Care Quality Commission

Western Sussex Hospitals NHS Foundation Trust

St Richard's Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

The trust serves a population of around 450,000 across a catchment area covering most of West Sussex. The three hospitals are situated in the local authorities of Worthing, Chichester and Adur. These areas have a higher proportion of over 65's compared to the England average. The three local authorities have a lower proportion of ethnic minority populations compared to the England average.

Adur and Worthing are in the middle 20% in England for deprivation. Chichester is in the top 40% of least deprived areas in the country.

The hospitals provide 953 inpatient beds which include 77 maternity beds and 32 critical care beds. Of these, 430 are at St Richard's Hospital. The trust employs over 5,600 staff (Whole Time Equivalent at end of August 2015). In the year 2013-14, there were more than 127,000 inpatient admissions and 533,000 outpatient attendances; over 135,000 patients attended the accident and emergency department.

The trust annual income is around £403 million. The trust has made a surplus every year, since the merger of the predecessor trusts, up to 2014/2015 and has paid back £21 million of legacy debt.

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

Overall we found that St Richard's Hospital was providing outstanding care and treatment to the community it served. We saw many examples of very good practice across all areas of the hospital. Where we identified shortcomings, the trust was aware of them and was already addressing the issues.

The trust is one of the 16 members of NHS Quest, a member-convened network for Foundation Trusts who wish to focus on improving quality and safety within their organisations and across the wider NHS. The members of NHS Quest work together, share challenges and design innovative solutions to provide the best care possible for patients. The trust was also a winner of a Dr Foster Better, Safer Care at Weekends award.

There was a strong governance structure and assurance framework. The board executive and non-executive directors were clear on their responsibilities and understood the hospital well. The governance was organised through four cross-site divisions (medicine, surgery, women and children and core services), each had a consultant from that speciality as a Chief of Service.

Our key findings were –

The executive team provided an exemplar of good team working and leadership. They had a real grasp of how their hospital was performing and knew their strengths and areas for improvement. They were able to motivate and enthuse staff to 'buy in' to their vision and strategy for service development. Middle managers adopted the senior manager's example in creating a culture of respect and enthusiasm for continuous improvement.

Innovation was encouraged and supported. We saw examples that, when raised directly with the Chief Executive and her team, had been allowed to flourish and spread across the services.

We saw respectful and warm relationships internally amongst staff teams, the wider hospital team and outwards to external stakeholders and the local community.

Summary of findings

Across the hospital there was an embedded culture of learning from incidents. Staff were encouraged to have an open and honest attitude towards reporting mistakes and incidents that were then thoroughly investigated. There was strong evidence of learning from incidents both locally and across the organisation.

The hospital was performing better, and sometimes much better than comparable trusts across England on many measures. Where this was not the case, the trust had clear action plans and investigations ongoing to bring about improvements.

An example of this was the 4 hour Emergency Department (ED) target where new and innovative approaches coupled with strong monitoring systems had resulted in the trust meeting the target over 95% of the time. They were amongst only a handful of trusts to meet the quarter four target.

In 2014/15 the trust improved their infection control ratings for the sixth successive year.

There was good management of deteriorating patients and systems in place to allow early identification and additional support when a patient's condition became unexpectedly worse.

Monitoring by the Care Quality Commission had not identified any areas where medical care would be considered a statistical outlier when compared with other hospitals. The trust reported data for mortality indicators, the summary hospital level mortality indicator (SHMI) and hospital standardised mortality ratio (HSMR). These indicate if more patients were dying than would be expected given the characteristics of the patients treated there. The figures for the trust were as expected. Information about patients' outcomes was monitored. The trust participated in all national audits it was eligible for. Where improvements were identified, the trust was responding and was making progress implementing its action plans in order to improve the quality of care they were providing.

Across all disciplines and in all core services we found a good knowledge and understanding of the policies and guidance relating to safeguarding vulnerable adults and children. Trust staff were involved in local initiatives, working with other key agencies to improve outcomes for babies and children from challenging or vulnerable families.

Staff of all grades and from all disciplines contacted us to tell us about their belief that the St Richard's was a very good hospital. They talked with great pride about the services they provided and all agreed they would be happy for their family members to be treated there. They talked of their commitment to making sure they did their very best to provide optimal care for patients. They talked about initiatives to improve patient care they had been involved in.

Specifically, all consultants from St Richard's Hospital who contacted us were very positive about how the trust provided services from this site. The majority of consultants employed at St Richard's responded to our invitation to submit written comments or to meet with us. They told us the executive team and medical director in particular, were supportive, encouraging of new ideas and approachable. They told us about the work that had been done to improve the mortality figures overall and in specific areas. This included the changes to the pathways for patients who suffered a fractured neck of femur where changes to the care and treatment of this condition had reduced the number of elderly patients who died as a result of this.

Medical, nursing and midwifery staffing levels were safe and allowed staff to provide good care. Staffing acuity tools were in routine use and staffing was reviewed frequently – in some areas such as ED this was done four hourly. However, there were areas where the trust did not meet the recommendations of professional bodies such as the royal colleges. This included medical staffing in the critical care unit and the number of supervisor of midwives. In both these cases the trust was already taking action.

Volunteers from across the hospital were also keen to tell us about how much they enjoyed working at the hospital. They told us they were supported and accepted as a part of the hospital team. Those working in clinical areas described a sense of belonging and felt their work helping people to eat and drink or occupying elderly patients was valued.

Summary of findings

We received an unprecedented number of letters and emails from people who used the service prior to, during and after the inspection visit. The overwhelming majority of these were very positive and told stories of staff going above and beyond the expected level of care. Staff we spoke with were exceptionally compassionate when talking about patients and we observed kindness not only towards patients but towards each other whilst on site.

The results of the Friends and Family Test supported the views of the many patients who contacted us. In most areas the hospital consistently scored above the national average.

The commitment of staff to providing good care coupled with good strategic and operational planning led to a service that was responsive to the needs of individuals. We saw flexibility and a willingness to make local changes to improve how people were cared for. There were numerous initiatives that improved patient experiences and allowed them equal access to care. These included Learning Disability nurses visiting the ED, interagency joint working in the hospital and community and the Harvey's Gang project.

The trust had introduced a ward accreditation scheme which was being rolled out.

Outstanding practice

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

The positive attitude of outpatient and diagnostic imaging staff was an outstanding feature of this hospital. The outpatient nursing staff knowledge of vulnerable adult and safeguarding children and how they should proceed if concerns arose and compliance with training in this area. The management of medical records meant that more than 99% of full records were available to staff in clinics.

The level of 'buy in' from all staff to the trust vision and value base was exceptional. We were flooded with requests from staff wanting to tell us about specific pieces of work they were doing, how much they liked working for the trust and how supportive the trust executive team were of innovative ideas and further learning as a tool for improvements in patient care. The trust ambassadors worked to promote the positive work that the trust was doing to other staff and visitors.

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

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

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

We were contacted by many consultants working at the hospital, from across all specialities who wanted to tell us about how good it was to work at the trust. They wanted to tell us the executive team were approachable and supportive, that their ideas were listened to and they felt the trust provided very good care to most people.

In ED the focus on access and flow, coupled with the work being done with local stakeholders such as GP's and CCG's had resulted in a department that was mostly able to meet the key performance targets. People were seen quickly and were not kept in the department overly long.

The attention and consideration of peoples' individual needs and genuinely patient centred care was evidenced across the hospital. The work of the learning disabilities nurse specialists, the neonatal outreach nurses and the SPCT were all

Summary of findings

notable. In the critical unit the staff remained focussed on the person and not the technology, with people being pushed out of the unit in a wheelchair, if they were well enough, to help them maintain a sense of normality. Staff encouraged fathers to stay overnight on the postnatal ward to provide support to their partner and to begin the bonding process with their baby.

The trust wide learning from incidents and complaints was well embedded. In all areas of the hospital, staff gave examples of where improvements had been made as a result of complaints, comments or incidents.

The executive team provided exceptional leadership and had a very good understanding of how the hospital was working in both the longer term (through a sound assurance framework) and on a day to day basis (through a regular ward and department presence and open door sessions). There was clear team work amongst the executive team and their positive leadership style filtered down through middle managers to local managers.

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

The 'Knowing Me' initiative along with the other initiatives to improve hospital experiences for people with dementia.

The involvement of a learning disabilities nurse for patients admitted who had a learning disability improved the outcome and experiences for this group of patients.

The level of staff engagement and involvement in service planning was exceptional, with the Trust Ambassadors giving a very clear message about staff 'buy in' and belief in the work they were doing.

The very strong governance systems allowed the trust to focus on safety and improved patient outcomes at all levels. Local managers could see how the wards and departments in their control were performing. The board involvement allowed proper assurance through involvement in governance meetings.

The trust executive had a very sound understanding of their hospitals. They did not need to look up how areas were performing as they were very aware of the areas of strengths and weaknesses.

However, we also saw things which the trust should review and take action where necessary;

The hospital should ensure all staff mandatory training is up to date.

The hospital should ensure the numbers of chemotherapy trained nursing staff on duty reflect the established number required at all times.

The Medicine Division should recruit consultants to ensure an adequate level of medical expertise which reflects the England average.

The hospital should ensure all staff receive an annual appraisal to ensure their continuous professional development needs are met.

The hospital should ensure there is an adequate supply of pressure relieving equipment for patients on all wards.

The hospital should ensure continuity on recording of medicines fridge temperatures on all wards, and that emergency medicines are checked in accordance with their own policy, to ensure they are always readily available for use in an emergency.

The hospital should review the levels of medical and nursing staff on each shift in critical care, in line with established national guidelines. The hospital should also consider the working practices of existing senior physicians during the pilot phase of a telemedicine model of care.

The hospital should review the security and storage of hazardous waste and chemicals on the critical care unit.

Summary of findings

The trust should ensure grading of referrals occurs within acceptable timescales.

The trust should ensure that RTT is met in accordance with national standards.

The trust should ensure staff who work in the diagnostic imaging department and who provide care to children have the appropriate level of safeguarding training.

The trust should ensure drugs in OPD that require refrigeration are stored in a temperature checked fridge, which should be used for the sole purpose of storing drugs.

The trust should review the availability of supervisors of midwives.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Outstanding ☆	Overall we rate the emergency department as 'Outstanding'. This was because the trust had demonstrated a very responsive and hospital wide approach to meeting treatment time targets. The hospital met, and sometimes exceeded, the national target of seeing, treating, admitting or discharging 95% of patients within four hours, ending the year in the top 20 trusts in the country. Departmental leaders and staff had implemented highly effective systems to maintain flow and escalate problems as soon as there were indications of delays in patient flow. There were clear arrangements in place to protect patients from abuse and avoidable harm. Medical and nurse staffing was at safe levels through effective recruitment and there were no 'No Events' or 'Serous Incidents' reported within the emergency department. There was a strong organisational culture of reporting errors and incidents. Incidents and complaints were investigated thoroughly, and lessons learnt were shared. Infection prevention and control practice was well established and staff followed the trust policy and national guidance. Patients were efficiently assessed, monitored, and cared for to prevent or respond to deterioration in their condition. Patients were asked about their wishes and supported to make decisions about their care and treatment. We saw staff consistently offered care that was kind, respectful, and considerate, whilst promoting patient privacy and dignity at all times. Staff supported patients promptly in managing pain and anxiety and we observed staff discussing treatment and pain management with patients in ways they could understand. The 2014 Western Sussex Trust staff survey showed the numbers of staff experiencing physical violence was worse than the national average score for acute trusts. In discussion with the trust this was identified as a result of the large numbers of patients with advanced dementia. The trust had worked with staff to address the risks by introducing a new elderly care pathway so these

patients had a reduced length of stay in ED and could quickly be transferred to a calmer ward environment or discharged to the familiar surroundings of their home.
CCTV was not installed within the paediatric area of the emergency department and doors were not locked, potentially allowing the public access with the risk of possible harm to children.

Medical care (including older people's care)	**Outstanding**	☆	Overall we rated medical care services as 'Outstanding'. This was due to the responsiveness of the service in the care of individual patients, coupled with a clear understanding of the needs of the population that used the service. Pathways were designed in collaboration with external stakeholders and community providers. The staff listened to feedback and acted on what they were told to fine tune services in the best interest of their patients. The trust executive and board had an exceptional understanding of what their service was and who their patients were. This approach was fed down so the directorate had a really good understanding of what they were meant to be providing and who the service was for - and created services that met the identified needs. Medical leaders focussed on getting the basics right and building on that to provide excellent care. For example, there were exemplary provisions made for patients living with dementia across the whole hospital. We received very high levels of very positive feedback from patients and relatives who had used St Richard's Hospital. The 'Sit and See' scheme allowed staff to experience the hospital from a patient perspective. Patients at risk of deteriorating were monitored and systems were in place to ensure a doctor or specialist nurse was called to provide additional support. The trust had an open culture and was prepared to learn from clinical incidents. Across the Division of Medicine there were enough medical and nursing staff to keep patients safe. The trust found it difficult to recruit new nursing staff; but was able to effectively fill gaps across the division by using bank and agency staff. We found care was provided in line with national and local best practice guidelines. Clinical audit was

undertaken and there was good participation in national and local audit that demonstrated good outcomes for patients. Patient morbidity and mortality outcomes were within expectations for a hospital of this size and complexity and no mortality outliers had been identified. The improvements in the care of patients with strokes was notable.
There was a good knowledge of issues around capacity and consent among staff.
Patients received compassionate care and were treated with dignity and respect. Most patients and relatives we spoke with said they felt involved in their care and were complimentary about staff. One person told us, “The staff are very, very kind and helpful. You just feel completely confident that they know their stuff." The Medicines division had good results in patient surveys with results indicating an improvement in patient views over the last 12 months.
The Medicines division were effective at responding to the needs of the community. The trust’s performance management team understood the status of the hospital at any given time. Bed availability was well managed. Elderly care pathways had been well designed to ensure elderly patients were assessed and supported with their medical and social needs.
The medical services were well led. Divisional senior managers had a clear understanding of the key risks and issues in their area. Medical areas had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day to day basis. The hospital had a risk register which covered most key risks. Staff spoke positively about the high quality care and services they provided for patients. They described the hospital as a good place to work with an open culture. The most consistent comment we received was that the hospital was a “nice” place to work and staff enjoyed working in their teams.

