidance with one midwife to every 34 births. Funding had been allocated for additional midwives and recruitment was underway which meant the ratio of births to midwives would improve. The staff were well trained, experienced and committed and the leadership was very good, particularly at head of service and matron level. There was a clear vision

# Summary of findings

and strategy and the culture was open with an emphasis on learning from feedback in order to improve the service. Standards were based on evidence-based practice and national guidance.

## Services for children and young people

Good



Services for children and young people were good. Most children and parents told us the staff were kind and attentive; the staff were described as 'lovely' and 'funny'. Ward areas and equipment were generally, clean and appropriate infection control measures were in place. There were enough trained staff on duty to ensure that safe care could be delivered. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs. Younger children received very good inpatient care and the ward was resourced to ensure their wider needs were met. Good facilities and staff support encouraged a parent to stay in hospital with their baby or child. The quality of care of adolescents was limited by the accommodation; we observed instances where the privacy and dignity of teenagers was not respected. The care on the neonatal intensive care unit was outstanding. The staff team were committed to ensuring best practice and optimal care for the babies admitted to the unit. Senior staff communicated well and staff were positive about the service. There was clear evidence that the wider multidisciplinary team worked well together for the benefit of the younger patients. Children's experiences were seen as the main priority. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements.

## End of life care

Good



We found that the trust had systems in place to ensure end of life care was safe and met the needs of patients and that staff were committed to providing person centred care to patients who were receiving end of life care. Patients spoke positively about the way they were being supported with their care requirements. Relatives also spoke very positively in regard to the support they and their relatives received. The specialist palliative care team were responsible for ensuring that end of life care was delivered to staff within the ward areas as part of their mandatory training. The specialist palliative care



# Summary of findings

team had developed an end of life care pathway tool which was in use in all the ward areas we visited. Staff in all of the ward areas we inspected were aware of the tools used for patients receiving end of life care and all staff were aware of how to contact the specialist palliative care team.

## Outpatients

### Requires improvement



Patients received compassionate care and were treated with dignity and respect. Patients told us that staff were kind and supportive, and they felt fully involved in making decisions about their care. Medicines and prescription pads were securely stored. The outpatient areas we visited were clean and equipment was well maintained. However, many clinic appointments were cancelled at short notice. Clinics were busy and patients sometimes had to wait a long time to be seen. Patients and staff told us one of the biggest challenges was clinics running late. Outpatient clinics were overbooked; there was not enough time to see patients, so clinics often over-ran. The large number of ad-hoc clinics ensured that the trust was meeting its waiting time targets. However, these clinics were run on the goodwill of staff. Medical records for clinics were often not complete, and clinics often saw patients with a temporary set of notes because notes could not be obtained in time for clinic appointments.

Good 

# East Surrey Hospital

## Detailed findings

### Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

## Contents

Detailed findings from this inspection	Page
Background to East Surrey Hospital	11
Our inspection team	11
How we carried out this inspection	11
Facts and data about East Surrey Hospital	13
Findings by main service	14
Outstanding practice	103
Areas for improvement	103
Action we have told the provider to take	104

# Detailed findings

## Background to East Surrey Hospital

East Surrey Hospital is part of Surrey and Sussex Healthcare NHS Trust. The trust is a provider of acute hospital services in West Sussex and East Surrey, providing care to a population of more than 535,000. It also provides services to non-local users due to the close proximity of Gatwick airport, the M25, M23 and local truck roads.

East Surrey Hospital had 650 beds and provided a wide range of inpatient medical, surgical and specialist services as well as 24 hour A&E, maternity and outpatient services. The trust also provided day care and outpatient services at Crawley Hospital as well as outpatient services at Horsham Hospital, Caterham Dene Hospital and Oxted Health Centre. These hospitals were all owned and managed by NHS Property Services.

East Surrey Hospital had been inspected seven times since it was registered with the Care Quality Commission (CQC). At its last inspection in February 2013, the trust was found compliant for all of the areas that were inspected. Crawley Hospital had been inspected once in August 2012 and was found to be compliant in the areas inspected.

We inspected this trust as part of our in-depth hospital inspection programme. We chose to inspect this trust as an example of a low risk trust as determined by CQC's intelligent monitoring system. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The inspection team inspected the following eight core services at East Surrey Hospital:

- Accident and emergency (A&E)
- Medical Care (including older people's care)
- Surgery
- Critical Care
- Maternity
- Children's care
- End of life care
- Outpatients.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Andrea Gordon, Deputy Chief Inspector of Hospitals, Care Quality Commission

**Team leader:** Carolyn Jenkinson, Head of Operational Delivery, Care Quality Commission

The team of 26 included CQC inspectors and analysts, two experts by experience as well as a variety of specialists. These included a medical consultant, a consultant orthopaedic surgeon, a consultant in critical care, a junior doctor, a student nurse, a retired trust chief executive, senior nurses and a midwife.

## How we carried out this inspection

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

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

Before, during and after visiting the hospitals 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 (CCG), community trusts, NHS Trust Development Authority, NHS England, Local authorities, Health education England (HEE), the General medical Council (GMC), the Nursing and Midwifery Council, the Royal College and the local Healthwatch.

## Detailed findings

We held two listening events in Crawley and Redhill on 20 and 21 May 2014 when people shared their views and experiences of Surrey and Sussex Healthcare NHS Trust.

We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff and allied health professionals. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services at East Surrey and Crawley Hospital. We talked with carers and/or family members and reviewed patient's records of personal care and treatment.

We carried out an unannounced inspection between 6pm and 10:30pm on Thursday 6 June 2014. We looked at how the hospital was run at night, the levels and type of staff available and how they cared for patients.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Surrey and Sussex Healthcare NHS Trust.

# Detailed findings

## Facts and data about East Surrey Hospital

East Surrey Hospital serves two growing populations of over 535,000 people. The Reigate and Banstead local authority in East Surrey was the 292nd most deprived area in England (out of 326 local authorities with 1 being the most deprived). The deprivation score increased between 2007 and 2010 meaning that the deprivation worsened. There is an increasing population in this borough and there is a lower than average proportion of black, Asian and minority ethnic residents. Life expectancy for men and women in this population was higher than the England average. All causes of mortality have fallen but the rates for heart disease and stroke have fallen by a rate that is better than the England average.

The local authority in Crawley, which is located in West Sussex, is the 170th most deprived local authority in England. The deprivation score also increased between 2007 and 2010 meaning that the deprivation worsened. There was an increasing population in this borough and there is a higher than average proportion of black, Asian

and minority ethnic residents. Life expectancy for this population was similar to the England average. All causes of mortality have fallen for women but the rates for men show no clear trends. The early death rate from heart disease and stroke had fallen and was similar to the England average.

100% of the trust's population are registered with a GP.

The trust employs a diverse workforce of around 3500 people. In 2012/13, the trust provided care to over 77,000 people as well as over 250,000 outpatients attendances. During 2012/13, the trust had over 80,000 attendances at A&E.

Bed occupancy at the hospital has been consistently higher than the England average at 89.4%. This rate is also consistently higher than the 85% threshold of when the quality of care provided to patients can be affected.

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Outstanding	Good	Good
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Good	Good	Good	Good	Good	Good

# Accident and emergency

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

## Information about the service

The Accident and Emergency department (A&E) at East Surrey Hospital provided care for both children and adults and was the front door of the hospital. The department saw 82,000 patients in 2013, a quarter of those were children. There had been a 62% increase in the number of patients attending the department over the previous three years. The unit had been built to support annual attendances of around 85,000 per year.

The Emergency department at East Surrey Hospital was made up of an A&E and a Clinical Decisions Unit (CDU) where patients could stay for a maximum of 24 hours. Children were cared for in a separate area of the department. This had its own paediatric resuscitation area.

Adult A&E was divided into two streams; minors and majors. The minor stream was staffed by nurse practitioners, nurses and paramedics. It cared for up to 12 people at a time. The major stream cared for people with more serious injuries and illnesses including major trauma. It could care for up to 28 patients at a time. Both areas were overseen by a consultant.

We visited A&E and CDU. We spoke with 30 patients and relatives to obtain their feedback on the care they were receiving and we reviewed information from comment cards that were completed in the waiting area. During our inspection we spoke with 25 staff of different grades; they

included medical and nursing staff, therapists and members of ambulance crews. We observed the care and treatment patients received and reviewed information about the hospital's performance.

# Accident and emergency

## Summary of findings

The emergency department was providing safe care. There were sufficient staff to meet the needs of patients. The department was clean and arrangements were in place to manage and monitor the prevention and control of infection. Evidence-based systems were used for treating very sick patients and risks were monitored and addressed. Staff were aware of clinical guidance for patients with specific needs or diseases. Patients were confident in the staff's ability to deliver high quality care. We saw excellent team working across disciplines with therapy staff available every day in clinical decision unit (CDU) promoting effective discharge.

We found not all staff were up to date with mandatory training but there were plans in place for all staff to complete this. We also found that the department was not always responding to complaints within the timescales set by the trust. This was being addressed and recent performance had improved.

Patients felt they were listened to and we observed patients being cared for with compassion and kindness. The trust had performed consistently better than the A&E national target since October 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged. There were systems in place to ensure A&E responded to patients' needs appropriately and in a timely manner. Support for patients with a learning disability or mental health problem was readily available; although services for children with mental health problems were difficult to access. Complaints and concerns were dealt with appropriately but the time taken to respond was not always in accordance with the trusts own policy. The emergency department was well led and staff were proud of the work they did. Governance processes involved all disciplines of staff as well as a patient representative.

## Are accident and emergency services safe?

Good



The two units making up the A&E were seen to be spacious, clean and tidy. Staff across A&E had systems in place to manage deteriorating, very sick and trauma patients. There were robust processes in place to ensure all staff learned from any patient related incidents occurring in the department. Staff knew how to raise concerns about adults and children who may be at risk from harm.

There were a number of nursing staff vacancies in the department and agency nursing staff were used in when necessary. There was a consultant present in the department between the hours of 8:00am and midnight, Monday to Friday and there was an on call system at all other times. Junior and middle grade medical staff felt well supported by the consultants.

Records confirmed that, across the department, approximately 60% of staff had undertaken mandatory training in the past year and dates had been assigned for the remaining 40% of staff to complete the training.

### Incidents

- The A&E department had no 'Never Events' between December 2012 and March 2014. A serious incident known as a Never Event is classified as such because they are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented
- Between March 2013 and February 2014 there had been 10 incidents in the A&E department reported to the National Reporting and Learning System (NRLS). One had resulted in a severe impact on a patient and one had resulted in death.
- There was a consistent and robust approach to investigating incidents with action plans put in place to address any issues raised.
- Staff were able to give us examples of practice changing as a result of incident reporting.
- There was good ownership of risk and learning within the department.

# Accident and emergency

- Any mortality and morbidity incidents were discussed on a monthly basis. Minutes from the meetings were taken forward to the regular governance meetings.

## Cleanliness, infection control and hygiene

- A&E and CDU appeared clean and tidy. Domestic waste, clinical waste and sharps bins were filled to an appropriate level and not over filled.
- Patients were positive about the cleanliness of the department.
- There were cleaning staff available 24 hours a day and we found the department also appeared clean during out of hours.
- Hand hygiene gel as well as soap and water were available; we observed staff washing their hands between patients and they wore personal protective equipment such as gloves and aprons.
- The “bare below the elbow” policy was adhered to.
- Equipment, including trolley mattresses, were labelled with green ‘I am clean’ stickers stating the date and time they had been cleaned. We checked this equipment and found it did appear clean.
- Sluice areas were clean and the commodes were appropriately labelled and cleaned after use.
- A&E had two side rooms available with en-suite facilities for people with possible infectious diseases.
- In addition the A&E had an ‘ice pod’. This was used to control outbreaks and manage patients who were known or suspected to be infected or colonised with a pathogen. Ice pods are temporary structures that can be erected quickly and, by providing additional single occupancy areas, it helped to increase the flexibility of the area.

## Environment and equipment

- A&E had been refurbished and upgraded with the last three years. Treatment areas were spacious and call bells were available. However, the resuscitation areas were still awaiting refurbishment, but this was scheduled for 2014.
- There was sufficient equipment for monitoring and treating patients for example cardiac monitors, defibrillators and infusion pumps.
- We saw two mobile ultrasound scanners available for use in A&E.
- Staff informed us they always had access to additional equipment from a central equipment store that was easily accessible.

- We saw a list of all equipment in the A&E. Electrical equipment had been checked within the previous 12 months.
- Bariatric equipment was available/accessible when required.
- Patients who had been identified as requiring to sleep in A&E because, for example, lack of beds on the wards or CDU, were placed on beds in A&E until they could be moved on or discharged. Appropriate pressure relieving mattresses were also provided if necessary. We spoke to a patient being nursed on a bed who said they had been made comfortable and had no complaints.
- Other than the waiting room the A&E department was locked to visitors. This meant no unauthorised visitors had access to treatment areas.
- There was a lack of occupational therapy equipment in department. This has been acknowledged by the trust and work was in progress to locate storage space.

## Medicines

- Following a risk assessment patients’ medication was placed in a bag and kept with the patient. Where this was not possible, medicines were locked away.
- Controlled drugs (CD’s) were logged into the CD register and locked in the CD storage cupboard.
- CD’s in adult A&E, paediatric A&E and CDU were kept securely. Stock levels correlated to the CD registers in each area and auditing of CD’s was undertaken on a regular basis.
- Medication stock was rotated. Pharmacy support was available seven days a week.
- Medicines, including those administered intravenously, were prepared in a clean, quiet and well lit room.
- Drug prescription records were written neatly in legible writing and were easy to understand.
- We viewed four drug administration charts at random. They were completed correctly.

## Records

- Patients records were kept in lockable cabinets and only accessible to healthcare professionals.
- Documentation for rapid assessment of patients was completed for all new arrivals in the department.
- Vital signs, such as temperature, blood pressure and pulse were recorded. Analgesia (pain relieving medicine) was prescribed when necessary.



# Accident and emergency

- Documentation used a medical model of assessment: presenting symptoms, history of complaint, past medical/surgical history, medication the patient was taking, allergies, examination and diagnosis.
- Nursing notes were not always consistently completed. For example, we looked at three patient's records and saw there was no record of the hourly checks on the patient. Nurses informed that although the checks were completed they didn't always have time to write them down.
- Risk assessments were completed, including assessment for falls, nutrition and skincare.
- The hospital used a system called "iFIT" which tracked patient records through the hospital by the use of a barcode.
- The quality of documents was audited monthly and these demonstrated the standard of record keeping was generally good.

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

- Patients who required procedures under an anaesthetic had their written consent obtained prior to the process being undertaken.
- Patients we spoke with told us they were asked for their verbal consent before procedures were undertaken.
- There was a process in place for patients who did not have the capacity to make informed choices.
- We asked staff about their understanding of capacity. Staff were aware of the process to follow if a patient did not have the capacity to make informed choices. We saw they were completing a two stage mental capacity assessment. We noted that this assessment was on the hospitals' intranet for easy access.
- We saw during our visit to the A&E, patients consent was gained and recorded appropriately.

## Safeguarding

- Staff we spoke with knew what constituted abuse and how to raise their concerns about adults and children who may be at risk.
- The department had two members of senior nursing staff who took the lead for safeguarding children and adults. They had undertaken extended training in relation to this.
- A doctor always checked the children's risk register if a child presented with a possible non-accidental injury in the department.

- There was a protocol in place to ensure children were protected if a child was suspected of having a non-accidental injury. This included referring children to the relevant authorities.
- Safeguarding policies were available for staff to follow.

## Mandatory training

- The trust's mandatory training included infection control, health and safety and safeguarding.
- The training was a combination of e-learning and face to face learning.
- Records confirmed that, across the department, approximately 60% of staff had undertaken mandatory training in the past year and dates had been assigned for the remaining 40% of staff to complete the training.

## Assessing and responding to patient risk

- Patients in both the adult and children's waiting room in A&E were visible to staff.
- Admissions via ambulance were seen by a triage nurse on arrival to determine the severity of a patient's condition and decide upon how quickly they needed treatment.
- Reception staff observed patients in the waiting room during the course of their shift. If they were concerned about a patient they would alert other staff.
- There was a robust escalation plan in place for the hospital when lots of patients required treatment or when unplanned incidents occurred. It was based on the College of Emergency Medicine's document 'Crowding in Emergency departments'.
- The A&E department was part of the South West Trauma Network. Any seriously injured patient would be transferred to St George's Hospital in South London for specialist care. Separate, comprehensive documentation for trauma patients was in use.
- A&E dealt with approximately 30 trauma calls every month and we saw there was a strict protocol for activating a trauma call within A&E. This included alerting the consultant on call if it was out of hours.
- The department used an escalation referral pathway for the assessment of patients. The Early Warning Score (EWS) tool was in use, (EWS is a simple, physiological score which primary purpose is to prevent delay in intervention or transfer of critically ill patients).
- A protocol with an accompanying policy was in place for patients suffering a massive blood loss.

# Accident and emergency

- We saw patients had their observations repeated and recorded while in the department, although we did find some records where not all observations had been recorded.

## Nursing staffing

- The trust did not have a full complement of its own nursing staff in A&E. However, permanent staffing levels had improved over the previous three years.
- Staffing was in line with the Royal College of Nursing recommended levels.
- 20% of nursing staff used in the ED were agency staff, some of whom had been used on a regular basis and therefore knew the department, processes and procedures well. We spoke with one of them. They told us they had worked in A&E “for a long time”, had received a good induction and really enjoyed the experience it had given them. They felt well supported by the permanent team in A&E.
- Vacancies at the time of our inspection were two band 7’s (sisters), five band 5’s (staff nurses) and eight nursing assistants. This meant there would be a 20% increase in the nurse staffing levels for the department.
- The Royal College of Paediatrics and Child Health had set standards for children and young people in emergency care settings. These included the availability of a qualified children’s nurse on each shift. We saw a qualified children’s nurse was always available in the children’s A&E area.
- We spoke with a student nurse who had been in their A&E placement for only a few days. They told us their induction had been very comprehensive and already felt part of the team and very well supported.
- There were no specialist mental health nurses in A&E or CDU. However, some general nurses had wished to undertake mental health training and the nursing lead for the unit was seeking educational funding to progress this.
- During times of ‘winter pressures’, we were informed staffing levels had been increased and there were plans in place to help staff get into work during bad weather.

## Medical staffing

- Eight consultants provided a service across both A&E departments and CDU. A ninth consultant was due to commence employment in August 2014.
- The Royal College of Emergency Medicine recommends 12 specialist consultants for an A&E department seeing between 80,000 and 100,000 patients per year.

- There had been difficulties recruiting a specialist paediatrician for A&E. We were informed one consultant in the department was due to commence paediatric training in September 2014 subject to final approval. That consultant took the lead for paediatrics in A&E.
- The paediatricians in the hospital provided support to A&E as required.
- Off duty for all levels of medical personnel in A&E and CDU for the month of May 2014 showed between the hours of 8:00am and midnight, seven days a week, there was always consultant cover in the department. Outside of these hours a consultant was always on call.
- We were informed by medical staff, consultants would always stay in the department if it was busy and senior support was required.
- There were three handovers during each 24 hour period; these were consultant led. The majority, if not all medical personnel were present, dependent upon patient need.
- Handovers for each patient included assessment, investigations, medical history and any co-morbidities.
- When locums were used in the department they were sent a three page induction pack prior to their first session. This included, but was not limited to, information relating to IT systems and where and how to access clinical guidelines and senior support.
- The A&E’s highest rates of complaints had been about locums. However, since using regular locums and an increase of permanent medical staff the number of complaints had reduced.
- A full complement of junior and middle grade medical staff were in post across the department. Two junior and middle grade doctors told us they felt the staffing levels were satisfactory and they felt supported by senior staff. One told us, “Consultants are always approachable and always willing to give advice.”

## Major incident awareness and training

- There had been a number of “table top” exercises throughout the hospital relating to major incidents. Various staff members from the department had attended these.
- The last such exercise involving the whole hospital had been in June 2012.
- The last trust wide major accident simulation had occurred in February 2011. The next one was due to be undertaken in the autumn of 2014.

# Accident and emergency

- We saw the decontamination suite in A&E. Patients could be brought straight into the suite directly from the car park. This was used for patients who were contaminated with chemical, nuclear or biological agents. The suite's water system was run daily to prevent legionella.
- We noted the hospital had major incident signage located around the hospital. This was particularly important given the close proximity to Gatwick Airport.

## Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Staff were aware of clinical guidance for patients with specific needs or diseases. Assessment of pain were undertaken as part of the admission process and dealt with effectively. Care bundles were in place and being used appropriately. Delays could occur when transporting patients because of the lack of portering staff.

Patients were confident in the staff's ability to deliver high quality care. A specially trained children's nurse was available at all times although medical paediatric specialist advice had to be obtained from the children's ward when required. We saw excellent team working across disciplines with therapy staff available every day in CDU promoting effective discharge.

## Evidence-based care and treatment

- The department used a combination of National Institute for health and Clinical Excellence (NICE) and Royal College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. Local policies were written in line with these and were updated.
- The department ensured that the A&E was managed effectively and in accordance with the clinical standards for emergency departments.
- We observed the process for treating a patient who had suffered a stroke. The specialist stroke nurse had been alerted and was present for the arrival of the patient. A specialist consultant was in attendance within 15 minutes. Staff were aware of the one hour timeline required for scanning patients with a stroke.

## Pain relief

- An assessment of pain was undertaken on a patient's arrival in the hospital. All but one patient we spoke with in A&E informed us pain relief had been given very quickly on arrival in the department, but this patient told us she had not requested any pain relief.
- We did not see any patient displaying verbal or non-verbal signs of pain during our inspection that was not being addressed by the staff.
- The Royal College of Physicians audit of falls and bone health in older people was undertaken. The core for patients receiving analgesia within 60 minutes of hospital attendance was within expectations.

## Nutrition and hydration

- Patients who stayed in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so. Hot food was available.
- Patients in CDU had access to all hospital meals. We saw jugs of fluids at their bedside.

## Patient outcomes

- The department participated in all the national clinical audits it was eligible to take part in during 2012/13.
- Unplanned re-admissions following an emergency admission did not indicate any risk and were significantly lower than the England average.
- There were no mortality indicators for the trust that were flagged as a risk or elevated risk.

## Competent staff

- Patients we spoke with felt confident in the staff's ability to care for them appropriately.
- Nursing staff had appropriate qualifications to care for acutely ill children.
- Children requiring specialist paediatric services were treated by paediatric doctors from the children's ward; A&E staff could always gain access to this.
- All the nursing staff we spoke with felt competent to undertake their role.
- Nursing staff told us they had opportunities to develop their knowledge and skills. We saw evidence of additional training nursing staff had been able to access in order to enhance their role. For example, advanced trauma nursing.
- Nursing staff were trained in basic life support and received regular updates. Paediatric nurses received specialist child life support training.

# Accident and emergency

- Medical staff we spoke with felt supported in their role by line managers.
- The department offered a middle-grade teaching programme of two hours protected learning each week although not all doctors felt able to attend this. The programme had recently been altered to address this and was to incorporate simulation training one day each month.
- Staff we spoke with had received annual appraisals. The time was also used to identify training needs and discuss development opportunities.

## Multidisciplinary working

- We saw excellent team working between medical and nursing staff throughout our visit.
- Medical and nursing staff worked across A&E with other specialists and therapy staff to provide multidisciplinary care.
- Medical staff informed us rapport was good with other specialties, although this could be improved with the orthopaedic teams. We saw no evidence of delays for patients requiring assessments by the medical and surgical inpatient teams.
- Patients requiring referral to psychiatric services were seen by a team based in the hospital. However, access to psychiatric services for children and adolescents was slow. One staff member informed us, "It's a particular challenge."
- There was a specialist team based within the hospital that worked closely with the A&E for stroke patients.
- There were close links with the radiology department.
- We observed consultants and junior doctors having discussions when advice was required. These discussions were also timely.

## Seven-day services

- All areas of the emergency department were open seven days a week.
- Support services were also available seven days a week, including for example x-ray, scanning and pathology
- Physiotherapists and occupational therapists offered a seven day service to patients in CDU.
- ED consultants were present in the department from 8:00am until midnight, seven days a week: they were available on an on call basis at all other times. Middle grade doctor cover was available all of the time.

## Are accident and emergency services caring?

Good



Patients felt they were listened to by health professionals and we observed patients being cared for with compassion and kindness. Pain relieving medication was offered quickly when needed and call bells were within reach for patients to call for assistance.

Staff were aware of the grieving process and knew how to treat relatives experiencing bereavement with dignity and respect.

## Compassionate care

- In our Intelligent Monitoring Report, March 2014 the trust was not rated a 'risk' compared with other trusts in relation to compassionate care.
- All the patients we spoke to across the two areas of the emergency department were complimentary of the care they had received.
- One patient told us, "They've been brilliant. I can't fault them." Another said, "They're so kind, even though they're busy all the time."
- We saw examples of caring professional interactions with patients given in a quiet and dignified Manner. All patients had call bells within their reach and a drink available when it was safe for them to have one.
- The 2012 Adult Inpatients Survey showed the trust performed about the same as other trusts for the questions relating to the A&E department.
- Compared to the England average, the Friends and Family Test score for A&E between November 2013 and February 2014 ranged from 76 to 80. This was significantly above the national score. In addition, the most responses (620) were received in this time period.
- We did not receive any comments at our listening events about the A&E department.

## Patient understanding and involvement

- We saw all staff introduce themselves to patients.
- Patients and relatives told us they had been consulted about their treatment and felt involved in their care and treatment options.
- We heard staff explaining and seeking consent from patients, including children, in a manner that they could understand.

# Accident and emergency

- We observed patients receiving information about their discharge.
- The Friends and Family test questionnaire was readily available for patients to complete.

## Emotional support

- We spoke with staff about caring for relatives who had just lost their loved ones in A&E. We were informed family members were taken to the relatives' room. Where possible, their loved one was placed in a side room and relatives were given the opportunity to spend time with them if they wished to.
- We were informed relatives could stay as long as they wished to in the department after a patient's death, drinks were provided and patients were not moved until the relatives were ready.
- The relatives' room was also used for relatives of very sick patients.
- We saw staff supporting patients and relatives throughout their stay in the department.

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

Good



The trust had produced better results on A&E waiting times during winter 2013/14 than the same period in 2012/13. The department consistently met the 95% target for all patients' waiting less than four hours to be admitted, transferred or discharged.

Patients informed us they felt treated as individuals and information was available to them on the complaints process if required. Staff had access to translation services through the use of a specialist telephone line. Support for patients with a learning disability or mental health problem was readily available; services for children with mental health problems were difficult to access.

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

- A robust electronic system was in place for tracking how long patients had been in the department to ensure they were moved along in a timely way.

- There has been a reduction of admissions to the main wards in the hospital due to the availability of therapists seven days a week within CDU.
- Sixty percent of patients attending A&E arrived by ambulance. We saw a triage nurse assessed all patients and streamed them into the appropriate area of the department. This was carried out in a dedicated assessment room. This meant patients were given privacy and dignity during this process.
- Walking patients were greeted by a receptionist, booked in and triaged as soon as possible.
- Although the reception area had been altered to increase privacy for patients whilst they gave their personal details, privacy was still a concern; confidential information could still be heard by other people in the waiting area. The trust had acknowledged this and was working towards a solution.

## Access and flow

- During our inspection A&E was busy but staff were able to deal with the volume of patients requiring care and treatment.
- The A&E department was rebuilt in 2011 and the unit was designed to support annual attendances of around 85,000 attendances per year. There was flexibility to move capacity to allow for changes in case mix (Majors vs Minors).
- The trust had produced better results on A&E waiting times during winter 2013/14 than the same period in 2012/13.
- From October 2013 to March 2014, the trust met the four-hour wait time in the department almost without exception.
- Information from our Intelligent Monitoring Report, March 2014 did not identify any risk in the data collected between October and December 2013 relating to waiting times for treatment over four hours.
- The trust's performance on the percentage of patients still waiting in A&E showed higher than England average throughout the period up to four hours and for several hours beyond that point.
- Data showed higher than England averages for the number of patients leaving A&E in the hours beyond four hours.
- During 2013 the trust was consistently below the England average for the percentage of patients that left A&E before being seen.



# Accident and emergency

- A&E had a robust electronic system in place for tracking how long patients had been in the department to ensure they were moved along through the department in a timely way.
- One person informed us it was frustrating not knowing how long they had to wait to be seen by a doctor. The hospital told us it was their ambition to have that information on a screen in the waiting room fairly quickly: the monitor was already in place.
- Percentage of patients with unplanned re-attendance at A&E within seven days of original attendance was within expectations for English trusts.
- The percentage of patients whose ambulance handover time was more than 30 minutes was within the expected range for English trusts.
- We spoke with ambulance personnel who transport patients to the hospital on a regular basis. They informed us handover times to hospital staff in A&E was, "Generally good."
- Data from the trust showed between September 2013 and January 2014 the incidents of turnaround times for ambulances over 30 minutes had varied between 35 and 115 each month. The highest number had been in January, the lowest in October
- There was age appropriate information available and toys available for children.
- We spoke with members of staff about their ability to help patients with a dementia when they needed to go to the department. They told us A&E cared for a lot of people with a dementia.
- Dementia training was part of the non-core mandatory training for all levels of staff and was undertaken on an annual basis.
- Dementia training was included in induction training for new members of staff.

## Learning from complaints and concerns

### Meeting people's individual needs

- Patients we spoke with felt they were treated as individuals.
- On person told us, "I've been treated as a person not as a problem."
- The hospital was situated only a few miles from Gatwick airport and frequently cared for patients whose first language was not English.
- The department employed many members of staff whose first language was not English, for example Portuguese staff. Two staff members informed us they had been used as translators in the past and had been pleased to help.
- The hospital had access to translation services through the use of a specialist telephone line. Staff were aware of this and knew how to use them. We did not see these in use during our visit.
- Signs and notices in A&E were only written in English. We did not see any printed information for patients in any language other than English.
- We did not speak with any patient who had a learning disability (LD). A&E staff informed us they had access to a specialist LD nurse if required.
- Information about how to complain was displayed in the department. Information leaflets were available to all patients. They contained helpful information about how to access the Patient Advice and Liaison Service (PALS) and how to make a complaint.
- There was a complaints leaflet available in an easy read format.
- The department followed the trusts complaints policy. The clinical lead received all complaints and a person was then allocated to investigate the concern. All investigations into complaints were signed off by the clinical lead.
- Informal complaints could be received by any member of the team. These were dealt with by the most appropriate person. Staff were aware of they could not resolve these they should advise the patient/relative how to use the formal complaints policy.
- Staff reported having a good relationship with the PALS service that could often help resolve concerns before they escalated into a formal complaint.
- Complaints and serious incidents and the lessons learned were discussed at monthly clinical departmental governance meetings. Where required, action plans were produced and progress was monitored on a monthly basis.
- From October 2013 to March 2014, the department had a total of 23 complaints. Eighteen of these complaints breached the deadline for their final response. The main reason for the breach was due to late drafts of the investigation/response letter by the department.
- The trust had recognised the need to improve performance in complaints handling and extra resources had been put in place in April 2014.