Surgery

Good

Overall we found that surgical services at St. Richard’s Hospital were 'Good'.
This was because patients were protected from avoidable harm. There were robust systems to report, monitor, investigate and take action on

Summary of findings

incidents. There were effective governance arrangements to facilitate monitoring, evaluation, reporting and learning. Risks were identified and acknowledged and action plans were put into place to address them.

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

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

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

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

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

Summary of findings

We found there were some environmental challenges where lack of facilities such as adequate storage, clinic room and toilet facilities presented a potential risk to patients and impacted on their care and treatment.
Staff were not monitoring ambient room temperatures in rooms where drugs were stored. There is a risk that certain medicines become less effective if stored at incorrect temperatures.
The availability of junior doctors out of hours was raised as a concern as staff felt they could not always access medical support promptly.

Critical care

Requires improvement

Overall we rated the CCU at St Richard's Hospital as 'Requires Improvement'.
This rating reflects the areas of good practice we found through our review of clinical audits, staff training, patient notes and outcomes as well as other performance indicators such as cleanliness and action taken on local audits.
Leadership in the unit was coherent, robust and well respected by the staff. We saw examples of innovation in improving patient safety and good practice, particularly in relation to the successful pilot of a new electronic patient records system that combined patient tracking software with observation charts and electronic prescribing.
Significant challenges relating to infection control and capacity were clearly understood by the matron and lead consultant. They had undertaken scoping exercises to address issues, such as the introduction of new bed space equipment.
Staff practised in line with clinical guidance of national organisations such as the National Institute for Health and Clinical Excellence (NICE), the Royal College of Physicians and the Intensive Care Society (ICS). Such guidance was embedded into the work culture and used to evaluate and improve practice through the sharing of learning and use of audits to update policies and procedures. Staff contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC). The CCU team had access to multidisciplinary specialists who routinely

contributed to decision-making and ward rounds in the best interests of patients. An established critical care outreach team (CCOT) supported patients across the hospital during limited hours.
The CCU was clean, hygienic and well maintained and staff demonstrated good infection control practices. However, there was room for improvement in the storage of waste and the management of related hazards. Equipment was serviced regularly and staff were certified in its use with regular training updates. We found full compliance with the trust's medicine management policy.
A robust incident reporting system was in place that staff used confidently to investigate incidents and errors. There was evidence that learning from investigations had taken place with an effective system in place to ensure all staff were aware of updates to practice. Overall this contributed to an environment in which safety was prioritised and patients received individualised care. This reflected the culture in the unit, however we found a lack of clarity over how staff effectively obtained decisions from the senior executive team regarding risks they were concerned about, particularly with regards to capacity and staffing levels.
We observed a commitment to personalised care delivered by staff who were competent, passionate and keen to develop professionally.
There were on-going problems relating to short staffing according to standards benchmarked by the ICS, the Royal College of Nursing (RCN) and the Faculty of Intensive Care Medicine (FICM). The unit did not always have a consultant intensivist present or on-call, which meant patients were not always seen within 12 hours of admission by a consultant intensivist. Nurse to patient ratios of 1:2 or 1:1 were consistently met, however ICS core standards guidance that a supernumerary senior nurse coordinator be present 24-hours, seven-days, was not always complied with.

Maternity and gynaecology — **Outstanding** ☆

Overall, we rated maternity and gynaecology services as 'Outstanding'.
People were protected by a strong comprehensive safety system, and a focus on openness,

Summary of findings

transparency and learning when things went wrong. This was demonstrated in safety thermometer results which showed the maternity service had achieved 100% since December 2014.
The service provided effective care in accordance with recommended practices. Outcomes were good and the service frequently performed better than the trusts own target. This was especially true of the work being done to reduce stillbirths and admissions to SCBU and NICU's. The service continually monitored outcomes for women and used incidents and complaints as opportunities for learning and improving services. There were high levels of multidisciplinary team working, both within the service and with external partners. Compliance with training was good and staff were offered additional opportunities for learning and development.
Care was compassionate and supportive and staff treated women and their families with respect and dignity. Outside the inspection visit we were contacted by many women who used maternity and gynaecology services who told us about their experiences. All those who contacted the CQC were extremely positive about the care and support they received. Performance in the FFT and the Maternity Services Survey 2015 showed performance above the national average.

Services for children and young people

Outstanding ☆

The children and young people's service was rated 'Outstanding' because it had a strong, open culture of safety and developed reporting and learning from incidents and complaints. There was also strong governance and an effective assurance framework which resulted in a cycle of monitoring and improvement.
The children and young people who used the serviced experienced good care that resulted in outcomes that were generally above national benchmarks. Where there was underperformance, it was recognised and addressed through robust action. Staff knew how the service was performing in specific areas and were motivated to make improvements. Innovation and ownership of the service was strongly encouraged.
There was a culture of joint working and learning from others. This worked across the trust with

examples such as 'Harvey's Gang' (which the trust is justifiably proud of) and with other local providers and children's agencies. The result of this was that children and families had a seamless journey through separate services, both internally and externally. Outcomes for very young children living in challenging circumstances benefited from this joint working.

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

End of life care

Outstanding ☆

The overall rating for end of life care services for St Richard's Hospital is 'Outstanding'.

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

A review of the data showed the trust had robust policies and monitoring systems in place to ensure it delivered good end of life care. However, it was the direct observation and conversations with staff, relatives and patients that made us judge the care

Summary of findings

outstanding. Individual stories and observed interaction provided assurance that staff of all grades and disciplines were very committed to the proactive end of life care agenda set by the board. Staff provided a service that was caring. The specialist palliative care team (SPCT), mortuary and chaplaincy staff worked effectively and cohesively as a team to provide a seamless service. Most audits performed by St Richard's scored above England averages, which underpinned the rating given for this service. Feedback made directly to CQC, from relatives of people who had died at St Richard's Hospital was overwhelmingly positive. They told us they, "could not have asked for more" and that staff in all areas of the hospital were caring, respectful and attentive. They talked about being involved and appreciated being supported to remain near their relative at all times.

The trust had prioritised the correct use of Do Not Attempt Resuscitation forms as a tool for engaging with patients and relatives about how they would like care to be delivered should there be an unexpected or expected but significant deterioration in the patient's condition. Consultants had oversight of decisions made by junior doctors in consultation with family and we saw examples of clear challenge where a consultant was not content that sufficient thought had been given to the decision to withhold resuscitation that was requested by the relatives.

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

The management structure, staff involvement and culture of the service were also outstanding. Staff feedback was exclusively positive throughout the inspection with all grades of staff supporting the trust focus on providing good end of life care. There was a positive vision for the future sustainability of the service.

Summary of findings

Outpatients and diagnostic imaging

Good 

Overall we found outpatients and diagnostic imaging to be 'Good'.
Staff contributed positively towards patient care and were proud of the services they provided. They behaved in a professional manner and treated patients with kindness, dignity and respect. Staff felt managers were approachable and kept them informed of developments within the trust.
Clinicians in outpatients had access to patients' records more than 99% of the time. The outpatient and radiology departments followed best practice guidelines and there were regular audits undertaken to monitor quality.
All areas were clean, tidy and uncluttered with good infection control practices in place.
However, the trust had consistently not met referral to treatment times since 2013 for adults and from March 2015 for children's services.

St Richard's Hospital

Detailed findings

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

Detailed findings

Contents

Background to St Richard's Hospital

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

The trust serves a population of around 450,000 across a catchment area covering most of West Sussex. The three hospitals are situated in the local authorities of Worthing, Chichester and Adur. These areas have a higher proportion of over 65's compared to the England average. The three local authorities have a lower proportion of ethnic minority populations compared to the England average.

Adur and Worthing are in the middle 20% in England for deprivation. Chichester is in the top 40% of least deprived areas in the country.

The hospitals provide 953 inpatient beds which include 77 maternity beds and 32 critical care beds. The trust employs over 5,600 staff (Whole Time Equivalent at end of August 2015). In the year 2013-14, there were more than 127,000 inpatient admissions and 533,000 outpatient attendances; over 135,000 patients attended the accident and emergency department. Its annual income is around £403 million. The trust has made a surplus every year up to 2014/15 since it was merged in 2009 and has paid back £21 million of legacy debt.

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

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop,

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The team of 63 included CQC inspection managers, inspectors and a variety of specialists; medical consultants, surgical consultants, a consultant obstetrician, a consultant paediatrician, and emergency medicine consultant, consultant midwives, junior doctors, board-level nurses, modern matrons, clinical nurse specialists in emergency medicine, critical care,

oncology and sexual health, a student nurse, a physiotherapist, a radiographer, an occupational therapist a pharmacist, a dietician and an expert by experience.

How we carried out this inspection

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

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

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

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

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

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

Facts and data about St Richard's Hospital

The trust serves a population of around 450,000 across a catchment area covering most of West Sussex. The three hospitals are situated in the local authorities of Worthing, Chichester and Adur. These areas have a higher proportion of over 65's (between 21.8% and 25.8%) compared to the England average (17.3%). The three local authorities have a lower proportion of ethnic minority populations compared to the England average with 93.7% and 96.7% of the population being white, compared to an England average of 85.3%.

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

The urgent and emergency services at St Richard's Hospital comprises of the Emergency Department, Clinical Decisions Unit (CDU) and Paediatrics Unit.

St Richard's Hospital had 87,345 attendances to their emergency department between April 2014 and August 2015. 16,701 attendees were under 17 years of age. During 2014/15 attendances in the emergency departments at the trust increased by almost 1,000 cases on the previous year. The trust Annual Report 2014/15 states it admitted a greater proportion of elderly patients with greater acuity, requiring longer stays in hospital, a trend that continued from the previous year. The hospital met the national target of seeing, treating, admitting or discharging 95% of patients within four hours, ending the year in the top 20 trusts in the country.

The emergency department provides a consultant led emergency care and treatment service. It is divided into several areas, providing care for patients with minor injuries and major trauma. The emergency department has an integrated system of working with GP admissions cared for through the department and a 'One Call' system. GP's are present within the emergency department to offer support and reduce admissions to department areas whilst supporting the timely discharge of patients.

The Clinical Decisions Unit (CDU) is an area close to the main emergency department for short stays which allows for further assessment and observation. The minor injury area has two dedicated treatment cubicles with equipment to manage patients with minor injuries. The department had a cubicle dedicated to the treatment and support of patients with possible infectious diseases and this enables the department to isolate and reduce risks of infections to other people.

We used a variety of methods to help us gather evidence in order to assess and judge the urgent and emergency services at St Richard's Hospital. We spoke with 19 staff, eight adults and five children that were either patients or relatives. We reviewed 28 patient records during this inspection, 15 of which related to children.

We interviewed the Director of Operations for the Medicine Division and the Chief of Medicine. We spoke with professionally qualified and auxiliary staff. We observed the environment and the care of patients and we looked at records. We also looked at a range of documents relevant to the service including policies, minutes of meetings, action plans, risk assessments and audit results.

Urgent and emergency services

Summary of findings

Overall we rate the emergency department as 'Outstanding'.

This was because the trust had demonstrated a very responsive and hospital wide approach to meeting the treatment time targets. The hospital met, and sometimes exceeded, the national target of seeing, treating, admitting or discharging 95% of patients within four hours, ending the year in the top 20 trusts in the country. Departmental leaders and staff had implemented highly effective systems to maintain flow and escalate problems as soon as there were indications of delays in patient flow.

There were clear arrangements in place to protect patients from abuse and avoidable harm. Medical and nurse staffing was at safe levels through effective recruitment and there were no 'No Events' or 'Serous Incidents' reported within the emergency department. There was a strong organisational culture of reporting errors and incidents. Incidents and complaints were investigated thoroughly, and lessons learnt were shared. Infection prevention and control practice was well established and staff followed trust policy and national guidance.

Patients were efficiently assessed, monitored, and cared for to prevent or respond to deterioration in their condition.

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

The 2014 Western Sussex Trust staff survey showed the numbers of staff experiencing physical violence was worse than the national average score for acute trusts. In discussion with the trust this was identified as a result of the large numbers of patients with advanced dementia. The trust had worked with staff to address the risks by introducing a new elderly care pathway so these patients had a reduced length of stay in ED and could quickly be transferred to a calmer ward environment or discharged to the familiar surroundings of their home.

CCTV was not installed within the paediatric area of the emergency department and doors were not locked, potentially allowing the public access with the risk of possible harm to children.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated 'Safe' for emergency services at St Richard's Hospital as 'Good'.

Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents and near misses and were fully supported by local and senior managers. Incidents were reported, investigated and lessons learnt shared. Infection prevention and control practice was well established.

Safeguarding vulnerable adults, children and young people was given a high priority. Staff responded appropriately to any signs or allegations of abuse. There was active and appropriate engagement in local safeguarding procedures.

Equipment records showed safety checks on the adult resuscitation trolley were inconsistently carried out.

Risks to people who used the service were assessed, monitored and managed well. This included identifying signs of deteriorating health, medical emergencies or behaviour that challenged staff. Medical and nurse staffing was at safe levels and patients were efficiently assessed, monitored, and cared for to prevent or respond to deterioration in their condition. Consultant cover was not available for more than 16 hours per day as recommended by the College of Emergency Medicine but this did not appear to have impacted on patient safety and the trust was already taking measures to address this.

Incidents

- We spoke with the Director of Operations who told us there have been no 'Never Events' or 'Serious Incidents' recorded in the emergency and urgent care departments. Records we reviewed confirmed this.
- Staff reported incidents using an electronic reporting system and we observed records where staff had used the system to report any concerns. All staff we spoke with were aware of the reporting system and knew how to raise issues and escalate concerns.
- We spoke with a nurse who explained the list of triggers for incident reporting regarding paediatrics and neonatal concerns.
- We observed records of team meetings held within the department area, the records clearly showed where learning from the incidents had been recorded, along with agreed actions. Staff were briefed on incidents including what had happened, why the incident had happened, and how learning from incidents was fed back to the wider staff team.
- A nurse described arrangements for conducting incidents and how the results of findings were cascaded to staff via email and newsletter every two to three months.
- Staff told us about the 'SAFETY' newsletter and monthly patient story that was used to share experience and disseminate learning from complaints and incidents to the staff teams.
- Mortality and morbidity meetings were held covering general, paediatric, mental health, and trauma cases. Staff told us they were advised of learning from such analysis through team briefings, team meetings, board rounds, emails to all staff, and regular displays of latest information around notice boards.
- All staff were aware of the Duty of Candour regulations. The trust had ensured wide awareness of this through staff emails and team briefings. We spoke with staff who could outline when this may be instigated and why. The Head of Clinical Governance held sessions with staff about Duty of Candour since October 2015 including a wide cross-section of staff.
- Duty of Candour guidance posters were displayed in the majors area and in the staff room. The trust policy was that staff resolved small matters locally but recorded all the concerns and action taken. For anything more serious the trust policy was that the family were invited to be part of the investigation process and were also invited to discuss the outcome of the investigation.
- We reviewed the trust responses to complaints and saw that the Duty of Candour policy was used correctly. Complaint responses shared with CQC prior to

the inspection visit showed patients and their relatives were invited to meet with members of the executive team to discuss complaint outcomes and that any shortfalls in care were shared openly.

Cleanliness, infection control and hygiene

- The department appeared visibly clean. Hand washing facilities, alcohol gel and hand conditioner was available throughout the department. We saw clear signage informing people to clean their hands when entering the department.
- We observed staff following hand hygiene, 'Bare below the Elbow' guidance, and wearing personal protective equipment such as gloves and aprons whilst delivering care in line with the trust's policy.
- We saw hand hygiene audits of the emergency department and the clinical decisions unit (CDU) had reported 96% compliance in August 2015. We saw staff washing their hands in line with the World Health Organisation's guidance 'Five Moments of Hand Hygiene.'
- Staff we spoke with could explain the protocol for patients with possible infectious disease and we saw a room specifically used to support patients who may pose risks to others unless their condition was managed in a separate area.
- The domestic staff were visible in the department throughout our inspection and constantly engaged in cleaning activities and we saw waste bins were emptied frequently during the course of the day.
- We spoke with a domestic staff member who explained the domestic regime and guidelines for infection prevention and control and how important it was to follow these to reduce risks to patients and staff.
- We spoke with the housekeeper and observed the cleaning schedule for the kitchen area, this area was visibly clean and the kitchen cleaning schedule was up to date, legible, and signed by staff.
- Patient trolleys, equipment, and disposable curtains providing privacy were visibly clean throughout the department and we observed staff routinely cleaning equipment between patients.
- 86.7% of medical staff had completed infection control training, the trust target for mandatory training is 90%.

Environment and equipment

- Toys were routinely cleaned by staff and the cleaning rota was up to date.
- Medical engineering staff routinely checked equipment and was clearly labelled with equipment checked stickers showing when equipment was checked and renewal dates.
- Staff were aware of the risk to patients with mental health problems and patients who may require specific care for their mental health. We saw a room within the emergency department designated for providing dedicated mental health support had been risk-assessed and adapted to remove specific dangers such as ligature points (places where someone could tie a ligature to strangle themselves and collapsible bed rails).
- Resuscitation equipment was readily available and checked routinely each day.

Medicines

- We saw that records and stock levels of controlled drugs in the paediatric area, resuscitation, and the emergency department were accurate, showing the correct amount of stock stored at the time of inspection.
- Controlled drugs in the paediatrics area were secure and cabinets locked.
- The fridge temperature checks were up to date and records showed the temperatures were within the requirements for safe storage of medicines. This meant medicines were stored in accordance with the manufacturers' recommendations.

Records

- Patient records were well completed. The quality of recording was audited regularly and showed good levels of compliance with trust policy. The ED had a star award system for staff who routinely maintained particularly good records.
- Information was initially recorded on an ED card which was filed into the patient's hospital medical records on transfer to a ward or discharge.
- The emergency team used a large wall mounted 'White Board' to record patient details within the emergency department. This board was visible to all people within

the emergency area of the department. The board had clearly identifiable patient information displayed, for example, the patient name, condition and test requirements. We noted one patient identified on the board by the use of a universal symbol for a mental health condition and the location of a patient being assessed due to the effects of domestic violence.

- However, the use of the board potentially compromised patient confidentiality as it was on the wall behind the nurses station where patients and visitors passed by.

Safeguarding

- We found there were clear processes and procedures in place for safeguarding children and adults in the emergency department. Policies and procedures on managing concerns or the risk of abuse were available to staff via the internal intranet and staff we spoke with knew how to raise concerns about adults and children at risk of abuse.
- Staff told us of a patient who arrived at the department who they felt was at risk from abuse based on their injuries and concerns raised by the patient regarding their social situation. We saw this incident was escalated in line with trust policy on safeguarding adults. An electronic incident record was completed and follow up communication between hospital staff and external agencies took place to ensure the patients safety on discharge. This showed staff understood and put into action local safeguarding procedures.
- The safeguarding team checked all paediatric notes each morning in order to manage and monitor risks to children within the department.
- Medical staff had achieved 100% compliance with child protection training and 86.2% had successfully completed safeguarding adults training.
- We saw an incident report relating to a safeguarding referral, the records showed staff had followed trust policy on the protection of adults from abuse and the records were accurate and legible. Patient records showed that staff had followed up the safeguarding referral with the community based health teams to ensure that the adult was safe following their discharge.

Mandatory training

- Staff receive training in key issues related to the emergency department.
- The trust target for staff completion of mandatory training was 90%.The ED staff (both nursing and medical) met the target for child safeguarding. The medical staff met the target for current resuscitation training (93%) but nursing staff fell just short with 87% having completed current resuscitation training.
- The numbers having completed conflict resolution training were lower (nursing 54%, medical 68%). This training programme had been introduced in response to NHS staff survey results which suggested higher levels of staff experiencing violence. This low level of completion brought the overall compliance with mandatory training into the Amber rating against the trust's own targets.

Assessing and responding to patient risk

- We saw patients on emergency trolleys had the safety sides elevated when required. This meant that elderly, frail patients or those with reduced levels of consciousness were cared for safely and protected from falls.
- We spoke with two mental health practitioners in the emergency department, one specifically to support patients over the age of 16 years and the other providing support to children, both staff told us they provided guidance and support to staff treating and supporting patients with mental health needs.
- The emergency department monitored the time taken from a patients arrival in the department to their initial assessment via triage. We saw that a nurse at the main entrance or ambulance bay assessed patients on arrival, that ambulance handover times were timely and better than the national standard, which is 15 minutes.
- We saw staff undertook rapid assessment of patient conditions on patients admitted to the department both by ambulance and by other means. We saw that the patient treatment bays were close to the ambulance entrance and were staffed by senior nurses and medical staff to undertake assessments and ensure diagnostic tests were done quickly.
- The triage system in the emergency department waiting room relied on the use of a blue flashing light to alert a nurse within the emergency department to attend the waiting area to triage any emergency patient on arrival.

Urgent and emergency services

- A National Early Warning Scoring (NEWS) system was in use to assist staff in identifying patients at risk of a sudden deterioration in their condition. The use of the tool was regularly audited with demonstrable good levels of compliance.
- The trust had participated in the NHS Quest Sepsis week during September 2015.
- Buffalo stickers were stuck to the front of the ED card where there was a possible diagnosis of sepsis. This sticker reminded staff of the necessary steps to take as part of the 'sepsis bundle'. Using bundles in health care simplifies the complex processes of the care of patients with severe sepsis. A bundle is a selected set of elements of care distilled from evidence-based practice guidelines that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.
- The department had a sepsis pathway that was in line with National Institute for Health and Care Excellence (NICE) and RCEM standards. However, we reviewed three sets of Sepsis notes which did not comply with the trust pathway. One patient did not have a Sepsis template present, one patient did not have antibiotics and fluid within an hour and one patient did not have fluid within an hour.
- The trust reported variance to the KPIs for sepsis management each month to the Chair of the NHS Quests steering group. Results showed that in October 2015 St Richard's hospital was providing antibiotics within an hour to 70% of patients with 'red flag' triggers.
- An internal neutropaenic sepsis audit report dated April 2015 showed that 67% of the included cohort had antibiotics administered within the gold standard 1 hour of arrival in the ED. Within two hours, 90% of patients had received antibiotics.
- A separate paediatric sepsis screening tool was in use for children presenting with potential sepsis.
- A Paediatric Early Warning Scoring (PEWS) was in use for children admitted to the ED.
- All patients under a year old and all patients returning for a subsequent visit with the same presenting symptoms were reviewed by a senior doctor prior to discharge.
- The department policy was that the initial observations on all patients were completed by a registered nurse. Health care assistants could complete subsequent observations, where the initial results suggested the patients condition was likely to remain stable.
- The emergency department have introduced "SPORT" (Staffing Patient Factors Expected Time of Arrival Reception Plan & Treatments & Tests Prepare) which follows the WHO guidance on best practice for critical handovers. This is used for all “ASHICE” (Age Sex History Injury Condition & Expected Time of Arrival) calls and transfer of critically unwell patients to other areas.

Nursing staffing

- At all times during our visit we found a suitable skill mix, with experienced and senior nurse staff available for the different areas of the department. We found staff rotated through different areas and covered each other appropriately for breaks.
- Staffing levels reflected the requirement to protect patient safety in the departmental areas and at different times of day. The department had staffing to allow one registered nurse to one cubicle in triage, one registered nurse to four cubicles in minors and majors, and one registered nurse to two cubicles in resuscitation. There were no significant staffing concerns during our inspection.
- We observed the staffing rota and saw that the majority of staffing shortfalls were covered via the use of an internal hospital bank staff system and agency staff were only used if the hospital's bank staff were unavailable.
- Bank staff were effectively inducted into the department and we saw records of agency staff induction including the induction topics covered by the staff team.
- Staff had ward huddles routinely throughout the day where staffing levels were a key feature and action would be taken to ensure safe staffing levels, for example calling in bank or agency staff to cover any shortfall.
- We found the emergency department had six vacancies for Whole Time Equivalents (WTE) nurses and three WTE health care assistant vacancies. We were assured that recruitment was taking place and staff would be in post by March 2016.

Urgent and emergency services

- The emergency department staffing is based on the NICE Safe Staffing Guidance for A&E Departments (2015). The staffing rota has a staggered start time to the shift pattern to correspond with peak activity times in the department.

Medical staffing

- We saw there was consultant cover in the emergency department throughout the day from 9am to 7pm. Consultant medical staff were available to manage care throughout the department as needed. One person was allocated as the emergency physician in charge so that there was clear leadership at all times internally and in dealing with other departments or services.
- We saw the departmental staffing rotas that showed two middle grade Doctors starting at 8am, there were one to three Consultants starting at between 8am and 9am. Doctors told us that shifts are matched overall to the department based on activity. There are another two middle grades that start between 2-4pm working until 11-12pm and the consultants were in the department until 7pm at St Richard's.
- At night across both St Richard's Hospital and Worthing Hospital there were two middle grades and Senior House Officers (SHOs) depending on the time of the night. Staff told us that there is a consultant on call on each site, who did attend, when required, for patient and departmental safety concerns. Staffing rotas reflected this.
- Consultant cover was not available for more than 16 hours per day in line with the recommendations of the College of Emergency Medicine. This was under review at the time of inspection. We saw a business case developed by the trust to increase consultant numbers from six to ten across Worthing and St Richard's to ensure that consultant cover was available to meet national guidance and the needs of the department. There was no discernible impact of this on patient safety.
- Staff roles and areas of work were clearly identified and staff were aware of their roles and responsibilities in the department.
- We observed staff handover; staff used an audible bell system in the department to draw staff attention to attend the meeting taking place. The handover included key staffing issues, the flow through the department and bed state.

Major incident awareness and training

- We saw that the department had major incident plans as part of the hospital and community-wide arrangements for dealing with a major emergency. Staff told us they had received training.
- We saw the major incident equipment within the department; it was ready for deployment with equipment in date and appropriate for use.
- There were clear protocols for dealing with patients suspected of having Ebola virus infection and staff told us they had training so they were aware of best practice. We observed that patients arriving by ambulance were asked specific questions to identify any possible risk of serious infection or other conditions likely to cause risks to the staff or public.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated 'Effectiveness' of emergency services at St Richard's Hospital as 'Good'.

This was because there was effective assessment of patients in a timely manner and treatment was provided in line with national guidance. There were effective levels of care 24 hours a day, seven days a week, with senior medical staff providing care directly or reviewing care to ensure accurate diagnoses and appropriate treatment.

Staff were appropriately qualified, were well supported through regular training and had competency checks to undertake specific roles. There were clear working protocols and procedures in place to support staff.

Staff from all disciplines worked collaboratively to maintain high standards of care and efficient working methods.

Urgent and emergency services

There were strong working arrangements with external stakeholders such as mental health liaison, Children and Adolescents Mental Health Services (CAMHS) and the Rapid Assessment and Treatment teams.

Evidence-based care and treatment

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

Pain relief

- We reviewed the notes of 15 children in relation to Pain Early Warning Signs (PEWS). Thirteen children had no pain scores recorded, showing inconsistency in the assessment recording process that meant staff could not demonstrate they had ensured pain was properly assessed. However, we noted they had been given analgesia.
- We observed examples of staff asking patients if they were comfortable, checking pain levels and ensuring timely analgesia was administered.
- Minutes from the ED sisters meeting in August 2015 showed delayed analgesia for pain was identified as a theme from a total of 9 complaints. Action was taken to address this and staff reminded to ask about pain when making their initial assessment.