# Accident and emergency

## Are accident and emergency services well-led?

Good



Staff were proud of the work they did. Governance processes involved all disciplines of staff as well as a patient representative, with lessons learned and practices changed as a result of incidents or complaints. The department had an innovative system in place to ensure all staff were constantly aware of governance issues.

There was strong leadership from the lead clinician for the department and the senior nurse/matron which other staff respected. They were aware of the real and positive changes in the department over the previous three years. However, they were not complacent in their attitude and were aware of additional changes that needed to be made to make further improvements. Staff were supported to raise concerns and the trust's whistleblowing policy gave them protection.

### Vision and strategy for this service

- Staff we spoke with knew of the visions and values of the trust: 'Safe, High Quality Healthcare which puts our Community First'.
- Senior members of the nursing and medical A&E staff knew of the positive changes made in the department over the previous three years but were aware of additional changes that needed to be made to improve the quality of care further.

### Governance, risk management and quality measurement

- We asked staff if they would and how they would raise issues about safety concerns or poor practice in their department. All staff we spoke with told us they felt very confident taking any concerns to their line manager and knew they would be dealt with.
- There were structured monthly governance meetings in place. We saw the minutes of May 2014. Personnel in attendance had included clinicians, nurses, therapists and a patient representative. Items discussed included results of local audits, local risk register, paediatric issues and patient experience.

### Leadership of service

- Staff we spoke with felt an excellent rapport existed between all levels of staff and we saw this during our visit.
- The lead clinician for the ED and the senior nurse/matron had developed a good relationship. They worked together and were aware of issues that needed addressing, for example improving confidentiality in the reception area of the department. They knew they would get support from the trust executive to undertake the work required.
- We spoke with a wide range of staff in the department. They were very knowledgeable about the services they delivered and proud to work in the department. They appeared to be passionate about giving good quality care. They told us leadership was good and everyone was on first name terms.
- We had a discussion with a student nurse who felt very supported in their first week in the department. They informed us they wanted to return to A&E after they qualified.

### Culture within the service

- Staff were willing to speak with the inspectors.
- All staff we spoke with throughout the A&E department told us they felt well supported by their line managers and could raise issues with them
- Staff sickness absence rates were below the England average.
- Staff informed us there was an open culture with the sharing of complaints and incidents. Discussions were held on lessons learned from them and practices changed where appropriate.
- The trust had a whistleblowing policy in place; part of the policy referred to protecting staff that raised concerns.
- Staff spoken with highlighted the regular presence of the chief executive officer of the trust in the department; they told us he was approachable, made time for them and always listened to what they had to say.
- The paramedics we spoke with felt included in the department.

### Public and staff engagement

- The Emergency Department had a patient representative who was a member of the department's governance group.

# Accident and emergency

## **Innovation, improvement and sustainability**

- A large monitor had been placed within the staff room to alert staff of governance issues with items of information. The system was updated following each governance meeting or earlier if an important issue was raised. There were plans to place an additional monitor in the doctors' office.
- We saw a video had been made by medical staff and had been uploaded onto "YouTube." The video had been produced to show prospective medical staff what it was like to work at the hospital.



# Medical care (including older people's care)

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

## Information about the service

Surrey and Sussex Healthcare provided inpatient medical services at the East Surrey Hospital. There were 14 inpatient areas including wards, an acute medical unit and a discharge unit. Specialities covered included elderly care, medical digestive diseases, respiratory, oncology, cardiology, stroke, and acute and general medicine. There were approximately 340 medical beds in total.

We visited the all the medical inpatient areas with the exception of Hazelwood. We spoke with over 40 staff of different grades of nurses, doctors, therapists, administrators, housekeepers and porters. We spoke with 27 patients and nine relatives.

We observed interactions between patients and staff, considered the environment and looked at care records and other records relevant to the running of the wards. Before and during our inspection, we reviewed performance information from, and about, the hospital and the medical wards.

## Summary of findings

We saw that patients were treated with respect and that their privacy and dignity were protected. We observed care that was in line with current guidance and best practice. The medical division had robust systems for monitoring safety, quality and performance including systems for reporting accidents and incidents. Generally there were sufficient staff to provide care although not all wards were consistently meeting the staffing levels they had deemed were necessary. We found that patient's individual care needs were met including pain relief and nutrition and hydration, although the provision of mouth care was not clearly recorded. We found one patient who had a pressure ulcer that had not been reported. Patients were adequately monitored and there were systems to manage those who condition was deteriorating. There was a focus on developing care for people living with dementia.

We found staff had received training on the Mental Capacity Act and the Deprivation of Liberty safeguards (DoLs) but not all staff were able to demonstrate a clear understanding about how it related to their role. We did not find this was having an actual impact on patient care.

The division was not responding to complaints within the agreed timescales. The trust recognised the need to improve performance on complaints and extra

# Medical care (including older people's care)

resources for the medical division were put in place in April 2014. Performance was improving and was being closely monitored through the governance arrangements at both divisional and trust board level.

Demand for medical beds often outstripped supply. In these circumstances there were arrangements to increase capacity through the use of additional beds. There were systems to ensure that care and treatment remained safe, that it was regularly reviewed and that there were staff accountable for these areas. Staff told us they felt supported by their leaders. There were arrangements to gather patient feedback and we saw that this feedback resulted in staff taking appropriate actions.

## Are medical care services safe?

Good



There were robust incident reporting mechanisms which were embedded, lessons were learnt from incidents and staff understood their personal responsibilities in relation to safety management.

Patients were cared for in clean and hygienic environments and there were sufficient staff with appropriate skills and experience to deliver care and treatment. There were arrangements to ensure that medicines were managed safely. Patients' records were kept securely and were fit for purpose,

However, not all staff fully appreciated their responsibilities under the Mental Capacity Act (2005), nor understood the requirements of the Deprivation of Liberty Safeguards.

### Incidents

- There had been one recent 'Never Event' reported in the division of medicine relating to a serious medication error. A serious incident known as a Never Event is classified as such because they are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented. We saw that this incident had been thoroughly investigated and actions taken and systems redesigned to prevent this recurring. Staff we spoke with were aware of the incident and the actions that had been put in place.
- Between March 2013 and February 2014 the medical division reported a total of 108 safety incidents, this accounted for 40.8% of all incidents at the trust. Eighteen were reported as severe incidents and five as deaths.
- Slips, trips and falls were the most numerous incidents and accounted for 47.6% of all incidents. The medical division has been focusing on falls reduction and the trust is recruiting a falls consultant nurse to explore ways of reducing these incidents. Actions were being taken to decrease the rate of falls. We saw that risk assessments for falls were completed for all patients and those at risk were identified by the use of a blue pillow case. Audit results showed that the modal average for the completion of completed falls risk assessments was 100%. We found that staff were aware

# Medical care (including older people's care)

of this alerting system but were told that availability of these pillow slips sometimes made it difficult to fully implement the system. Monitoring had identified an increase falls rate on Tilgate ward and focused work promoting appropriate footwear had decreased this rate.

- All staff we spoke with were aware of their personal role and responsibilities in reporting accidents and incidents. They told us that they received feedback following any investigation. The division has appointed a safety coordinator to support staff in the reporting, investigation and analysis of safety incidents.
- Matrons monitored incident information and this was discussed at formal meetings with the ward managers. We saw minutes of the divisional Quality and Risk Committee which showed that the divisional management team reviewed incident data and followed these up to ensure appropriate management.
- We saw records of mortality and morbidity meetings held by each speciality within the division which demonstrated that individual events or trends were identified and actions taken. Our monitoring showed that there no mortality indicators which demonstrated a risk of increased mortality. The indicators showed that the trust was performing better than expected when benchmarked against comparable hospitals.

## Safety thermometer

- Ward managers collected monthly data as part of the NHS Safety Thermometer scheme. Key safety information, such as days since the last fall, incidence of pressure damage or avoidable infection was clearly displayed at the ward entrance in a format that was easily understandable to patients and their families.
- For patients suffering new pressure ulcers the trust performed better than the England average for eight months of the year, In January 2014 the trust was better than the England average by 1%.
- Divisional performance indicators showed that no grade three or four pressure ulcers were reported in the medical division from September 2013 to February 2014. There were 16 instances of grade 2 pressure damage in the same period. However, during our inspection we found two instances which may suggest that staff may be underreporting. We saw pressure damage at grade three which had been reported as grade two, and an instance of pressure damage which had not been reported.

- Trust performance on the number of patients suffering falls with harm was worse than the England average eight months out of 12. Performance had fluctuated across the year and in March 2013 it was better than the England average. From September 2013 to February 2014, divisional performance indicators showed there were a total of 408 reported falls. Of these eight resulted in a bone fracture or head injury.
- The trust's performance of incidence of new venous thromboembolism (VTE) was worse than the England average for 10 months of the year. In March 2013 the trust performed above the average by 3.4%. During the period September 2013 to February 2014, divisional performance data showed that between 94.9 and 96.3% of patients were risk assessed for VTE each month.
- For patients suffering new urinary tract infection (UTI) the trust performed better than the England average for seven months out of 12.

## Cleanliness, infection control and hygiene

- Ward areas were clean and hygienic. There were audit arrangements to ensure standards were maintained and the results of these were good.
- We judged requirements of the Department of Health's 'Code of Practice on the Prevention and Control of Infections and Related Guidance' were being met.
- We saw that staff adhered to the trust dress code, for example 'bare below the elbows' and that hand-washing practice complied with the World Health Organization's 'Five Moments of Hand Hygiene'. Hand hygiene audit results show the division achieved a 100% compliance rate in five months between September 2013 and February 2014; the January 2014 result was 98%
- The level of MRSA and clostridium difficile infections at the trust between April 2013 and February 2014 were not judged to be statistically significant. The division reported five cases of C. difficile and one MRSA bloodstream infection from September 2013 to February 2014. MRSA screening rates in the same period were either 99% or 100%.
- In 2013, the Patient-Led Assessment of the Care Environment (PLACE) scored East Surrey Hospital 97.2% for 'cleanliness'.

## Environment and equipment

- Ward areas were pleasant and appeared well maintained. There were no obvious health and safety risks in the areas we visited.

# Medical care (including older people's care)

- Equipment was maintained and the service history was attached as a label. For example, we saw that all electrical equipment had undergone Portable Appliance Testing which was repeated at appropriate intervals.
- Decontamination labels indicated that patient equipment was clean and ready for use.
- Clinical electrical equipment was kept in an equipment library. Staff told us this was a 'godsend' as it meant they could be sure that equipment used in the treatment of patients was tested and functioning.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention. We were told that the response to such reports was timely and effective.
- We looked at the results of the 'Your Care Matters' patient survey for six medical wards for the last year. For the item 'staff explained the purpose of medicines in a way you could understand', the average score was 7.6 (out of 10) with a range of 6.9 to 8.1.
- Medication errors per 1,000 were within statistically acceptable limits for the trust overall. Between October 2013 and February 2014 the division reported 96 medication areas, but none of these had resulted in an adverse incident.

## Medicines

- Medicines were securely stored in locked cupboards. Controlled drugs were stored in accordance with legal requirements and records of their supply, use and destruction were comprehensive and current. These records included daily stock balance checks. Medicines that need to be refrigerated were kept in appropriate fridges, and the temperatures were checked to ensure that the medicine was stored at the correct temperature.
- There was a ward pharmacy service. The ward pharmacist visited the wards daily to check prescriptions, and to advise clinical staff and patients on all aspects of medicines management.
- A range of medication audits were undertaken, including the appropriate prescribing of antibiotics. We saw results of this audit which showed that good practice was being maintained with medical wards scoring 100% on most elements. The overall score for medicine was 96% with 86% of cases reviewed achieving full compliance across all elements of the audit.
- We observed drug administration and saw that it was safe and met the Nursing and Midwifery Council's guidance on the safe administration of medicines.
- Consideration was given to ensuring medicines were given on time. For example, it was identified that patients requiring medicines outside of usual drug rounds did not receive their medicines on time. A system had been developed to readily identify to nursing staff those patients who required medicines outside of drug rounds.

## Records

- Records were in paper format. Those we looked at were mainly complete and current and documented patient's needs, treatment and care. We found that on the Acute Medical Unit (AMU) not all risk assessments were completed within reasonable time frames and on Abinger ward some fluid balance charts had not been fully completed.
- Records were kept so that unauthorised access to them was minimised. There were suitable arrangements for the disposal of confidential waste. Risk information was highlighted to staff using symbols to prevent confidential information being displayed publicly. For instance, on Chaldon ward whiteboard those at risk of falling were identified by a diagram of a walking person.

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

- We saw that patient's permission was sought before day-to-day care and treatment was commenced.
- Some patients lacked the capacity to consent to a decision. We saw that the principles of the Mental Capacity Act 2005 (MCA) were adhered to. However, not all staff we spoke with could clearly articulate their personal responsibilities to ensure their personal practice complied with the Act.
- Training in the MCA formed part of the mandatory training programme, and staff confirmed that they had received this. We saw that some staff carried printed aide memoires reminding them of the MCA principles. The trust has introduced e-learning programmes to be completed on a three-yearly basis covering Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.
- Few staff we spoke with showed any understanding of the Deprivation of Liberty Safeguards (DoLS) although

# Medical care (including older people's care)

this was part of the mandatory training programme. Two senior nurses could recall incidents when DoLS applications had been made historically but could not recall the process.

- The process for making a DoLS application was available on the trust's intranet and staff knew it was there.

## Safeguarding

- Training in safeguarding adults and children formed part of the mandatory training programme. Staff reported that they had received this.
- Staff demonstrated an awareness of safeguarding processes. We saw examples in patient records of appropriate safeguarding referrals being made.
- Safeguarding information, including contact numbers and the trust lead were kept on the wards and staff were aware of how to access this.

## Mandatory training

- The trust had a three day mandatory training programme covering awareness sessions in areas such as infection control, falls prevention, safeguarding and life support. Some specialists who delivered this training expressed some concern that the time allocated to each session. They felt the 45 minutes allocated was inadequate to deliver meaningful training. Concern was also raised that the groups contained all grades of clinical and non-clinical staff which made it difficult to deliver the training at an appropriate level.
- In February 2014, 72% of divisional staff were up to date with statutory and mandatory training. Managers and staff told us that mandatory training was up to date, although there was a waiting list to access training. Staff indicated that they found the training useful.

## Assessing and responding to patient risk

- The medical wards used the national early warning score (EWS) tool to escalate care for acutely ill patients. There were clear directions for escalation printed on observation charts. Staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring.
- We checked observation charts and found that vital signs and the EWS were consistently and accurately recorded. We saw that staff had followed the actions

outlined when the score indicated that a patient's condition was a cause for concern. For example, we saw that observations were repeated within the prescribed timescales.

- A system to ensure that concerns were clearly articulated when they were escalated was in place. This followed the format Situation, Background, Actions, Review (SBAR). Staff were aware of this tool and it was published on the observation charts. However, there was no clear way to record this escalation that made it easily identifiable as it formed part of the routine nursing notes.
- Emergency equipment to deal with medical emergencies was readily available in each clinical area and staff were aware of its location. This equipment was checked daily to ensure it was ready for use.
- Staff were aware of actions they should take in the event of a medical emergency. Staff and managers told us that training in life support was mandatory and that staff were up to date.
- The critical care outreach team were available to support ward staff at all times. Ward staff told us they could always be contacted and valued the support and advice they offered.
- Nursing handovers took place at the beginning of each shift. A handover sheet was produced that contained all relevant information about a patient's needs, risk factors and plan of care to enable staff to care for patients safely. Medical handover between doctors took place at the beginning of each shift. There was a specialist consultant on call at all times.

## Nursing staffing

- Nursing staffing levels had been reviewed to meet national best practice guidance on recommended nurse: patient ratios. The division was aiming for a ratio of 1:7 during the day and 1:10 at night. These ratios were being met during the day on medical wards with the exception of Bletchingley ward (1:8.6) and Hazelwood ward (1:8).
- Only the acute medical unit and Hazelwood ward complied with the set ratio at night. The other wards ranged from nurse to patient ratios of 1:10 to 1:14. These levels were increasing as the trust employed new nurses.
- Each ward had a minimum staffing level and this, along with the actual staffing numbers for each ward, were displayed for staff, patients and the public to see.



# Medical care (including older people's care)

- The division, in line with other comparable trusts, was experiencing high levels of nursing vacancies. In March 2014, there was a total of 17.37 whole time equivalent (WTE) vacancies for untrained nursing staff and 47.6 WTE registered nurse vacancies in ward areas. Holmwood and the acute medical units were the wards with the most vacancies with WTE totals of 9 and 12.7 respectively. Abinger ward had the fewest vacancies totalling 1.22 WTE. In February 2014 the vacancy rate represented 6% of all staff within the division. The divisional management team had been proactive in recruitment, participating in recruitment fairs for newly qualified staff, recruiting from overseas and exploring the option of offering rotational posts.
- The matrons and ward managers told us that if additional staff were required to meet particular demands this was approved. For example, we saw that one particularly distressed patient had been nursed on a one-to-one basis for some weeks.
- Shortfalls in staffing were filled by the use of bank or agency staff. Ward managers told us that they used the same temporary staff wherever possible to promote continuity of care. Ward managers told us that requests for temporary staff were usually filled but not always, especially if shifts were requested at short notice.
- In February 2014, 41 WTE agency nursing staff were employed, and 76 WTE bank nursing staff were used. We looked at the percentage of requests for temporary staff that were not filled. We found that a total of 5.1% of requests for registered staff were not met and 9.9% of requests for untrained staff were unfilled. We found there were systems to induct temporary nursing staff to ward areas to ensure patient safety. We saw records of these inductions and observed a bank nurse being orientated to a ward.
- The division's expectations of junior medical staff were clarified in the documents, 'General Internal Medicine Junior Doctor On-call Rota – Guidance for junior doctors' and General Internal Medicine On call Rota – Roles and Responsibilities'.
- On call consultants were available in each speciality at all times. At weekends and bank holidays consultant ward rounds took place in the following specialities; General Medicine, Elderly Care, Cardiology, Gastroenterology and Acute Medicine.
- The division had recruited six physicians' assistants. A care of the elderly consultant told us that their contribution had been invaluable by carrying out in-depth geriatric assessments, ensuring routine tasks were carried out, and keeping patients and their families involved in their care. It was estimated the average length of stay on the ward had decreased by eight days since their appointment. Physicians' assistants were also used in the acute medical unit. Junior doctors from other specialities such as cardiology expressed support for the introduction of physicians' assistants in their specialities.
- The junior doctors' rota made use of a variable shift system which ensured that the greatest numbers of doctors were available at time of peak demand. For example, there were three 'twilight' doctors working a shift from 4pm until midnight. Medical handover between doctors took place at the beginning of each shift. The division were evolving a system of cross speciality working out of hours which they called 'Hospital 24/7'.
- Locum medical staff were used when necessary. A consultant explained that longer-term locum arrangements were preferred and usual to promote continuity of care. In February 2014 a total of 10 WTE agency doctors were employed and three bank doctors.
- The acute medical unit was covered by an on-site consultant every day, including weekends. Speciality consultants performed a ward round on the unit every day. After 7pm the unit was covered with the on call teams. The unit had been awarded a commendation award by the Society of Acute Medicine for its rota design.

## Medical staffing

- The medical division had invested in the recruitment of additional consultants. For example, the number of respiratory consultants has increased from two to five. Consultants and junior doctors reported that consultant cover and input was good.
- Junior doctors felt there were sufficient staff on the rota although junior doctors on Holmwood felt more staff were needed as the speciality was felt to be particularly busy and it was difficult to cover colleagues who were away carrying out on call-duties, or were absent.

## Major incident awareness and training

- Staff we spoke with were aware there was a major incident plan. One person told us that there had been a

# Medical care (including older people's care)

simulation exercise in the past year. Staff we spoke with knew their role in the event of a major incident being declared. This was particularly important given the close proximity of Gatwick Airport.

- The divisional historically encountered capacity and flow problems during the winter months. Staff, matrons and managers told us that this current winter had shown a great improvement. Escalation areas (extra beds) had still been used frequently but all staff told us that now the systems for doing this were clearer and ensured patient safety and staff accountability. For example, each potential escalation area had a matron and a consultant assigned to it and divisional staff staffed them with appropriate backfill to their substantive posts.

## Are medical care services effective?

Good



Patients received care that was based on current guidance and best practice from competent staff working in multidisciplinary teams. There was a programme of national and local audit to ensure practice reflected relevant guidance. There were adequate arrangements for ensuring services were available out of hours and there were plans to expand these. Indicators such as mortality rates demonstrated that the medical division was providing effective care.

## Evidence-based care and treatment

- The medical division used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to guide the treatment they provided. The division had a system for evaluating new guidance from NICE and learned societies and for disseminating this to clinicians.
- We saw that NICE guidance relating to the assessment of malnutrition risk and the risk of pressure damage was being implemented.
- The medical division participated in all national audits for which it was eligible in 2012/13. These included national audits in adult asthma, dementia and diabetes. For example, performance was found to be better than expectations for one of the five Myocardial Ischemia

National Audit Project indicators. Performance was rated as within expectations for all of the 19 Royal College of Physicians Audit of Falls & Bone Health in Older People indicator.

- We looked at the acute medicine Clinical Audit Programme for 2013/14 and noted that a total of 12 local audits had been scheduled and five had been completed. A wide range of topics was included including 'Medical management of self-harm and overdose at SASH – NICE CG16', 'Record Keeping Audit – Acute Medical Unit (AMU)', and 'Acute Kidney Injury Management'. We saw that the progress of these audits was monitored and recorded, including the development of any necessary action plans.

## Pain relief

- Patients told us that they had received appropriate pain relief. We observed staff assessing patients' pain levels and taking appropriate actions to ensure that appropriate pain relief was given.
- We looked at the results of the 'Your Care Matters' patient survey for six medical wards for the last year. For the item 'staff did everything to control pain' the average score was 8.5 (out of 10) with a range of 8 to 9.1.
- Staff could, and knew how to, access the specialist acute pain team when their advice was indicated. The palliative care team also provided support and advice in the pain control of those who were terminally ill.
- The observation chart contained a numerical patient pain scale. However, we noted that this was not routinely used when assessing pain. We also found that non-pharmacological approaches to pain relief were not explored.

## Nutrition and hydration

- We saw that patients were routinely assessed and reassessed for their risk of malnutrition. Audit results showed that screening rates showed an average of 100%. We saw that appropriate actions, such as referral to dietician or keeping food charts were taken as described by the risk assessment tool.
- We observed a meal service and saw that the ward adhered to the principles of protected meal times. We saw that patients were helped to eat. Some housekeeping staff had received training to enable them to help patients eat.
- There was an adequate choice of food available and those requiring cultural diets, such as halal food, were accommodated.

# Medical care (including older people's care)

- We observed the care of a person who was being fed via a naso-gastric tube. We saw that the dietician was fully involved in their care and that the care delivered was appropriate.
- We saw people being helped to drink. The division operates a system where red topped jugs are used to identify those who need help with drinking. However, this was poorly understood by staff and did not appear to influence practice. On Abinger, we saw that some patients fluid balance charts were not always fully completed and it was difficult to assess if patients had received sufficient fluids to meet their needs.
- We saw that some patients of Tandridge and Abinger wards appeared to have dry mouths. There was no record of mouth care being given. There was no consensus on the medical wards how and where episodes of mouth care should be recorded, and it was rare to find it had been.

## Patient outcomes

- Our intelligent monitoring programme did not identify any risks at the trust. This included indicators such as Emergency readmissions and mortality rates by speciality. Readmission rates for both emergency and elective admissions are as expected when compared to comparable hospitals. Likewise mortality rates were as expected for all medical specialities.
- The medical division participated in all national audits for which it was eligible in 2012/13. These included national audits in adult asthma, dementia and diabetes. These audits showed some positive results. For example, performance was found to be better than expectations for one of the five Myocardial Ischemia National Audit Project indicators. Performance was rated as within expectations for all of the 19 Royal College of Physicians Audit of Falls & Bone Health in Older People.
- The Enhancing Quality (EQ) programme in South East Coast has continuously monitored the heart failure service. The latest full year results demonstrate that more than 90% of patients received all four interventions identified as representing best practice and this was higher than any other provider involved in the enhancing quality programme across South East Coast. Similarly, the EQ programme has monitored performance in relation to pneumonia; performance of

the division in 2013 was the best region. In 2010 there was a Dr Foster alert for pneumonia mortality at the hospital; crude mortality has fallen and for 2012/3 the SHMI for all pneumonia admissions was 89.

- The Sentinel Stroke National Audit Programme (SSNAP) is a new programme of work which aims to improve the quality of stroke care by auditing stroke services against evidence based standards. The division met national standards in the number of admissions with suspected stroke receiving a brain scan within one hour and the percentage of hospital stay spent on a specialist stroke unit.

## Competent staff

- Staff received an annual appraisal. However, we saw that the division had identified that many appraisals were overdue. The ward teams had focused on this issue and appraisal rates had increased. Appraisal rates in the division for February 2013 to January 2014 were 85.7%, which was above the trust average of 83%.
- Staff told us that they had an appraisal and they found it useful. Appraisal records showed that detailed personal development plans were developed and staff told us that they were supported to achieve the objectives they contained. We were shown an example of how concerns about an individual's lack of competence were being addressed and managed.
- There were opportunities for staff to access informal training via specialist nurses, for example, dementia training. They could also apply to study accredited courses at academic institutions.
- Junior doctors praised the quality of the training they received and told us about the protected teaching time they had scheduled. The division enjoyed higher than average pass rate for Membership of The Royal College of Physicians.
- There was a robust system to ensure that nursing staff maintained current registration with the Nursing and Midwifery Council. Consultant medical staff were engaged in the process of revalidation.

## Multidisciplinary working

- Each of the medical wards had a team of therapists attached, including physiotherapists and occupational therapists. Staff could access speech and language therapists, and dietician. Specialist nurses such as falls coordinator or dementia consultant nurse could be contacted.



# Medical care (including older people's care)

- Therapists told us that they participated in a multidisciplinary meeting each morning on the ward. On Meadvale we were told there was a weekly discharge planning meeting which representatives for the local authority social services department attended.
- Psychiatric services were provided by an NHS mental health trust on an in-reach basis. Staff on the acute medical unit told us that they could call on mental health liaison nurses based at the hospital and they responded quickly.

## Seven-day services

- Consultants from acute and general medicine, cardiology, respiratory medicine and cardiology performed a daily ward round including weekends and bank holidays.
- Physiotherapy operated an on call rota to cover weekends and bank holidays.
- Physiotherapy and occupational therapy were planning to commence a seven day service and we were told this would be operational by October 2014.
- There were no difficulties with accessing diagnostic services, including pathology and imaging out of office hours reported to us.

## Are medical care services caring?

Good



Patients and their relatives told us that they were treated respect, and that their dignity and privacy were respected; we saw observed care and treatment being delivered in this way. Patients were made aware of their named nurse and consultant. Patients' views were sought and their feedback generated action. There were staff resources, including the chaplaincy service, to support patients emotionally.

## Compassionate care

- In February 2014, the trust was scoring higher than the national average on the friends and family test overall. However, five medical wards scored below the trust average of 70. When questioned, Bletchingley was a ward that patients would be 'extremely unlikely' to recommend to other people.

- We looked at the friends and family test results for six medical wards for April 2014. Scores for 'net promoters' (those who would recommend the ward) ranged from 33 (Bletchingley) to 100 (Meadvale). The average score for these wards was 76.5.
- We looked at the results of the CQC National Inpatient Survey 2012 and saw the trust was performing within expectations when compared to comparable hospitals. However, it performed worse in one area; "Were you ever bothered at night by noise from other patients."
- The trust has performed worse than other trust's nationally for 21 of the 69 questions asked in the 2012/13 Cancer Patient Experience Survey. The chief executive explained that currently cancer care is shared with another hospital meaning patients travelling long distances for appointments which was felt to lead to a poorer patient experience. The trust showed us advanced plans, including the building of radiotherapy facilities, to provide more integrated services from the East Surrey Hospital.
- In 2013, the Patient Led Assessment of the Care Environment (PLACE) scored East Surrey Hospital 87.6% for privacy, dignity and wellbeing.
- Comments and reviews appearing on the NHS Choices are varied and praise staff who are kind, caring and professional, good communication and patients being kept fully informed.
- We looked at the results of the 'Your Care Matters' patient survey for six medical wards for the last year. For the item 'treated with dignity and respect the wards scored on average 9.1 (out of 10) with a range of 8.8 to 9.4. For the item 'given enough privacy when being examined or treated' the average score was 9.5 with a range of 9.2 to 9.6.
- Patients with spoke with told us they felt the staff were very caring. One relative said the care had been 'outstanding'. A typical comment from a relative of a patient with complex needs was, "We are immensely impressed. The care is much improved since two years ago and is beyond all we expected."
- During the inspection we observed that patients were treated with courtesy. Requests for help were responded to promptly, staff introduced themselves and 'knocked' before entering rooms or going behind curtains. Patients appeared to be clean and comfortable.

# Medical care (including older people's care)

## Patient understanding and involvement

- Patients were allocated a named nurse at the commencement of each shift. We saw this name was clearly displayed by each patient's bed and was current. At the entrance to each ward the name and photograph of the ward manager and the matron responsible for the ward were clearly displayed, along with their contact details.
- At the entrance to each ward the name of the consultant in charge was displayed. On some wards, for instance Bletchingley, this was accompanied by a photograph.
- We looked at the results of the 'Your Care Matters' patient survey for six medical wards for the last year. For the item 'involved enough in decisions about care and treatment' the average score was 7.3 (out of 10) with a range of 6.8 to 7.9.

## Emotional support

- There was a range of specialist nurses who could provide emotional support to patients. These included the palliative care team and the discharge coordinator. The dementia consultant nurse has started running sessions to support relatives and carers of those living with dementia.
- There was a hospital chaplaincy team with representatives from all major world religions who could support patients and their families spiritual needs and provide emotional support. Ward staff told us that the chaplaincy team were easy to contact and attended patients promptly. Their support was valued.
- We looked at the results of the 'Your Care Matters' patient survey for six medical wards for the last year. For the item 'given enough emotional support during stay', the average score was 7.8 (out of 10) with a range of 7.1 to 8.5.

## Are medical care services responsive?

Good



The demand for medical beds exceeded capacity during busy times but there were procedures in place to manage these situations in a way that protected patients' safety and wellbeing.

There were facilities and systems to meet patients individual needs, although staff needed to be more familiar with the arrangements for obtaining translation services,

There were systems to manage complaints, and to learn from them. Not all complaints were responded to in the timescales set by the trust. This had been identified and action had been taken to improve performance. Data suggested performance was starting to improve and there was regular monitoring in place.