Nutrition and hydration

- We observed staff offering patients drinks if clinically safe and they had been in the department for some time.
- We spoke with house keepers who told us they routinely make drinks for patients and relatives on request, but they always checked with senior staff to ensure it was safe to do so.

Patient Outcomes

- The percentage of patients leaving the emergency department before they are seen was approximately 3.3% in September 2015 which is worse than England average of around 2.7%.
- The unplanned re-attendance rate within seven days for the emergency department shows that the trust was performing at 2.5%, which was better than the England average of 7% and better than the trust's own target of 5% in September 2015. The unplanned readmission rate to the ED within seven days of treatment was consistently better than the England average.
- The results of the Royal College of Emergency Medicine (RCEM) Severe Sepsis and Septic Shock Audit showed results broadly in line with the England average.
- Serum lactate measurement was obtained in the ED for 75 % of patients.
- Ninety percent of patients with potential sepsis had antibiotics administered in the ED but only 30% were within an hour of admission.
- The trust Quality Strategy Highlight Report dated August 2015 showed that the organisation had a lead clinician for oversight of the implementation of the action plan from the Severe Sepsis and Septic Shock Audit. The report confirmed that implementation of a sepsis care bundle had taken place across the trust. There was dashboard monitoring via the Quest Operational Board
- The results of the RCEM Fitting child audit showed 100% compliance with most of the key performance indictors which was better than the England average. It must be noted that this was for a very small cohort.
- The results of the RCEM Mental health audit showed that St Richard's Hospital scored better than the England average in 5 of the 8 key performance indictors.

Urgent and emergency services

- In the last published national data (October to December 2014) both trust sites were graded 'C' (an improvement from 'E' in the case of St Richard's Hospital at the beginning of the year). For context, of the 204 trust sites in England and Wales 86 (42%) were graded C or above, 89 (44%) were graded D and the remaining 29 (14%) were graded E.

Competent staff

- Staff told us they had access to training and were provided with opportunities to develop relevant skills for their role.
- Staff told us teaching and induction was available for all new staff starting work in the emergency department. We reviewed staff Continual Professional Development (CPD) folders and there was evidence of staff attending training appropriate to their roles. We also saw they received feedback on their performance.
- Staff told us that lots of study days were available. We saw in staff CPD folders that staff had attended training on specific study topics for example Advanced Life Support, Sepsis, and Infection Control & Prevention.
- In staff CPD folders we saw records of appraisals and supervision were completed and up to date. Staff we spoke with told us the appraisal process was a positive experience for them and supervision enabled them to reflect on practice.
- A senior nurse explained the process of performance management and how this would be utilised to support staff that were underperforming in their roles. The hospital has a capability policy, which we saw and the senior nurse we spoke with gave a clear example of utilising this to support her staff performance. This demonstrated staff knew how to follow and implement the trust policy on staff performance management.
- Staff we said there was good support for professional development and access to training programmes to develop their knowledge and skills.

Multidisciplinary working

- There was good multidisciplinary team working and integration with the rest of the hospital. All admissions were assessed in the emergency department and seen by the emergency department or medical staff interchangeably.
- There was effective internal multidisciplinary team working within the emergency department. We saw that occupational therapists and their assistants worked effectively as part of the team enabling patients to be discharged safely and efficiently.
- Staff told us that they could access multidisciplinary staff and that the occupational therapy team were available seven days per week. We saw the rota and the service was available from 8am to 6pm seven days per week with planned time for the ED.
- The emergency department had access to mental health workers who provided support to adults who covered seven days per week . There was also a part time childrens mental health worker as part of a pilot scheme offering support Monday to Friday 9am to 5pm. Staff told us that this had supported them in their roles, either by direct contact with patients or via advice on the phone or email. This enabled access to early intervention to support patients' mental health.
- Another example of good MDT working to improve patient outcomes was an internal audit of the prescription of Gentamicin for abdominal sepsis was undertaken in October 2014. The audit showed good multidisciplinary working in the management of acutely unwell patients. The audit was triggered by anecdotal reports from the infection control team but was carried out by the pharmacy team. There was good evidence of dissemination of learning from this audit.

Seven-day services

- The emergency department at St Richard's Hospital was open at all times and senior medical staff were available to provide patient care and advice at all times. They also provided on-call cover for major trauma cases, providing advice to other trauma units and attending the emergency department as needed when patients were admitted. Nursing staff told us that consultants were often in the department through the night attending trauma cases or supporting the team at time of high activity.
- Occupational therapy and mental health services were available seven days a week. Staff told us this had a positive impact on patients as they would be able to see a professional for guidance on their wellbeing or condition that may enable them to return home more quickly or avoid admission.

Urgent and emergency services

- There were two CT scanners available and a radiographer available 24 hours a day, seven days a week enabling patients to access scanning services at any time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of the Mental Capacity Act (2005) and how to comply with this within their roles. We saw the trust's policy on MCA provided guidance to staff who could access this via the hospital intranet.
- We observed staff sought consent from patients before undertaking treatments and that capacity to consent was recorded on the patient notes when appropriate.
- We observed staff discussing care and treatment with patients and their relatives. Detailed explanations were given as part of discussions to support patients in making informed choices and to clarify consent.
- Staff had a good understanding of the need to consider whether a child was competent to consent when treating children under 16 years of age.

Access to information

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

Are urgent and emergency services caring?

Good

We rated 'Caring' for emergency services at St Richard's Hospital as 'Good'.

This was because of the very high levels of extremely positive feedback made on site and direct to CQC. The trust consistently performed much better than other trust in the Family and Friends Test and was as good or better than other trusts in the A&E survey. People who contacted us felt staff went the extra mile and the care they received exceeded their expectations. Some talked of the hospital ED as "Being a shining example of the NHS at its best."

We observed a strong, person centred culture with patients and their relatives being well cared for. There were good levels of privacy despite quite cramped working conditions. We observed staff promoting patient dignity and offering choices to patients.

Staff included patients and their relatives in decisions about their care. Staff supported patients promptly in managing pain and anxiety.

Compassionate care

- Friends and Family test scores for patients recommending the emergency services at St Richard's hospital were 90.1% in November 2015. The trust has consistently scored much better than the England average during 2014-15.
- We saw staff offering compassionate care and treating people with dignity and respect at all times.
- We received lots of very positive feedback made direct to CQC before and after the inspection. Comments included, "No complaints at all, a wonderful hospital with caring staff and fantastic doctors. Never have to wait long in A and E" and "Top class hospital here in Chichester. I have witnessed really good care of a friend in the A&E area. They were all so kind."
- One mother said, "My son aged 4yrs old managed to cut his toe badly while running around the garden. It was his birthday. We took him to ED, the nurses were great especially when they found out it was his birthday. A member of staff found him stickers including a special birthday one. They were wonderful with my son even making him laugh. They made sure he was finished in time for his party."
- Another relative said, "My 90 year old mother spent the day in ED at St Richard's in September 2015. I spent the afternoon with her there. I was very impressed by the care the staff took of my mother. I was worried that they might not bother too much with a very elderly person but she had tests, x-rays, discussions with me about her physical and mental state, and was treated with kindness and dignity despite her confusion."

Urgent and emergency services

- One patient described their experience as, "I want to praise the ED for the help and support I got in there when I was admitted for a stomach problem. Two staff, a nurse and a sister looked after me as if I was a personal friend! Nothing was too much trouble for them and they both continued to make me as comfortable and smiling while I was in there."
- In the A&E survey 2014, the trust performed in line with other trusts for most indicators but better than average for 3 indicators.
- A 'Sit and See' report showed a porter had checked whether a patient had finished their breakfast before taking them for an x-ray and helped the patient put their slippers on before assisting them to a wheelchair.

Understanding and involvement of patients and those close to them

- We observed staff being caring and respectful with patients and relatives. Staff informed patients of the plan of care and about any procedures or tests that were explained in a way that they could understand and gave time for questions and reassurance.
- As patients arrived in the department on trolleys, a registered nurse, trained to undertake assessment met them. This was an immediate reassurance to patients who were rapidly provided with any first aid, then moved to the relevant part of the department.
- We spoke with the mother of a sick child seen by a consultant on arrival in the emergency department and saw the consultant giving clear information to the parent on the use of pain management and reassurance regarding the child's condition. The mother said, "The staff here have been amazing."
- People wrote to us about the care their relatives had received and gave details of how frail elderly people, some who were very confused, were cared for in a kind and gentle way. They told us nothing was too much trouble and they were never made to feel like they were wasting time.

Emotional support

- Bereavement counselling services were available in the emergency department including for parents of children that may die in the department.
- Support was also available for staff involved in caring for families where there was severe trauma or a sudden infant death. The department had a specific room set aside for this purpose and access to the hospital chaplaincy services.
- We observed a student nurse showing great care and attention to a patients wellbeing at a time The department offered referral to the WORTH Services, an independent domestic violence service to support people affected by domestic abuse in West Sussex. The service is available seven days a week from 9am until 7pm and we saw information, leaflets, and posters were prominent across the emergency department.of significant distress.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Outstanding ☆

We rated the 'Responsiveness' of emergency services at St Richard's Hospital as 'Outstanding'.

One of the main reasons for this judgement was the highly effective and proactive management of the flow of patients through the emergency department. Clear leadership and continuous monitoring of the number of patients who might need admitting allowed the site management team to work proactively with other hospital staff to ensure backlogs did not develop. This work recognised that for many patients, community care was a more appropriate option and the trust staff worked with local stakeholders and other hospital staff to reduce emergency admissions and to provide a rapid discharge to community services, when appropriate.

The hospital performed as well or better than most other trusts in England on most performance indicators. The service had adapted to ensure exceptionally good patient flow as this was considered key to ensuring optimal care for all. The departmental leaders and staff had implemented systems to maintain flow and escalate problems as soon as there were indications of delays in care and patient flow.

The Emergency Department had been developed to deliver services to meet the needs of patients and recognised the

needs of the local population. Consideration had been given to meeting the specific needs of people with learning disabilities and innovative approaches to their care in the ED had been initiated. There was a high number of elderly people with dementia in the local community and their needs were considered with adaptations clearly identifying their needs. The care of frail elderly patients was exceptional with a clear strategy to 'turn people around' quickly to avoid admission and all the ensuing complications for the frail elderly this often results in. The staff worked hard to minimise and avoid the time that people with dementia and other frail elderly patients were cared for in the inappropriate environment of an emergency department.

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

Service planning and delivery to meet the needs of local people

- Patient flow through the emergency department was recognised as a key issue. We observed this being discussed at team meetings and handovers with the intention to improve the flow and experience of patients whilst promoting safe care.
- Staffing levels in the ED were assessed four hourly to ensure there were adequate staff to support a rapid throughput and avoid blocks in ED.
- Any ED target breaches were escalated to the matron and upwards to the executive team. Immediate review of the department took place to make adaptations and maintain flow.
- The elderly care pathway was refined to ensure elderly patients were not kept in the ED unnecessarily but were either admitted or discharged in a timely manner.
- An Edit team was responsible for making sure newly admitted patients had initial tests and observations completed and were helped to put on a gown, where necessary to ensure blood test results and ECG results were available when patients were assessed by the medical team. This reduced the time spent waiting in the ED and improved flow.
- The emergency department senior team recognised the population it served. They showed us the trust annual review 2014-15 which gave details of a local population and needs analysis. They explained how the services were planned accordingly utilising multidisciplinary teams to meet individual needs.
- The trust has a contract and worked collaboratively with the local commissioners to provide GP services within the emergency department to provide condition management and to reduce the number of patient admissions whilst maintaining flow through the hospital.
- As part of the trust Quality Strategy 2015-2018 the hospital was implementing care bundles to improve the recognition and care of physiologically deteriorating patients including sepsis, acute kidney injury and preventing cardiac arrest. Sepsis bundles were already introduced.

Meeting people's individual needs

- The emergency department had access to translation services and we saw leaflets and information in relation to the services accessible within the department. Staff told us the local population has a large Polish community and they were aware of the need to access translation services at times. Staff gave an example of a patient who became distressed whilst receiving treatment, a member of staff was Polish speaking and was able to reassure and support the patient in order for consent to be taken.
- There were two Whole Time Equivalent (WTE) learning disabilities nurses available at the trust, one based at St Richard's Hospital, the other at Worthing Hospital. They were employed by another trust but worked under a service level agreement within Western Sussex Hospitals Foundation Trust. The nurses ran a report each day which allowed them to check the patients who had been admitted with a learning disability. They could discuss these with the clinical team and provide appropriate support.
- The electronic patient administration system allowed patients with learning disabilities to be flagged. The learning disabilities nurses could add new flags to the system as required and the system can be viewed by all clinical teams. The trust patient appointment system ensured that any patient who is being booked for a clinic or procedure could be recognised as having a learning disability prior to attendance.