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

- Patients were admitted to medical wards via the A&E department or via their GP. GP requests for admission were assessed in the AMU. This incorporated an area for ambulatory care where patients could be assessed in chair spaces rather than beds. The AMU had a capacity of 40 beds. Patients were discharged from the AMU or transferred to the appropriate specialist medical ward. Latest waiting times for assessment in AMU were one hour, an improvement since the waiting time a year ago was two hours.
- Demand for medical beds frequently outstripped supply. In these circumstances patients could be placed in available beds outside of the speciality, or escalation beds could be opened. The most commonly used area for escalation beds within the division was the angiography area where additional beds were used on a total of 117 days in the period January to April 2014. There were arrangements to ensure outlying patients were reviewed by speciality teams and nursing staff reported they worked well. There were arrangements to ensure any escalation areas had a designated matron and consultant to oversee them.
- Trust occupancy, was consistently higher than the 85% target, with an average of 89% occupancy from October to December 2013. The monthly bed occupancy rates for the medical division from April 2013 to April 2014 ranged from 96% to 100%. However, the trust consistently achieved its accident and emergency access target of admission or discharge within four hours, suggesting that there were adequate bed resources to ensure prompt admission.
- Some patients had their discharge delayed. There was a discharge unit managed by the medical division. During the two days of our inspection a total of 67 patients were discharged via the discharge unit and staff reported that the unit was full to capacity on occasions. We were told the most common reason for discharge via the unit was patients waiting for discharge medication or ambulance transport.

# Medical care (including older people's care)

- During the period September 2013 to February 2014 the division achieved best practice in the 18 week treatment target and elective access. It was also achieving targets in cancer waiting times.

## Meeting people's individual needs

- The trust employed a dementia specialist nurse. Staff we spoke with felt the post holder was a valuable source of support and information. Some medical wards had designated dementia champions. We saw documents that demonstrated that the development of 'Dementia Care – A Standard Operating Procedure 2014–2016' were well developed. We saw posters, especially on Abinger ward, promoting the care of people living with dementia and advising staff, patients and their relatives of avenues of support. The use of the Alzheimer's Disease Society, 'This is Me' document was being rolled out to ensure staff had relevant information about individuals so they could support them more effectively. Some consideration had been given to making the environments dementia-friendly such as painting door frames in contrasting colours. Over 95% of patients aged over 75 years were screened for dementia.
- People with learning disabilities were supported by a community in-reach team. There was a 'passport' system whereby staff were provided with relevant information about an individual's needs so they could be supported in appropriate ways. The leaflets detailing how to make a complaint was available in an easy-read format suitable for people with a learning disability.
- Staff told us that they had access to specialist equipment to assist them to safely care for bariatric patients. This included chairs, commodes and special beds. Staff reported that there were no problems obtaining this equipment when required.
- Interpreting services were available through a telephone translation service. However, not all staff in the division were fully aware of how to access this saying that the ward clerks had all the contact details which weren't available when they were not on duty. This was significant as the trust served a diverse local population. We saw two examples where patients where English was not their first language were not being supported through the appropriate use of translation services.
- We received some negative comments from relatives regarding car parking availability.

- We did not see any instances of mixed-sex wards and the division did not report any breaches of this standard between September 2013 and February 2014.
- The medical wards had all produced ward specific information leaflets containing useful information such details of staff, contact numbers, ward routines and discharge arrangements. We saw that these were freely available for patients and their relatives.

## Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff directed patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- The division was not responding to complaints within the agreed timescales. From April 2013 to January 2014 the division received 52 complaints of which 27% were dealt with in the agreed timeframe. The reason for delay in 28 complaints was cited as the division drafting a response late.
- The trust recognised the need to improve performance on complaints and extra resources for the medical division were put in place in April 2014.
- In May 2014, the division's performance on complaints handling was 63% which was a significant improvement.
- Complaints data and performance was reviewed and discussed on a monthly basis at divisional governance meetings.
- There were systems that ensured all relevant staff were informed of a complaint, the results of investigations, actions to be taken and lessons learned. Matrons monitored complaints to identify any emergent themes and complaints were discussed with ward managers at their formal meetings. The divisional management teams reviewed complaint data during Quality and Safety meetings.
- Real life anonymised complaints were distributed to ward teams to act as discussion and learning aids. Staff told us they found this a particularly useful approach in reflecting on a wide range of issues.
- Key points of patient feedback were displayed at the ward entrance, along with the actions the ward had taken to address any negative issues raised. For example, one ward had received feedback about long waits for discharge medication and process changes to speed up this process were described.

# Medical care (including older people's care)

## Are medical care services well-led?

Good



The chief executive was well known in the organisation and staff valued his leadership which they felt had brought positive change in the last two years. The trust strategy and nursing strategy were well publicised and staff understood the underlying ethos.

Within the medical division we saw strong clinical leadership and arrangements that ensured good governance. The divisional strategy made clear the objectives for medical care and described how these would be achieved. Due consideration was given to the impact of any cost savings plans on quality and safety of care. Staff expressed positive attitudes about working in the division.

### Vision and strategy for this service

- We saw copies of the trust vision statement on each ward we visited. Copies of the trust's nursing strategy were also available. While not all staff we spoke with could quote the strategy documents, they all knew of its existence, and were able to describe the underlying ethos.
- The medical division had produced its own strategy document outlining its key objectives which linked to the overall organisational objectives. The strategy detailed the rationale for the developments, and described the plan to achieve them. It was evident that senior clinicians had been involved in the development of this strategy.

### Governance, risk management and quality measurement

- The division held bi-monthly quality and safety meetings. The agenda included feedback from patient surveys, review of complaints, serious incident reviews, health and safety and clinical audit results. We looked at the minutes of these meetings and saw that actions to be taken were identified and progress of these was monitored.
- The medical division received a 'Divisional Detailed Scorecard' as part of the 'SaSH Performance Assurance Framework'. Performance over the last six months for a wide range of indicators in a number of domains, including the delivery of safe, high quality, coordinated

care, ensuring patients were cared for and about, and becoming an effective sustainable organisation. We noted from the divisional scorecard that the division was judged to be 'delivering'.

- The medical division maintained a risk register which contributed to the organisational risk register. We saw that risk on the register was assessed to determine the level of risk using a scoring system and that mitigating actions were identified. We could see that risks were reviewed. We were told that any staff member could ask for a risk to be entered on the register, although there was a validation process led by the divisional management team before the entry was made.
- We saw that ward managers were provided with regular reports on incidents that occurred in their area, complaints, survey results and staffing data. This information was discussed with the matron for the area, who monitored themes and trends.
- Medical specialities had been subject to a 'deep dive' review where the specialities performance and plans were scrutinised by a board-level panel. We saw notes of these reviews and saw that specialities had identified their strengths and weaknesses, including examples of good practice in relation to the five key questions asked during a CQC inspection.
- We found that matrons, lead consultants and members of the divisional management team showed an awareness of how the division was performing, and could readily identify the areas of strength and areas requiring improvement. This demonstrated good governance in the division.

### Leadership of service

- All staff we spoke with were aware of the name of the chief executive, who was praised for his leadership. There was a strong expressed opinion that the improvements they felt the trust had made in the past two years were enabled by his leadership. His weekly messages were read and appreciated for their positive content. Staff told us that the chief executive was frequently seen around the hospital.
- Staff knew the name of the director of nursing and commented that she was visible in the ward areas.
- Staff spoke positively about clinical leads. We judged the clinical lead in acute medicine to be exceptional in his enthusiasm, and commitment to high-quality care and innovation.

# Medical care (including older people's care)

- Ward staff told us that they felt supported by the matrons, who visited the ward areas at least daily. We saw the matrons on ward areas talking to staff and patients frequently during our inspection.
- Leadership training was available and ward managers told us they had participated in leadership programmes. A total of 40 staff in the division completed a range of leadership development programmes in 2013/14 including total of 15 ward managers undertook the ward managers' leadership programme.

## Culture within the service

- Staff we spoke with were positive about the organisation and the care they provided to patients. The 2013 NHS Staff Survey indicated staff at the trust were more likely to agree that their role makes a difference, feel supported by their immediate management and be motivated and satisfied with their work. Staff from the medical division participated in this survey.

- The trust overall sickness rate of 3.9% was below the England average of 4.2%. We looked at the sickness rates for the medical division from November 2013 to April 2014. They ranged from 2.7% to 3.9% per month, less than the England and trust averages.







## Public and staff engagement

- Patients had opportunities to provide feedback about the care and treatment they had received via the 'Your Care Matters' survey scheme.

## Innovation, improvement and sustainability

- The divisional management team explained their approach to ensuring any cost improvement plans were sustainable and did not adversely impact on patient safety and quality of care. All cost improvement plans were risk assessed and mitigating actions described. The divisional team worked closely with the trust board to ensure that any cost savings were sustainable, and realistic.

# Surgery

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

## Information about the service

The surgery department at Surrey and Sussex Healthcare Trust provided a range of surgical services to a population of 535,000. It delivered surgical specialities including colorectal, vascular, breast, gynaecology, urology, ear nose and throat, orthopaedics and obstetrics. It also offered a range of laparoscopic (keyhole surgery) procedures as well as a 24 hour emergency and trauma service.

The Crawley hospital site had a Day Surgery Unit (DSU) that offered a range of surgical procedures including Upper and Lower Gastrointestinal, Gynaecology, Ophthalmology, ENT (Ear, Nose and Throat), Chronic Pain, Breast Surgery, Orthopaedics, Dermatology as well as pre assessment clinic facilities.

In order to carry out this inspection, CQC reviewed information from a range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, other external stakeholders, and held a listening event where members of the public were invited to share their experiences. We visited the surgical wards and observed care being delivered by staff. We reviewed online patient feedback and took the information we received before, during and after the inspection process from members of the public. 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 SASH.

During the inspection the inspectors visited ward areas and the theatre department. They also visited the DSU at Crawley Hospital. We spoke to 36 staff, 21 patients, 11 relatives and attended two public listening events and staff focus groups.



# Surgery

## Summary of findings

Patients who used the service experienced safe, effective and appropriate care and treatment and support that met their individual needs and protected their rights. The care delivered was planned and delivered in a way that promoted safety and ensured that peoples individual care needs were met. We saw patients had their individual risks identified, monitored and managed and that the quality of service provided was regularly monitored. We found the clinical environments we visited and other communal areas in the hospital meticulously cleaned. Hospital-acquired infections were monitored and rates of infection were of a statistically acceptable range for the size of the trust.

Outcomes for patients were good and the department followed national guidelines. Complaints were investigated and handled in line with standard policy. We saw the trust use patient's complaints and comments used as a service improvement tool and the trust actively encourage feedback from its patients and their relatives or loved ones.

## Are surgery services safe?

Good



The department use the safety thermometer to monitor and assess the quality of care being delivered. We saw people care needs were assessed, planned and delivered in a way that protected their rights and maintained their dignity. The hospital used an Early Warning Score (EWS) to identify and monitor deteriorating patients and the care pathways we reviewed provided an audit trail of the actions taken by staff when patients deteriorated.

Incidents were reported, monitored, investigated and learned from and reported as per national guidance. We found there were enough staff on duty to meet patients' needs. Staff had received appropriate mandatory training and reported feeling competent to meets peoples care needs. We did identify a lack of clarity surrounding mental capacity and Deprivation of Liberty Safeguards (DoLS) issues amongst some staff but did not find any impact to patient outcomes.

### Incidents

- We saw the hospital incident reporting system used appropriately to report incidents. The incidents were reviewed regularly by team leaders/senior sisters. If the incidents reported were related to falls, pressure area care or nutritional concerns we saw that the specialist /consultant nurses were involved in review of the incident. This meant there was a multidisciplinary approach to clinical incident investigation and future prevention planning.
- We found the learning from incidents was consistent and led to changes in practice to ensure patient safety. Staff received information on incidents at ward meetings, emails, staff notice boards and participated in debriefing sessions. We saw documentary evidence that confirmed this.
- The trust performed better than average for staff reporting errors, near misses and incidents.
- Between March 2013 and February 2014 surgical specialties had a total of 47 incidents reported which were categorised as 37 moderate, five severe and five abuse and no deaths. We saw all incidents were reviewed, fully investigated and had a recorded outcome and action plan produced.

# Surgery

- We reviewed trust board meeting minutes which demonstrated that incidents were reviewed regularly at board level.
- The trust submitted 30 severe harm notifications between March 2013 and February 2014, 77.7% of which occurred within inpatient areas. Surgical specialties accounted for five incidents with two being categorised as treatment, procedure, implementation of care and ongoing monitoring/review. The remaining surgical specialty incidents were categorised as consent, communication, confidentiality, patient accident and treatment/procedure, with one each.
- Team debriefs always took place after any incident had occurred. We saw documentary evidence that this practice had been well established in the department.
- A serious incident known as a Never Event is classified as such because they are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures had been implemented. The trust previously reported two never events happening between December 2012 to March 2014. One of the two events identified occurred in the surgical department. We saw evidence that this incident was fully investigated and learned from. One of these Never Events occurred at Crawley Hospital DSU and we saw evidence that the department had learned from the event and had increased the WHO (World Health Organisation) five step check to six steps as a result.
- The trust submitted document evidence that confirmed Mortality and Morbidity (M&M) meetings happened regularly in all surgical disciplines. We viewed comprehensive data that demonstrated M&M reviews were firmly embedded within the surgical department. We were also provided with minutes from the safety and quality committee which reviewed M&M data on a monthly basis and had documented actions and outcomes from the review.
- The trust had no indicators rated as risk or elevated risks in the March 2014 CQC Intelligent Monitoring Report.
- The NHS staff survey 2013 demonstrated the trust scored tending towards worse than expected for the fairness and effectiveness of incident reporting procedures. Staff we talked with during our visits did not raise this as a concern with us.

## Safety thermometer

- The clinical areas we visited were able to demonstrate routine data collection for the national safety thermometer.
- We saw evidence that safety thermometer data was being used to improve the quality of care.
- We saw documentary evidence in ward areas that demonstrated good clinical practice in relation to pressure area care delivery. Patients had risk assessments in place and where a risk was identified, action was taken to ensure a patient's position was regularly changed and they had an appropriate pressure relieving equipment in place and specialist nurse input where required.
- We saw that the trust had a falls strategy in place that was having a positive impact and reduction on the amount of slips, trips and falls in the hospital. New incentives included patients being issued with anti-slip stockings and ensuring that a nurse was present in bays overnight where an increased risk of falls has been identified. The trust had employed a falls nurse consultant as a measure to reduce falls during hospital admission and provide expert advice and clinical support for staff.
- We found hand hygiene performance was recorded monthly. However, we noted a disparity in participation in the theatre department. We found that although the audit was carried out in the recovery area if was not carried out on the theatre staff. We brought this to the attention of theatre management at the time of inspection.
- The trust performance of new VTEs (venous thromboembolism) was worse than the England average for 10 months of the year.
- We saw day surgery patients had anti-embolism stockings in place where their use was indicated. We also found patients were having their risk of developing a VTE assessed.
- The trust recently performed a root cause analysis of hospital-acquired thrombosis for 2013/14. As a result, improvements to practice had been made and performance had improved in recent months.

## Cleanliness, infection control and hygiene

- We found the surgical wards and theatre department to be adhering to national infection control guidance. We found a very high standard of cleanliness in all the areas



# Surgery

we visited and throughout the communal areas in the hospital. Each area had its own cleaning logs and audit process in place to ensure standards were consistently maintained.

- Where applicable, we saw there was provision of appropriate treatment for those who were affected by a healthcare associated infection.
- We found staff had access to an adequate supply of reusable medical devices and consumables.
- Sufficient hand washing facilities were available in all areas and there was an ample supply of PPE (Personal Protective Equipment) available for staff.
- We found ample supply of alcohol gel for visitors and staff.
- We saw that equipment was regularly cleaned and labelled to identify it was ready for use.
- Clinical areas, communal areas and visitors' toilets were reviewed at our unannounced inspection and we found all these areas to be cleaned to a very high standard.
- The clinical notes we reviewed contained evidence that demonstrated patients were MRSA screened prior to admission and on admission if they did not go through the pre-assessment pathway. We also reviewed evidence submitted by the trust that demonstrated MRSA screening compliance was monitored monthly and that the trust had an average compliance rate of 99% between September 2013 and Feb 2014.
- We viewed staff washing their hands and wearing appropriate PPE before they provided any care to patients.
- The trust had a dedicated infection control team that provides support to staff five days a week. The team was made up of a lead Infection prevention and control nurse, senior infection prevention and control nurse, infection prevention and control nurse and an intravenous nurse specialist.
- The trust's infection rates for clostridium difficile and MRSA infections lie within a statistically acceptable range for the size of the trust.
- We noted that 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.
- We spoke to a dermatology consultant who could demonstrate a very in-depth audit system that took account of surgical site infection rates and surgical outcomes for the patient's receiving this service.

## Environment and equipment

- We saw a wide range of equipment available and staff told us that they had access to the necessary equipment they required to meet peoples care needs.
- Staff told us the hospital operated an effective on site equipment library that was staffed five days a week. We were told that nursing staff and access to this area out of hours and weekends and that equipment was effectively provided at all times.
- We saw that equipment was regularly cleared and labelled to identify it as ready for use.
- Resuscitation equipment in all areas was found to be regularly checked and emergency drug kits were found to be readily available and in date.
- Each clinical area also had an in date anaphylaxis and first aid boxes available.
- The staff we spoke to told us they had received relevant training on how to use equipment and felt confident and competent they could deal with a foreseeable emergency in their clinical areas.
- We found the operating lights in the theatre department to be old and ineffective.
- We could see that the environment on the orthopaedic ward did not have an ideal amount of space, storage facilities or day areas for patients. We were told that this has already been identified as a concern by the trust and that a strategic plan was in place to move the facility when the next phase of building work was completed. We identified a very old call bell system on these wards that when used, rang very faintly. The trust was also aware of this issue and had recorded it on the trust risk register. We did not see any impact to patients as a result of this.

## Medicines

- We found patients were receiving their medications at the time they need them and in a safe way.
- We saw medication was stored appropriately and handled safely in the department.
- The hospital regularly audited MARs (medication administration records) to identify medication errors of missed medication.
- We reviewed a sample of MAR's on each clinical area we visited and found them to be complete, legible and contained evidence of best practice in relation to medication administration.
- All staff received a competency based assessment before administering medication.

# Surgery

- We spoke to a member of staff from the pharmacy department who told us about medication audit activities in the hospital. This was also evidenced in the data submission made by the trust.
- We carried out random medication checks in some ward areas and found all stock drugs to be stored appropriately and in date.
- We also carried spot checks on controlled drug register, storage and expiry dates and found all the areas checks to be following national guidance.

## Records

- We found records including medical records were accurate, fit for purpose were stored securely and remained confidential.
- We were told by the ward clerks that notes were easily accessible and on the rare occasions where notes were not available there were systems in place to create temporary notes.
- We saw appropriate storage units in place for confidential paper shredding.
- The sample of care plans we reviewed in each area had relevant, updated and complete risk assessments in place. This included falls risk assessments, MUST (Malnutrition Universal Screening Tool) and where used bed rail risk assessments.
- We found that all patients had undergone an electronic VTE assessment on admission. We saw details of this assessment was printed out and stored in patients care plans. The MAR we reviewed did not always have the VTE assessment signed by the admitting doctors. We identified one patient on our unannounced visit who had had a completed VTE assessment in place, VTE medication administered but did not have anti-embolism stockings in situ.

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

- We found the trust carried out a snapshot consent audit in the surgical department in 2013. We noted Urology carried out a speciality specific audit in 2013/2014. This demonstrated that compliance with national guidelines for consent was audited.
- We were provided with evidence that all doctors at all grades were required to undertake online training in Deprivation of Liberty Safeguards (DoLS), mental capacity and consent. We saw documentary evidence that this training was followed up by a training day that included Vulnerable Adults/MCA teaching.

- Staff had received mandatory safeguarding training which had included information about the MCA and DoLS. However, we found not all of the staff we spoke with had a clear understanding of the MCA and DoLS. Staff were aware that there was a policy available and guidance was on the intranet.
- The consent forms we reviewed were complete, and demonstrated the risks associated with the surgical procedure were recorded.
- The patients we spoke to told us they received enough information about their procedures prior to consenting for treatment.

## Safeguarding

- The trust submitted 34 abuse notifications between March 2013 and February 2014, 14.7% of those occurred within surgical specialties with just over half (55.9%) of incidents were categorised as patient abuse (by staff/ third party) with a total of 19, the remaining 15 were categorised as disruptive, aggressive behaviour (includes patient to patient).
- We found all staff had completed safeguarding training as part of their mandatory training programme.
- We were provided with documentary evidence that medical staff had undertaken a formal teaching session on safeguarding and online training.
- We saw that staff had access to a safeguarding adults pocket guide produced for the NHS in the south of England. This booklet contained information on the following areas: staff responsibilities, categories of abuse, staff role as an alerter, information sharing, capacity and consent, pressure ulcer categories, mental capacity act decision making flow chart, DoLS.
- The staff we spoke with were able to define a safeguarding incident and describe the steps they would take to report a concern. They were also able to locate the adult safeguarding emergency telephone numbers which we noted were displayed in each clinical area.

## Mandatory training

- We found the trust had an annual three day mandatory training programme for staff.
- We reviewed the training matrix that confirmed that staff had received mandatory training.
- The staff we spoke to told us that their training needs were continuously met and that if they required extra training that it was provided.

# Surgery

- The NHS staff survey demonstrated better than expected results for: staff reporting receiving job relevant training learning or development in the last 12 months, percentage of well-structured appraisal.

## Management of deteriorating patients

- The trust operated a EWS (Early warning score) to aid the identification and management of deteriorating patients.
- The care plans we reviewed demonstrated that EWS was being used appropriately and care pathways contained an audit trail of actions taken by staff when the patient's condition required escalation.
- We were told by nursing staff that when a medical review was necessary that the on-site anaesthetic and surgical consultants were responsive in reviewing patients.
- There were measures in place to aid the transfer of deteriorating patients from the Crawley Hospital DCU to the main hospital site by ambulance.
- The surgical department had embraced and fully embedded the WHO (World Health Organization) safer surgery checks and the trust could demonstrate an audit cycle to reflect its use and identify any shortfalls.
- We noted that the trust had a continuous 100% completion rate for the completion of this check since November 2013. We observed the theatre team using the check list during the inspection.
- In response to a serious incident the trust had increased the five step check to six to ensure a higher standard of safety.

## Nursing staffing

- From our observations, the rotas we viewed and the conversations we had with staff we found an appropriate staff numbers and skill mix in clinical areas.
- The hospital used a staffing acuity tool that monitored staffing levels on a daily basis and took patient's acuity into consideration. This meant that clinical areas were appropriately staffed.
- Staffing was reviewed at a senior level on a daily basis or more regularly if the service indicated a change in acuity or identified pressures on service delivery.
- The staff we talked with told us that they felt there were enough staff to meet people's care needs.
- We noted from rotas viewed and conversations with staff that every effort was made to offer permanent staff outstanding shifts to promote continuity of care.

- When this was not possible agency and bank staff provided cover where vacancy remained unfilled or when acuity had increased.
- Theatres used agency to fill the more specialised roles whilst the trust were in the process of recruiting staff.
- Agency and bank staff completed an induction prior to working at the hospital and records of the induction were viewed during the inspection.
- Nursing staff participated in regular handovers to ensure that patients care needs were discussed to ensure effective continuity of care.
- Our unannounced inspection noted that staffing on SAU (Surgical Assessment Unit) and Newdigate ward appeared stretched but we did not find that patient care was adversely affected.

## Medical staffing

- The trust reported 20 vacancies (inclusive of all grades) in the surgical department. We saw from the data provided the trust had made significant progress in recruiting into these positions. The data suggested that nine positions had been filled; another three were in the interview phase of recruitment. The six outstanding posts were junior post in anaesthetics which were remained outstanding at the time of inspection.
- The junior doctors we spoke with during the inspection told us they felt there was enough doctors to meet people's care needs.
- The trust performed similar to expected in the General Medical Council – National Training Scheme Survey 2013 in the surgical directorate. However, the trust scored worse than expected for junior doctors attending regional training. During the inspection we talked with juniors who told us that this was no longer the case.
- We saw the trust performed within the national expectations for handovers in the general medical council national training scheme survey. The junior doctors we spoke did not raise any concerns relating to handovers.
- The trust was employing locums to ensure appropriate medical cover and quality care for patients. We saw significant and successful attempts had been made to recruit permanently into these positions.
- The trust had consultants available on site five days a week and provided an on call system at weekends and out of hours.
- Consultant led ward rounds were in place at weekends.

# Surgery

## Major incident awareness and training

- We reviewed the major incident policy and procedures.
- The staff we spoke with could tell us their role in managing a major incident and expressed confidence in doing so.
- The trust had an appropriate major incident/business continuity plan in place.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures existed and were deemed fit for purpose.

## Mandatory training

- We found the trust had an annual three day mandatory training programme for staff.
- We reviewed the training matrix that confirmed that all staff had received mandatory training.
- The staff we spoke to told us that their training needs were continuously met and that if they required extra training that it was provided.
- The NHS staff survey demonstrated better than expected results for staff reporting receiving job relevant training learning or development in the last 12 months, percentage of well-structured appraisal.

## Are surgery services effective?

Good



We found the care delivered in the department to be evidenced based and adhered to national and best practice guidance. The care delivered was routinely measured to ensure quality, adherence to national guidance and improve quality and patient outcomes. The trust was able to demonstrate that it was continuously meeting national quality indicators.

The trust had a dedicated pain team that provided specialist pain services to patients and staff. The patients we spoke to told us that pain medicine was administered in a timely fashion and that they were satisfied with the way their pain was managed. We saw evidence of best clinical guidance was in place for patients who received patient controlled analgesia PCA and epidural infusions.

## Evidence-based care and treatment

- For patients suffering new pressure ulcers the trust performed below the England average for eight months of the year, In January 2014 the trust was below the average by 1%. In June 2013 the trust performed above the England average by 0.8%.
- The trust's performance of new VTEs was worse the England average for 10 months of the year. In March 2013 the trust performed better the average by 3.4%. In August 2013 the trust performed below the England average by 0.2%.
- There was a multidisciplinary team approach to reviewing any cases where a patient developed a VTE whilst being an inpatient or within 90 days of surgery.
- For patients suffering new urinary tract infections (UTI's) the trust performed worse than England average for seven months out of 12.
- For patients suffering falls with harm the trust performed worse than the England average eight months out of 12, in August 2013 by 1.5%. In March 2013 the trust performed better than the England average by 0.5%.
- The trust's infection rates for clostridium difficile and MRSA infections lie within a statistically acceptable range for the size of the trust.
- We found evidence that national guidance was being followed in the department and that hospital policies were based on NICE/Royal Colleges' guidelines.
- Care was provided in line with NICE CG50 (Fall Prevention Guidance) and CG83 (Rehabilitation After Critical Care Guidance), CG92 (VTE Guidance), CG29 (Pressure Area Care), CG139 (Infection Control), and CG124 (Fractured Neck or Femur Guidance).
- There was evidence in the care plans and notes we reviewed to demonstrate compliance with local hospital policies.
- The trust complied with NICE CG 135 (organ donation identification) for any patient where the planned withdrawal of treatment was to be referred to the Specialist Nurse in Organ Donation.
- There was a planned focus in the department for 2014/15 of standardising orthopaedic protocols for surgical site dressings and skin preparation and to audit compliance with the Surgical Site Infection NICE Quality Standard 49.
- We saw evidence of local audit activity exclusive of mandatory submissions within the surgical department. Clinical audit was actively encouraged amongst staff.

# Surgery

## Pain relief

- The hospital used appropriate pain scoring tools to assess adult and paediatric pain levels.
- Pain levels were assessed pre and post operatively if applicable.
- Patients who were receiving PCA and epidural infusions had a prescription in place for anti-sickness and reversal medication as well as an intravenous bag of fluid to be used in the event of an emergency in line with national guidance.
- Pain assessments and patient expectations were discussed with elective patients at pre assessment appointments with the clinical specialist nurses.
- The hospital employed a dedicated pain team that provided support to ward areas five days a week. Out of hours and at weekends clinical advice could be sought from anaesthetic staff or the recovery team.
- The patients we spoke to told us that their pain was well controlled and that analgesia was administered in a timely manner when requested.
- The DSU used an appropriate pain scoring tool to assess adult pain levels.
- Patients in the DSU were prescribed and dispensed pain medication before leaving the department.
- Patients received appropriate information on discharge detailing how to manage their pain.
- The patients we spoke to told us that their pain was well controlled and that analgesia was administered in a timely manner when requested.

## Nutrition and hydration

- We spoke to patients during our inspection who told us that they were very happy with the meals that they received during their stay.
- Staff told us that quality of the food had greatly improved and was cooked on the hospital site.
- We saw a range of (colour coded) menus available to meet people's individual dietary needs. Each colour related to a different type of diet.
- We saw lists in the hostess's areas that identified people's dietary needs. We were told that this list was updated by the nurse daily so the hostesses have the most up to date information.
- Patients were given food options daily so they could choose what they wanted to eat.
- When patients missed the opportunity to choose food in advance could choose from a range of sandwiches or lunch box items or opt for tea and toast.

- We saw patients who required support with eating being assisted in a kind and caring manner by support staff.
- Patients were screened using the Malnutrition Universal Screening Tool (MUST). If a risk of malnutrition was identified a food and weight diary was kept by the staff.
- Patients' weights were recorded on admission and monitored to identify any weight loss during their hospital admission. These were evidence of good clinical practice on the wards with the majority of patients being weighed as per hospital policy.
- Post-operative patients were offered sandwiches, biscuits and a range of fluids.
- Patients were also given dietary advice specific to their surgery type prior to discharge.

## Patient outcomes

- During the inspection we observed a discharge and found it to be robust with appropriate verbal and written information provided which was specific to the patient's admission. Information was also given about post-operative medication and support. The patients we spoke to told they felt they were given enough information and had many opportunities to talk to nursing and medical staff about their concerns should they need to.
- The trust participated in all the clinical audits it was eligible to take part in 2012/13.
- The trust's performance for two of the five National Bowel Cancer Audit Project indicators was found to be better than expected.
- The trust's performance was rated as within expectations for all of the 19 Royal College of Physicians Audit of Falls & Bone Health in Older People indicators, except for the indicator "Does an occupational therapist routinely assess for potential hazards within the patient's home", which was not included.
- The department was meeting all nine standards of care measured within the National Hip Fracture Database.
- The length of stay at the Surrey and Sussex NHS trust was reported as 4.7 days on average or a median of two.
- The majority of patients admitted to the Day Services Unit were discharged on the same day unless their condition required overnight observation.
- Data supplied by the trust suggested it treated 90,175 patients in 12 months. Of those 5637 were readmitted within 30 days of surgery which demonstrated a readmission rate of 6% in the specified time frame. This rate is not concerning.



# Surgery

## Competent staff

- Training data supplied by the trust identified that staff training was being delivered in an effective and consistent manner across the department.
- We saw records that demonstrated staff had received annual appraisals.
- The staff we spoke to during the inspection assured us that they felt competent to undertake their roles. We were also told that if staff identify a learning need, this was addressed and training was provided.
- Nursing staff had a competency based assessment before administering medication.
- Nursing pin numbers were checked annually to ensure all nursing staff had a valid registration and appeared on the national register.
- All medical staff took part in a regular revalidation process.
- There was an onsite library which we saw was utilised by staff using the inspection. There was an area where audit activity and best clinical guidance was on display for staff to access recent and relevant healthcare information.
- Staff at Crawley Hospital could access the post graduate facilities that were owned and managed by another trust. Staff did express concern that due to future planned changes they might not be able to access them in the future.

## Multidisciplinary working

- It was evident that there was a functional multidisciplinary approach to the care delivered in the surgical department. The documents we reviewed and the staff we spoke with confirmed this.
- We observed physiotherapy, occupational therapy and specialist nursing input into care during the inspection.
- We were told about the positive relationship with adult social care and community care staff and the support provided for patients in the community.
- We saw a regular multidisciplinary team (MDT) meeting in progress whilst visiting a clinical area and we were told that this was only one of many MDT's that took place in the ward.
- We identified successful multidisciplinary working between the East Surrey Hospital site and Crawley Hospital sites.

## Seven-day services

- Consultant cover was available seven days a week. This meant that consultants were on site from 8:00am to 5:00pm and an on call system operated out of hours and at weekends.
- All new admissions were seen by a consultant within 12 hours of admission.
- Daily consultant ward rounds were in place seven days a week.
- Nursing staff told us that medical cover at weekends was appropriate and accessible.
- Physio and OT services were provided Monday to Friday but there were plans for this to become a seven day service in the near future.
- We found out of hours imaging and pharmacy support were available. However, we did identify a problem with staffing in the radiology department. The trust was attempting to resolve the problem and have steps in place to ensure that clinical care is not affected. We were aware that radiology staffing is a national problem and not unique to this hospital.
- The DSU at Crawley Hospital delivered a day surgery service five days a week.
- We were told that the unit occasionally operated on a Saturday to be able to meet its waiting time targets. The unit was undergoing an open consultation with staff relating to providing a 24-hour service in the future.

## Are surgery services caring?

Good



The patients we spoke with during the inspection told us that they were treated with dignity and respect and have their care needs met by “kind” and “caring” and “dedicated” staff. We observed patients being treated in a professional and compassionate manner by staff. The staff we talked with told us that they loved their jobs and felt ‘happy’ coming to work. They also talked about being dedicated to delivering good quality patient care and making a real difference to people. We saw patients’ feedback displayed in all ward areas that demonstrated satisfaction with the service provided.

Patients reported feeling involved in planning their care and told us they received enough information about their

# Surgery

conditions. The trust employed a range of specialist nurses who were able to provide emotional support for patients and make referrals to external services for support if necessary.

## Compassionate care

- We noted a very welcoming and pleasant atmosphere throughout the surgical department and the DSU at Crawley Hospital. This was confirmed by our conversations with patients during the site visits.
- The trusts friends and family test score was better than the national average. None of the surgical wards scored below the trusts average score.
- The staff team we observed and talked with during the inspection were noted as being hard working, kind, approachable and dedicated to delivering high-quality patient care.
- We observed staff treating patients with dignity and respect and conversations with patients and their relatives confirmed this.
- We observed staff being professional, empathetic and responsive to patients' individual needs.
- We also observed staff deal with patients private and sensitive concerns with great tact and professionalism.
- Staff provided support to patients and their loved ones so they could understand their care and the choices available to them.
- From the conversations we had with staff and our observations it was clear that the staff put patients at the centre of their care and treatment and supported them to make informed decisions.
- Patients were able to express their views, so far as they were able to do so and were informed in making decisions about their care options.
- The trust performed "within the expected range" for 10 of the 10 Adult Inpatient Survey sections.
- Patients were discharged with relevant information about their post-operative care and were given a telephone number to call if they were worried about their condition for 24 hours after their procedure.
- The ward staff on the DSU had an effective follow-up system in place for reviewing patients who had surgery. Staff phoned each patient the day after their procedures to assess their post-operative recovery and give advice and support if needed.
- There was very poor mobile signal at the Crawley Hospital site. Relatives were given a bleep that meant

they could be contacted if they left the clinical areas. This meant that people were not restricted to stay in one place for long periods of time and could be effectively contacted by staff.

- The CQC inpatients survey revealed that patients were bothered by increased noise at night. There was evidence that the trust was addressing this issue by offering to move patients to quieter areas on the ward and supplying ear plugs.

## Patient understanding and involvement

- The hospital ran a 'your care matters' programme which actively encouraged patients to comment on their recent experience of the services provided.
- The patients we spoke told us that they received good quality care. Some of the comments received about the staff were "Brilliant" and "Everyone has been so kind."
- Patients were encouraged to give feedback about the staff and service provided during their admissions. The feedback we reviewed was very complimentary.
- The patients we spoke with told us that they felt involved with their care and that they were given ample opportunities to ask any questions they had about their care and treatment.
- We saw that each patient had a dry wipe board over their bed which displayed their named nurse (This is a ward nurse who had special responsibility for a patient while they were in hospital).

## Emotional support

- The trust had a wide range of clinical nurse specialists available to provide support for patients. Specialists included pain, continence, stoma care, nutritional, falls prevention, infection control, pre-assessment nurses and Macmillan, mental health, learning difficulties and dementia.
- We were told that clinical nurses could provide some counselling for patients or refer to community services if appropriate.
- The chaplaincy team were available to provide support for patients.

## Are surgery services responsive?

Good



There was evidence that the trust placed a great value on patients' comments and complaints and demonstrated



# Surgery

that it listened to these and changes practice as a result. There was also evidence that it listened to its staff and encouraged open and honest feedback. We noted a vast improvement with engagement with local people and other external organisations.

Continuous work was being carried out to best understand the health needs of the community served by the hospital and plans were in place to increase and improve the services provided and the hospital site.

We did not identify any concerns with people accessing services at the trust, but we did identify escalation beds in use during our onsite visit. We found the trust ensured that the care delivered for this client group was safe and responsive.

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

- We saw from our inspection and data submitted prior to inspection the steps taken by the trust to ensure it delivered a safe service during busy times. Staffing was reviewed daily or more frequently if patients' acuity increased. When escalation beds were used the status of location and the patient's condition was monitored by senior nursing staff several times a day until they were found an appropriate environment.
- If there was an unresolvable pressure on beds elective surgery was cancelled in order to manage the situation.
- Patients that were not being cared for in their specialty area received good-quality care. However, they were not always cared for in appropriate environments. The trust was addressing this and new escalation facilities were being provided.
- Engagement with the local community was ongoing and their feedback was used as a service improvement tool.
- The DSU had been meeting the local demand for surgery by providing additional lists on a Saturday.
- The pre-assessment clinic at Crawley Hospital had been extended into the evening in a response to feedback and local demand.
- At the time of inspection the DSU was undergoing a consultation about providing 24-hour care.

## Access and flow

- Between October 2013 and December 2013, the trust's bed occupancy was 89.4% compared to the England

average of 85.9%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.

- We saw from the data submitted that between October 2013 and March 2014 there were a total of 103 elective surgical cancellations recorded. This placed the trust the 78th trust out of 139 (1 being the trust with the least number of cancellations). There were no cancellations at Crawley Hospitals day surgery unit.
- Data suggests that the admission processes for elective and emergency patients' functions at the same level are other similar trusts. Patients did not raise concerns about the admission process they experienced and some commented that their admission had exceeded their expectations.
- The hospital used electronic discharge system and we were told that this system worked effectively. The patients we spoke to told us that they were discharged effectively and did not have to wait for excessive lengths of time to be discharged. We observed the discharge process during the inspection and found relevant and appropriate information and advice leaflets were provided. Medication advice was given prior to discharge. We also note that the patients were given a discharge letter for their reference and a copy of the letter was sent to their GP electronically.
- The trust reported that all patients were treated within 28 days of last minute cancellation due to non-clinical reasons. The trust is benchmarked as being "similar to expected" when compared to other hospitals for proportion of patients whose operations were cancelled.
- The trust also met its targets for the number of patients being treated within two days of a cancelled procedure.
- The trust scored better than expected for the number of patients not treated within 28 days of a last minute cancellation for a non-clinical reason.
- 90% of patients needing surgery were treated within 18 weeks of referral.
- Data reviewed suggested that there was no risk identified for patients who required treatment for fractured neck of femur. Orthopaedic wards displayed fracture neck of femur times to surgery for patients and the public to see. Seventy five percent of patients were operated on within 24 hours of admission and 100% of

# Surgery

patients were treated within the nationally set timeframes. The hospital achieved their targets by ensuring consent for treatment was obtained in line with best interest guidance which alleviated long delays.

- We did not identify any concerns with patients flow in the surgical department. However there were occasions when the demand for beds was higher than supply. In these cases patients were cared for in other areas. There were tracking systems in place to ensure these patients received the same access to treatment.
- Between October 2013 and March 2014 a total of 5650 day case procedures at Crawley were booked and no cancelations were reported in that in that period. 100% of the cases were completed.
- We did not identify any concerns with the flow of patients in the day case unit at Crawley Hospital.

## Meeting people's individual needs

- Translation services were available.
- The trust had a learning difficulties team available to provide support for staff and patients.
- There was also provision of a specialist community dental service.
- The hospital had clinical and support staff who also worked as translators which provided instant access to a translation support. There were also agreements in place for external translators to provide support for patients if a member of staff was unavailable.
- We saw clinical areas had a named dementia champion in place.
- We also visited one surgical ward where a patient who was living with dementia was being cared for. The circumstances around the admission meant that the patients spouse was also admitted to hospital at the same time. The patient living with dementia became very distressed in an unfamiliar environment without his spouse. This ward identified a two-bed side room and ensured that both patients were together to alleviate the anxiety and distress of the rest of their admission. This demonstrated individualised, holistic and empathetic nursing care delivered by staff who have an ability to 'think outside of the box' and put patients individual needs at the forefront of decision making.
- People's individual needs were identified at pre-assessment, which meant that there was ample time to ensure extra measures were in place prior to admission.

- The CQC Adult Inpatient Survey 2013 asked a total of 60 questions, the trust performed better than other trusts in one question and worse than other trusts in two questions. One was regarding noise at night preventing patients from sleeping. We found the trust had sought solutions to this by offering to move patients to a quieter ward area and ensuring ear plugs were available.
- The trust had a range of patient information leaflets available.
- We saw a wide range of condition specific information available for patients in the DSU. However, we noted the information had not been updated or reviewed for some time.

## Learning from complaints and concerns

- There were effective systems in place to deal with comments and complaints, including providing patients with information about how to raise concerns or make a complaint.
- The trust provided support to patients and or others acting on their behalf to make comments and complaints. There was a Patient Advice and Liaison Service (PALS) in the hospital and staff told us they were very responsive. Information about PALS was on display in the ward areas.
- We saw evidence that complaints were responded to and considered in full. Not all complaints were responded to within the timescales set.
- We saw evidence in every clinical area of learning from complaints and patients feedback. Service improvement information was displayed in each clinical area.
- The patients and relatives we spoke told us that they felt confident that any concerns they raised would be listened to and dealt with appropriately and were confident that they would not be discriminated against for raising concerns or making a complaint.

## Are surgery services well-led?

Good



The trust operated an effective governance structure and a quality and a separate clinician led quality and safety

# Surgery

board. The departments risk register demonstrated that risks were identified, recorded and actioned appropriately as well as ensuring a transparent audit trail of the risks identified.

We identified a very positive staff culture irrespective of grade or position. We saw evidence of patient and public engagement that influenced positive change on the services delivered. The service demonstrated that it was innovative and strived for continuous improvement. The last NHS staff survey revealed that staff at the trust were more likely to agree that their role 'made a difference', felt supported by their immediate management and were motivated and satisfied with their work. This was evident in the conversations we had with the majority of staff during the inspection. However, we did identify some dissatisfaction amongst the admin/ward clerk group.

## Vision and strategy for this service

- The trust had a clear strategy to improve quality within the department and take account of recommendations from the inquiry reports by Sir Robert Francis and Sir Bruce Keogh. It underlined the responsibility and opportunity of all staff in contributing to patient care.
- There were regular reviews of data and information by the divisional governance meetings. There were four subcommittees in place (Patient Safety, Clinical Effectiveness, Patient Experience and Responsiveness). These committees reviewed progress against delivering their vision and strategy for 2014/15.
- The service was striving to improve 'Nil by mouth' times in the department and therefore reduce harm.

## Governance, risk management and quality measurement

- It was evident from the documents we viewed and our conversations with staff that the trust had a very active and productive governance committee.
- There was a safety and quality committee in the surgical directorate that was predominantly led by clinicians. The purpose was to assist the board of directors in executing their responsibility for seeking and monitoring assurance around safety, quality and patient experience. Key areas for discussion at the monthly meetings were clinical audit, CQC compliance, mortality, incident managements, infection
- Information from governance meetings was cascaded to staff via emails, meetings, handovers and through ward newsletters.

- We found the trust risk registers accurately identified risks, were regularly maintained and reviewed and demonstrated an effective audit trail for any identified risk.
- There was evidence of regular quality monitoring in place which influenced changes to clinical care and service delivery.

## Leadership of service

- The staff we spoke with reported a high level of confidence in their immediate line managers and senior hospital management.
- They described feeling involved in changes and felt 'listened to at all levels' when they raised a concern or make a suggestion to improve the services delivered.
- Staff told us how they had positive, open and supportive relationships with the chief executive, director of nursing and other senior staff.
- Staff reported feeling involved, consulted and encouraged to drive change that would improve standards and patient experience.
- We visited Woodland ward where we judged the leadership to be outstanding. We saw a very effective multidisciplinary approach to care delivery and consistent commitment to ensuring patients' individual needs were met.
- The admin/ward clerk staff we spoke to reported feeling very involved respected and valued in their own teams.

## Culture within the service

- All trust board meetings started with a patient story. We were told that this practice encouraged reflection and aids learning from a patient's perspective. We viewed minutes of the meetings that demonstrated that the 'patient story' was firmly embedded at board meetings.
- We perceived the surgical department to have a cohesive and positive work culture and attitudes. Staff morale appeared to be high and they described a feeling of 'enjoying' coming to work and 'locality' to the patients, service and executive management team.
- We found all staff at every level to be optimistic, enthusiastic and undisputedly sincere when expressing their dedication to patients, their colleagues and hospital management team
- We identified a positive approach to multidisciplinary working in the surgical department. The staff we talked with confirmed that multidisciplinary working in the trust was firmly embedded in the culture and approach to care delivery. We observed this during the inspection.

# Surgery

## Public and staff engagement

- The trust regularly encouraged patient engagement. There was evidence in every clinical area in the surgical department to suggest that this information was valued and acted upon and used as a mechanism to change practice and drive standards upwards.
- The staff we spoke to were able to evidence changes to practice that was driven by patients and member of the public and we saw that ward areas proudly displayed 'you said, we did' information boards.
- Staff told us that they could attend meetings with the chief executive and other members of the senior management team.
- Staff reported feeling involved and consulted about changes.
- We saw a comments and questions boxes available in the staff room to encourage staff to raise concerns, questions or give feedback about the service and the proposed changes to the service.

## Innovation, improvement and sustainability

- The trust had a smartphone application for the monitoring and management of antibiotic usage
- There was an effective hologram in the foyer of the main hospital that gave information to patients and visitors about infection control measures at the hospital. We observed patients/visitors entering through this entrance and almost all of them were drawn to the hologram and used the hand hygiene gel that was provided.
- We found the orthopaedic wards were in the process of trialling an electronic observation and early warning score system for patients. This system ensured that staff had the information they needed to care for patients whose condition may be deteriorating.
- We saw staff wearing "Ask me anything" badges. These badges encouraged patients and their loved ones to engage with staff to improve communication.

# Critical care

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

## Information about the service

The trust's intensive care and high dependency unit were located at the East Surrey Hospital. The intensive care unit (ICU) had 10 beds for patients who needed advanced support and care in relation to renal support, cardiovascular support and mechanical ventilation and is managed by the intensive care consultants. The high dependency unit (HDU) had six beds and provided care and support for patients who were acutely unwell and needed closer observation than a general ward could provide. The HDU was not managed by the intensive care consultants but by the individual general surgical or medical consultants who had their patient located on the unit. This structure was due to change in August 2014 when the intensive care consultants would take over the management of both units. The service also provided a critical care outreach service for patients who are ill but not critically ill to necessitate admission to ICU, this included supporting patients on wards who are receiving non-invasive ventilator support. The unit admitted approximately 580 patients a year.

We visited the ITU and HDU in the hospital. We talked with seven patients, three relatives and 19 staff. These included nursing staff, a student nurse, junior and senior doctors, a physiotherapist, a pharmacist, domestic staff and managers. We observed care and treatment and looked at four care records. Before the inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

Patients we spoke with gave us examples of the good care they had received in the unit. The leadership of the unit created a culture of reporting and learning from incidents. There was good multidisciplinary working to ensure patient needs were met. Guidance from recognised professional bodies were followed and audited to ensure their effectiveness.

Patients were treated with compassion, care and dignity. The service demonstrated responsiveness to the needs of patients and the local population. Changes were being made to the management of high dependency unit (HDU) to improve patient flow through the service. We found the relatives room on the unit was in need of some refurbishment.

# Critical care

## Are critical care services safe?

Good



Overall, critical care services were safe. All staff we spoke with said they were encouraged to report incidents and received direct feedback from their manager, and themes from incidents were discussed at staff meetings. The environment was clean and hygienic, and most medicines were stored correctly. Nursing handovers occurred twice a day and were conducted well. Staffing levels were appropriate and risks to patients whose condition may deteriorate were escalated appropriately. All professionals involved with a patient during their admission to the unit added their notes to the same records and this ensured continuity and a team approach to delivering care.

### Incidents

- There had been no recent Never Events attributed to the service. A serious incident known as a Never Event is classified as such because they are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- All staff we spoke with said they were supported and encouraged to report incidents and received direct feedback from the senior nurse. Themes from incidents were discussed at staff meetings. Information was displayed about changes made to care practices in response to incidents, for example new dressings were being used to reduce the risk of sores as a result of equipment used to aid patients with breathing.
- Mortality and morbidity meetings were held monthly. These were attended by medical and nursing staff. Record of meetings showed that incidents of death and poor outcomes for patients were reviewed and where appropriate action was planned and implemented to improve outcomes for patients.
- Risk assessments for patients for pressure ulcers and VTE were being completed appropriately on admission. Risk assessments for VTE were completed on the computerised record system and were not consistently transcribed onto the medication or observation charts. However, we saw that treatment was prescribed and administered to reduce the risk of patients developing VTE's.

### Safety thermometer

- NHS Safety Thermometer information was clearly displayed at the entrance to the intensive/critical care unit. This included any new pressure ulcers or whether a patient had a blood clot, known as 'venous thromboembolism' (VTE) or catheter urinary tract infection. The unit was performing as expected for these areas.
- Staff told us the use of the safety thermometer has helped to improve practice.

### Cleanliness, infection control and hygiene

- The unit looked clean. Information about cleaning schedules and cleaning audits were displayed.
- The unit had achieved 98% in its cleanliness audit in April 2014.
- Information was displayed at the entrance to the unit about hand washing to prevent the risk of spread of infection.
- Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to and hygienic hand washing facilities and protective personal equipment, such as gloves and aprons, were readily available and used by staff between patients.
- Antibacterial hand gel was available at the entrance and throughout the unit for the use of staff and visitors. Visitors and patients confirmed they were advised about the importance of hand washing and that all staff washed their hands before attending to their relative.
- There were effective arrangements for the safe disposal of sharps and contaminated items.
- The unit contributed their patient data and outcomes to the Intensive Care National Audit and Research Centre (ICNARC) and so was evaluated against similar departments nationally. ICNARC data showed infection rates: for example, methicillin-resistant staphylococcus aureus (MRSA) rates were low and below the national average.
- There were no unit acquired C. difficile infections reported during the period October 2013 to March 2014.
- There was provision to care for patients with infectious diseases in side rooms, one of which had a built in air flow system that further reduced the risk of airborne cross contamination.

### Environment and equipment

- In the ICU cabinets and trolley's had been identified as needing replacing. This was because the lining on surfaces was lifting or had peeled off. This meant the



# Critical care

cabinets were unable to be cleaned effectively.

However, audits showed this had not resulted in any increases in infection rates. We saw that replacement equipment had been ordered.

- Pre-inspection data had indicated that monitoring equipment used in the unit was outdated. Staff told us, and we saw records, that confirmed new monitoring equipment had been purchased. There was a programme to ensure all staff received training to use the new equipment prior to it being installed, and ongoing training and support after the equipment had been installed.
- Resuscitation equipment was maintained and checked to ensure it was in date and in working order. This included specialised paediatric resuscitation equipment.

## Medicines

- Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked to ensure medicines stored there were kept at temperatures that did not adversely affect their effectiveness.
- All nursing staff completed annual training and competency assessments with regard to the management and safe administration of medicines. This included training and assessments with regard to the administration of intravenous medicines.
- We observed medicines being administered in a safe manner following the unit's procedure.

## Records

- Standardised nursing documentation was kept at the end of the patient's bed. Observations were well recorded; the timing of such was dependent on the acuity of the patient.
- All records were in paper format and all healthcare professionals documented in one folder.
- We saw records were well maintained.

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

- Staff could tell us that the safeguarding training covered the essentials of the Mental Capacity Act and deprivation of Liberty safeguards, but in general were unable to expand upon the concepts of the MCA. However, there was no evidence to indicate that the MCA was not being complied with.

- We saw evidence that the use of the two stage test to assess mental capacity had been considered.
- Patients were consented for procedures appropriately and correctly.
- We observed a patient who lacked capacity due to their critical illness. Restraining methods had been used to reduce the risk of the patient removing vital bits of equipment. We saw the "Best Interest," decision making process had been followed and documented.

## Safeguarding

- All staff reported they completed training about safeguarding vulnerable adults and children as part of mandatory training updates. Records confirmed this was occurring.
- Staff demonstrated a good understanding about safeguarding procedures. They gave examples of when they had alerted the local safeguarding team to protect patients.

## Mandatory training

- The unit had a dedicated educational sister who planned training for all nursing staff to ensure they met their mandatory training targets. Records and staff confirmed mandatory training was completed annually.

## Assessing and responding to patient risk

- Patients' physical health was monitored using recognised observational tools. The frequency of observations was dependant on the acuity of the patient's illness. Monitoring equipment was set to alert members of staff to changes on patient's condition. This meant a deteriorating patient would be identified promptly so appropriate relevant medical action could be initiated.
- There was a Critical Care Outreach team who were present on site 24 hours a day, seven days a week. The National Early Warning Score (NEWS) escalation process for management of acutely unwell adults was used to identify patients who were becoming unwell, ensuring early and appropriate referral to the Critical Care Outreach Team.
- The outreach team also reviewed all patients who had been discharged from the critical care unit within six hours of discharge. They attended all cardiac arrest calls and managed patients who required non-invasive ventilation.

# Critical care

## Nursing staffing

- Staffing levels were in line with guidance from professional bodies.
- All level one patients were nursed one to one, and all level two patients one to two. Staff reported that any staffing gaps were filled with regular bank staff or regular agency staff. There were processes in place to ensure all agency and bank staff had the appropriate experience and qualifications to provide safe care to patients, which included a structured induction programme.
- A member of the nursing staff was identified as the coordinator for each shift and worked in a supernumerary position for that shift.
- Over 50% of the nursing staff had their post-registration award in Critical Care Nursing
- Nursing handovers occurred twice a day. A short handover where staff were updated on a patient's condition initially took place in a room with a closed door to maintain patient confidentiality. This was followed by an individual handover at the bedside, which ensured key pieces of information were communicated.

## Medical staffing

- Care in the ITU was led by a consultant in intensive care. A consultant was present on the unit from 8:00am to 9:00pm, seven days a week. Outside these hours, a consultant was able to attend the unit within 30 minutes if required.
- The consultant to patient ratio was 1:12 which was in accordance with national recommendations of 1 consultant to 14 patients.
- The consultants worked on ITU in consecutive five day blocks. This was in line with national guidelines for intensive care.
- Consultant ward rounds took place twice daily. All potential admissions had to be discussed with a consultant and all new admissions were reviewed in person by a consultant within 12 hours of admission.
- Consultants were supported by a team of other doctors that included a specialist registrar and junior doctors.
- The HDU was led by surgical consultants, who each had responsibility for the care and treatment of their patient in HDU. Following a review of this process, the

management of the HDU was being transferred to the intensive care medical staff in August 2014 to ensure the right expertise was available for those who required critical care treatment.

## Major incident awareness and training

- There was trust wide policy for major incidents. This included detailed instruction cards for the critical care unit. This meant staff working in the unit would be clear what their role was in the event of a major incident occurring. Staff were knowledgeable about the major incident policy.

## Are critical care services effective?

Good



The unit had an annual clinical audit programme to monitor how guidance was adhered to. All staff, including student nurses, were involved in quality improvement projects and audit. There was good multidisciplinary team working. Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit, and the subsequent plan for their rehabilitation needs was documented in the notes. There was an effective training programme that ensured all staff had the required competencies to provide care and treatment to critically ill patients.

## Evidence-based care and treatment

- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment it provided. Local policies were written in line with this.
- There were care pathways to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated.
- The unit had an annual clinical audit programme to monitor how guidance was adhered to. All staff, including student nurses, were involved in quality improvement projects and audit.

## Pain relief

- Patient's pain levels were monitored and pain relief given accordingly.
- Patients told us they did not experience any pain, and told us about the types of pain relief they were receiving.

# Critical care

- During ward rounds, the pain relieving needs of each patient were discussed and their pain relieving medication was adjusted accordingly.

## Nutrition and hydration

- All patients were assessed for risk of malnutrition using a nationally-recognised assessment tool.
- Patient's nutritional and hydration needs were assessed at each ward round and appropriate action was taken to ensure their needs were met. Records showed, that where required, nutritional and fluid intake was monitored.
- There was dietician input to the unit on a daily basis to ensure patient's dietary needs were met.

## Patient outcomes

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. This demonstrated that mortality was below the national average and unplanned readmissions were similar to those in other trusts.
- ICNARC data was displayed in the unit so that patients, their relatives/carers and staff could see the quality of care on the unit.

## Competent staff

- Fifty three per cent of the nursing staff had achieved a post registration award in critical care nursing.
- The National Training Scheme Survey, GMC, 2013 indicated that the training given to junior doctors in anaesthetics was overall similar to other trusts.
- All staff received supervision and appraisals.
- The dedicated training sister supported all nursing staff to follow a structured training programme to meet the demands of their job role and to support their professional development. This included for newly appointed staff a comprehensive four week induction programme during which time the member of staff was supernumerary. Staff told us the induction process meant they felt prepared with to provide care to critically ill patients and were able to recognise when a patient's condition was changing.
- The dedicated training sister also provided a comprehensive training and support package for student nurses who were assigned to work in ITU/HDU. Comments from student nurses included "ITU was a brilliant learning experience," and "The staff on the unit are the best teachers I have ever had."

## Facilities

- The unit had a dedicated quiet room where discussions could be held with relatives. However, this room was bland in décor and not very welcoming. Staff said that they did not find the décor and ambience of the room conducive to discussing distressing information with relatives.

## Multidisciplinary working

- There was a twice daily ward round which had input from nursing, microbiology, pharmacy and physiotherapy. At the weekends, support was available on site from the multidisciplinary team, including microbiology, physiotherapy and pharmacy.
- There was a twice weekly, multidisciplinary meeting on the unit that had input from medical, nursing, pharmacy, speech and language therapy and physiotherapy
- Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the critical care unit and the subsequent plan for their rehabilitation needs was clearly documented in the notes. There was a dedicated team of physiotherapists and speech and language therapists for the unit. The unit had access to the occupational therapist team, but did not have a dedicated occupation therapist attached to the unit.
- There was a critical care pharmacist who was based on the ward. In addition, a dietician provided support to the unit five days a week.
- The Critical Care Outreach Team worked across the whole hospital to follow up patients discharged from ITU and provide clinical support in the event of patients deteriorating on the general wards.

## Seven-day services

- A consultant was present on ITU daily from 8:00am to 9:00pm and undertook ward rounds twice daily. Consultants were supported by a senior registrar and junior doctor.
- All potential admissions to ITU had to be discussed with a consultant and all new admissions were reviewed in person by them within 12 hours of admission.
- Consultant cover for patients on HDU was by their surgical consultant and the surgical consultant on call rota.
- A physiotherapist was on duty for both ITU and HDU at weekends.

# Critical care

- Radiology services were led by a consultant and were available on Saturday and Sunday until 6:00pm and was then on call over the rest of the weekend.
- There were pharmacy services available seven days a week.
- The critical care outreach team provided a service seven days a week.

## Are critical care services caring?

Good



Patients we spoke with gave us examples of the good care they had received in the unit. Patients and relatives were given good emotional support, and throughout our inspection, we saw patients being treated with compassion, dignity and respect. Communication with patients and relatives was effective, which meant they had a good understanding about their or their relative's illness and were involved in making decisions about their treatment and care.

### Compassionate care

- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Patients and relatives we spoke to were highly complementary about all the staff and the care received in the unit. Comments from patients included, "My stay in ITU has been a pleasurable experience," "Everything is explained and I can make my own decisions, nothing is too much trouble," and one person said staff create a "very uplifting" environment.
- Relatives told us that communication was very good with staff explaining what was happening with the family member and that staff were always responsive and informative when they phoned the unit at any time of day or night.
- Relatives were encouraged to visit and routine visiting hours were from 3:00pm to 7.30pm. Visiting times had recently been extended in response to comments made by relatives and patients. Flexible visiting time was at the discretion of the nurse in charge for relatives who found it difficult to visit during routine visiting times, for new admissions and patients who were at their end of life.
- The trust used the 'friends and family test' and 'your care matters' survey for feedback about the service

provided on the unit. There was no recent feedback from either of these surveys for the ITU. Feedback from the HDU showed that patients and relatives had positive experiences of the care and support provided.

### Patient understanding and involvement

- Due to the nature of the care provided in a critical care unit, patients cannot always be directly involved in their care. We saw that whenever possible, the views and preferences of patients were taken into account.
- Where possible, patients were asked for their consent before receiving any care or treatment and staff acted in accordance with their wishes. Those patients who could not consent for treatment had mental capacity and best interest decisions recorded appropriately.
- Patients we spoke with told us they were kept fully informed about their care and treatment.
- Nursing staff kept patient diaries by the bedside outlining what events had taken place whilst they were unconscious. These diaries helped patients fill in the missing gaps in their lives during their stay in the ITU, especially for those patients who had been in a coma. The completed diary, which remained the property of the patient, was returned to them if desired at a follow up consultation.