Urgent and emergency services

- The emergency department had a specific room identified to support family and relatives at times of bereavement.
- The emergency department had 'Dementia Drawers' containing resources staff utilised for patients in order to regulate their behaviour and promote their wellbeing.
- There was a 'Knowing Me Magnet', the trust's recognised symbol for dementia on show at the top of the patients bed so all staff could immediately see that a person may have difficulty with communication. There was a 'Do Not Move' sign for people with dementia to minimise the number of moves these patients experienced. There are known risks associated with frequent moves of patients living with dementia and this helped minimise these.
- There was a weekly audit of the 'Knowing Me' documentation which showed that staff were ensuring documentation was being used in order to meet individual needs.
- The department used an IT system that allows them to flag all patients with a confirmed diagnosis of dementia.
- Finger food was made available for patients with dementia, to encourage them to eat, when their condition allowed. Housekeeping staff had training in dementia awareness.
- The department offered referral to the 'WORTH Services' an independent domestic violence service to support people affected by domestic abuse in West Sussex. The service is available seven days a week from 9am until 7pm. Information, leaflets, and posters about this service were prominent across the emergency department.
- 86.2% of medical staff had completed equality and diversity training, the trust training for medical staff is 90%.
- We saw the paediatric waiting area was equipped and the space was adapted to be appropriate for children and families.
- The paediatric waiting area could only be accessed via the ED minors area so people entering had to walk past the nursing station. However, the door to the children's area was unsecured and there was a risk that an unauthorised person could enter without staff realising.
- The hospital met the national target of seeing, treating, admitting or discharging 95% of patients within four hours, ending the year in the top 20 trusts in the country. The year to date figure for the four hour target was 97.2% on 23 September 2015.
- The senior nurse and the emergency physician in charge on each shift proactively manage delays or problems transferring to departments or other departments and monitored the flow of patients and activity levels in the emergency department.
- The percentage of emergency admissions via the ED waiting between 4 and 12 hours from the decision to admit to the actual admission was consistently better than the England average. There was a spike in December 2014/January 2015 where the hospital had a sudden increase in the numbers waiting longer, but this was true nationwide. Between 31 March 2014 and 28 June 2015 there were 1,554 people waiting 4-12 hours and one person waiting over 12 hours from decision to admit to admission, which was better than the England average.
- Since February 2015, less than 5% of patients had waited more than four hours from the decision to admit to the time of admission which was better than the England average of over 10%.
- Between April 2015 and September 2015, around 3.8% of patients left the department without being seen. This was worse than the England average performance for this indicator which is 2.7%.
- Between November 2014 and October 2015, 97% of ambulance handover times were recorded by the trust as being under 35 minutes. The ambulance trust target is 35 minutes to hand over care of a patient from ambulance staff to hospital staff. We witnessed timely handovers between ambulance crews and ED staff which included a detailed assessment of individual needs.
- The patients experiencing under a four-hour maximum wait from arrival to admission, transfer, or discharge was at 97.28% in August 2015 and the average year to date 2015-16 was 97.48% which is better than the trust target of 95%.
- We observed regular handovers between medical staff about the status of the department overall at shift

Access and flow

changes and clear clinical handovers when transferring or referring patients. When patients were held up because teams were unavailable from other parts of the hospital decisions were made about diagnostic tests and admission to department areas by the senior medical staff in the emergency department to prevent delays.

- Staff were aware of procedures to promote safe working and guide staff through escalation procedures when the department was full or the hospital bed state was causing a backlog to the emergency department.
- Staff told us that a lack of seating in the paediatric waiting room became an issue at times leading to children having to wait in the main emergency department waiting room when the department was busy. The trust were aware of this as a part of their A&E Risk Register and were taking mitigating actions to make improvements in this area.
- The Rapid Assessment and Treatment team had a positive impact on patient outcomes through finding appropriate services and equipment to return people to their own homes and avoid admission to hospital where possible.

Learning from complaints and concerns

- Between October 2014 and September 2105, the emergency department at St Richard's received 36 complaints regarding all areas of clinical practice, 20 regarding communication and 16 complaints were in relation to staff attitudes. The responses were managed in a timely and comprehensive manner.
- We examined the team meeting minutes and governance meeting minutes, all of them detailed feedback and learning from complaints which had been received.
- We spoke with 19 members of staff during our inspection and we specifically asked them about what feedback or learning they were aware of regarding complaints. All were able to provide examples of where information had been shared through meetings, during handovers, on information boards and in during supervision with managers. We were assured that feedback and lessons learnt from complaints was being provided.

Are urgent and emergency services well-led?

Outstanding ☆

We rated leadership and management of the emergency department at St Richard's as 'Outstanding'.

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

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

Senior staff told us they were actively engaged with strategic planning and options being investigated to improve the service. There was a strong sense of ownership and belonging across all staff groups.

There were high levels of staff satisfaction in the ED. Staff were proud of the organisation as a place to work. There were high levels of constructive engagement with staff through meetings for all grades of staff and hospital wide initiatives. Staff at all levels were actively encouraged to raise concerns and we were told that senior staff were approachable.

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

There was very strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences. All staff were focussed on

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

Vision and strategy for this service

- The emergency department staff had been involved in planning future service configuration. This had included discussion and planning about short, medium and long term plans for the future in the context of the NHS finances and local opportunities with a specific reference to the trust own vision.
- Staffing and service configuration for the medium and long term were being developed at the time of our inspection. This included capital projects to improve security in the paediatric areas and increase in staff establishment to provide more consultant hours.
- There was a clear strategy for the service and improvement goals set out in the trust Quality Strategy 2015-2018. This was known to staff locally and there was evidence of local leaders working towards these goals. For example, as part of the operational introduction of care bundles for specific high risk conditions. Consultants attended the Operational Senior Nurses meeting to highlight the new Sepsis Screening Tool which was to be introduced shortly. Copies of the new tool were circulated at the meeting together with copies of the new Buffalo stickers which needed to be placed in the patients ED card, where sepsis is suspected.

Governance, risk management and quality measurement

- There was a Divisional Clinical Governance Committee (DCGC) half-day monthly with a standing agenda which included mortality trends, incidents and SIRI's and lessons learned from RCA reports.
- There was also a bi-annual multidisciplinary speciality meeting of ED staff for discussion of the standing agenda items from the DCGC meetings that applied specifically to the ED.
- Quality or audit meetings were held and action points created. We saw that these were communicated to the teams in flexible ways, for example by email and team meetings and supervision to ensure continual improvement to quality of the service.
- Learning from incidents led to changes in practice. A senior staff member explained how they had recognised a difference in practice between trusts regarding the use of sedation. This led to a patient receiving the wrong dose of sedative. We saw how the incident had been managed, and the development of a new flow chart to support staff decision making and consistency was implemented across the staff team.
- The department held a risk register which identified current risks and the mitigating actions. Key risks noted were the lack of safety, privacy and dignity due to lack of space in the paediatric area, and the safety of children due to only having one paediatric nurse to cover children. An action plan was in place and we saw the mitigating actions taken by the trust in practice.
- The 2014 NHS Staff Survey showed the percentage of staff experiencing physical violence from patients, relatives or the public was 18% during 2014, which is higher than the national average score for acute trusts is 14%. Staff told us of incidents in the department where patients had become violent and aggressive towards them and this was escalated by senior leaders to the trust board. In discussion with senior managers this appeared to be related to the high numbers of elderly people with dementia who attended the department and who might become agitated and aggressive in the unfamiliar surrounding of an emergency department.
- Divisional Governance Meeting minutes showed that the trust had taken action in response to this finding. Staff focus groups had been held supported by divisional managers and the Human Resources Department. There had been an increased presence of security staff in the ED. A 'No tolerance letter' had been written for staff to hand to patients, family and visitors when unacceptable behaviour was identified. Staff had been offered training in conflict resolution.
- The national clinical audit programme for the division was reviewed quarterly to ascertain progress made with the annual programme. Progress with each of the

projects was assessed and monitored using a traffic light system. All audits led by the ED team were rated green, demonstrating good leadership and oversight of audit programmes within the department.

Leadership of service

- There was good leadership of the emergency department. Senior staff were visible as clinical and managerial leads, with clear levels of accountability and control over operations within the department. There were identified roles allocated on each shift and displayed on a large board in the department.
- Nursing teams were established with experienced staff supporting and appraising junior members of staff. Staff told us they felt that the management of the department was supportive, offered opportunities for professional development and that the service was focused on improvements for the patients.
- All of the Clinical Standards for ED were discussed at joint consultant meeting in September 2015 and leads allocated. The teams had ownership of the standard and decided how to audit / monitor the standard within the trust. The progress of the implementation of the standards was discussed on a monthly basis with a dashboard to monitor maintenance of the quality standard.
- Local leaders had been instrumental in working with colleagues across the service to raise the grading of the stroke provision from an 'E' at the beginning of the year to a 'B' at last assessment in published national data. There were clear goals put in place to improve the service further during 2014/15. These included, "All CT scans for patients admitted to hospital with a likely diagnosis of acute stroke will be undertaken within 12 hours of admission and all patients that may benefit from stroke thrombolytic treatment will be scanned immediately and treated within 60 minutes of hospital arrival." This target was achieved and demonstrated a rapid improvement in the stroke service brought about by strong local leadership.
- Local leadership had set a culture of good service that was reflected in Friends and Family Tests that consistently rated the service well above the national averages provided a response rate that was above the national average.

Culture within the service

- Nursing staff told us they felt it was a supportive department to work in; they said staff work well together across the professional disciplines. We saw staff interacted in a supportive way to ensure safety and efficiency for patient care and staff particularly noted the leadership of the consultants, they described these as extremely approachable and supportive.
- Junior doctors told us it was a good place to work, in particular, the attitude of all staff with each other was seen as supportive and a good place to develop skills and experience.
- Domestic staff reported that the emergency department was a good place to work, that they were seen as part of the department team and felt pride in maintaining clean areas for patient care.
- Ambulance crews visiting the emergency department told us staff in the emergency department were particularly supportive of new and student paramedics. We spoke with a student paramedic who said staff in the department were always willing to engage and involve them in patient care, treatment and support. “The staff are brilliant here, they really want you to learn and be part of the department.”

Public and staff engagement

- Patients were invited to provide feedback and comments using comment cards. Comment cards were analysed within the department and reviewed in order to provide regular feedback to staff on areas they needed to improve. The team were able to give an example of an improved change to the waiting room environment because of patient engagement through comment cards.
- Feedback from complaints and the Patient Advice and Liaison Service (PALS) enquiries and comments were placed on social media and the NHS choices website. Feedback from patients and relatives could be accessed via Healthwatch West Sussex. This meant the trust were transparent with the local population, sharing feedback on complaints and concerns to raise awareness of the trusts performance.

Urgent and emergency services

- The Board Highlight Report dated August 2015 showed an ED patient experience group had been convened to get feedback from patients and relatives who had used the ED and urgent care services.
- Staff told us they are informed and included in developments of the service. There were daily team briefings and weekly notices with useful information and latest important changes and learning from incidents or complaints.
- Staff were engaged in innovative ways across the hospital but with impact on the ED. The 'Sit and See' report for St Richard's Hospital was carried out by a ward clerk from Worthing Hospital. They completed an observation that was shared with the ED managers and through them to staff. There were many positive comments about named staff.
- Meetings took place between service managers and all grades of staff. There were minutes available from the Emergency Nursing Assistants (ENA) Forum, Housekeepers meetings and meetings of Band 5's, Band 6's and Band 7's. These were all held separately to allow all grades of staff to have a voice.

Innovation

- The department has created a pathway for offering a meeting with families whose loved ones have experienced sudden death to talk about what actually happened and answer any questions they may have going forward. This was introduced due to recognition that often families have trouble understanding what happened and have a number of unanswered questions that they need to resolve in order to move forward in the grieving process.
- The emergency department have introduced 'SPORT' (Staffing, Patient Factors, Expected Time of Arrival, Reception Plan & Treatments & Tests Prepare) which followed the WHO guidance on best practice for critical handovers. This is used for all 'ASHICE' (Age, Sex, History, Injury, Condition & Expected Time of Arrival) calls and transfer of critically unwell patients to other areas.
- Staff informed us of 'One Call One Team', a single point of access for urgent care referrals. The service facilitates rapid assessment and access to urgent care management options to prevent avoidable hospital admissions for adults. Packages include medical care, therapy, and personal care. The principles are to improve patient experience and choice, reducing unplanned admissions and A&E attendances from both home and residential settings. There is a 24/7 single point of access for community services, GPs, ambulance crews, nursing homes and social care professionals. The multi-agency Rapid Assessment and Treatment Team led by community geriatricians provides fast-response home visits followed by up to 72 hours of intensive support to prevent admissions.
- Clinicians at the trust have developed a scoring system - the Acute Kidney injury Prediction Score (APS) utilising physiological measurements, biochemical parameters and known co-morbidities to identify patients at risk of developing AKI following hospital admission before markers of kidney deterioration appear. This work will support the acute kidney injury bundle being rolled out as part of the Quality Strategy.

Medical care (including older people's care)

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

Information about the service

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

St Richard's Hospital had 20,222 admissions between January 2014 and December 2014, of which 55% were emergency admissions, 5% were elective and 40% were day cases. The most common specialities for these admissions were general medicine (54%), gastroenterology (21%) and clinical haematology (10%).

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

To help us understand and judge the quality of medical care services we reviewed performance information from, and about the trust before our inspection. We visited wards at St Richard's Hospital where we looked at the quality of the ward environment and observed how staff were caring for patients, including the care of eight patients in detail. We reviewed more than 30 patients' care and treatment records.

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

We looked at a range of policies, procedures and other documents relating to the running of the service including audits, staffing rotas, divisional quality performance dashboards, and governance meeting records.

Medical care (including older people's care)

Summary of findings

Overall we rated medical care services as 'Outstanding'.

The reason it was outstanding overall was due to the responsiveness of the service in the care of individual patients coupled with a clear understanding of the needs of the population that used the service. Pathways were designed in collaboration with external stakeholders and community providers. The staff listened to feedback and acted on what they were told to fine tune services in the best interest of their patients. The trust executive and board had an exceptional understanding of what there service was and who their patients were. This approach was fed down so that the directorate had a really good understanding of what they were meant to be providing and who the service was for - and created services that met the identified needs. The medical leaders focussed on getting the basics right and building on that to provide excellent care.

For example, there was exemplary provision made for patients living with dementia across the whole hospital. We received very high levels of very positive feedback from patients and relatives of patients who had used St Richard's Hospital. The 'Sit and See' scheme allowed staff to experience the hospital from a patient perspective.

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

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

There was a good knowledge of issues around capacity and consent among staff.

Patients received compassionate care and were treated with dignity and respect. Most patients and relatives we spoke with said they felt involved in their care and were complimentary about staff. One person told us, "The staff are very. very kind and helpful. You just feel completely confident that they know their stuff." The Medicines division had good results in patient surveys with results indicating an improvement in patient views over the last 12 months.

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

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

Medical care (including older people's care)

Are medical care services safe?

Good

Medical care provided at St Richard's Hospital was rated as 'Good' for safety.

The trust had effective processes in place for reporting, investigating and learning from incidents.