### Emotional support

- Following admission to the unit, the consultant covering the unit would arrange to meet with relatives to update them on their progress. They were given a written overview of the intended plan for the patient alongside what they could expect from the unit. One of the nursing staff would also attend this meeting.
- When necessary, further face to face meetings were organised, and all relatives we spoke with stated that they had been kept fully updated and had had opportunities to have all their questions answered.
- There was a dedicated quiet room for speaking with relatives. However, the décor and furnishings in this room were bland and did not present a comforting or welcoming area in which to discuss distressing information.
- The service had identified a need to increase support to families who had experienced the death of a relative in the unit soon after admission. To facilitate this there was a plan being implemented to contact families with a letter after their bereavement.

# Critical care

## Are critical care services responsive?

Good



The critical care services were responsive to the needs of their patients. Support for patients with physical and learning disabilities was available if needed, and staff demonstrated a good understanding of people's social and cultural needs. In August 2014 the ICU medical staff were taking over the management of HDU beds with the aim of improving access and flow through the whole Critical Care Unit. Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those receiving them into their care.

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

- At busy times, sometimes patients stayed on the unit longer than required because of the lack of available bed space elsewhere in the hospital. We were told that patients were occasionally treated in the recovery area in theatres and staff with the appropriate skills were made available to support these patients.

### Access and flow

- For the period April 2013 to April 2014 the ITU had a bed occupancy rate of 90.9% and on HDU 94.4%. This was above the Royal College of Anaesthetists' recommendations of 70%. Persistent occupancy of more than 70% suggests a unit is too small and occupancy of 80% or more is likely to result in non-clinical transfers, with associated risks. The overwhelming reason for the bed occupancy was delayed discharges from the unit because of the lack of availability of general hospital beds.
- The trust had identified some problems with the flow of patients through the unit and discharge to the general wards. This had meant patients were sometimes being cared for in an inappropriate critical care setting.
- ICNARC data detailed that the unit had low rates of transfers out of the unit for non-clinical reasons.
- Most discharges from the unit occurred during the day between 8am and 10pm, which followed national guidelines.

- Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those receiving them into their care.
- All professionals involved with a patient during their admission to the unit contributed to the plan for their discharge.
- The critical care outreach team was involved in discharge planning and visited patients after discharge from the ITU to offer continued support.

### Meeting people's individual needs

- Support for patients with physical and learning disabilities was available if needed.
- Interpretation services were available both by phone and in person.
- Staff demonstrated a good understanding of people's social and cultural needs and how these could be met in the intensive/critical care unit.
- Privacy and dignity arrangements were acceptable. Both ICU and HDU were mixed sex wards. The use of effective screening meant that patients had their privacy protected. However, one patient spoke about their experience on the ITU area where there was no facility to use the toilet or have a shower in private. This issue had arisen because the patient was well enough to go to a general ward area but there had not been a bed available. The patient did confirm that staff made all efforts to protect their privacy and dignity when using the commode or having a wash behind the curtains/screening.
- Paediatric patients were only treated in the ITU area to stabilise their conditions prior to transfer to a specialist paediatric intensive care unit. There was a designated paediatric room to ensure the child was treated separately from adult patients.

### Learning from complaints and concerns

- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the shift leader. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- Patients and relatives confirmed to us they knew who to approach if they needed to raise a concern or complaint.



# Critical care

- Complaints posters were displayed in the unit and information leaflets were available.
- There had not been any complaints received in the past six months.

## Are critical care services well-led?

Good



There was strong local leadership of the unit. The unit was a member of a critical care network which enabled shared learning to occur. Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty was the expectation for the unit and encouraged at all levels. Staff were encouraged to complete incident forms or raise concerns. Staff worked well together and there was obvious respect. Risks were being managed appropriately and staff were involved in quality improvement projects.

### Vision and strategy for this service

- A strategy for increasing improving the patient flow through for the unit was in place. From August 2014 the HDU was going to be managed by the ICU consultants. Funding had been obtained to recruit extra intensive care consultants and medical staff to support this new management structure.
- There was a plan to improve the care and outcomes for patients by who required non-invasive ventilation by locating these patients in one ward, rather than the current practice of being spread across several wards. This was a service that was supported by the Critical Care Outreach Team.

### Governance, risk management and quality measurement

- The division had monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were cascaded to staff during regular unit meetings and minutes of the meetings were available.
- Risks inherent in the delivery of safe care were clearly identified on the trust's risk register. Supporting actions were identified and discussed at governance and board meetings.

- The unit was a member of a Critical Care network which enabled them to share and learn from good practices in other critical care services.

### Leadership of service

- The intensive/critical care unit was led by a lead nurse and consultant clinical lead.
- The Critical Care unit was part of the surgical division of the hospital which was led by a chief nurse
- Each shift was led by sisters who had supervisory responsibility for the staff working for them.
- Staff spoke told us there was strong, supportive and cohesive leadership on the unit.

### Culture within the service

- Staff within the unit spoke positively about the service they provided for patients.
- Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty was the expectation for the unit and encouraged at all levels. We observed shift and unit leaders who were compassionate and led by example.
- Staff were encouraged to complete incident forms or raise concerns.
- Staff worked well together and there was obvious respect. Staff were engaged and worked well with other departments within the hospital.

### Public and staff engagement

- Information about critical care services was available on the trust website. This meant the public were informed about the service provided by the unit. The website also provided links so patients could give feedback about their experience of receiving care and treatment.
- Staff told us that the use of staff meetings and handover sessions meant they were fully informed and involved in the running of the service.

### Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. All staff, including student nurses, were involved in quality improvement projects and audit. Staff were able to give examples of practice that had changed as a result. For example, changes in the management of tracheostomy tubes had resulted in an improvement in skin integrity for patients who had tracheostomy tubes in place to aid their breathing.



# Maternity and family planning

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

## Information about the service

Approximately 4500 deliveries took place at East Surrey Hospital each year. The facilities on the consultant led delivery suite included eight delivery rooms, a two-bed high dependency unit and a dedicated obstetric theatre. There was one birthing pool on the delivery suite. There was also a new refurbished midwife led birthing unit with three rooms all with birthing pools and en-suite facilities. The triage service and the home birth team were based at the East Surrey Hospital.

Postnatal care took place on the 28 bed Burstow ward. This ward includes some 'amenity rooms' that could be booked for a fee. These rooms had en-suite facilities.

Rusper Ward had a four-bed antenatal day unit which was open seven days a week, a five bed induction unit and six bed antenatal area. There was a level 2 neonatal unit with 20 cots (see children's services for more details of this) and a five bed transitional care ward where mothers and their babies were cared for together but the babies received additional care and support from the neonatal team.

East Surrey hospital also ran antenatal clinics including a clinic to discuss birth choices. There were screening services with an ultrasound department.

## Summary of findings

The service was offering good, safe compassionate care for women and their partners. The refurbished facilities of the new midwife-led birthing unit provided excellent facilities for normal, uncomplicated births in a relaxed, calm, non-clinical environment. The consultant-led facilities were soon to be refurbished to the same standard and offer excellent multidisciplinary care and treatment. An active service user group had been involved in planning for and making the changes to the service.

Midwife to birth staffing levels were not in accordance with national requirements with one midwife to every 34 births, but this ratio would be improved as recruitment took place. The staff were well trained, experienced and committed and the leadership was very good, particularly at head of service and matron level. There was a clear vision and strategy and the culture was open with an emphasis on learning from feedback in order to improve the service. Standards were based on evidence-based practice and national guidance.

# Maternity and family planning

## Are maternity and family planning services safe?

Good



The maternity ward areas were clean and well equipped. The birth to midwife ratio was not in accordance with national guidance but additional funding had been approved and recruitment was underway. Staff were well trained and experienced. Record keeping was thorough and patient notes were well designed.

Incidents were fully investigated and any lessons learnt were shared between colleagues to improve the service. Medicines were stored safely and appropriately.

### Incidents

- Sixty three serious incidents occurred in the trust between December 2012 and March 2014. Of these, three occurred in maternity services. This number was consistent with the numbers that would be expected in a trust of this size.
- One of the incidents involved an intrauterine death and one involved the unplanned admission of a mother to the intensive care unit. The third serious incident was the closure of the maternity services to new admissions for a day in February 2014 because the service had reached full capacity.
- We saw a list of the other incidents that were classified as causing no harm, to minor or moderate harm. These incidents were reported through the incident reporting system and included details of the investigation of the incident and the follow up actions. The midwives we spoke with were aware of the process and were using it to report all incidents. They said that they were aware of the investigations, the findings and follow up action taken.
- There was a trigger list of situations which acted as a prompt for reporting.
- We noticed that the same type of incident was sometimes recorded as causing no harm or mild or moderate harm. We were informed that this was a training issue and was being addressed. The Datix reporting system was fairly new within the service and the level of reporting had risen since it had been adopted. The lead midwife for risk said that it was important to report 'near misses' as well.

- A review of clinical incidents was undertaken 2 to 3 times a week. This involved a team of three midwives and two midwives involved in risk management assessing all incidents and reporting back to individual midwives. There was also a weekly review of incidents with the lead obstetrician and midwives.
- We found evidence of learning from incidents. For example, there had been several instances of women developing 'blisters' from pressure dressings applied at the time of caesarean section. From investigation it was identified that pressure dressings were being left in situ longer than recommended. Therefore, the tissue viability nurse was invited to give a presentation on good practice as part of the fourth day of mandatory training.
- There were no 'Never Events' reported as having occurred in the maternity services.
- We attended a multidisciplinary meeting at which the midwives and consultants reviewed the deliveries from the last 24 hours that had resulted in an intervention or a caesarean section. We saw how they went through the notes reviewing the decision's made at significant points in the delivery. They used a process called 'fresh eyes' at regular intervals throughout deliveries so that progress and decisions could be examined by an objective colleague who was not directly involved in managing the case. We observed how the meeting was used to reconsider the decisions made and assess whether different decisions would have been more appropriate.
- Daily safety huddles took place and the matrons provided an update on any issues relating to safety including staffing levels.

### Safety thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the frequency of avoidable harmful conditions occurring in patients including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls.
- These measures are less relevant in maternity services than in other departments but the service monitored harm free care and displayed the outcomes on wipe boards on every ward in a way that the general public could understand.
- Safety bundles were used including the 'waterlow' score to measure pressure on skin and an assessment for venous thromboembolism.

# Maternity and family planning

- A proforma had been developed locally for the treatment and documentation of shoulder dystocia, eclampsia, haemorrhage and sepsis.

## Cleanliness, infection control and hygiene

- Sluice areas were clean and the commodes were appropriately labelled and cleaned after use.
- All the wards and units we saw in maternity services were clean. We noticed that staff adhered to the trust's infection control policy and washed their hands regularly and applied hand hygiene gel. Clothes were worn that were 'bare below the elbow'.
- Infection rates for the hospital overall were within expected levels.
- The 2013 CQC survey of Women's experiences of maternity services revealed that the trust performed to about the same level as other trusts in response to questions about the cleanliness of the hospital room and ward and the toilets and bathrooms. During our visit, patients were positive about the cleanliness of the unit.
- Equipment was labelled with green 'I am clean' stickers stating the date and time they had been cleaned. We checked this equipment and found it did appear clean.

## Environment and equipment

- Resuscitation equipment was modern and well maintained. We saw that the checklist was up to date and that the checklists were numbered so that they could be easily matched to the equipment.
- Resuscitation equipment was in every room in the delivery suite.
- The environment was clean, bright and uncluttered, particularly in the new birthing unit.
- The midwife-led birthing unit has been refurbished to a very high standard and the facilities had been planned and designed with staff and the service user input.
- There were three new birthing pools in the midwife led birthing unit.
- The unit had a dedicated on-site obstetrics theatre facility with a dedicated maternity recovery area.
- Cardiotocography (CTG) surveillance was available with a large screen available in the handover room. There were plans for online access for consultants on call.
- New resuscitaires had been purchased that produced blended air and complied with national guidance.

## Medicines

- There were safe and appropriate facilities for the safe storage of drugs.
- Controlled drugs were checked and audited and documentation was countersigned by two people.
- Fridge temperatures were monitored.

## Records

- Red child health books were distributed to mothers at birth.
- Maternity handheld notes had been locally developed. The notes were modular with pink for antenatal, blue for intrapartum, green for postnatal and white for neonatal.
- Notes are well designed and comprehensive and included valuable information for the mother including details of breastfeeding, stopping smoking and contact numbers. There were also proformas for a raised BMI, delivery and for patient wellbeing standards.
- We saw there was a high standard of record keeping with individual care plans, birth choices, previous history and recommendations for birth all consistently and fully completed.
- Handovers were documented. The records provided evidence that the handover included staffing, resuscitaire checklist, emergency trolley, fridge and blood sugars, controlled drugs, management of operational issues, risk issues, any patient outliers and any other issues.

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

- Staff were aware that there was a protocol in place for what to do if they suspected a patient lacked mental capacity. They knew to contact mental health professionals via the emergency department so that they could do first assessment of mental capacity.
- Staff told us if this occurred they would raise an adult safeguarding alert via the safeguarding team.
- Training on MCA and DoLS was included as part of the safeguarding training. Staff were aware of the main principles of the Mental Capacity Act.

## Safeguarding

- There was a named midwife for safeguarding who was 0.6 WTE but picked up any safeguarding issues every day. The named midwife represented the service at adult safeguarding meetings.

# Maternity and family planning

- There was also a lead consultant in women's and children's for safeguarding with three programmed activities a week to discharge this responsibility.
- The service worked closely with two local authority contact centres. There was good support from social services and the midwives attended the West Sussex Multi Agency Risk Assessment Conferences which deal with domestic abuse.
- There was a fortnightly meeting with the health visitor liaison team to review any relevant cases.
- Safeguarding training was mandatory and 95% of midwives had level 3 competencies. All new staff received safeguarding training during their first year of employment and it was also part of the preceptorship programme for newly qualified midwives. Midwives were supported to attend multidisciplinary training along with the police and social services.
- We saw evidence of staff dealing appropriately with safeguarding concerns and developed action plans with the measures to be taken at the time of admission or at birth.

## Mandatory training

- Ninety five percent of staff were up to date with their mandatory training.
- In the last 12 months the service had extended the mandatory training from three to four days to include more time for learning from local incidents, complaints and the review of practice. A scenario based approach was being taken to learning which involved working through actual incidents.
- Scenarios and the simulator were used as learning tools and obstetrics drill procedures were incorporated into the mandatory training. Low risk birth scenarios were also used to promote learning, such as, how to deal with a postpartum haemorrhage in a home birth setting.
- Each member of staff was sent a letter setting the dates for the mandatory training. A copy of this letter was also sent to the ward manager. If the member of staff does not attend it was followed up by the ward manager.
- There was a multidisciplinary approach to the training involving the medical staff, midwives and midwifery support workers.

## Assessing and responding to patient risk

- The Maternity Early Warning Score (MEWS) chart was used to record and monitor temperature, blood pressure, heart and respiratory rates. It had a colour

coded track and trigger system and a referral pathway. The chart also included a reminder of the SBAR tool and a visual infusion phlebitis score (to measure any inflammation of the vein).

- We saw the MEWS records were completed in full and compliance was being audited regularly.
- Neonatal notes included a comprehensive record including a new-born examination and a neonatal early warning score (NEWS) system incorporated in the notes to prevent this record getting lost.

## Midwifery staffing

- The head of midwifery informed us that, having calculated the desired midwife staffing levels through the Birth Rate Plus staffing tool, it was revealed that the service had a shortfall of 10 whole time equivalent (WTE) midwives. A plan was to be presented to the executive board in June recommending the addition of ten midwife posts. We saw evidence just after our inspection that this had been approved and recruitment into these new posts had commenced.
- A daily safety huddle took place with the senior staff, it looked at the staffing levels available for the day and any risks were identified and addressed.
- The Head of Midwifery was not anticipating any problems with recruiting to the 10 posts. She told us she had previously recruited successfully from Ireland and had retained all the midwives.
- The risk of patient safety being compromised due to an inability to provide one to one care in labour caused by a shortage of midwives had been included as a risk on the maternity risk register.
- The Head of Midwifery said that she had authority from the board to over recruit to cover for maternity leave within the service.
- The service was not using an 'acuity' tool (a method for matching staffing levels to the dependency level of patients), but was planning to purchase Birth Rate Plus.
- The service was benchmarking against the South East Coast birth rate to midwife ratio of 1:30. Currently the service was operating with a ratio of 1:34. The safer birth ratio recommended by birth rate plus is 1:28. This meant the service was not meeting nationally-recognised guidance.
- The service had a system called "Daily hands on help," which helped to deal with peaks in activity. There was a midwife on call that could specifically assist in peaks of activity.

# Maternity and family planning

- The service mainly used its own bank of staff to cover for shortfalls and used agency staff occasionally.
- If agency staff were used, they were taken from a small cohort who were already familiar with the service. There was a handbook for temporary staff about the service.
- The service had two midwife sonographers and two other sonographers.
- The caseload of community midwives was 1:130, although some of the community midwives said that their caseloads were much larger than this.
- Community midwives could rotate and work in the home birth team and in the birthing unit.
- 19 midwives were able to perform the checks on new-born babies so that they could leave the hospital without needing to be seen by a medical practitioner.
- Healthcare assistants supported midwives on the delivery suite and maternity support workers supported midwives on the postnatal ward.
- One woman we spoke with said, “They are busy but I think there are enough staff. It helps that there are other people to help with breastfeeding”.

## Medical staffing

- There were 98 hours of consultant cover on the labour ward. This was from 8:00am to 10:00pm, Monday to Thursday. On Friday there was a 24-hour resident middle grade cover, and over the weekend there was a resident middle grade cover from 8am until 5pm.
- Consultants were on call outside of the hours they were present on the unit.
- There was 24 hour anaesthetics cover and 10 sessions of consultant anaesthetics cover.
- Consultant ward rounds were four hourly or at the changeover of consultant.
- Midwives told us there was a clear escalation pathway for alerting medical staff of concerns. They said that there was rarely any delay even if both registrars were in theatre.
- At night there was one registrar and one foundation year 2 doctor covering obstetrics and gynaecology.
- The trust, like many other trusts, faced challenges recruiting doctors and consultants.
- Most of the women we spoke with praised the medical staff, however, one woman said, the doctor said something during the surgery that made her believe that he had not read her notes and did not know all her history. She said that this made her feel, “concerned and unsafe”.

## Are maternity and family planning services effective?

Good



Maternity services were effective and care and treatment was based on national evidence based practice and guidance. Staff were competent and the medical staff and midwives worked well together in a cooperative team of professionals who respected each other's roles.

There was an emphasis on facilitating normal birth and work was ongoing to reduce the rates of caesarean section and induction. Pain relief was available and services were available seven days a week.

## Evidence-based care and treatment

- The head of midwifery said that she was looking to benchmark maternity services against various standards. We saw that midwives were using the ‘FRIDAY’ initiative: Focus, Reflect, Inspire, Discuss, Analyse and Your care first.
- Proformas for the treatment of sepsis, shoulder dystocia, obstetric emergency eclampsia and obstetric haemorrhage were all based on evidence based practice and guidelines from the National Institute for Clinical Excellence and Royal College of Obstetrics and Gynaecology.
- There were World Health Authority and UNICEF baby friendly breastfeeding initiatives in the trust. This is an initiative designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care. The trust was working towards an assessment against the standards for level 2 accreditation early in 2015.
- New resuscitaires had been purchased to comply with national guidance.
- We were told about a productive ward module called ‘releasing time to care’ which captured the time it took for midwives to locate the keys for the drugs room. This amounted to one WTE midwife over a year. As a result, the lock on the door to the drugs room was replaced by a key pad and the key for the controlled drugs was kept in a central place. The key pads were changed regularly and when a member of staff left.



# Maternity and family planning

## Pain relief

- Birthing pools and birthing balls were available. Beds could be adjusted to be at different heights and angles.
- We spoke with a woman who had an epidural which she said, “was done expertly and I had all the information I needed.”
- Other types of pain relief was available including Entonox and pethidine and some women were using a tens machine.

## Nutrition and hydration

- The Maternity Services Liaison Committee reported that the food was bland and not readily available when new mothers had delivered their babies. The service had responded and now provided a toaster on the postnatal ward.
- Mothers on the delivery ward had requested an ice machine and that had also been provided.
- One woman we spoke with said she was happy with the food and said, “There was variety and it was healthy.”

## Patient outcomes

- There were no maternity outlier alerts for maternal or neonatal readmissions.
- The maternity service reported an annual caesarean section rate for 2012/13 of approximately 28% of all deliveries. They had a target for this to be 23% of all deliveries and were working to improve this.
- The service had introduced the birth choices clinic specifically to reduce caesarean section rates. All women were offered an appointment for this clinic. Staff had developed a proforma, which was completed at the birth choices clinic to ensure there was a detailed plan of care in place.
- Between October 2012 and November 2013 the trust had a higher emergency caesarean section rate of 16.6% (compared to an England average of 14.6%) and a lower elective caesarean section rate of 8.7% (compared to an England average of 10.7%). This would suggest that fewer women were having a planned caesarean section which could have then resulted in an emergency.
- The rate for Induction of Labour was 29.4% of all deliveries at the trust in March 2014 against a target of 20%.
- Twenty percent of all women were booked to give birth in the midwife led birthing unit.
- Water births had increased from 4% to 8.9% of all births.

- There was a breastfeeding initiation rate of 83% which was better than the England average score of 74%. Infant feeding coordinators were now working at offering more support to women who had a caesarean section and women in the high dependency unit.

## Competent staff

- Sixty seven percent of the staff working in the maternity services had an appraisal. The head of midwifery told us the rate was lower because midwives sometimes perceived there was an overlap with the supervision they received from the supervisor of midwives.
- Managers had been set a target to complete four appraisals a month in order to achieve 100% compliance.
- All midwives had supervisory reviews and the ratio of midwives to supervisors was 1:18 against a target of 1:15. We were informed that the ratio would be falling as more midwives became prepared to be supervisors.
- There were four midwives who were trained to obtain consent for neonatal/perinatal post mortem.
- There was an antenatal/new-born screening coordinator in post and a full range of national screening programmes were available as part of the service.
- Peer support workers for breastfeeding were in place and they won trust team of the year in 2013.
- Women we spoke with on the postnatal ward said that they were pleased with the experience and quality of the staff. One woman said, “Even the students are excellent and the midwives have years of experience.” Another woman said, “They seem really well trained and knowledgeable.”
- We spoke to a patient who said that she had encountered complications with the birth. She had been induced but when the baby’s heart rate dropped she was rushed into surgery for an emergency caesarean section. She said she was ‘overwhelmed’ by how responsive the staff were. She said, “I was helped so efficiently and was surrounded by a competent team who made me feel safe and comforted.”

## Multidisciplinary working

- Handovers were multidisciplinary and we saw evidence of cooperative team work and a full review of consultant management.
- Clinical activity was continuing on the labour ward but this did not stop the multidisciplinary review of cases from the last 24 hours.



# Maternity and family planning

- There were effective links with the perinatal pathologist at St Georges Hospital in London. The perinatal pathologist attended an annual mortality meeting with consultants and midwives to give feedback on all post-mortems and facilitated any lessons to be learnt.
- We saw evidence of good team working with respect for each other's roles.
- There was a weekly multidisciplinary team meeting in the antenatal and new-born screening team that involved the fetal maternal medicine consultant, screening coordinator and paediatricians. At this meeting they developed management plans and completed a high-risk combined screening communication sheet.
- There was close and effective working between hospital and community-based midwives. Some midwives rotated between the home birth team, the hospital birthing unit and the community.

## Are maternity and family planning services caring?

Good



Women we spoke with, and the Maternity Services Liaison Committee, reported that the care they received was compassionate and caring. We were told that the midwives were responsive and offered excellent care and support. However, the trust scored below other trusts for two areas of the CQC survey of women's experiences of labour and birth and postnatal care in 2013.

Women we spoke with said that they appreciated the support from the breast feeding peer support workers and that they were given information about their care and treatment.

### Compassionate care

- There was positive feedback from the Maternity Services Liaison Committee about the care offered to women within the service.
- A woman we spoke with on the postnatal ward said, "The staff responded extremely quickly when I used the buzzer."
- We spoke with a new mother who said that, "the midwives had gone above and beyond the call of duty." She said that they had, "a lovely manner and were very experienced".

- The service scored worse than other trusts for two of the three areas of questioning in the CQC survey of women's experiences of maternity services in 2013. These areas were for labour and birth and care in hospital after the birth. The trust scored about the same as others for staff during labour and birth.

### Patient understanding and involvement

- Breast feeding peer support workers attended daily.
- A woman we spoke with praised the breast feeding support and she said that she was reassured and helped when, at first, she was unable to breastfeed.
- There was open visiting for partners and they could stay overnight.
- Ward notice boards had a section entitled 'Meet the Matron' where the matron could address concerns and complaints about the service.
- Women told us they felt involved in their care and they knew what was happening to them.

### Emotional support

- Debriefing and counselling was available from the trained midwife counsellor.
- Bereavement facilities were situated adjacent to labour ward. The room was small but had all the facilities required. Partners could also stay.
- There was good support and liaison with the Stillbirth and Neonatal Death (SANDS) charity and support group.
- Facilities were provided for a local photographer to take photographs of babies and take plaster casts for keepsakes.
- There was a midwife leading on stillbirth and early pregnancy loss.

## Are maternity and family planning services responsive?

Good



We saw evidence of good case management and handovers between staff and midwives worked to manage access to the service and flow within. There were clinics for women who had higher risk pregnancies and the service responded well to meet individual needs.

# Maternity and family planning

There was an active Maternity Services Liaison Committee and the service had responded positively to the feedback received. Complaints and concerns were used as an opportunity to learn lessons and make improvements to the care and treatment.

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

- The head of midwifery was introducing a paging system for women waiting for an appointment so that they could wait in the gardens or café without losing their place in the queue.
- There was a birth choices clinic where women were given an hour long appointment to discuss their options and preferences.
- There had been some increase in deliveries in recent months and managers were considering longer term options to meet the capacity issues.
- The service was about to introduce a perinatal mental health clinic.

## Access and flow

- The service was sometimes running close to capacity. On one occasion in February 2014, the unit had to be closed to new admissions. This was due to capacity rather than to staffing levels. The service used the Local Supervising Authority proforma to ensure that this was handled safely. Women were diverted to other local hospitals including Chichester, Worthing or Brighton. The matron followed up this closure by writing to the people who were diverted to explain why this was necessary.
- We attended the early morning handover session and observed the use of the 'SBAR' tool which stands for Situation, Background, Assessment and Recommendations. This tool kept the information given at the handover concise but led to a full evaluation of the risks.
- Bed occupancy rates in maternity services between October 2013 and December 2013 were at 61.3% which was a little higher than the England average of 58.6% for maternity.
- The antenatal screening policy was prescriptive in terms of when to see mothers and when they were to receive results and any follow-up. The service complied with these timescales.
- There was some pressure on the theatres and it had been agreed to improve completion of elective lists and to leave capacity for emergency obstetric procedures.

- The average length of stay was two days, which was consistent with the England average.
- Staff told us more and more women were choosing to have their babies at the hospital because of the excellent facilities that were available.

## Meeting people's individual needs

- There was a high dependency unit on the labour ward supported by critical care outreach team.
- We saw there were patient survey results displayed in the wards that included comments and complaints and the actions taken as a result.
- Information was provided in English, Arabic and Polish on these boards.
- A translation service was available.
- The trust had purchased an ice machine and toaster in response to patient feedback.
- There was a patient user group in place and we saw a listening event had been advertised for the summer.
- Birthing suites were all accessible for women who used a wheelchair.

## Learning from complaints and concerns

- The service published a quarterly maternity newsletter which identified learning from good practice, complaints and concerns and included guidelines and updates.
- We saw there was information on display in the wards with information of how to make a complaint. This was also printed in other languages.
- A complaint from a new mother was featured as a 'patient story' at the February 2014 board meeting. The complaint revealed the lack of very basic nursing care. The board also received details of the response from the head of midwifery and the lessons learned and action to be taken.
- The midwives we spoke with in one of our focus groups during the inspection indicated that they were aware of complaints and concerns raised by women and their partners and were keen to learn from them to improve the service.

# Maternity and family planning

## Are maternity and family planning services well-led?

Good



Leadership of this service was excellent and staff responded well to the open culture of learning and development. Arrangements for governance, risk management and quality measurement were well development and embedded in the delivery of the service.

Staff were supported to innovate and introduce improvements to the service. The active involvement of staff and the Maternity Services Liaison Committee in planning the refurbishments to the birthing unit had led to the creation of some excellent facilities.

### Vision and strategy for this service

- There was a clear written strategy for nursing and midwifery for 2013/16. Midwives we spoke with were aware of the strategy and said they were proud of what they were doing and where they worked. Midwives said that the service and the trust overall had improved its performance over the last year or so.
- The temporary staff handbook set out the values and philosophy of maternity care at the trust.

### Governance, risk management and quality measurement

- Governance, risk and quality management were well embedded within the service and within the training on offer for staff.
- There was a monthly divisional quality and risk meeting attended by midwives, obstetricians, anaesthetists and paediatricians as well as representatives from human resources, infection control, blood transfusion and the patient advice and liaison service. Serious incident investigations were discussed at this meeting and there was a review of actions from previous meetings until all actions were completed.
- The divisional risk manager for maternity services was a member of the patient safety subcommittee. She told us this had given clinicians a voice as they were well represented on this panel and as members of the board. This meant that issues were communicated from the ward to the board.
- There was a notice board in the training room which displayed key risk management information. This was

also the room where midwives took their breaks and so was a good use of this facility. This information included any trends that had been emerging from incidents and evidence of learning from incidents. For example, it have been discovered that some blood samples were being incorrectly labelled and so changes were made to distinguish cord blood from other blood samples.

- The risk register for maternity services included three items: midwifery staffing levels, obstetric theatre capacity and resuscitaires no longer fit for purpose. New resuscitaires had been purchased and the other two items were being monitored appropriately.

### Leadership of service

- Several members of staff said that the head of midwifery was inspirational and motivational in her style of leadership.
- We saw evidence of high levels of clear communication and emphasis on high standards and compassionate care.
- We saw that the head of midwifery gave responsibility to colleagues and supported their development into new roles. The leads for birth choices and risk were excelling in their roles and the ward matrons were setting high standards of care and performance. The midwife leading on supporting women who had lost of delivered a stillborn baby demonstrated genuine commitment to provide the best levels of care and support.

### Culture within the service

- The culture appeared to be very open and staff were able to report incidents and learn from complaints and concerns.
- We saw evidence of strong team working with medical staff and midwives working cooperatively and with respect for each other's roles.
- We also saw a commitment to patient care and treatment.

### Public and staff engagement

- There was a Maternity Services Liaison Committee which met six times a year to discuss the issues raised by the users of the maternity services. There was good involvement of this group in the planning of services and service changes particularly around the midwife led birthing unit.
- The lay chair of the Maternity Services Liaison Committee also attended the Divisional Governance meeting







# Maternity and family planning

- There was evidence of 'You said - we did' on ward notice boards throughout the unit.
- The head of midwifery was seeking to innovate with the introduction of pagers for patients so they could go a have a drink and use the garden areas in the hospital whilst waiting for an appointment.

## **Innovation, improvement and sustainability**

- A visit was planned to Shrewsbury NHS Trust to see if there was some good practice to learn from them as they were reporting low rates of caesarean sections.
- We saw evidence of the service analysing data to discover how best to promote normal birth and reduce the caesarean and induction rates.
- We saw evidence of good practice being incorporated into all areas including bereavement support, record keeping and breast feeding.

# Services for children and young people

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

## Information about the service

Children up to 16 years of age were cared for by dedicated paediatric staff across the trust. In certain circumstances older adolescents could be admitted to the children's ward, if it was in their best interest and space was available. Facilities included a 30-bed children's inpatient ward including a day surgery unit, a children's assessment unit and a children's outpatient department. On the children's inpatient ward three cubicles were reserved for children requiring chemotherapy. There was a 20-cot neonatal intensive care unit that provided level 2 care for sick babies born after 27 weeks gestation, adjacent to the maternity unit.

The named doctor, nurse and midwife for child safeguarding worked across all areas of the trust and provided the lead for safeguarding all children and young people up to 18 years of age. Policies were well developed and good practice was embedded.

Most children were seen in a children's outpatients department that was staffed by paediatric staff and which was resourced to meet the needs of younger patients. Some specialities, such as ophthalmology, saw children in the main outpatients clinics where the facilities for children and families were very limited. Children presenting with pregnancy related conditions were cared for by obstetric and midwifery staff with input from the paediatric staff, if necessary. Almost all children's care was provided at the East Surrey Hospital site but some outpatients clinics were held at the Crawley Hospital site. The Crawley outpatients clinic for children was staffed by paediatric staff from the children's team at the East Surrey hospital.

We visited all areas of the hospital where children were being cared for; the facilities for children in A&E and critical care are reported under those sections of this report. We spoke to many parents and children who were using services at the time of our visit. We also spoke to key members of staff about how they provided services for children. Data relating to the services that the trust provides for children is limited and reported as part of the women and children's directorate. This means we were more reliant on local data and direct observation to inform our findings. The data that CQC hold and information provided by the trust did not highlight any particular concerns relating to the care of children at the trust.

# Services for children and young people

## Summary of findings

Services for children and young people were good. Most children and parents told us the staff were kind and attentive; the staff were described as 'lovely' and 'funny'. Ward areas and equipment were generally, clean and appropriate infection control measures were in place. There were enough trained staff on duty to ensure that safe care could be delivered. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs.

Younger children received very good inpatient care and the ward was resourced to ensure their wider needs were met. Good facilities and staff support encouraged a parent to stay in hospital with their baby or child. The quality of care of adolescents was limited by the accommodation; we observed instances where the privacy and dignity of teenagers was not respected. The care on the neonatal intensive care unit was outstanding. The staff team were committed to ensuring best practice and optimal care for the babies admitted to the unit.

Senior staff communicated well and staff were positive about the service. There was clear evidence that the wider multidisciplinary team worked well together for the benefit of the younger patients. Children's experiences were seen as the main priority. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements.

## Are services for children and young people safe?

Good



The services provided for children and young people at East Surrey Hospital were generally safe but the inconsistent use of the early warning system meant that there was a risk of children deteriorating and this not being recognised or acted upon as swiftly as might otherwise be possible. We did not find any evidence of harm caused by this.

There was a recognised tendency to under report 'near miss' and incidents that carried risk but where no harm occurred. A trigger list to prompt staff as to what to report had been produced but ward nursing staff were unaware of its existence.

The trust had very good child safeguarding arrangements and worked closely with two local safeguarding children boards and colleagues from the mental health trust.

The resuscitation arrangements for children and neonates were very good. Policies were clear and the monitoring of the provision was managed by a well-attended and effective resuscitation committee.

Staff were skilled at managing seriously ill children and recognising when they were unable to meet a child's needs fully. Appropriate arrangements were in place to ensure that children who were critically ill were transferred as swiftly as possible to a hospital providing higher levels of care.

### Incidents

- There had been no "never events" reported that related to children's services. A serious incident known as a Never Event is classified as such because they are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- No serious incidents that relates to the children's services had been reported during the preceding year. Discussion with senior staff led us to believe that there may have been a trend of under reporting 'near misses' and risks where harm had not occurred.



# Services for children and young people

- We were told that a 'trigger list' had been provided to staff to assist them in recognising when an incident should be reported. The staff we spoke with were not aware of this list.
- There was good learning from Serious Case Reviews (SCR). The trust considered whether they could improve any areas of practice following the SCR of a baby's death in another trust.
- Mortality and morbidity meetings were well attended with detailed minutes of discussions that took place and action points recorded.
- We looked at a root cause analysis of a serious incident concerning medication. The incident had been fully investigated. An action plan was created and had been updated to show the progress against the learning points.

## Cleanliness, infection control and hygiene

- Ward areas and equipment were generally clean. The ward and assessment unit were cramped and did not lend themselves to easy maintenance of a clean environment. Some equipment stored at higher levels was dusty.
- Staff followed the trust policy on infection control. Staff used hand hygiene gel and personal protective equipment, such as aprons and gloves appropriately.
- Patients at risk of, or suffering from, an infectious illness were cared for in single rooms to reduce the risk of spreading infection. Designated cubicles were available for children having chemotherapy to protect them from infections.
- Staff on the neonatal unit had a good understanding of barrier nursing and babies needing intensive care but who had an infectious illness were isolated in their incubators rather than in single rooms. There was no incidence of infections being transmitted between babies.
- Feeding equipment, such as babies bottles were single use or sterilised using a steam steriliser. Where sterilising fluid was used this was changed daily.
- No incidence of hospital acquired infections had been recorded on the children's ward.

## Environment and equipment

- There was sufficient equipment on the wards to ensure safe care. We were told that 'borrowing' equipment, such as syringe drivers, from other wards was not necessary. The linen cupboard was well stocked.

- Equipment was regularly checked and well maintained. Broken equipment was replaced.
- The neonatal ward had procedures to replace older equipment on a rolling cycle. Resuscitaires had been replaced because an improved model had become available that were able to deliver a combination of air and oxygen and better met the needs of the babies. Staff had felt that the phototherapy units were becoming outdated; they were asked to submit a business case to secure the necessary funding.
- The play specialist was aware of choking risk from very small toy parts and had taken steps to minimise this.
- The intensive care bay of the neonatal unit was very cramped. Staff felt this could impact on the care they delivered and was a risk, particularly in an emergency situation where a team of staff needed access to the baby.

## Medicines

- Medicines were stored appropriately. The treatment room was secure. Fridge temperatures were monitored and identified rises were dealt with appropriately to ensure that medicines remained effective.
- There was a pharmacist allocated to the ward and the neonatal unit. They supported the correct prescribing of medicines.
- Very few medication errors were reported; which could be because errors were rare or because of under reporting of 'near miss' incidents.
- A medication error on the neonatal unit was thoroughly investigated and action taken to minimise recurrence.

## Records

- All wards used either standard pathways or multidisciplinary notes. All staff wrote in the same set of notes. This ensured that all disciplines had access to current and comprehensive information on each patient.
- Notes were kept in a trolley in a supervised environment to maintain confidentiality.
- All patients had an admission sheet completed, giving details of their religion, any language needs, who had parental responsibility, allergies, immunisations and previous admissions to hospital. These had been completed sufficiently to provide care but some had unfilled sections or 'in A&E notes' as the record. Medical notes tended to be more comprehensive than nursing notes.

# Services for children and young people

- Medicines record sheets were well completed and reviewed daily by the ward pharmacist.
- All patients had a care plan that identified specific care needs.
- Audits of the quality of record keeping were performed and action plans identified the areas for improvement.

## Consent

- All children admitted for surgery had a correctly completed consent form that detailed the procedure and the potential risks or complications. This was signed and dated by the surgeon.
- Children who were competent to give consent were included in the process and there was space for older children to sign to say they had given consent.
- Records of post-operative children showed that the correct checks had been made prior to surgery using the World Health Organization Surgical Safety Checklist to ensure informed consent had been obtained.
- Children and parents we spoke with felt very well informed about the procedure and the likely outcome. We observed verbal consent being obtained before care was delivered.
- Staff had a sound understanding of the Gillick competency guidance in relation to consent by children and ensured competent children were offered the opportunity to make decisions relating to their care.

## Safeguarding

- The department had robust systems to safeguard children. They had undergone a trust level peer review of safeguarding in May 2012, as recommended by the Royal college of Paediatricians and Child Health (RCPCH). Some of the needs identified included a review of training plans and records to ensure that they reflected the latest national guidance. The trust had an action plan to respond to these issues. Progress on the action plan had been made and the safeguarding board was monitoring progress. A focus on training had resulted in 81% of staff working directly with children had completed level 3 training.
- There were clear policies and procedures for handling potential safeguarding concerns; the trust worked in partnership with two local safeguarding children boards (LSCBs) and had adapted its policies to include an algorithm, which ensured that staff followed the protocols for both authorities.
- Children identified as a potential safeguarding concern had a specific care plan. Birth plans included details of

child protection issues and any prenatal child safeguarding plans were shared with the relevant staff. All children with a safeguarding concern or with a child protection plan were seen by a consultant paediatrician prior to their discharge. In the year preceding the inspection, 1,400 child safeguarding referrals were made.

- A consultant paediatrician post had been created to oversee all child safeguarding arrangements across the trust. Frequent audits were taking place which focused on the A&E department due to the identified increased risk of morbidity and mortality when children first present with acute injuries.
- Any children who failed to attend an appointment were followed up using the trust protocol. Any child who presented with self-harm, alcohol induced illness or drugs misuse was automatically referred to the Child and Adolescent Mental Health Services (CAMHS). All such children were admitted and not discharged from the inpatient ward until they have been seen by CAMHS.
- The trust has recognised that their location, close to a major international airport, increased the likelihood of girls presenting in the A&E department with complications of female genital mutilation. The safeguarding implications of this had been incorporated into the training programme.
- Multidisciplinary safeguarding meetings were held weekly. All information sharing forms were considered and any shortfalls in the management or referral process were identified and actioned.

## Mandatory training

- Staff working in the children's unit had completed mandatory training updates annually.
- Some staff felt there was a backlog of people applying for courses which resulted in delays.
- Nurses on the children's unit had completed both paediatric basic life support and intermediate life support.
- The neonatal unit staff (nursing and medical) linked with staff from across the neonatal network and attended simulation days and clinical days to share best practice.
- A practice education facilitator attended team days on the neonatal unit each month.

# Services for children and young people

## Management of deteriorating patients

- The trust had developed a Paediatric Early Warning Scores (PEWS) system and provided guidance to staff on the use of the tool to help identify children who were at risk of a sudden deterioration in their condition.
- We saw four instances where the tool had not been used properly. This meant there was a risk that children who were becoming unwell were not identified quickly. We did not find any evidence that children were at risk because this tool had not been used properly. An audit undertaken by the trust following our inspection also confirmed that all children were safely observed and any deterioration in their condition had been escalated appropriately.
- We spoke with staff about this issue and they told us they were aware staff were not always following the trust policy. This was due to the trigger score not being robust; if a child was asleep the score would increase, yet the child was not actually at increased risk. Following our inspection, the trust confirmed the policy was under review.
- The children's ward had two beds that could be used for children who required a higher level of care. This area was not a designated High Dependency Unit (HDU) but the staff could provide care for children who required non-invasive ventilation and very close monitoring of their condition.
- Children requiring stabilisation prior to transfer to an intensive care unit were cared for in a side room on the adult intensive care unit but remained under the care of the paediatrician and an anaesthetist with paediatric experience.
- The hospital had a good reputation with the South Thames Retrieval Service, which managed the transfer of children requiring intensive care to tertiary units. The turnaround time between the retrieval team arriving and departing with the child was below average, as the child had usually been stabilised effectively. An audit by the STRS evidenced that the retrieval service were involved as early as possible in a child's care.
- The neonatal unit used an early warning tool specifically designed for new-born and preterm babies and we did not identify any problems with the use of this tool.
- The trust had a well-attended multidisciplinary resuscitation committee that met bi-monthly to discuss the arrangements for resuscitation of children and young people across the trust.

## Nursing staffing

- There were enough trained children's nurses on duty to ensure that safe care could be delivered. Duty rotas showed staffing levels were generally good.
- Comprehensive medical and nursing handovers took place between shifts and ensured that all pertinent information was passed on.
- Very few agency staff were used on the children's ward. There were times when a specific patient required one to one care and an agency staff member was used. These occasions were not frequent.
- The Department of Health report on staffing of neonatal units was used to calculate the staffing needs of the unit. Adjustments were made as demand for the service changed but remained at a safe level at all times. Senior nursing staff felt that they would be supported in a request for more staffing whenever it could be demonstrated as necessary.
- Staffing of the area used for high dependency care was allocated from the main children's ward staffing complement.

## Medical staffing

- The trust operated a seven day work pattern for consultant paediatricians, with two consultants on call over each 24 hour period (one for neonatal care and one for general paediatrics).
- Consultants were available every day, including weekends and bank holidays. On most days, a consultant was available until 9:00pm each evening. At weekends the on-call consultant completed a full ward round each morning and remained on site as "long as necessary". The guidance issued by the RCPCH suggests that consultant paediatricians should conduct two full ward rounds every day, including at weekends.
- Visiting consultants from tertiary centres provided specialist input for children with complex or rare conditions. Consultants from the trust also worked some sessions at a specialist centre which enhanced the shared care relationships and knowledge base.
- The rota showed adequate middle grade doctor cover at all times. The numbers of junior doctors were reduced at weekends as there were no clinics or teaching sessions.

**Are services for children and young people effective?**

# Services for children and young people

Good



Children were usually treated according to national guidance. The staff had participated in national audits and peer review programmes such as the National Paediatric Diabetes Survey 2012. Whilst the final report was not available the findings suggested that the trust provided an outstanding service to children and young people with diabetes.

The appointment of a number of clinical nurse specialists had enhanced the care children and families with chronic conditions such as diabetes, childhood cancers and cystic fibrosis or allergies.

A dedicated paediatric phlebotomy service was provided on the children's assessment unit which meant the children had blood taken by someone who was very practised at taking blood from small children and that junior doctors or nursing staff were freed up to do other tasks.

Shared care with specialist tertiary hospitals meant that children with complex conditions could attend appointments closer to home and that very specialist advice was readily available to staff working at the trust when any such children were admitted as inpatients.

All patients had an initial assessment that involved discussion with both the child and their parent/carer. Daily ward rounds were performed to ensure ongoing needs were assessed.

## Evidence-based care and treatment

- Children were treated according to national guidance included those from the National Institute of Health and Clinical Excellence (NICE) and Royal College of Paediatrics and Child Health (RCPCH). Most local policies and procedures used within the department were based on national guidelines and were up to date.
- Children's protocols were developed that were specific to the needs of children when trust level documents were not appropriate.
- Elective surgery was provided by a general paediatric surgeon for children over five years of age; General surgeons carried out emergency surgery on children over five years of age.
- The neonatal unit had access to the bereavement room provided by the Stillbirth and Neonatal Death Society

(SANDs). Here, parents could spend time with their baby in a nonclinical environment supported by staff or allowed privacy to grieve. Staff from the children's hospice had attended a recent team day.

- Screening of neonates for congenital conditions, such as phenylketonuria and cystic fibrosis, were carried out routinely.
- The children's unit scored well in the Good Antibiotic Prescribing audit with 38% of children being prescribed antibiotics. Of these, 100% had a recorded clinical indication and 100% had a review or stop date recorded.
- The preoperative fasting policy detailed the variation necessary between adult fasting and children fasting preoperatively and followed the Royal College of Anaesthetists recommended 2-4-6 rule for children and babies. Clear evidence based reasoning for preventing prolonged fasting was given to support the policy and practice guidance.

## Pain relief

- A pain assessment tool was incorporated into the children's services pathways tools but this was not always completed. Older children that we spoke with assured us that they were given pain relief medication frequently. Medication charts seen showed that analgesia was prescribed and administered regularly.
- The play specialist understood the value of adequate preparation and distraction techniques when managing children's pain during procedures. Nursing staff recognised the analgesic effect of a parent's presence for babies and young children.
- The neonatal unit had a 'Use of sucrose and breast milk policy' for the management of pain in babies undergoing procedures such as heel prick blood tests. A more comprehensive policy on pain management was in the process of being agreed.
- A dedicated children's phlebotomist was employed to take blood from children and babies. This ensured continual practice and skill maintenance with a consequence that pain was reduced. Topical anaesthetic was routinely used for blood testing and cannulation.

## Nutrition and hydration

- Breast feeding was actively encouraged on both the neonatal and children's ward.
- Separate rooms were not always available but privacy could be afforded for mothers who wanted to feed their baby discreetly.

# Services for children and young people

- Storage facilities and pumps were available for mothers who wanted to express milk. On the neonatal unit mothers were encouraged to express beside their baby to stimulate milk production.
- On the children's ward a designated milk kitchen was used to prepare all babies feeds.
- Simple food such as sandwiches and toast were available on request.
- When necessary fluid and food intake was monitored and recorded. However, the chart of one very young baby with diarrhoea had not been completed. The previous day had been completed but the total amount offered was less than the required amount that had been calculated based on their weight.

## Patient outcomes

- The trust reported participation in the Epilepsy 12 audit (Childhood epilepsy), Neonatal intensive and special care in the 2012/2013 quality report. The trust also participated in the British Thoracic Society audit of paediatric asthma and pneumonia during the same period. This showed that the trust participated in all the national audits that it was eligible for.
- Children requiring intensive care were transferred promptly to optimise the chances of a positive outcome. There were no concerns arising from either the Dr Foster Hospital Standardised Mortality Ratio or the paediatric/neonatal mortality rates monitored by the CQC Surveillance Programme.
- The Sussex Collaborative report on the Self-Assessment July 2013 Audit of Royal College of Surgeons' Standards for Children's Surgery showed that the trust was fully compliant with 70 of the standards, partially compliant with nine of the standards and not compliant with six further standards. Areas for improvement included providing a written policy to support surgeons and anaesthetists who undertook lifesaving interventions in children who cannot be transferred. The report highlighted a lack of children's nurses in theatre and recovery as a shortcoming. The trust recorded that staff in recovery had training in the care of children but there were not registered children's nurses on duty.
- All children were seen by a consultant paediatrician at the morning ward round. Where there are concerns about a child they will be reviewed again later in the day. The trust did not meet all the standards assessed

using the RCPC tool, Back to Facing the Future: An Audit of Acute Paediatric Services 2013, which recommends twice daily ward rounds including at weekends.

- All children or young people with an acute medical problem who were referred for a paediatric opinion were seen by, or had their case discussed with, a paediatrician on the consultant rota or a paediatrician on the middle grade rota.

## Competent staff

- Senior nurses provided supervision to student nurses, nursery nurses and healthcare assistants.
- Staff told us they felt supported and most had attended clinical supervision where they could discuss and reflect on work practice.
- The hospital had responded to the national shortage of paediatric nurses' by 'growing their own'. Healthcare assistants had been supported to qualify as registered children's nurses. Some had been supported to complete neonatal intensive care training.
- Clinical Nurse Specialists provided direct care and support to other staff caring for children with complex chronic conditions.
- An advanced neonatal nurse practitioner supported other nursing staff on the neonatal unit to develop skills and review practice.
- Medical staff adhered to the protocols of the specialist tertiary hospitals and had good access to specialist advice when providing care to children with complex or rare conditions.
- Membership of local and regional networks such as the neonatal network and oncology network allowed for the sharing of best practice and updating of knowledge.

## Multidisciplinary working

- Team work and strong interdisciplinary relationships were described as a key strength of children's services by all the staff we spoke with.
- The staff had begun to work with two local hospices to improve end of life care for children and babies with life threatening and life limiting conditions.
- The service had good links to the National Centre for Children and Young People with Epilepsy and has appointed a Clinical Nurse Specialist in the care of children with epilepsy.
- Transition to adult services was usually at 16 years of age. However, young people aged between 16 and 18



# Services for children and young people

might be retained under the care of the paediatricians if it was felt appropriate. Transition arrangements for children where care was shared with a tertiary centre was dependent on the protocol of the other hospital.

- The team had daily contact with the CAMHS team and referred all children who were admitted with self-harm, alcohol related illness or drug misuse. Children with acute illness due to eating disorders were admitted to the ward where they needed physical intervention but were referred for care elsewhere in the longer term.
- Shared care with tertiary hospitals enabled children to receive the best possible management for complex and rare conditions closer to their home. Joint clinics with consultants from East Surrey Hospital and the tertiary centre ensured consistency of message and a clearly understood shared care plan.
- Neonatal staff worked closely with midwifery staff on the postnatal ward and transition unit.
- The safeguarding children leads worked effectively with all grades and disciplines of staff across the trust.

## Seven-day services

- The service maintained a seven day a week service for inpatients, with on call consultant presence out of hours. Two consultants were on call at any one time covering both paediatrics and neonates.
- The children's assessment unit was not a 24 hour service and closed each evening. Children were assessed prior to the unit closure to determine whether they required admission for overnight care or observation or whether they would be discharged.
- Elective surgery was only performed as day cases on children over five years of age. Any children developing complications or requiring a longer recovery period were admitted to the inpatient ward overnight.

## Are services for children and young people caring?

Good



Most young people and parents told us the staff were caring and kind. Young children and their parents/carers were treated with dignity and respect but, as already outlined above, the care of older children was

compromised by the environment. Staff had a very tolerant and understanding attitude towards all children including young people presenting with mental health issues such as self-harm or overdose of drugs.

The children's ward had open visiting times for families. Parents were encouraged to stay overnight; there was a kitchen area for making refreshments but no separate lavatories or bathroom facilities. This helped parents to support their child and reduced the impact of hospitalisation on the children. The neonatal unit had open visiting for parents but restricted access for other visitors to reduce disturbance for the babies. Grandparents and siblings were encouraged to visit, particularly if the grandparent was to be the main support for the mother.

Parents of children with complex needs who required constant supervision were supported to take breaks and go home overnight, if they wished. A healthcare assistant was allocated to provide one to one care to allow this to happen.

Services for children aged 16 to 18 years of age (particularly those with special needs) were less well developed and staff understanding of what happened to this group across the trust was inconsistent. It was acknowledged that this was an area that needed further consideration.

## Compassionate care

- Children, young people and parents all told us that the staff were kind and caring. They described the service as having improved significantly over a period of a few years. They said staff were happier and more friendly now than on previous visits.
- Donated new presents and small toys were collected by the play therapist and given as rewards to children who had undergone procedures.
- We saw that the mother of a new-born baby was attending the children's assessment unit and had brought her two other young children with her. Their needs were accommodated by allocating a single room where the mother could supervise the children safely and providing toys, cakes and drinks to the siblings. This meant the mother was more relaxed about waiting and able to focus on caring for her sick baby.

## Patient understanding and involvement

- Children and their parents were involved in decisions about their care and treatment.



# Services for children and young people

- Play specialists were used to support children to understand their illness and any procedures. Children were offered preoperative visits and the play staff had a range of resources to help them understand what having an operation meant.
- All patients had an initial assessment that involved discussion with both the child and their parent. Daily ward rounds were performed to ensure ongoing needs were assessed.
- Parents and children were encouraged to give direct feedback to senior nursing staff and to raise any concerns locally through an initiative called 'Don't take your troubles home'. The times when senior staff would be available to speak with parents and children were displayed on the children's ward. The lead nurse for children's services visited the ward daily and spoke with parents informally to ensure they were happy with the care their child was receiving.
- Staff on the neonatal unit encouraged parents to be present for the ward round each morning. Where this was not possible, staff ensured that the nurse caring for the child provided feedback and arrangements were made for a doctor to speak to the parents later in the day.
- Parents who had not visited their baby on the neonatal unit for more than a day were telephoned to ensure all was well and to offer support, if necessary.
- When the postnatal ward staff were too busy to bring recently delivered mothers to the neonatal unit, the staff went and collected the mother to allow her to spend time with her baby and be involved in their care.

## Emotional support

- A chaplaincy service provided support to the children's ward and neonatal unit and visited, if requested. The chaplain had contacts with clergy from all the major religions and could arrange for them to visit.
- Parents leaving hospital with their baby from the neonatal unit were followed up by telephone calls from unit staff as part of an outreach programme to ensure they were coping well and had no ongoing concerns.
- Each year the neonatal staff organised a reunion for families who had a baby cared for on the unit.
- Clinical nurse specialists provided specialist support to children and families with complex or chronic

conditions. They also provided signposting to support organisations and local resources such as the SANDs and the children's hospices sibling groups and bereavement services.

- Mothers of babies on the neonatal unit were encouraged to have skin to skin contact to promote bonding.

## Are services for children and young people responsive?

Good



The children's and neonatal services at East Surrey Hospital were very responsive to patients individual and group needs. The needs of the parents were considered because staff understood that parental involvement improved the outcomes for children by reducing the child's perception of pain and minimising their length of stay.

The service responded to changes in the healthcare needs of the local population. Further consideration was needed for children from different cultural backgrounds and for teenage children who had a learning disability.

The facilities for older children were restricted because of the environment.

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

- The service adapted well to meet the changing needs of the local population. A consultant paediatrician and a clinical nurse specialist had been appointed to manage children with tuberculosis. This was because the trust had recognised an increased need as the demographics of the population changed.
- A close working relationship between the children's services at the East Surrey Hospital and the Royal Alexandra Children's Hospital facilitated the swift referral and shared management of children requiring elective surgery. Paediatric surgeons from the children's hospital visited to hold clinics and operate on children admitted for day surgery.
- The children's outpatient team moved to the Crawley hospital site to provide children's clinics that reduced travelling times, costs and stress for families.

# Services for children and young people

- However, the care of teenagers was not fully considered and their needs were not always met due to limitations imposed by the accommodation.

## Access and flow

- Children were brought to the A&E department by parents or an ambulance when they presented with a very acute illness or following an accident. There was a dedicated area of the department for children and whilst care was provided by A&E staff, paediatric medical staff were asked to review children.
- Children could be referred to the assessment unit by accident and emergency, GPs, the out of hours service or the telephone triage service. This enabled children who were acutely ill to be assessed by paediatric staff and either discharged from the assessment centre following advice or treatment or, if necessary, admitted to the inpatient unit.
- There was a total of 30 beds on the inpatient ward but this was divided up into several discreet areas. The seven bed day surgery unit only admitted children over five years of age for day surgery and closed overnight and at weekends. Three cubicles were reserved for children receiving chemotherapy. This meant that in practice, the 30 beds were actually only providing 20 beds for children across the trust.
- Two beds were designated as a high dependency unit but this had not been formally commissioned and was not resourced as an HDU.
- Bed occupancy levels were high which resulted in younger children and toddlers being cared for alongside teenagers in the adolescent bay.
- Children who presented with injuries and a history that might indicate a non-accidental cause were always referred to a consultant paediatrician and admitted for further consideration.
- The neonatal unit was a level 2 unit for babies born after 27 weeks who required specialist or intensive care. Those born before 27 weeks or who required complex specialist treatment were transferred to other hospitals with a larger, specialist, neonatal unit.

## Meeting people's individual needs

- Children with complex needs were often admitted to a cubicle to allow them privacy and a safe environment. Appropriate play equipment was provided for them.
- Where children were admitted for prolonged periods or they were concerned about exams, the local authority was asked to provide a hospital teacher.

- There was some written literature available to parents in relation to specific conditions but these were only available in English. The trust served a population which included many people who speak little or no English and had not made provision for this in the written material available.
- There were no books available for younger children that were written in any language other than English and limited recognition of the diversity of the local population in displays and toys.
- A telephone translation service was available; staff recognised the limitations of using family members for translation purposes, particularly when having difficult conversations or providing detail about medical conditions and treatments. Children under 16 years of age with learning difficulties were afforded the same care and facilities as all children. Diets, toys and their daily routine were all adapted to ensure their needs were met.
- The trust catered less well for children over 16 years of age with learning difficulties; there was no consistent and clear policy about how this cohort's needs would be met.
- Breastfeeding mothers with babies admitted to the children's ward were provided with meals to ensure that they had sufficient calorie intake to maintain milk production.

## Learning from complaints and concerns

- Children's services received very few complaints and most were resolved locally. The Women and Children's Directorate held a complaints meeting monthly to monitor complaints received and the action taken.
- The PALS monitors and responds to formal complaints made to the trust.
- An initiative called 'Don't take your troubles home' had been introduced which encouraged parents and young people to talk to senior nursing staff if they were unhappy with any aspect of their care or have any suggestions for improvement.
- All complaints were responded to by a senior nurse. They were investigated and the investigations were timely and appropriate. Complainants were invited to face to face meetings or received a phone call to discuss their issues. The lessons learned from complaints were communicated to the department via team meetings or emails, and incorporated into training modules if necessary.

# Services for children and young people

- The 2014 children's survey was very positive with only minor suggestions for improvement.
- The accommodation of both the children's assessment unit and the children's ward limited the ability of staff to provide fully for the needs of adolescents.
- On the child assessment unit, older children shared a bay with babies and toddlers. Screening was too short to be effective and there were no privacy curtains around the beds.
- The day surgery unit was one bay so children of all ages shared the same space.
- An adolescent bay 'the den' was an area designated for care of older children and adolescents but was used to accommodate much younger children when the other bays and cubicles were busy.
- Parents and children shared lavatories and bathrooms. All facilities were unisex and not designated for use by gender. There was no capacity for gender segregation for older children.
- The children's outpatient department was completely separate to the main hospital and had its own entrance. It was light, well-resourced and full of toys and books.
- The children's assessment unit waiting area was dark and uninviting. There were some toys but it was not especially child friendly. This unwelcoming space was mitigated by short waiting times on the unit.
- The ward playroom was bright, well stocked and open at all times.
- Play staff spent time in the playroom as well as with individual children who were confined to bed.
- A portable multisensory module was available for children with complex needs or toddlers who were confined to bed.
- Halal and kosher meals were available but not particularly to children's tastes. Parents often prepared food at home and bought it to the hospital in flasks. Takeaways were also permitted.
- A paediatric dietician was available to offer advice to staff and parents.

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

Good



Services for children and young people were very well led. The senior management team were all committed to the same vision where the care and wellbeing of children was central to the decision making process.

Lead staff continued to work in a clinical capacity and this ensured that executive decisions were based on operation reality. Clinical staff trusted the executive team.