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

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

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

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

Incidents

- There had been a total of 31 serious incidents (SI's) reported through the NHS strategic executive information system (STEIS) between August 2014 and June 2015. The most commonly reported incidents were slips, trips, and falls (25) and diagnostic incidents (3).
- Most staff we spoke with understood their responsibilities to raise concerns, record safety incidents, and near misses, and to report them internally and externally. However, staff on Ford ward told us they didn't always report perceived staffing shortages as incidents, but this had not had an impact on patients' care.
- The electronic incident reporting system sent feedback on the outcome of incident investigations automatically to the original reporter if this was requested on the electronic form at the time of reporting. This meant that staff were aware of outcomes of incident investigations and could identify points of learning from incidents they had reported.
- The trust's electronic incident reporting system prompted staff to categorise the level of harm with all incidents. Where 'moderate' or 'permanent long-term harm' was reported the trust clinical leadership was automatically notified. The patient safety team then contacted the ward to follow up the incident and monitored the investigation process until the investigation was complete.
- Events causing moderate or severe permanent or long term harm were assessed by a senior divisional member of staff. We saw examples of Root Cause Analysis (RCA) reports that confirmed this happened in practice.
- We viewed four reports from RCA investigations. We found relevant staff were involved in investigations and the reports included a chronology of events prior to and following serious incidents. RCA's we viewed recorded that patients were involved in the investigation and informed of any actions taken as a result. Lessons learnt were recorded on the RCA investigation reports.
- The education department reviewed all new entries on the trust's electronic incident reporting system monthly and reported these to the education executive. This enabled the trust to monitor staff in training and for them to be supported and educated. For example, on Ford ward a patient had developed an avoidable grade 3 pressure sore. As a result of the investigation health care assistants had to report any 'pink' areas on the skin to the senior nurse.
- Recent RCA investigations were discussed at quarterly clinical governance half days. This encouraged wider participation and greater dissemination of learning from incidents across the hospital. These meetings were chaired by a clinical lead consultant. The quarterly meetings were well established in the division and seen as a priority in terms of learning and improving patient care.
- We saw minutes from divisional meetings where incident reports were discussed and learning disseminated. These included quality and safety

board meeting, clinical governance half days, sisters' meetings, and ward meetings. A divisional dashboard was updated monthly and circulated to all consultants and senior nursing staff to highlight any recent concerns.

- All patient deaths were routinely reviewed by the consultant responsible for their care to ensure that the death certification was accurate, and also identify whether the death was avoidable. Medical staff told us there were regular meetings where mortality and morbidity was discussed. However, there were no specific meetings held for mortality and morbidity, but significant issues were presented and discussed at the monthly clinical governance half days. Notes of the meetings were taken, but these were not circulated as minutes. A senior manager informed us that an official agenda would be issued with formal minutes taken with immediate effect.
- The Head of Clinical Governance was the operational lead for the Duty of Candour (DoC) in the trust and information was available to staff on the trust intranet.
- The Head of Clinical Governance had presented to several groups of staff about DoC since October 2014. Staff we spoke with were aware of their professional responsibilities relating to the DoC. We saw several complaint response reports that showed staff had been open and honest when there were shortfalls in the care provided.

Safety thermometer

- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism. Overall the division was regularly meeting the trust's 95% target for harm free care.
- The trust had met their targets for Grade 3 and above hospital attributable pressure sores. Safety Thermometer information indicated that between July 2014 and July 2015 there were 33 pressure ulcers reported of all grades. We found the prevalence rate of pressure ulcers reported in the Safety Thermometer had varied over time but there had been no real decrease or increase in the rate from July 2014 to July 2015.
- The Divisional Quality Scorecard showed that the division was meeting their target for 80% of patients having a falls risk assessment completed within 24 hours of admission. The number of falls during the year to date showed the trust was likely to meet their year-end target.
- The divisional dashboard indicated the division was meeting National Institute for Health and Clinical Excellence (NICE) guidance on the assessment and risk of venous thromboembolism (VTE). The dashboard recorded that the division had met the 95% compliance target from August 2014 to March 2015. The current year to date performance suggested the trust would continue to meet the target at year-end.

Cleanliness, infection control and hygiene

- The importance of all visitors cleaning their hands was publicised and we observed visitors using hand gels and washing their hands. The trust's infection prevention and control team's patient information leaflet on hand washing was available in wards, and explained good hand washing technique as well as when patients should clean their hands.
- We saw staff routinely cleaning their hands between treating patients. Hand washing facilities and hand sanitising gels were readily available. We saw staff adhering to the hospital's 'bare below the elbow' policy. Staff routinely used gloves, aprons, and other personal protective equipment (PPE).
- The Division of Medicine at the hospital regularly achieved 99% compliance with hand hygiene.
- The ward areas appeared visibly clean. We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- The infection rates for Clostridium difficile (C.Diff) from November 2014 to November 2015 was 0.4 per 1,000 admissions. The rate for hospital acquired methicillin-resistant Staphylococcus aureus (MRSA)

was 0. The rate for methicillin-susceptible Staphylococcus aureus (MSSA) was 1.2, and the E-coli rate was 4.3. These rates were better than better than the year to date targets.

- Patients were screened for MRSA bacteria. The divisional spreadsheet for patients who had received MRSA screening showed that, between June 2015 and December 2015, they regularly achieved 100% of patients being screened with the average being 98%. This ensured patients with MRSA carriage were identified and action was taken in a timely way to address MRSA risks to patients.
- Infection control audits were followed up with a report that identified areas of non-compliance, made recommendations for improvements and were followed up in subsequent infection control audits. Audits we viewed for St Richard's hospital indicated that the hospital was meeting the trust's 85% performance target for infection prevention and control.
- Equipment such as commodes, which are shared between patients was cleaned after each use and labelled with a green 'I am clean' label and dated. We saw equipment across the wards labelled with the stickers.
- 89% of staff had up to date training in infection control in line with a trust target of 90%.
- The hospital had an infection prevention and control nurse who staff could contact if they required advice.

Environment and equipment

- The division had good outcomes for patient-led assessments of the care environment (PLACE) assessment score from November 2014 to November 2015 of 92%. This was better than the trust target of 85%. PLACE assessments focused on the environment in which care was provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity was supported.
- Overall, staff told us there was sufficient equipment to meet patients' needs. For example, ancillary staff at a focus group told us generally there was sufficient equipment to keep people safe. However, staff on Ford ward told us a merger with Graffam ward had resulted in a shortage of pressure relieving equipment. We noted that a patient who had been the subject of an RCA investigation for a pressure sore did not have a pressure relieving cushion. This meant the hospital had not always ensured that there were sufficient quantities of pressure cushions to ensure the safety of the patient and to meet their needs.
- A physiotherapist told us across the trust there was a shortage of electric beds and recliner chairs, and whilst this had not resulted in patient safety being compromised it could have an impact on the patient experience and independence.

Medicines

- A new electronic prescribing system had recently been introduced. We received positive feedback from the two medical wards we visited of the electronic medicines system. Nurses told us that there were fewer missed doses and errors in prescribing.
- Pharmacists told us that they were more easily able to ensure patients had a timely medicines reconciliation of their admission medicines because they could prioritise from the electronic records.
- Pharmacists and technicians dispensed on the ward and there were 'to take away' (TTA) packs available for out of hours use. However, staff on medical wards told us that there was sometimes a delay in obtaining discharge medicines.
- A few junior doctors said that they had concerns about gaining access to the electronic system. The lead for the electronic system told us access was by a pass card or a log in and that there was a 24 hour helpline available for advice on the prescribing system. We saw the training records for prescribers and staff administering medicines. This included online drug chart training and a Deanery prescribing assessment.
- All staff we spoke to knew how to access medicines supplies out of normal working hours which were 9am to 5:30pm Monday to Friday and a limited service on Saturday and Sunday.
- All staff we spoke with knew how to report a medicines error on the trust's electronic incident reporting system. We saw minutes of the monthly medicines

optimisation meetings and medicines safety reports. The trust had a medicines safety officer and the number of incidents reported was benchmarked to other similar trusts and considered comparable.

- The last trust storage audit was in June 2015. We saw that medicines cupboards were not locked in the chemotherapy unit and intravenous fluids were not locked in the acute admissions unit. This meant there was a risk of unauthorised access. We saw that the results of the storage audits were discussed at the medicines optimisation meetings and action plans set for September 2015.
- There was lack of continuity on recording fridge temperatures in four wards we visited. In one unit there were no records at all and on others the records showed a number of dates where the temperature had not been recorded.
- We saw emergency medicines were not always checked daily to ensure they were always available for ready use in an emergency. This meant the hospital had not always ensured the proper and safe management of medicines.

Records

- Overall, records we saw were found to be in good condition. Medical notes were found to be legible and well completed in accordance with the General Medical Council (GMC) guidance 'Keeping Records'.
- The division had good rates of staff training in records management. For example, 96% of staff had up to date information governance training, better than the trust target of 90%. We saw that records were stored securely on the wards we visited.

Safeguarding

- 87.3% of eligible nursing staff had completed level 2 safeguarding adults training. 95.7% of eligible staff had completed level 3 adults safeguarding training. This was better than the trust target of 90%.
- Directly delivered Level 1 safeguarding adults training was undertaken by groups of staff who were not clinical but had contact with patients, for example, porters.
- Staff we spoke with demonstrated a good understanding of the types of abuse people may experience. We saw information on how to report safeguarding was available on all wards we visited.
- Staff told us if they had safeguarding concerns they would contact the safeguarding lead. Staff said safeguarding care management plans would be in place where safeguarding concerns were identified.
- Staff we spoke with were aware of the trust's safeguarding guidance and multi-agency procedures. Staff told us this was readily accessible on the trust's intranet and were able to show it to us.

Mandatory training

- Staff mandatory training was monitored by the divisional dashboard. Mandatory training covered a range of topics including, fire awareness, infection control, basic life support, safeguarding, role specific training including manual handling. The dashboard indicated that staff consistently met the trust's 90% target for role specific training, such as manual handling, or dementia care training for staff on elderly care wards. However, overall the division was not meeting the trust's 90% target with 78.8% of all staff had completing mandatory training from August 2014 to August 2015.
- We viewed the division's training spreadsheet for basic life support. Over 80% of staff had up to date training in basic life support in all wards and departments, with the exception of clinical lead nurses at 75% and dermatology nurses at 50%.

Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS). The NEWS is based on a simple scoring system in which a score is allocated to physiological measurements when patients are being monitored in hospital to identify patients at risk of deterioration in their condition, and ensure appropriate escalation in their care.
- Staff were aware of the appropriate action to be taken if patients NEWS scores were higher than expected. We examined a number of NEWS records during our

announced and unannounced visits. We found that overall scores had been totalled correctly, and where concerns had been raised by a high score the issue had been escalated.

- The hospital was in the process of developing a measure on the divisional dashboard to monitor the use of the NEWS tool provide information on the use of NEWS and to aid monitoring its use.
- Staff told us they felt well supported by doctors when a patient's deterioration was sudden and resulted in an emergency. Medical staff we spoke with told us that they were called appropriately by nursing staff when a patient's condition had deteriorated.
- We viewed the NHS 'Quest' deteriorating patient operational group' strategic dashboard and action plan. This provided evidence of comprehensive risk assessments being introduced across the division, as well as risk management plans being developed in line with national guidance. For example, on 30 November 2015 the trust had agreed to participate in the 'Quest - Making Safety Visible' initiative and as a result new electronic sepsis assessment was being introduced, along with a Sepsis education and training package.
- We viewed the divisional annual work plan which included the implementation of care bundles to improve the recognition and care of deteriorating patients. The bundles included sepsis, acute kidney injury (AKI), preventing cardiac arrest, and stroke or high risk transient ischaemic attack (TIA).
- We viewed the divisional quality scorecard. This recorded that between 1 June 2015 and 1 November 2015, 88% of eligible patients had received a falls assessment within 24 hours of admission, against a trust target of 80%. The trust's 'falls collaborative' met every six weeks to review the hospital's performance in regards to falls reduction.

Nursing staffing

- Nursing staffing levels had been reviewed and assessed using the National Safer Nursing Care Tool. Managers and staff acknowledged that there was a shortage of permanent Band 5 nursing staff. However, staff told us that when there were nursing shortages on the roster, these would usually be made up from bank or agency staff. For example, a ward sister on Ashling ward told us they would never have more agency staff on a ward than their own staff. They added that, where possible, they would employ agency staff in the longer term to ensure continuity of care for patients.
- The divisional dashboard displayed the ratio of actual numbers of staff against planned numbers per shift expressed as a percentage. Staff records showed the average ratio per month was over 96%.
- The divisional dashboard for staffing also recorded the actual/planned staffing ratio for qualified nursing staff at night. The lowest rate was 96.9% in February 2015 to the highest rate of 98.8% in July 2015. The average night time qualified nursing staffing rate was 97%.
- Staff told us there was a lack of chemotherapy trained nurses on one ward. The divisional manager told us there was a chemotherapy nurse rostered on every shift. We were unable to confirm or the numbers of chemotherapy trained nurses on each shift.
- The Divisional Risk Register recorded qualified nursing staffing shortages as a risk to patient safety. The Risk Register Policy stated instances of staffing shortage should be documented as an incident. It also recorded actions the trust were taking to mitigate the risks posed by staffing shortages, including daily reviews of staffing by all wards and departments to ensure the allocation of staff ensured each clinical area was safe.
- Ancillary staff at a focus group told us staff attended ward or departmental daily safety huddles at 8:30am. These were introduced in June 2015 to improve communication in regards to staffing and ensure staff were aware of any staffing issues.
- We spoke with the Director of Medical Services, they told us nursing recruitment was ongoing and the trust had recently had a drive to recruit nursing staff from overseas. We saw nursing vacancies advertised on the trust's website and on the NHS jobs website.