Staff of all grades were positive about the organisational culture and management behaviours. The inclusive and encouraging style of management resulted in happy staff who enjoyed providing good quality care.

Whilst the longer term vision was clear and formal audits resulted in action plans to drive improvement, there was a lack of immediacy about making obvious changes when shortfalls had been identified. An example is that the staff were all aware that the PEWS system and tool were not working but no action had been taken to ensure either the policy was changed or clarification of its use was provided.

### Vision and strategy for this service

- All the staff we spoke with had a very clear shared vision and aspirational ideas of where they wanted to take children's services. All levels and disciplines of staff were enthusiastic about where their directorate wanted to be and all reported similar changes that had already happened that had taken the service towards achieving the vision.
- The vision for improved premises and accommodation for children's services closer to the accident and emergency department had not yet received funding and may be difficult to achieve within budgetary constraints.
- The commissioning of the HDU beds as a dedicated HDU was being discussed with commissioning groups and the PICU network. The shortage of PICU and dedicated HDU beds made this a realistic next step in the development of children's services at the trust.

# Services for children and young people

## Governance, risk management and quality measurement

- There was a sound governance model in place for the trust that allowed information and data from children's services and the neonatal unit to be passed up through the various layers of governance and for information from the board to be disseminated effectively.
- A programme of internal audits and service review was in place and informed service development.
- There was a trend of under reporting of near misses and incidents where no harm occurred but where there was a significant risk of harm. The lead children's nurse was aware of this and had created a 'trigger list' to remind staff about what should be reported through the incident reporting system. Nursing staff spoken to were not aware of this list which suggested that the dissemination of the information had not been effective.
- Several senior nursing staff told us that they were aware that the PEWS tool and policy was flawed and that this was why we had seen significant inconsistency in its use. We were unable to identify that any action had been taken prior to our visit in respect of this. We were assured, however, that immediate action would be taken in the form of an email to all children's staff and further training would be provided.

## Leadership of service

- The current dynamic and committed leadership of the children's services was a real strength for the trust.
- The associate director for women's and children's services was known to all staff because they visited clinical areas daily. They had previously been a clinician and understood fully the potential impact of any suggested cuts to frontline staff.
- The lead nurses for children and neonatal services continued to work clinically alongside unit and ward staff to ensure they understood how the care was being provided and to identify any shortfalls in quality that needed addressing.
- The clinical director for the Women and Children's Directorate was a consultant paediatrician with a full clinical role.

## Culture within the service

- The ward sisters were fully aware of their service and communicated well with staff.
- Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements. We were given the example of the neonatal outreach service phone calls to all parents whose babies had been discharged from the neonatal unit. This had been the idea of one of the nursery nurses.
- Staff worked well together in multidisciplinary teams to provide holistic care to children. Staff told us that the ward and unit team was wider than the nursing staff and included housekeeping staff, medical staff, play staff and administrative staff. Medical staff respected the views and professional opinions of the nursing staff.
- Staff on the wards and in the children's outpatients department said it was, "A lovely place to work".

## Innovation, improvement and sustainability

- Innovation and ideas from staff were actively encouraged. We were given several examples of small changes that had been made as a result of staff ideas.
- Bereavement and palliative care services had been recognised as an area where the service could develop and improve provision. Steps had been taken by both paediatric and neonatal staff towards this.
- The appointment of an advance neonatal nurse practitioner and children's clinical nurse specialists had improved the care provided to families.
- A shared cared network for managing children with the most complex and rare conditions had enabled families to be supported and treated closer to their homes. It also enabled access to the best possible advice for these families.
- An accepted practice of 'growing their own' specialist nursing staff whereby healthcare assistants or general nurses were supported and encouraged to gain additional qualifications and become registered as children's nurses or neonatal nurses was an effective way of succession planning.

# End of life care

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

## Information about the service

The Surrey and Sussex Healthcare NHS Trust end of life and palliative care services sat within the newly formed cancer services directorate and works as an advisory service to Easy Surrey Hospital and Crawley Hospital. The team also regularly liaised with St Catherine's Hospice. The trust did not have any wards which were specifically established to provide end of life care. With the support of the specialist palliative care team there was the potential for many of the wards to provide support, care and symptom control to people who required end of life care.

The specialist palliative care team provided a full holistic assessment and used the Somerset cancer register to capture its activity and details of care provided. The team allocated a key worker to each patient and patients were discussed on a weekly basis at multidisciplinary team meetings. The team consisted of one consultant, one lead nurse, four cancer nurse specialists, one palliative care training post, two volunteers and one team secretary. The end of life team provided symptom management, information and advice for staff caring for patients requiring end of life care and their families. End of life care was also provided by other members of the multidisciplinary team: for example, chaplaincy and the bereavement office.

Throughout our visit to the Surrey and Sussex Healthcare NHS Trust we visited the chemotherapy suite, Charlton, Capel and Meadvale wards, the bereavement centre, the mortuary and the chapel. We spoke with four patients, five relatives, 18 members of staff including nurses, doctors,

ward clerks, mortuary technicians and staff in the bereavement centre. We also spoke with six members of the specialist palliative care team. We observed patient care and we also looked at seven patient records.

# End of life care

## Summary of findings

We found that the trust had systems in place to ensure end of life care was safe and met the needs of patients and that staff were committed to providing person centred care to patients who were receiving end of life care. Patients spoke positively about the way they were being supported with their care requirements. Relatives also spoke very positively in regard to the support they and their relatives received.

The specialist palliative care team were responsible for ensuring that end of life care was delivered to staff within the ward areas as part of their mandatory training. The specialist palliative care team had developed an end of life care pathway tool which was in use in all the ward areas we visited. Staff in all of the ward areas we inspected were aware of the tools used for patients receiving end of life care and all staff were aware of how to contact the specialist palliative care team.

## Are end of life care services safe?

Good



We found that systems were in place to ensure end of life care was safe and met the needs of patients. Staff were committed to providing person-centred care to patients who were receiving end of life care.

Patients told us they felt safe on the wards we inspected and staff assured us they knew the procedures to take to keep patients safe. Relatives told us that they felt their relatives were safe and well cared for.

### Incidents

- Staff reported incidents by an electronic system. We were told the system was effective and any incidents were investigated and resolved in a timely manner.
- Data collected prior to our inspection indicated there had been no recently reported “Never Events” within the area of end of life care at the trust. A serious incident known as a Never Event is classified as such because they are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Staff understood their responsibilities with regard to reporting incidents and they knew how to report them. They also told us that they received direct feedback relating to the incidents.
- The palliative care team audited incidents when they carried out a management standards survey in January 2014.

### Cleanliness, infection control and hygiene

- Ward areas and the mortuary were clean, and domestic staff undertook audits of the environment to ensure continued cleanliness.
- Domestic staff told us that there were sufficient staff to be able to carry out their job role.
- We observed staff adhering to the hospital’s policy for the prevention and control of infection through washing their hands between tasks and using personal protective equipment (PPE) such as gloves and aprons. Staff adhered to the ‘bare below elbow’ policy.
- Staff spoken with were aware of their roles and responsibilities in regards to infection control.
- We observed that where patients were being nursed in isolation, staff adhered to isolation procedures. For



# End of life care

example, we saw that patients were being nursed in a side room and that staff were using appropriate personal protective equipment (PPE) on entering the room. We also saw that staff washed their hands before they left the room.

- Infection prevention and control policies and procedures were in place and accessible to staff on the intranet.
- One patient told us they always saw staff wearing protective clothing and they washed their hands regularly.

## Environment and equipment

- Each ward area and the mortuary had sufficient moving and handling equipment to enable patients to be safely cared for. Although we found a hoist was broken on one ward, contingency plans had been put into place to ensure that people's needs were met in a safe way.
- Equipment was maintained and checked to ensure it continued to be safe to use.
- Maintenance and calibration of syringe drivers and associated equipment was undertaken by an Electronics and Medical Engineering Department technician. Syringe drivers were tracked in and out of the department by an electronic spreadsheet to ensure the equipment was readily available when needed and staff could start sub-cutaneous infusions, to help with symptom control in a timely manner.
- We saw that all patients were able to reach their call bell in order to attract the attention of a member of staff if they needed to. We observed a staff member explaining to one patient how to use the buzzer and what it was for.
- The mortuary had contingency plans in place for caring for bariatric patients if the equipment was insufficient.

## Medicines

- Medicines in the trust were stored safely. Record keeping was in line with legal requirements.
- We were told by staff that patients who required end of life care were written up for anticipatory medicines.
- We saw that anticipatory end of life care medication was appropriately prescribed.
- Two relatives told us that staff had ensured that they relative was pain free and kept comfortable. They said they had been able to discuss pain relief with the staff and they had been involved in decisions about the medicines in use.

## Records

- We looked at Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms throughout the ward areas and found that these had been filled out in line with guidance published by the General Medical Council. We looked at 24 forms and found two where the junior doctor had signed the decision. All decisions relating to DNACPR should be signed by a consultant.
- The trust audited the DNACPR forms annually to ensure they were completed properly. Results of the audit demonstrated the trust had good performance in relation to this.
- We saw DNACPR forms had been completed for those who lacked capacity. We saw the decisions had been made in accordance with the MCA requirements. We saw that the forms had been completed to show how the decision had been reached that this was in the patient's best interests.
- The palliative care team had placed information packs on each ward to enable staff to implement the end of life care pathway when required. This included information such as the referral criteria, the use of the Mental Capacity Act, medicine prescribing and guidance for staff on people's different religious and cultural needs.
- We looked at patient records for those who had been placed on the end of life pathway. We found that relevant plans of care such as pain management, managing restlessness, agitation and distress and managing nausea and vomiting were in place. These care plans reflected national guidance and provided sufficient information for staff to provide safe, effective care. Although care plans were pre-printed there was additional information within the patient's notes to ensure staff were aware of their individual needs and personal preferences.
- On Meadvale ward we also looked at the records of a patient who was at risk of developing pressure ulcers. We found the patient was receiving appropriate care relating to the prevention of pressure ulcers. There was a care plan in place to tell staff how to provide care relating to the patient's needs.
- Charts were used to monitor a patient's general health and wellbeing such as food and fluid intake and skin condition. We saw patients were formally assessed as to

# End of life care

the appropriate use of these charts at the end of life. The charts were accurately completed and staff therefore had an accurate assessments of a patient's condition, such as if they were properly hydrated.

- Within all of the ward areas we saw that records were stored securely in order to ensure they could not be accessed by people who did not have the authority to access them.

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

- The staff we spoke with told us that they had received training in relation to consent, the MCA and DoL safeguards.
- When we spoke with staff their understanding in regard to this was variable. Whilst some had in depth knowledge, that of more junior staff was in some cases limited. Nevertheless, their knowledge was sufficient for their job role and they told us they would seek further guidance and information if required.
- There were systems in place to ensure patients who did not have the capacity to consent to end of life care were treated in their best interests by staff.
- We saw evidence of Mental Capacity Assessments being undertaken within patient's medical records.
- We saw that consent was obtained from patients who had the capacity to give consent.
- We observed staff asking for patients consent when they were supporting them with care needs.
- We looked at patient records and found some examples of documented discussions with patients and relatives about treatment decisions where appropriate.
- Relatives told us that they had been involved in discussions as required. One relative said, "We have had in-depth conversations and discussions about care and treatment. We are always involved."
- One patient said, "I am treated with respect, the consultant explained treatment and I have had opportunities to discuss my care at any time. I know exactly what is going on."
- We saw staff offering patients choices and providing them with information to allow them to make informed decisions. We also saw staff asking patients for their consent prior to supporting them with their care needs.

## Safeguarding

- Staff told us that safeguarding training was mandatory and all the staff we spoke with had undertaken safeguarding training.

- Staff were able to explain what constituted a safeguarding concern and the steps required to report such concerns.
- Staff also knew about their whistleblowing policy and how to report concerns if they had them
- Patients told us they felt safe being cared for within the Surrey and Sussex Healthcare NHS Trust.
- Relatives told us they felt that their relatives were kept safe and they were well cared for.

## Mandatory training

- Staff told us that they felt supported to complete mandatory training.
- The specialist palliative care team told us that end of life care was part of mandatory training and the current statistic for attendance was 90%.
- In addition to the mandatory training, consultants and cancer nurse specialists were trained to advanced communications skills, and level two in Psychology.
- Staff nurse development was also available on a quarterly basis which included communication, breaking bad news and end of life care.
- Members of the specialist palliative care team had also attended courses and conferences in the last year such as; End of life care for people with dementia, a five day course at St Catherine's Hospice and 2nd Guildford Advanced Pain and Symptom Management two day course.

## Management of deteriorating patients

- We saw that an early warning system was used to identify when patients were deteriorating. We saw evidence of this on one of the wards where a patient had been scoring more highly than normal. Medical staff had been alerted and the patient was given treatment in order to stabilise their condition.
- Specialist support was available from the specialist palliative care team when required and out of hours specialist advice could be sought via telephone.
- The specialist palliative care team were considering implementing the AMBER care bundle. The AMBER care bundle is a simple approach used in hospitals when doctors are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the person die.

# End of life care

## Nursing staffing

- The hospital specialist palliative care team at the Surrey and Sussex Healthcare NHS Trust included one consultant, one lead nurse, four cancer nurse specialists, one palliative care training post, two volunteers and one team secretary. The team were responsible for providing support for ward staff who were delivering end of life care.
- Recruitment was also underway for specialist cancer nurses.
- Although patients on end of life care had a keyworker, all staff were made aware of the palliative care team to ensure they knew who to contact if necessary. Staff spoken with told us the specialist palliative care team were always visible on the ward and they knew how and when they could contact them. They told us that the support received from the team was excellent.
- The specialist palliative care team visited patients on end of life care on a daily basis to ensure that appropriate reviews took place and nursing staff, patients and their relatives were supported appropriately.
- Ideal and actual staffing numbers were displayed on the ward areas. Staff told us they normally had enough staff and that any gaps were filled with agency staff. Staff in both the bereavement office and the mortuary also told us there were sufficient staff available.
- We found that the specialist palliative care team had looked at and prepared a business case for increasing the team and they were jointly working with Marie Curie to improve discharge experience for patients and families and lessen workload from the team.
- The trust monitored the ward staff (numbers and skill mix) on a daily basis to ensure adequate staffing was in place.

## Medical staffing

- The end of life care team had one consultant in palliative care. They worked with other consultants and junior and senior in the trust to ensure continuity of care.
- The palliative care team told us that training in end of life care was rolled out to junior and senior doctors in the trust. This training included end of life care, opiate prescribing and ethics.
- Staff spoken with told us that medical staff were available when required.

## Major incident awareness and training

- The mortuary technicians told us they had a contingency plan in the event that the mortuary became full. The senior technician had an agreement with a local undertaker, and knew of the circumstances under which they should use this plan.
- Staff working on the ward areas told us they received training in regards to major incidents and they were able to discuss what action they would take in the event of a fire.

### Are end of life care services effective?

Good



During our inspection we visited patients who were in receipt of end of life care. Patients spoke positively about the way they were being supported with their care requirements. Staff in all of the ward areas we inspected were aware of the tools used for patients receiving end of life care and all staff were aware of how to contact the specialist palliative care team. We saw that training in end of life care was part of the mandatory training delivered to all staff. The specialist palliative care team coordinated multidisciplinary care and visited people on end of life care on a daily basis.

Ward staff were aware of the trust's definition of end of life care. They were appropriately trained and essential nursing care for assessment and monitoring of pressure ulcer management, pain relief, comfort and managing distress was delivered appropriately. Mortuary and the bereavement centre staff were also aware of the trust's definition of end of life care and they were able to demonstrate an understanding in the principles and values of the trust's strategy for end of life care.

## Evidence-based care and treatment

- The specialist palliative care team told us that care was based on the Department of Health's end of life care strategy and quality markers and NICE Quality Standard QS13. This quality standard defines clinical best practice within end of life care for adults.
- The specialist palliative care team had carried out audits to benchmark where they were against the 16

# End of life care

quality statements for the end of life care as published by NICE. There was evidence of them preparing an action plan to address the identified shortfalls which were weekend services and psychological support.

- In addition to leading on strategic development, the specialist palliative care team also provided clinical care to patients who were at the end of life on the wards, supporting and empowering staff, patients and carers and promoting the use of recommended best practice tools.
- In response to the national withdrawal of the Liverpool Care Pathway, the trust had rolled out replacement guidance to all inpatient areas.
- Staff we spoke with were clear about the trust's definition of end of life care.
- Staff were aware of patients who required end of life care on the wards we visited.

## Pain relief

- The specialist palliative care team had drawn up prescribing guidance for ensuring anticipatory prescribing took place and to ensure pain relief was administered to patients in a timely manner.
- Medical and nursing staff could contact the specialist palliative care team for advice about appropriate pain relief if required.
- Appropriate medication was available in the ward areas, and there were examples that anticipatory prescribing was being managed.
- Patients on the ward areas told us that pain relief was given as needed. We did not observe patients to be in pain during our inspection.
- We saw positive interaction when a staff member was establishing whether a patient was in pain. They communicated effectively and empowered the patient to discuss their symptoms and what had previously been effective. We saw the staff support the patient in a kind and dignified manner to ensure they became more comfortable.

## Nutrition and hydration

- Protected meals times were in place on all wards we visited and out of hours snack boxes were available if a patient had missed a meal.
- We observed that all patients had access to drinks which were within their reach.
- Patients and relatives on one ward told us the food was "very good". Patients told us they got enough to eat.

- Staff told us that snacks were available for patients throughout the day and night and we saw examples of this on the wards that we visited.
- We observed one person who was receiving nutrition, fluids and medicines via a naso gastric tube. A naso gastric tube is a thin tube which is passed down the nose into the stomach and used as a way of giving food, fluids and medicines directly into the stomach. We saw there was a clear plan in place to ensure this person received regular oral care.
- We saw that fluid and nutrition was accurately recorded when it needed to be. The ward areas maintained fluid balance charts, and these were accurately totalled. This meant they could be used to make clinical decisions when required.
- We saw that patients were screened using the MUST screening tool and those who were nutritionally at risk were identified by signage above their bed.
- We saw that on all wards relatives were encouraged to come in at meal times if a patient required support to eat their meal.

## Patient outcomes

- The specialist palliative care service participated in internal and external validation (peer review) as well as self-assessment of the service to evaluate their performance against the NHS England National Cancer Peer Review themes.

## Competent staff

- Cancer nurse specialists were either working towards or were trained to degree level.
- Staff within the specialist palliative care team had clinical supervision to support them in their role and they told us that they undertook peer reviews to ensure clinical excellence was developed and maintained.
- Medical staff had annual appraisals and they were meeting continuing professional development requirements.
- All new staff were provided with an induction period in which they undertook mandatory training. Two recently new members of staff confirmed that they had undertaken a period of induction on starting at the hospital.
- Staff told us that they received annual appraisals and that they had regular supervisions within their ward areas.
- The specialist palliative care team delivered training to staff as part of their mandatory training.

# End of life care

- Nursing staff displayed good knowledge about the needs of patients who required end of life care
- All of the staff told us they knew they could get support from the palliative care team if they needed it.
- In addition to the mandatory training, consultants and cancer nurse specialists were trained to advanced communications skills, and level two in Psychology.
- Staff nurse development was also available on a quarterly basis which included communication, breaking bad news and end of life care.
- Members of the specialist palliative care team had also attended courses and conferences in the last year such as; End of life care for people with dementia, a five-day course at St Catherine's Hospice and 2nd Guildford Advanced Pain and Symptom Management two-day course.
- Bereavement staff told us they felt confident in their job role but they felt that specific training in regards to bereavement would be beneficial.

## Multidisciplinary working

- The specialist palliative care team worked in a collaborative and multidisciplinary manner. The service included spiritual support from the chaplaincy team and bereavement support from the bereavement centre.
- A specialist palliative care multidisciplinary team (MDT) meeting with input from the chaplain and other specialities took place weekly to discuss hospital inpatients' treatment plans. The team also held ward rounds and worked closely with other clinicians to coordinate treatment, avoid overlap and to facilitate well-coordinated care.
- Staff reported that there was an effective multidisciplinary team-working and decision-making approach to end of life care.

## Seven-day services

- The palliative care team were available Monday to Friday from 9:00am to 5:00pm. A member of the palliative care team was also available one day over the weekend. The team also provided out of hours support by telephone. In addition, there was one cancer nurse specialist clinic per week at Crawley and the team regularly liaised with St Catherine's Hospice.
- As there had been developments in regard to extending the service and moving towards a six day service, the specialist palliative care team told us that they ensured patients referred to them had a plan of care to meet

- their needs over weekends. A handover would be given prior to the weekend period to ensure continuity of care. This was to ensure that medical cover at the weekend was provided by the on call doctors from other specialities who were more familiar with the patients.
- The bereavement centre operated a pick up collection service for death certificates over the weekend. Also, in addition to their normal office opening times, they offered an out-of-hours service via telephone.
  - The chaplaincy service provided 24 hour, on call support for patients and relatives.
  - Ward staff told us the specialist palliative care team was a responsive and supportive service. Ward staff also confirmed that this service was available out of hours.
  - The mortuary staff were on call 24 hours a day

## Are end of life care services caring?

Good



We observed care that was attentive and sensitive to the needs of patients and staff treated patient with dignity and respect. We received positive comments from patients and their visitors. Patients told us they were satisfied with the service and were involved in their care.

Patients' feedback or views on their experiences were regularly collated and updates on action that had been taken as a result was available on display in each ward area.

Patients and their relatives had good emotional support from the specialist palliative care team, chaplaincy, and bereavement office and ward staff.

## Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered in a timely manner. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- The patients we spoke with told us "The staff are great, I am treated well." Another patient told us, "They treat me well; they are always there if I need them."
- Relatives all spoke positively about the care and treatment their relatives received. One relative said, "It is excellent care, the staff respond to any concerns or anxieties and they are responsive to changes in



# End of life care

medicines. We have received a tremendous level of support.” Another relative said, “It is excellent, nothing is comparable to this level of care, attention and compassion. If patients don’t have visitors, staff make the time to sit with patients.”

- During our inspection we visited the mortuary and spoke with the mortuary technicians. On discussion staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death.
- During our inspection we also visited the bereavement office and the chaplaincy staff. They also demonstrated a good understanding of end of life care and showed compassion and respect.
- Normal visiting times were waived for relatives of patients who were at the end of their life.
- Ward staff were aware of patients who were receiving end of life care. They were able to discuss their needs and the support that they required. They showed a good understanding and demonstrated compassion and respect.
- We looked at patient records and found they were completed sensitively with detailed discussions that had been had with patients and relatives.
- The specialist palliative care team told us that a patient satisfaction survey was underway to evaluate the service provided.
- During assessments, the needs of the patient were identified and their wishes acknowledged and responded to.
- The trust took part the 2012/13 Cancer Patient Experience Survey, which comprised of a number of questions across 13 different cancer groups. Of the 69 questions asked, Surrey and Sussex Healthcare NHS Trust was rated by patients as being in the bottom 20% of all trusts nationally for 21 of the 69 questions. The trust had an action plan to address the areas that required improving.

## Patient understanding and involvement

- Patients we spoke with told us that they felt involved in their care.
- Relatives we spoke with told us they had been involved in decision making as necessary.
- We saw that doctors and nurses spoke to patients about their care so that they could understand and be involved in decisions being made.

- We saw that where patients had been assessed as not having capacity to make decisions, care options had been discussed with their next of kin.
- When we looked at records we saw there was evidence of patients and/or their relatives being involved in the development of their care plans.
- We saw where advanced directives were in place that these were discussed and taken into account in regard to the care delivery and treatment options.
- We saw that bereavement packs were available in the ward areas with information about access to support.
- We saw on Charldon ward that weekly clinics were held with relatives, consultants and multidisciplinary staff.

## Emotional support

- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their visitors.
- We observed instances within the ward areas where emotional support was given to patients and their extended families.
- We saw that privacy and dignity was maintained and opportunities were taken to further inform the patient and their family of the situation.
- During holistic assessment the specialist palliative care team identify patient’s beliefs and cultural needs.
- The specialist palliative care team, the chaplaincy and nurse specialists provided emotional support to patients and relatives.
- During our inspection we visited the bereavement centre where we saw there was a bereavement counselling service. One relative told us that they had been advised that they may access this support.
- The bereavement staff sent a follow-up letter to the documented next of kin offering bereavement support to them or any other family members. This is limited to patients known to the hospital palliative care team.
- Chaplaincy staff were visible within the hospital and staff within the ward areas told us they could access religious representations from all denominations.
- We saw that emotional support was also offered following death by staff from the mortuary as families come to visit their loved ones in the chapel of rest.
- The mortuary technicians and bereavement centre staff told us that they had close links with various



# End of life care

representatives of different denominations for example, the local mosque would provide them with any updates required to ensure they were fully aware of any developments within the Muslim community.

- The specialist palliative care team told us that there were plans to roll out SAGE & THYME. This is a model that was designed to train all grades of staff how to listen and respond to patients or carers who are distressed or concerned
- We saw that discussions took place with patients and/or their families in respect of access to side rooms when someone was nearing the end of their life.
- Staff in all ward areas told us they had sufficient staffing levels which enabled them to provide end of life care and particularly emotional support.
- At the Crawley hospital site there was access to support and counselling services via 'The Olive Tree.'

## Are end of life care services responsive?

Outstanding



The specialist palliative care team were working hard to ensure every person receiving end of life care had a positive experience. Patients referred to the specialist palliative care team were seen promptly according to their needs. The trust had monitored data on meeting patients' preference on where they wanted to die, to see if patient's needs were being met. Emphasis had been placed on ensuring care was carried out in the patients preferred place. The specialist palliative care team had introduced a rapid discharge home plan for people who had identified a wish to be cared for in their own home.

Staff had received training in end of life care to ensure patients and their families who required end of life care were supported. The specialist palliative care team had close working relationships with the consultant nurse for older people and dementia; learning disabilities and safe guarding team. We saw that complaints were handled in line with the trust policy and action plans were in place to address complaints and concerns.

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

- The palliative care team were available Monday to Friday from 9:00am to 5:00pm. A member of the palliative care team was also available one day over the

weekend. The team also provided out of hours support by telephone. In addition, there was one cancer nurse specialist clinic per week at Crawley and the team regularly liaised with St Catherine's hospice.

- The palliative care team told us that patients were seen within 24 hours of referral.
- Staff had received training in end of life care to ensure patients and their families who required end of life care were supported.
- End of life care tools had been rolled out within the ward areas to facilitate coordinated care that gives the patient choice.
- The specialist palliative care team were aware of the cultural and religious beliefs of the multicultural society. The chaplaincy presence in the multidisciplinary team worked closely with local representatives of various denominations.
- Additional information in regard to cultural and religious needs of local people had been placed in the end of life pathway folder to ensure staff were aware of people's individual needs. Ward staff were able to demonstrate a basic understanding but stated that they would always consult the patient and/or relative for additional information.
- Emphasis had been placed on ensuring care was carried out in the patients preferred place. The specialist palliative care team had introduced a rapid discharge home for people who had identified a wish to be cared for in their own home. They could do this in as short a time as was necessary and it could be within a couple of hours.
- Where possible side rooms were prioritised for patients at the end of their life.
- Since September 2013, following the fourth National Care of the Dying Audit, the trust had been developing services to improve end of life care for their patients.

## Access and flow

- The specialist palliative care team had put in a care pathway tool for patients in all areas of the hospital. This to ensure that patients who required end of life care were identified at the earliest opportunity and to facilitate the most appropriate care in the most appropriate place for each patient.
- Patients requiring specialist palliative support were referred through one single point of access to reduce the risk of missed referrals. The team supported patients with a range of progressive, non-curative illnesses.

# End of life care

- Patients referred to the specialist palliative care team were seen within 24 hours.
- We saw that multidisciplinary team board rounds were undertaken on each of the ward areas each morning where plans relating to appropriate discharge were discussed.
- On Meadvale and Charldon ward, we saw that where a patient's condition had deteriorated, staff included their family in conversations relating to whether it was appropriate to place the patient on the end of life care pathway and whether to contact the specialist palliative care team. We saw following this that the palliative care team had been involved on a daily basis with the patients continuing care.
- We saw that when a patient had been identified as being at the end of their life that relatives were able to offer their help by coming into the ward and providing some sort of care for their loved one. For example they could help the person to eat their meal or provide personal care.

## Meeting people's individual needs

- The trust had a rapid response service for discharge to a preferred place of care to ensure patient preferences at life's end were identified and met. The trust interpreted rapid as meaning a quick discharge within a few hours.
- A quality audit of these figures was undertaken, which demonstrated that the trust was meeting the required target. We saw from 1 January 2014 until 31 March 2014 that 85% of patients died at their preferred location.
- The palliative care team had submitted a business case to provide a supported discharge model. This would enable a discharge liaison nurse and a nursing assistant to facilitate the patient to be discharged to their preferred place of death, or set up a temporary package until a more permanent package could be arranged.
- Multifaith chaplaincy was available 24 hours seven days a week. Arrangements had been made with the mortuary and local coroners to ensure where necessary for religious reasons, bodies could be released promptly.
- The specialist palliative care team had close working relationships with the consultant nurse for older people and dementia; learning disabilities and the safeguarding team.

- An electronic records system, shared with a regional cancer centre, provided staff with up-to-date information on patient chemotherapy treatment and progress.
- Interpreters were available where necessary. Staff told us that a telephone service was available or staff working within the hospital would facilitate translation. We also saw that provision had been made for a relative to stay with a patient to translate for them as they did not speak English.
- We were told about a patient who was near the end of life had requested a wedding to take place at the hospital. Although there was no time to arrange a marriage, the chaplain worked with the ward staff to organise a suitable ceremony and for the patient's family and friends to attend. The catering department arranged a buffet and celebration cake after the ceremony.
- Written information and supplementary leaflets were available to support communication with patients and relatives. Patients and their relatives told us they had access to appropriate information.
- The specialist palliative care team had developed a leaflet in response to the NICE guidelines to ensure that patients and relatives had written as well as verbal information.

## Learning from complaints and concerns

- Patients we spoke with felt they would know how to complain to the hospital if they needed to.
- Information was available in the hospital to inform patients and relatives about how to make a complaint.
- The hospice staff engaged with recently bereaved families by writing to them within six weeks of the death of their relatives. They used this feedback to consistently improve their service.

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

Good



We found that end of life care services were well led at the trust. There was a trust strategy for palliative and end of life care and staff were aware of these visions and values.

We found that staff on the ward areas shared the visions and values that the specialist palliative care team were working to promote. The main emphasis on ensuring all

# End of life care

patients and their families requiring end of life care had a good experience and that every patient was given a choice about their preferences for end of life care. The specialist palliative care team were described by staff as good leaders. The specialist palliative care team were passionate about the service they offered and they monitored and improved the quality and safety of the services that they offered.

## Vision and strategy for this service

- We saw that the Surrey and Sussex Healthcare NHS Trust had an end of life care strategy which was based on the department of health's quality markers for end of life care in acute hospitals. This set out its strategic objectives to empower, develop and support its staff and to encourage positive leadership at every level; enhance patient experience by providing local care tailored to the individual needs of patients; develop partnership arrangements to promote and deliver integrated services.
- We met with the specialist palliative care team for end of life care who told us that patients should expect to receive a good end of life care experience which offered them choice.
- The vision for end of life care was visible within the ward areas.
- Staff were keen to talk about their role and how they felt about supporting people at the end of their life. They were keen to share their experiences and how they were going to put their learning into practice.

## Governance, risk management and quality measurement

- Governance systems were in place to ensure learning and improvements were shared across the service.
- An End of Life Steering Group had been developed and the specialist palliative care team held regular team governance meetings.
- Complaints, incidents, audits and quality improvement projects for the specialist palliative care service were regularly monitored and actions implemented for their service.
- To continue developments, the palliative care team met with various other commissioners such as the South East Coast Strategic Clinical Network & Clinical Senate, End of Life Care Advisory Group and St Catherine's Hospice joint communication meetings.

- There was evidence of a trust-wide audit programme to assess compliance with the Quality Standard for End of life care for Adults' (NICE, 2011; updated 2013).
- We saw that quality dashboards were on display in the ward areas we visited. This is important so that staff can see what good looks like for the service and what they are aiming for.
- Patient health and wellbeing monitoring records were reviewed regularly to ensure staff had accurate information with which to make informed decisions about patients' care.

## Leadership of service

- We saw there was strong leadership within the team responsible for end of life care. All were passionate about ensuring patients and their families received a good end of life care experience.
- All of the staff we spoke with knew who the leads were for end of life care. Staff spoke highly of the specialist palliative care team and said they were visible and supportive at all times.
- Staff told us that the chief executive was often visible within the trust and was approachable.
- Staff told us that they felt supported in their job role and that the leadership within the trust was strong.

## Culture within the service

- Staff within the specialist palliative care service were passionate about their job role and the quality of end of life care provision. They told us they felt well supported and that the executive team were seen and were visible, which clinically made a difference regarding business planning with the new directorate.
- Staff we spoke with thought highly of the hospital. They spoke positively about the service they provided and likened the hospital to a family community they described good, supportive working relationships with the specialist palliative care team.
- There was a culture of sharing knowledge between specialist palliative care and other services through formal and informal teaching opportunities.
- Staff reported positive working relationships and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines
- Staff were positive about the service they provided for patients and expressed they wanted to do their best for patients.

# End of life care

## Public and staff engagement

- A patient survey has been developed to give ongoing feedback on the experience of patients and carers to help ensure good care was identified and areas where improvements could be made could be acted upon.
- Staff were positive about the visibility of the leadership board and the accessibility of the chief executive officer.
- All staff had access to the trusts intranet which included the palliative care information.
- The palliative care team had held a Dying Matters awareness week in May 2014 which was part of a national initiative to help people talk about death and dying more openly.
- A palliative care news leaflet was sent out monthly to staff.





## Innovation, improvement and sustainability

- The end of life care team was planning to roll out the AMBER care bundle which is a tool used to support

teams in identifying and responding to a person's end of life care needs when their recovery is uncertain. It is designed to enable treatment to occur alongside palliative care

- It was identified that cancer services were getting lost in the trust and therefore a separate directorate for end of life care was formed in September 2013.
- As cancer care services were growing the trust identified plans to open a new radiotherapy suite on site.
- A business case had been put forward to work with Marie Curie to develop care coordination and discharge planning.
- Work was taking place with the Macmillan Cancer Support to provide an information centre for patients.
- The trust achieved the third place development award from the International Journal of Palliative Nursing in 2010.

# Outpatients

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

## Information about the service

The outpatient services provided by the trust were located at three hospital locations, East Surrey Hospital, Crawley Hospital and Horsham Hospital. The latter two hospitals were owned and managed by another NHS trust. The main outpatient service was located at East Surrey Hospital in a dedicated area. This area was divided into sections with two separate areas for Ophthalmology and Breast Clinics. There were separate reception areas for each area.

Outpatients at Horsham Hospital were located over two floors with two main outpatient areas. There was a dedicated reception area which was located on the entrance to the department. The outpatient services at Crawley Hospital were located on the ground floor with two main outpatient areas. Each outpatient area had a separate reception area which was located on the entrance to the department.

The trust offered outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required.

During our inspection we spoke with twenty three patients, two relatives, and nineteen members of staff at East Surrey Hospital, seven staff, eleven patients at Crawley Hospital and seven patients, one relative and six staff at Horsham Hospital. Staff we spoke with included reception and booking staff, clerical and secretarial staff, cleaning staff, nurses of all grades, doctors, and consultants. We observed care and treatment. We received comments from our listening events, and we reviewed performance information about the department and trust.

## Summary of findings

Patients received compassionate care and were treated with dignity and respect. Patients told us that staff were kind and supportive, and they felt fully involved in making decisions about their care. Medicines and prescription pads were securely stored. The outpatient areas we visited were clean and equipment was well maintained.

Many clinic appointments were cancelled at short notice. Clinics were busy and patients sometimes had to wait a long time to be seen. Patients and staff told us one of the biggest challenges was clinics running late. Outpatient clinics were overbooked; there was not enough time to see patients, so clinics often over-ran.

The large number of ad-hoc clinics ensured that the trust was meeting its waiting time targets. However, these clinics were run on the goodwill of staff. Staff were very concerned that patients' medical records for clinics were often not complete. Patients could be seen in clinic with either no notes or a temporary set of notes. This meant staff did not have a full and accurate medical history of the patient they were reviewing.

Staff were particularly concerned about this.

# Outpatients

## Are outpatients services safe?

Requires improvement



Staff were reporting incidents on Datix. However, we were told about incidents concerning medical records that had not been reported.

Medical records were not being managed safely. We were told multiple accounts of medical records being incomplete, incorrect because information had not been updated. We were also told that medical records could not always be obtained in time for clinics which were being routinely arranged on an ad-hoc basis. This meant that patients were being seen in clinic with temporary notes and medical staff could not obtain a past medical history of the patients that they were seeing in clinic. This could result in unsafe or inappropriate care.

### Incidents

- Staff in the outpatients department (OPD) used an online reporting tool (Datix) to record any accidents, incidents or near misses that occurred. We were told that only senior nursing staff had received training on this system. This included band 6, band 7 and band 8 staff members who had passwords and were able to access and use the tool. Other grades of staff had to rely on trained staff to help them report incidents.
- We saw that staff had used the reporting system for a variety of incidents which included patient transport issues, IT issues which had affected clinics, and patient falls. There had been 18 incidents reported between December 2013 and March 2014 (nine at Horsham Hospital, two at Crawley Hospital and seven at East Surrey Hospital). All incidents were recorded as having no harm or minimal harm to patients.
- Staff told us about medical records not being available. They were not reporting these occurrences on the Datix system. Therefore, although staff from both the department and medical records told us that this happened regularly, there was no data available to establish the extent of the problem, which meant evidence of the extent of the problem could not be accurately assessed.
- The OPD manager told us that they would feed back any learning from incidents and accidents to staff. However, staff that we spoke with told us that they had never

received feedback from any Datix forms that they had submitted. The manager told us that once they had submitted a Datix the person investigating would send an email outlining their investigation outcomes. However, they said that they did not consistently receive this feedback.

### Cleanliness, infection control and hygiene

- There were systems in place to reduce the risk and spread of infection.
- Patients we spoke with all told us that they felt the department was cleaned to a good standard. During this inspection, we walked around the department looking at the cleanliness of the patient waiting areas, some clinic rooms, patient toilets, dirty utilities and corridors.
- We observed that most of these areas were clean and free from unnecessary clutter.
- Cleaning staff were responsible for cleaning public areas, clinic rooms, and toilets in the OPD. The housekeeping department audited the cleaning standards against the national standards for cleanliness within the NHS. The required audit scores for this department were 85%. Audits showed that the department had scored 98% in its recent audit of cleanliness.
- Clinical staff had completed checklists to show that treatment couches and equipment were cleaned between patients. We saw that these checklists were comprehensive and had been completed correctly by staff.
- Mandatory training records held in the department showed that 75% of staff had received infection control training within the past year.
- Staff that we spoke with understood their role in the prevention of the spread of infectious disease.

### Environment and equipment

- Building maintenance was managed by the estates department for the hospital. We were told that where issues were found these would be reported to the relevant estates department who would log the requirements and issue the department with a job number. The OPD kept a log of the work that they had reported to estates and kept track of when and how issues were resolved. We were shown the departments log book which evidenced that staff were reporting and tracking maintenance issues.
- When equipment failed staff followed guidance for decontamination and arranged for the electronics and



# Outpatients

medical engineering department (EME) to collect, repair and return the item. We were told by the manager that when this happened they would borrow equipment from other areas of the hospital to replace equipment until it was repaired.

- The manager told us that when they required more equipment they would ask the division that the equipment was required for to supply this. They also said that the hospitals league of friends were always supportive where the department had asked for funding for equipment.

## Medicines

- Medicines were stored in locked cabinets within the department. All medicines were ordered by nursing staff through the hospitals pharmacy.
- The majority of medicines were administered by doctors. Where nurses were required to administer medicines such as analgesia these would be prescribed by the clinician and recorded on a prescription chart which would be stored in the patient's medical records. The nurses would then sign and date the prescription to confirm that they had administered the medication.
- The department held prescription pads which doctors used to prescribe medications. Opposite the OPD entrance was a chemist that patients could use to collect their prescriptions. Patients told us that they found this to be convenient.
- Prescription pads were stored in a locked cabinet. The department had processes in place to ensure the safe use of prescription pads.

## Records

- An ongoing safety issue in the OPD had been patient records not being available for clinics. This meant that staff were using temporary sets of notes for some patients in clinics. Therefore clinicians would not have all the information required for them to make safe decisions about patients care. This could lead to unsafe or inappropriate treatment.
- All of the staff that we spoke with told us of incidents where notes were incomplete, where records had not been updated with information such as a change of address, or where patients attended clinic with a temporary set of notes as their medical records could not be obtained in time for clinic. Some staff told us that this had happened on multiple occasions in the past

month. However, although the manager told us that they would expect these incidents to be reported data showed that no incidents of this type had been reported since December 2013.

- We spoke with staff from medical records during a staff focus group. They told us that they were aware of this as an ongoing issue. They told us that ad-hoc clinics were being arranged at short notice on a daily basis. They said that this did not give them time to locate and prepare notes for the clinic appropriately. They also told us that they were often unable to update address labels in notes because their equipment had failed, or they had run out of the stationary required for the task.
- We were told that across the hospital the location of patient records could be challenging. The medical records staff told us that once records had been dormant for over twelve months they would be transferred to a facility in Southampton to be stored. However, they told us that this system had glitches and that records would often be sent to this facility when they were still needed in the hospital. This meant that staff were unable to obtain medical records at short notice.
- The trust had invested in a new electronic tracking system for medical records. Medical records staff told us that this system had glitches and did not always track records as it should. They said that this was due in part to staff throughout the hospital not understanding the way that the system worked. However, they also said that the system itself sometimes failed to recognise barcodes on notes. This meant that notes were not always located in the hospital in the place that the tracking system said they were.
- Medical records staff also told us that they were reliant on temporary staff due to vacancies and the staffing templates not meeting with the demands of the service. They also felt that their working space was too small and cluttered which impacted on their ability to perform tasks in a timely manner. We looked at their work areas and found them to be cramped, dirty and cluttered. We saw a desk space that was infested with what looked like mites. We brought this to the attention of the executive team at the hospital and this was dealt with immediately.
- The trust provided us with an audit of the number of patients who did not have their medical records available at the out patients clinic. The data showed that 1.5% of patients of patients attending clinic in

# Outpatients

March 2014 and 1.8% of patients attending in June 2014 did not have their medical records present in clinic. All staff, including medical staff, reported concerns about the absence of medical records in clinic.

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

- Staff were trained in the MCA and DoLS during safeguarding training.
- We found that staff knowledge around MCA and DoLS was varied. Some staff we spoke with were unable to demonstrate a good understanding of their responsibilities around MCA and DoLS legislation.
- The Macmillan breast care specialist demonstrated a good understanding of The Mental Capacity Act 2005 (MCA) and had applied its principles in an example given. They demonstrated that they had considered the least restrictive ways of caring for the patient concerned in accordance with the MCA and with DoLS safeguards.
- We saw an information folder was available for staff which contained information on MCA and DoLS.
- Some staff carried a card which outlined their main responsibilities around MCA.

## Safeguarding

- Training records showed that 100% of staff had completed training in adult safeguarding at level 2 and child protection level 1. The Ophthalmology OPD had two nurses trained to level 3 in child protection.
- We spoke with staff during our inspection who demonstrated that they understood their role in the protection of vulnerable adults and children.
- The manager and sisters that we spoke with gave us examples where they had raised safeguarding concerns. They demonstrated that they had followed procedures when escalating their concerns.

## Mandatory training

- The OPD kept their own records for mandatory training.
- The trust ran an enhanced statutory training course which covered all areas of mandatory training. Seventy five percent of staff had attended this training in the past year. Staff that had not attended were booked to attend future courses.

## Assessing and responding to patient risk

- Staff that we spoke with were aware of their role in a medical emergency. For example, we spoke with a nurse who was able to describe their role and how this had worked in a recent medical emergency within their department.
- Seventy five percent of nursing staff in the department had received adult resuscitation and life support training within the last year. No nursing staff had received paediatric life support training.
- We saw evidence that adult resuscitation equipment stored in the department to assist staff during an emergency had been checked regularly by staff. Staff had signed to say that the equipment had been checked, was available and within its expiry date. We were shown the procedure for checking the resuscitation equipment.
- There was no resuscitation equipment in the outpatients department at Horsham Hospital. In the event of a patient suffering a cardiac arrest, staff told us they would go to a ward within the hospital that belonged to another NHS trust to borrow that.

## Nursing staffing

- We were told that the skill mix of staff did not meet with the needs of the service. Both staff and managers told us that there were not enough trained nurses in the department as a result of inadequate staffing templates.
- All of the staff we spoke with told us that although care was safe the trained nurses were “run ragged” trying to work between clinics.
- We were told that the main OPD only used bank staff that had been assessed in the department’s competencies and were therefore able to perform their roles.
- We spoke with agency nurses working in the cardiac OPD on the day of our inspection. They told us that they felt able to perform their roles and had been orientated by the OPD sister prior to starting work in the department.

## Medical staffing

- The medical cover for clinics was arranged within the divisions, who agreed on the numbers of clinics and patient appointment numbers. The divisions had provided the appointment teams with templates which showed where appointment spaces were available.

# Outpatients

- We spoke with one consultant who told us that morale was low in their department (ophthalmology) as they had difficulty recruiting consultants.
- We were unable to speak with all of the medical staff during our inspection. However, doctors that we spoke with told us that workloads were increasing, and that ad hoc clinics were used excessively in order to meet with the demand of increased referrals.

## Major incident awareness and training

- The major incident plan was on the intranet and staff were able to access this as required. The manager demonstrated an understanding of the department role in a major incident.
- A business continuity plan was in place for the service and was accessible to staff through the trusts intranet.

## Are outpatients services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in outpatients departments.

## Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance for smoking cessation had been met within the department. The OPD assessed each patient who accessed the service to establish whether they would benefit from a referral to the smoking cessation service. Staff would refer patients to the service where a need was established.
- National Institute for Health and Care Excellence (NICE) guidelines for Macular Degeneration had been met in the Ophthalmology OPD. The department had ensured that patients referred into the service had been given an Optical Coherence Tomography (OCT) and had seen the consultant and started on a five-week treatment plan where needed within two weeks of referral.
- National Institute for Health and Care Excellence (NICE) guidelines for Diabetic Macular Odema had been met in the Ophthalmology OPD. The department had also ensured that patients had been seen by the consultant and received diagnostic tests within two weeks of referral.

## Patient outcomes

- The OPD ran a continuous patient experience survey which patients were encouraged to complete following their visit to the department.
- Results of these surveys were shared with staff in department newsletters.

## Competent staff

- Along with mandatory training staff in the OPD were expected to demonstrate competencies in the areas that they worked in. For example, we were shown competency assessments for staff who administered eye drops in ophthalmology.
- Staff attended a trust induction on starting work at the service. The OPD also ensured that staff completed a local induction programme. We were shown the band 5 registered nurse orientation programme for Ophthalmology OPD.
- Records demonstrated that staff had a 100% record for appraisals. These records showed that staff had all received an annual appraisal and a six-month progress check. Staff in ophthalmology OPD had also attended appraisal and development courses to prepare them for their appraisal.

## Multidisciplinary working

- Specialist nurses supported medical staff in clinics (for example, rheumatology).
- Ophthalmology clinics were always multidisciplinary with medical staff, nurses and optometrists working side by side. These clinics were also supported by volunteers.
- Staff referred patients to other disciplines where needed for example, district nurses came into clinics to liaise over wound care.
- The OPD also made relevant referrals to services such as osteoporosis specialist nurses, occupational therapists, orthotics and the psychiatric liaison service where appropriate.

## Seven-day services

- Both ad-hoc and routine clinics were running during the evenings throughout the week, and on Saturdays.
- These clinics were supported out of hours by pathology and radiology.

## Are outpatients services caring?

# Outpatients

Good



Patients received compassionate care and were treated with dignity and respect. Patients told us that staff were kind and supportive, and they felt fully involved in making decisions about their care.

## Compassionate care

- We observed staff interactions with patients as being friendly and welcoming. We saw staff stopped in clinics to greet patients that they knew and ask after their wellbeing. We observed that patients that attended clinic regularly had built relationships with the staff that worked there.
- The Your Care Matters score for April 2014 showed that 90% of patients felt that they had been treated with dignity and respect.
- All of the patients we spoke with were complimentary about the way the staff had treated them. A patient said, "They are too busy, but the staff are lovely." Another patient said, "They do their best, and always have a friendly smile for me."
- Patients also told us that they had been treated with dignity in the department. One patient told us, "They are always respectful."
- The OPD reception areas were mostly situated in the waiting areas. These areas were busy with patients waiting for appointments. Reception staff told us that when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk. The receptionist told us that as they checked patients personal information they ensured that other people stood back and lowered their voices so that they could not be overheard. This showed that staff had considered ways to ensure that patient's personal information was protected. However the OPD layout was not ideal for protecting patient's personal information.
- Clinic rooms did not have privacy signs on the doors. However, we were shown that each room had a lock on the door and we were told by staff that they locked doors to protect patient's dignity during examinations.

## Patient understanding and involvement

- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account.
- There were patient leaflets in each waiting area which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We saw patients reading this information. When asked, they all said that the information was in a format that they understood.
- Patients received a copy of the letter that was sent to their General Practitioner (GP) that outlined what had been discussed at their appointment and any treatment options.

## Emotional support

- The OPD was a calm and well-ordered environment, although at busy times waiting rooms became overcrowded. We saw nurses constantly updating patients on clinic waiting times and checking that patients were comfortable and happy. One patient said, "My appointment is delayed but they have offered me a cup of tea which I think is very kind."
- Although we saw staff informing patients of clinic delays during our inspection. Your Care Matters scores for April 2014 showed that 70% of patients who had been delayed by more than 16 minutes in clinic had not been informed of delays by staff.
- With the exception of the breast clinic the OPD did not have specific rooms set aside for patients who had received distressing news. Staff told us that if this happened they would find an unused clinic room to give people privacy in these circumstances.

## Are outpatients services responsive?

Requires improvement



Clinic appointments were often cancelled at short notice. There were 3,154 clinics cancelled between April 2013 and April 2014. Outpatient clinics were overbooked; there was not enough time to see patients, so clinics often over ran. Although staff and patients were all aware of this issue the department had not routinely audited how long patients were waiting, or how many clinics were overbooked.

# Outpatients

Poor communication meant that on occasions clinics would be cancelled but patients were still arriving for their appointments. This caused stress and anger to patients, and anxiety and frustration in staff.

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

- The clinic waiting areas were crowded, some patients had chosen to wait in other areas or stand as there were not enough chairs for them in the area of the OPD they were placed in.
- The ophthalmology department was particularly busy and staff and doctors in this area told us that the current area was not fit for purpose as they needed more clinic rooms and waiting area space to meet with the demands of the service. There were plans in place to address this in the future.
- Although there were some children's toys, separate play areas were not available.
- Waiting areas had televisions showing patients information about the trust.
- The OPD was clearly signposted to allow patients to find their way around.
- Multiple patients complained to us about the car parking facilities and prices. They told us that it was very difficult to get a space to park and that this put pressure on them when they had an appointment time to meet.
- Staff told us that there was a facility for patients to claim back parking costs if their clinics had been delayed for over one hour. Patients that we spoke with were unaware that this was available to them.

## Access and flow

- NHS England and CCGs in the responsibilities and standing rules regulations 2012 state that patients have the legal right to start their NHS consultant led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.
- Patients also have the right to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. In order to manage the demands of this legislation the trust ran a central OPD booking system which opened between 8:00am and 8:00pm.

- The 'Choose and Book' system (choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic) accounted for 20% of appointments booked by the OPD.
- The trust had met national targets for the two-week wait target for patients with a suspected cancer. The trusts 2013 data showed over 94.19% compliance (national average 93%) from April 2013 to April 2014. The trust had maintained an above national average outcome consistently on every month of the year.
- The 18 week targets had also been met. In the latest data for February 2014 the trust had seen 95.9% of patients within the 18 week target (NHS operating standard is 92%).
- In order to manage the appointment waiting times the central booking team updated each division of the trust daily and passed on the relevant information for patients that had not been seen within the 18 week target.
- Templates for clinics were agreed in divisions. In order to meet with two-week and 18 week targets templates were consistently overbooked (meaning patient waiting times were long), or ad-hoc clinics were arranged.
- The high number of ad-hoc clinics caused significant problems for staff and patients. We heard many accounts of patient records not being available for these clinics. Data showed that from April 2013 to April 2014, 677 ad-hoc clinics were arranged in the trust. This involved 20,626 patients having their appointments moved due to template changes.
- Patients told us about the frustration of their appointments being rearranged multiple times.
- 3,154 clinics had been cancelled between April 2013 and April 2014 due to the absence of clinicians. The trust's policy required clinicians to give a minimum of six weeks' notice prior to cancelling clinics. However, in that period 32% of the clinics were cancelled at short notice.
- We heard accounts from staff of clinics that had been cancelled without patients being informed. Staff told us of the pressure this put on them when angry patients had come to clinic to be told that their appointment's had been cancelled.
- Patients and staff also told us about frustration over clinic waiting times. One patient feedback comment said, 'I didn't manage to see my consultant as my appointment was two hours past my appointment time so I couldn't wait'.



# Outpatients

- Staff and patients also talked about notes not being in clinic due to ad-hoc clinics being arranged at late notice. One patients feedback on patient surveys said, 'I was unwell, I got out of bed to get to my appointment. My notes were not there. I waited 45 minutes as I was told they would be there soon. As they did not arrive and I was unwell I told reception that I was going home to bed'.

## Meeting people's individual needs

- Where patients required translation services the OPD would access these. This could be done over the phone using a telephone translating system which could be accessed by staff at any time with no requirement for prior arrangement with the service. The manager told us that where patients needed a more complex consultation and where it had been identified that telephone translation was not appropriate the OPD was able to book face to face translators, although this service needed to be organised in advance. The manager told us that some of patients attending the department from supported living environments brought with them a 'Healthcare Passport' document. This outlined to staff how they should be supported with their care needs.
- Those patients attending the department without this information would have their needs met by the OPD contacting their carers or family for advice on ways that the department could best support them with their care.
- Staff told us that they would identify patients with dementia and provide them with the support they required during their treatment.
- The OPD did not have any specific tools that they used to identify patients that may require extra support.
- Patients' specific religious and cultural needs were met for example, when a female patient's culture or religion required that they only be examined by a female doctor, the OPD staff would ensure that this requirement was respected.

## Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct patients to the PALS if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- In all the areas we visited information on how to make a complaint was displayed.
- Patients told us that, if necessary, they would not hesitate to raise a concern.

- The outpatient department had the best performance in the trust for responding to complaints within timescales.

## Are outpatients services well-led?

Requires improvement



Although data, and patient feedback identified areas of concern regarding the amount of ad-hoc clinics, patient records, and clinic delays these areas had not been addressed.

Staff were all aware of the issues in the OPD but did not feel empowered to make changes that they felt would improve patient experience.

## Vision and strategy for this service

- Trust wide communications had been displayed in staff areas for staff to read.
- The manager and sisters that we spoke with were all aware of the trust's current strategy. Most staff were also able to express the trust's values and commitment to patient care.
- Staff told us about open sessions with the chief executive that all staff were able to attend. They said that staff from all grades and departments were invited to ask any questions that they had. Staff spoke positively about this experience. They said that it made them feel listened too.

## Governance, risk management and quality measurement

- Outpatients held a monthly clinical governance meeting and produced a monthly governance report which was used to inform the trust's board and other stakeholders. During the meeting all areas of governance were discussed and reported on along with any learning or changes to the service. The agenda for this meeting included incident reporting, complaints, training, human resources (HR) management, infection control, risks, health and safety, and audit results.
- The OPD used a number of tools to gather the data required to meet with the trust's governance arrangements. Incidents/accidents and near misses were recorded and investigated using the Datix



# Outpatients

electronic recording system. The number of datix incidents and whether they were of a minor, moderate or serious nature were fed up to the trust board in the department's governance report.

- The governance report also outlined staff attendance at mandatory training, staff sickness levels, and compliance with the departments audits such as the hand hygiene audit.

## Leadership of service

- Staff were positive about trust leadership, but some staff identified problems with senior leadership in OPD. Staff in some areas did not feel listened to by the OPD senior management team.
- Medical records and medical secretary staff were less positive about their leadership and felt they were not listened to. We brought this to the attention of the executive team during our visit. The chief executive had previously met with medical secretaries. These staff were concerned about changes that were being introduced.
- Nursing staff reported that the trust level leadership team was visible and proactive. One member of staff said, "The chief executive not only comes to see us, but he listens to us. He has turned this trust around. My biggest fear is that because he has been so successful here he will be head-hunted and will move on elsewhere."

## Culture within the service

- We spent some time during the inspection sitting and observing the staff, the flow through the department and the experiences of patients. We saw that staff treated patients with respect, and worked hard to make their experience a positive one.
- We saw staff interacting with their managers and saw that they did this in a relaxed and friendly way. The managers were seen supporting more junior members of staff when it was required.
- One member of staff told us, "The priorities in this trust have changed. It is a really positive place to work now."
- Another staff member told us, "We have come under a lot of direct criticism as a trust in the past but that really does feel in the past now. We have moved forward."

- Staff did however speak with us about the frustrations they had within the department. One consultant said that morale was low because the medical staffing did not meet with the demands on the service. Another member of staff told us, "We are the ones taking the brunt of it when patients are kept waiting for hours, or turn up and their clinic is cancelled. Its demoralising and we feel that our managers are not listening."

## Public and staff engagement

- Staff we spoke with felt engaged with the trust wide improvements but demonstrated less engagement with potential changes to improve their department.
- The exception to this was the ophthalmology team. The sister for this area had engaged staff and was enthusiastic about their department and what they could do to improve the patient experience.

## Innovation, improvement and sustainability

- Staff we spoke to were aware of the issues in the OPD around overbooked clinics and waiting times for patients. Staff told us that these were decisions that were made and influenced outside of their department and did not therefore feel able to make changes.
- The central booking service was able to give patients appointments within the NHS England and CCGs regulations 2012 two and 18 week targets. However, the cost of this was that the trust was relying on large numbers of ad-hoc clinics to meet with the demands of the service. We were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the trust met with these targets.
- Templates set for some clinics did not meet with patient requirements. Data which evidenced this was being collected daily by the OPD, the central booking department, and medical secretaries. Although we were told that the trust was working on a 'five year plan' to improve these issues staff we spoke with did not feel that problems which they felt had persisted for a long time were being recognised or improved.
- The department relied on the goodwill of its staff in being flexible with their shifts and taking on extra hours. This meant that, although the department's staffing currently met the needs of the service, this might not be sustainable in the long term.

# Outstanding practice and areas for improvement

## Outstanding practice

- There was very poor mobile signal at the Crawley Hospital site. Relatives were given a bleep that meant they could be contacted if they left the clinical areas. This meant that people were not restricted to stay in one place for long periods of time and could be effectively contacted by staff.
- The pre-assessment clinic at Crawley Hospital had been extended into the evening in a response to feedback and local demand.
- We also visited one surgical ward where a patient who had a dementia diagnosis was being cared for. The circumstances around the admission meant that the patients spouse was also admitted to hospital at the same time. This caused anxiety for both patients, especially for the patient with dementia. This ward identified a two bedded side room and ensured that both patients were kept together to alleviate the anxiety and distress of the rest of their admission.
- We saw staff wearing “Ask me anything” badges. These badges encouraged patients and their loved ones to engage with staff to improve communication.
- Staff (including the chaplain, catering and ward staff) had arranged for a patient near the end of life to have a “wedding” with a small party afterwards. The catering staff provided a wedding cake for the celebration. Although there wasn’t time for this to be an official marriage ceremony it was an example of staff working together to meet the individual needs of their patients.
- The facilities provided for women in the midwife led birthing unit were outstanding.
- The care on the neonatal intensive care unit was outstanding. The staff team were committed to ensuring best practice and optimal care for the babies admitted to the unit.
- We visited Woodland ward within the surgical directorate where we judged the leadership to be outstanding. We saw a very effective multidisciplinary approach to care delivery and consistent commitment to ensuring patients’ individual needs were met.
- The trust has recognised that their location, close to a major international airport, increased the likelihood of girls presenting in the A&E department with complications of female genital mutilation. The safeguarding implications of this had been incorporated into the training programme.

## Areas for improvement

### Action the hospital MUST take to improve

- Carry out a review of the outpatient service to ensure there is adequate capacity to meet the demands of the service.
- Implement a system to monitor and improve the quality of the outpatient service that includes the number of cancelled appointments, waiting times for appointments and the number of patients that do not have their medical records available for their appointment.

### Action the hospital SHOULD take to improve

- Review the training provided to clinical staff on the Mental Capacity Act to ensure all staff understand the relevance of this in relation to their work.

- Ensure that a review of mouth care is undertaken so that staff are clear where this should be recorded in the patient’s care record.
- Review the action taken to engage with medical secretaries, ward clerks and medical records staff to ensure these groups feel more included in decisions relating to their role.
- Review the working environment for the medical records staff.
- Continue to focus on improving the trust’s performance on complaints handling.

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p><b>How the regulation was not being met:</b></p> <p>People who used the outpatient service were not protected against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to:</p> <ol style="list-style-type: none"><li>1. Regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of the Regulations; and</li><li>2. Identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.</li></ol> <p><b>Regulation 10 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010</b></p>