Medical staffing

- The hospital had a lower percentage of consultants and a similar percentage of junior doctors compared to the England average. For example, 27% of medical staff were consultant level, this was worse than the England average of 34%. Middle career doctors made

up 4% of medical staff worse than an England average of 6%. The trust had a higher percentage of registrars and junior doctors than the England average. For example, the medical staffing percentages for registrars was 44%, higher than an England average of 39% and junior doctors made up 25% of medical staff compared to an England average of 22%. This meant the trusts' medical workforce was more reliant on junior staff than the national average.

- There was a divisional on-call rota for out-of-hours (OOHs) medical staffing cover included evenings and weekends. For example, the general medicine consultants worked day shift from 9am to 5pm. An OOH consultant was on-call outside of these hours. The on-call rota showed the name of all the division's on-call consultants, with details on how they could be contacted. The rota also carried the details of on-call registrars, doctors and junior doctors, as well as their bleep contact details when on shift.
- We viewed medical staffing rotas and saw actual medical staffing levels were congruent with the established number of medical staff required to staff the department.
- Most doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and out of hours. They also told us consultants were supportive when present and contactable by phone if they were needed for support out of hours.
- The Medicine Division had handover arrangements whereby the incoming consultant met with the outgoing junior medical team at 8am. New patients' conditions were discussed in detail. Incoming junior doctors attended the consultants' morning ward rounds. There were daily consultant board rounds at 3pm. Newly admitted patients up to 7pm were reviewed by the duty on-call consultant.
- There were 'hospital at night' meetings at 8:30pm. These discussed updates on patients and information on new patients. These were attended by the on-call doctors and staff from the ward based teams.
- Medical consultants worked seven days a week in the trust. At weekends, consultant cover in the hospital was eight hours a day. Most medical admissions were seen by a consultant within 12 hours of admissions.
- In May 2015, the GMC found that junior doctors reported handovers were comprehensive.

Major incident awareness and training

- Emergency plans and evacuation procedures were in place. Dedicated leads were in place in case of an evacuation.
- Staff told us that if the electronic records system failed there was a separately networked computer system where patient notes were available.
- The hospital had two escalation wards which could be used in busy periods.

Are medical care services effective?

Good

We rated medical care at St Richard's hospital as 'Good' for effective.

This was because the Division of Medicine provided evidence based care that followed guidelines and legislation.

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

There was a multi-disciplinary and collaborative approach to providing care and treatment by appropriately qualified and competent staff.

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

Evidence-based care and treatment

- The Division of Medicine adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. The trust had an effective process for monitoring the implementation of NICE and Royal College guidelines. For example, we viewed a selection of the division's monthly clinical governance board meeting minutes and saw these had reviews of NICE guidance as a standard agenda

item. This ensured patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation, and ensured consistency of practice.

- We viewed the trust's 2016 audit plan and saw that an audit of NICE quality standards and guidelines were included. This meant the trust was taking steps to ensure that staff followed appropriate guidance and guidelines, and patients could be sure that their care was based on best practice.
- The division reviewed the national clinical audit programme to ascertain the progress made with the trust's annual audit programme. Progress was assessed and monitored using a traffic light, red, amber, green, (RAG) system. All national audits that were scheduled for 2015 were green rated; this indicated that evidence had been seen by the divisional leads that the audits were progressing to schedule with one exception. The. This audit had been assessed as delayed in March 2015 and there was action plan work was in progress to monitor the audit to ensure it remained on track.
- The division had a clinical audit programme in place for 2016. There was a '4-step' model for prioritising audits. For example, audits prioritised as 'priority 1' were external 'must do' audits. These were national projects taken from the Healthcare Quality Improvement Partnership (HQIP) programme, February 2015. which were not 'Priority 4' audits were ad hoc clinical interest audits and were not part of the annual audit planner, these audits were based on ideas from clinicians that could provide local changes in clinical practice and education. This meant there was a comprehensive system of audit was in place to monitor the effectiveness of patient care.
- Guidance and guidelines from the trust and NICE were available to staff on the trust intranet. Staff we spoke with told us that guidance was easy to access, comprehensive and clear.

Pain relief

- The hospital had a pain management service available for patients who were referred by medical clinicians. This was staffed by a small team of specialist nurses. Staff from the pain management team told us at a focus group told us they were well supported by the anaesthetic department.
- Patients we spoke with told us their pain was well managed and staff would respond promptly if they needed pain relief.
- We observed staff monitoring the pain levels of five patients and recording the information. Pain scores were recorded the patients' notes we examined.
- The carers' survey for the 1 March 2015 to 23 August 2015 found that 62% of carers thought staff did everything they could to help the patients pain,14 % thought patient's pain was managed sometimes.

Nutrition and hydration

- The trust was using a nationally recognised tool to assess patients nutrition and hydration. The twelve nutrition assessments and fluid balance charts we examined in patients' records were complete and up to date with documented dietician reviews where appropriate.
- We saw nutrition and fluid plans were followed with fluid balances that had been scored, and acted upon where appropriate.
- A dietician was available on referral to the hospital's dietetic service. Dieticians provided specialist support to some medical services such as stroke patients.
- Patients were offered three main meals and three snacks each day. A choice of meals was available from a menu that was circulated the previous day. Staff assisted people to complete their meal requests.
- Patients we spoke with were generally positive about the quantity and quality of the food they received.
- There was a restaurant and two small coffee shops that patients and relatives could use, if they wished.
- The hospital operated a protected mealtime policy. This meant patients would not be interrupted during mealtimes and visitors (including unnecessary staff) would not be admitted onto the ward during mealtimes, unless this had been pre-arranged with the ward. It also freed staff to assist patients rather than attend to visiting staff.

Medical care (including older people's care)

- Trained hospital volunteers were available on some wards to support people in eating and drinking at mealtimes.
- The trust ran a 'Lets do Lunch' initiative which paired staff who do not normally work on wards with some of the more elderly patients. They were, in effect, dining companions who provided both company and assistance. Volunteers also participated in the scheme. Staff taking up the opportunity were very positive about it and included PA's, secretaries and other non clinical staff.
- Welcome home packs had been introduced to provide frail and isolated patients with enough food and drink to ensure they do not have to worry about their first 24 hours at home. Local supermarkets were providing the goods which contained essentials such as milk, bread, fruit and cheese.

Patient outcomes

- The hospital episode statistics (HES) covering the period December 2013 to November 2014 showed the standardised relative risk of readmission in medicine was a score of 97 for all elective admissions.. A score below 100 is interpreted as a positive finding, as this means there were less observed readmissions than expected. For example, elective gastroenterology scored 94. However, an outlier was clinical haematology, which scored 121 which was attributable to the very elderly population who were more likely to develop complications.
- The HES statistics for standardised relative risk of readmission in medicine was an overall score of 89 for non-elective readmissions. For example, general medicine scored 89; and cardiology scored 74. The exception was gastroenterology, which scored 124. This was worse than the national average but given the demography of the area this was interpreted as a neutral finding.
- The summary hospital level mortality indicator (SHMI) was reported by the hospital to the trust board on a monthly basis. The most recent performance figures for January 2014 to December 2014 found that the SHMI was 'as expected' for a hospital for this size and configuration.
- The trust conducted a mortality review in July 2015 to assess the trust's new mortality form. As a result of the review the mortality review form was redesigned to ensure the accuracy and clinical confidence of staff in using the form when undertaking reviews.
- A list of diagnosis groups where the trust was an outlier in terms of expected performance was provided to clinical leaders and the trust's monthly Quality Board. An outlier is a measure that lies outside the expected range of performance and which we identify using statistical techniques. Outliers are patients who require an unusually long hospital stay. At the time of our inspection there were two diagnosis groups where the trust was an outlier. These were 'acute and unspecified renal failure' and 'cardiac arrest and ventricular fibrillation'. These were new outliers, triggered by the trust's decision to move to a new monthly base level measure. Investigations into why these groups were identified as outliers were in progress at the time of our inspection demonstrating that the division was actively seeking to manage any potential underperformance.
- We viewed the 'myocardial ischaemia national audit project', (MINAP) audit for 2013-2014. The trust performed better than the England average. Unstable angina is a type of recurring chest pain, and NSTEMI (non-ST-segment-elevation myocardial infarction) is a type of heart attack. 96% of NSTEMI patients were seen by a cardiologist or a member of the cardiology team, better than the England average of 94%. 77% of NSTEMI patients were admitted to a cardiac unit or ward, better than the England average of 56% and 98% of NSTEMI patients were referred for or had angiography, either as either inpatients or following discharge. This was better than the England average of 80%.
- The hospital participated in the Joint Advisory Group on GI Endoscopy (JAG), including accreditation level. This involved the hospital demonstrating they were meeting agreed levels for domains of the Endoscopy Global Rating Scale (GRS) in clinical quality, quality of the patient experience, workforce; training, ensuring there was a safe environment for patients and staff;

and meeting the requirements for decontamination. We viewed the GRS ratings for October 2015 and found the hospital had an 'A' rating across the 'aftercare', 'assessment' and 'timeliness' domains.

- The National Diabetes Inpatient Audit (NaDIA) from September 2013, published in October 2014, found out of 21 outcomes, 13 outcomes were better than the England average and eight were worse than the England average for the hospital. Better than the England average results included patients being visited by a specialist diabetes team, prescription errors and being seen by the multi-disciplinary foot-care team within 24 hours. Outcomes worse than the England average included medication and insulin errors.
- The hospital demonstrated improvement in the sentinel stroke national audit programme (SSNAP) from previous audits. St Richard's Hospital overall SSNAP score from July 2014 to June 2015 was a level C (where A is the highest and E the lowest level of attainment) for both patient centred and team centred key indicators (KI).

Competent staff

- Staff we spoke with told us that the trust's initial induction programme was detailed and comprehensive.
- Induction was identified in the 2014 National Training Survey (NTS) as an area for improvement. The trust employed an induction manager and had made over 50 induction videos to help doctors in training to orientate themselves.
- The division had not consistently met the trust target of 90% of staff receiving an annual appraisal in the previous 12 months. Appraisal figures between August 2014 and August 2015 varied between 72% and 78%. This meant over 20% of staff had not received a review of their continuing professional development needs in the previous 12 months.
- We viewed the General Medical Council visit report from May 2015. The visit reviewed medical staff access to education, training and supervision opportunities. The report found doctors in training had access to supervision, but junior doctors covering gaps in the staffing rota occasionally meant they missed teaching sessions.
- Nursing staff had access to a programme of in-house training. For example, training included patient group directions (PGD), (these are written instruction for the sale, supply and/or administration of medicines to groups of patients), and medicines management, and VTE assessment and anti-coagulation (medicines to prevent high risk patients from developing blood clots).
- Healthcare assistants (HCA's) were supported to attain the National Care Certificate. This was a compulsory element of training for HCA's at St Richard's Hospital.
- Registered nurses we spoke with told us they were supported with preparing their revalidation. A number of staff told us that a record was kept of when staff needed to update their professional registration and reminders would be sent via email by the trust's human resources team.
- Most staff we spoke with told us they had regular team meetings and were supported with their continuous professional development. However, a band 7 nurse on the Endoscopy unit told us there had not been a team meeting since they started their employment in September 2015.
- Locum medical staff received an induction pack, which included a DVD for locum staff to watch as an introduction to the hospital. The hospital had also introduced smartcards for locum staff to address previous issues of locums not being able to access the electronic recording systems. Locum staff we spoke with confirmed they had received an induction and felt this had prepared them to work at the hospital.
- The trust informed us all junior doctors undertook a prescribing assessment when first employed. Junior doctors with a lower score were directed towards additional e-learning relevant to their assessment outcome, and were offered support and supervision from their clinical supervisor. The plan and outcome of this was communicated to their local faculty group lead and their local academic board.

- Junior medical staff reported good access to teaching opportunities and said they were encouraged to attend education events. The junior doctors we spoke with told us they received good educational supervision and said the consultant staff took an active interest in their learning and development.

Multidisciplinary working

- When patients received care from a range of different staff, teams or services, this was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering patient care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Throughout our inspection, we saw evidence of multidisciplinary team (MDT) working in the ward areas. Clinical staff told us nurses and doctors worked well together within the medical speciality. There were daily multidisciplinary board rounds, which included doctors, nurses, and either an OT or physiotherapist.
- At an interview with the safeguarding adults team staff told us MDT working was generally effective. They highlighted good joint working between the children and adults safeguarding teams, who shared an office at the hospital.
- We viewed the emergency admission pathway algorithm for frail elderly patients. This gave clear guidance to staff on the steps to be followed in the event of a frail older person presenting at the emergency department. This included guidance for staff on the referral pathways for the hospital's speciality teams as well as the department of medicine for the elderly (DOME). This meant patients had specific routes to specialist services which would speed up their access to appropriate care and treatment.

Seven-day services

- Enhancing seven day services was a trust priority and work was in progress towards meeting the NHS improving quality agenda.
- Hospital in-patients had scheduled seven day access to diagnostic services. Consultant directed diagnostic tests and their reporting were available seven days a week: They were available within one hour for critical patients and 12 hours for urgent patients.
- Urgent access to interventional radiology was available on weekdays only. Outside these hours patients would be transferred to a dedicated hub.
- Patients had urgent access to endoscopy 24 hours of the day, including weekends.
- An OOH emergency physiotherapy service was available across all inpatient areas for patients experiencing or at risk of respiratory deterioration. The service is staffed by an on call physiotherapist available to attend on-site. The service was accessible through a pager via the main switchboard and operated 4:30pm to 8:30am on weekdays and for 24 hours at weekends.
- Medical consultants worked seven days a week in the trust. At weekends, consultant cover in the hospital was eight hours a day. Most medical admissions were seen by a consultant within 12 hours of admission.

Access to information

- Overall, staff could access the information they needed to assess, plan and deliver care to patients in a timely way. When there were different systems to hold or manage care records, these were coordinated. We found information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary. However, a few members of staff told us the mix of paper and electronic patient records could be confusing at times.
- The hospital used an e-observations platform for paperless capture of patients' vital signs and clinical data. This meant staff had access to up to date clinical information on patients.
- The trust had introduced an electronic handover system in 2015. Staff across the Medicine Division were positive about the electronic handover system and said it had made accessing handover information on patients easier.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA). People were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.
- When people aged 16 and over lacked the mental capacity to make a decision, 'Best Interests' decisions were made in accordance with legislation. For example, on Ashling ward a band 5 agency nurse told us they would speak with a doctor, the nurse in charge, or the trust's mental capacity link nurse if a decision was to be made about a patient's best interests.
- The trust achieved the 85% 'Commissioning for Quality and Innovation' (CQUIN) target for the percentage of staff receiving mental capacity act training.
- We found staff had a good understanding of capacity and consent issues and were able to describe the correct process for establishing capacity and obtaining consent. They were also able to describe where they would get further advice and support if needed. For example, some staff told us they could contact the trust's safeguarding lead.
- Deprivation of Liberty was recognised and only occurred when it was in a person's best interests. It was used as a proportionate response to the risk and seriousness of harm to a patient and where there was no less restrictive option available that could ensure the patient got the necessary care and treatment.
- Nurses were clear about the procedure they would follow to initiate 'Deprivation of Liberty Safeguards' (DoLS). Staff told us this subject was covered during their safeguarding training. Agency nurses told us they would contact the lead nurse if they were concerned about a patient. Information supplied to CQC about DoLS applications and approvals showed the referrals were appropriate and mostly upheld by the supervising authority.
- The trust met the CQUIN target for monitoring DoLS and Independent Mental Capacity Advocate (IMCA) consultations, by reviewing 10 applications a month. This meant vulnerable patients who required DoLS could be sure the trust monitored the quality of their applications and ensured they had appropriate access to independent advocacy services to support them through the DoLS process.

Are medical care services caring?

Good

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

This was because feedback from patients and those close to them was positive about the way staff treated them. Staff demonstrated caring, compassionate attitudes and built positive relationships with patients. Patients were supported emotionally to cope with their care and treatment.

Staff involved patients and partners in their care and supported them to make decisions.

Compassionate care

- Feedback from patients and those close to them was positive about the way staff treated them. Stakeholders we spoke with also spoke highly of staff compassion and approach.
- We saw people were treated with dignity, respect and kindness during all interactions staff and relationships with staff were positive.
- The Medicine division's response rate to the 'Friends and Family Test' (FTT) was better than the national average rate of 35%, at 37%.
- During the period November 2014 to November 2015 between 91% and 94% of respondents said they were likely or very likely to recommend the hospital.
- We observed patients being treated with compassion, dignity and respect. The patients and families we spoke with were generally positive about the care provided. Patients told us doctors, nurses and other staff were caring, compassionate, and responded quickly to their needs. A patient's family told us, "The care here is brilliant."
- The trust's carers survey for 1 March 2015 to 23 August 2015 found that 90% of carers thought patients had always been treated with respect and dignity.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their families about the care and treatment options.
- Patients and relatives we spoke with told us they had been kept informed regarding the care that they were receiving and the medical and nursing staff were approachable if they wished to discuss their care. For example, a relative who was visiting a patient on Ashling ward told us, "If I want to know anything I can ask. If there are any changes they inform me."
- The trust was rolling out ward screens which provided real-time communication to improve the consistency and reliability of information that was available to patients and visitors. The units displayed the safety thermometer results, FFT recommendation rating, Staff uniform guide, actual versus planned staffing levels and information about the number of falls and pressure related skin damage.

Emotional support

- Chaplaincy details were advertised in the patient guide that was available at patients' bedsides.
- We viewed the ward level 'care, kindness and compassion' observation results. We found that overall across the division the results were positive for 'demonstrable care and compassion when patient appears anxious or distressed'. For example, the emergency floor scored 100% for June 2015.

Are medical care services responsive?

Outstanding ☆

We rated medical care services as 'Outstanding' for responsiveness.

The trust catered for a very demanding population in terms of healthcare needs, yet managed to maintain good flow throughout its medical services. Care of the frail elderly was actively managed from the time of referral to the point of discharge and back out into the community. There was an understanding that the needs of their most vulnerable patients could not be met by the hospital treating the presenting condition in isolation. Pathways recognised the need for integration of community and acute service provision.

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

The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. Staff and local groups were involved in deciding the Quality Strategy and were involved in service planning. The trust was forward thinking and worked with other stakeholders to develop initiatives that would improve services for all.

There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs. This included the development of an elderly care pathway to reduce the time the frail elderly spent in the ED and very good oversight of medical patients on other speciality wards during times of high demand.

The services promoted equality and met the needs of patients in vulnerable circumstances. This was evident in the way the service provided for the need of patients with dementia.

Medical care services reviewed, investigated and acted on complaints and other feedback to improve its services. The trust worked with local stakeholders and individual patients to improve services.

Service planning and delivery to meet the needs of local people

- Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to the ED or if they did, making sure that their medical and social care needs were quickly assessed. This meant that elderly patients spent less time in the ED and were either admitted to the ward or supported in going home.
- There had been a collaborative agreement with the local authority and CCG's that allowed people a 48 hour admission before existing care packages were

cancelled. This made it possible for a rapid assessment, treatment and return home to be managed without the need for a lengthy reassessment of care needs and potential delays in discharging patients.

- The hospital had a level 2 chemotherapy and haematology service. Both services were linked with Brighton University Hospitals NHS Trust and had been peer reviewed as an aspect of MDT between the services.
- The 'Coastal Cabinet' was an initiative with the local Clinical Commissioning Group (CCG) to redesign the 'front door' of hospital services. This involved improvements in the way the hospital, community health services and the local authority worked together. Staff told us the hospital was also working with the CCG on stroke care reconfiguration in West Sussex; and the redesign of musculoskeletal (MSK) services.
- The minutes of the Divisional Clinical Governance Meeting, dated August 2015 showed the trust had worked in consultation with staff to reduce the impact of people needing a general anaesthetic for an endoscopic procedure. The outcome of changes to the way these were done had freed up time in the main operating theatres for surgical admissions.
- The trust had worked in consultation with the CCG and local GP's to reduce the number of people with headaches being seen under the 2 week rule. The referral pathway was changed and workshops were offered to local GP's to make them aware of this. It meant people were not put through the stress of a referral for a potential cancer unnecessarily and freed up staff to see patients who did need to be seen within the 2 weeks.
- The trust was working with local stakeholders and the 'One team, One call' project staff to reduce the number of medically fit patients who were remaining in hospital whilst local community provision was sourced. The team was in the process of creating a discharge team that would take over the immediate care of these patients in the community whilst more permanent arrangements were made.

Access and flow

- Ninety percent of admitted patients started consultant-led treatment within 18 weeks of referral. Individual medical speciality performance ranged from 100% for neurology and geriatric medicine to 92% for cardiology. This ensured patients had timely access to initial assessment, diagnosis or urgent treatment.
- We viewed the trust's cancer waiting times. We found the trust met the national 96% standard in every month from April 2015 to November 2015. We also found the trust consistently met the 85% standard for a two month wait from a GP urgent referral to a first treatment. This meant cancer patients could be sure they would receive timely treatment.
- St Richard's Hospital had a longer length of stay for non-elective stays, between January and December 2014, at 7.1 days compared to the England average of 6.8 days. All medical specialities had length of stays greater than England averages. Given the local demography, this should be considered a neutral finding.
- The average length of stay at St Richard's Hospital for all elective stays in medicine between January and December 2014 was 1.7 days better than the England average of 4.5 days.
- Performance for individual medical specialities was mixed and ranged from an average length of stay of 2.8 days in cardiology against an England average of 1.9 days. However, respiratory medicine was worse than the England average with an average length of stay of 12.6 days against an England average of 3.5 days. The demography of the local population impacted on the length of stay because there was a predominance of frail elderly patients.
- The Medicine Division was effective at managing the flow of patients through the hospital. The division had developed pathways that reduced the need for patients to access services through the ED department.
- There was a trust wide discharge planning and bed management team who were responsible for the co-ordination of capacity and bed availability. They

liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new patients to be admitted and ensured patient discharges were timely.

- The Medicine Division risk register identified there was a lack of medical and Department of Medicine for the Elderly (DOME) bed capacity at the hospital resulting in patients outlying in surgical beds and the opening of escalation areas. This caused additional staffing problems for nursing and medical teams. In these there was a risk of patients not being in an appropriate ward, causing the risk of delays in assessments, treatments and pathways with resulting increased length of stay.
- The hospital addressed this via regular operational site meetings at 8am, Midday, 4pm and 8pm to review bed capacity and agree decisions between divisions as to the most appropriate plans for patient placements. For example, patients were zoned in the hospital to consultant paired wards.
- The site team tracked patients not on their own speciality ward on a daily basis to review progress, treatment plans, and expected date of discharge and ensure consultants were aware of patients being moved. Where possible outlying patients were placed into surgical wards rather than escalation areas. Discharge co-ordinators supported wards in processing discharge arrangements There were extra DOME junior doctors on duty to oversee patients on wards for other specialities, and extra bank or agency nursing staff were requested to assist staff on the wards. The number of patient moves and patient outliers were escalated to the chief nurse on a weekly basis.
- We visited eight medical outliers on Wittering ward. These are patients placed in other departments due to a lack of beds. The hospital had nominated medical teams to provide care for outlying patients. There was a system in place where the endocrinology team would take the first eight outlying patients, and the department of respiratory medicine would take a further eight. Staff told us the system was effective and junior doctors were always available to visit outlying patients.
- The trust was meeting their Commissioning for Quality and Innovation (CQUIN) target for the 'percentage of discharge summaries with four key items of information, as assessed by audit of 25 notes per month'. The target was 23 and they had achieved better performance at 27 per month.

Meeting people's individual needs

- The trust was using the 'red tray' system to identify patients who may have needed support with eating. We observed that staff adhered to this system and provided assistance to people, when needed.
- Information in languages other than English could be provided on request. Staff gave examples where interpreters were available both in person and via the telephone.
- The trust had undertaken a Learning Disabilities Peer Review which looked at a range of criteria such as reasonable adjustments, the environment, and staff awareness of the Mental Capacity Act 2005.
- Staff used a 'Hospital Passports' scheme for patients living with a learning disability, which allowed them to identify to staff their likes and dislikes in a pictorial format. There was also an 'Easy Read' menu available for patients.
- The hospital also had a learning disability liaison nurse to support patients with their care and treatment. The nurse visited all patients with learning disabilities, including in the ED.
- The 'Knowing Me' initiative allowed staff to know more about the lives, likes, and dislikes of patients with dementia. Each patient with dementia or other conditions affecting memory had a 'Knowing Me' book which could be completed either by the patient or their carers. The book allowed staff to get a fuller understanding of the patients in their care, everything from the individual's life story to specific pieces of information such as how they might behave when thirsty, how they relaxed, or how they reacted when in pain.
- Patients with dementia had completed 'Knowing me' forms in place. These had been completed in

consultation with the person who knew the patient the best. This allowed staff caring for people with delirium to understand what was important to each of them.

- There were dementia friendly signs on lavatory doors on wards.
- 'Can move' magnets were provided and used on ward whiteboards to identify patients who were suitable to be moved to another ward, if demand for beds increased. This system protected the more vulnerable patients from unnecessary moves without highlighting the reason they were to remain on the same ward.
- There were reminiscence materials and activity boxes available on ward for staff and volunteers to use when working with patients with dementia.
- The hospital had implemented the Dementia Buddies initiative where volunteers were trained to provide company, stimulation and one-to-one attention for inpatients, especially at meal times.
- Individualised care plans were used throughout the hospital. The hospital also used a variety of care pathways and care bundles to assess and monitor the nursing care provided. This meant patients had records that took account of their individual needs and preference regularly recorded the outcomes of their care.
- 'Intentional rounding' was recorded in each patient's record. This is a structured approach demonstrating that nurses had conducted checks on patients at set times to assess and manage their fundamental care needs. Overall, patients records demonstrated nursing staff had regularly helped people change their position, drink and assist patients in going to the lavatory.
- We did not see any patients or families receiving bad news. However, nurses told us there was a general shortage of space for speaking with families in private but that space could usually be found.

Learning from complaints and concerns

- Complaints were managed in accordance with trust policy and lessons were learnt. Staff and managers told us that they preferred to resolve concerns locally at ward level. Staff said these were not recorded, but if they could not deal with the concern immediately patients would be directed to make a formal complaint. This was in accordance with the trust's policy on complaints. There were clear procedures and staff responsibilities for managing and responding to complaints.
- The complaints procedure included a flowchart to guide staff on the procedure to follow. This ensured that their complaint was investigated at the right level and that key managers and governance personnel were aware of the complaint and its progress.
- All the patients we asked said that they had not raised any complaints with the service, and they found staff approachable if they wished to raise issues. A patient on Ford ward told us they had received a letter of apology from the hospital after developing a pressure sore.
- Information regarding complaints and concerns was available on all the wards and in the patient bedside information packs. We only saw information packs in English. Staff told us information in all languages could be requested from the hospitals accessible communications team. We saw information leaflets provided the contact details of the patient advice and liaison service (PALS) and explained that people could receive support from PALS in making a complaint. The leaflets also advised that support for non-English speakers and people who needed support with communication was available via the advocacy Complaints and concerns were discussed at the monthly quality and safety board meetings. The minutes of these meetings showed that complaints to the service were a standing agenda item and discussed at the meetings to ensure the quality of services improved. Learning from complaints was shared at team meetings and across services where applicable.

Are medical care services well-led?

Outstanding ☆

We rated medical care services as 'Outstanding' in terms of being well led.

This was because the leadership, governance and culture was used to drive and improve the delivery of high quality person centred care. The leaders of the service reached outside the hospital walls for solutions and strategies fro meeting the complex needs of the local community. There was a very proactive approach to identifying problems and seeking sustainable solutions before the problem escalated out of control.

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

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

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

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

Vision and strategy for this service

- Ancillary staff told us there had been a "big emphasis" on the trust's 'Patient First' vision and values. This had included posters around the hospital, emails, and the trust's intranet.
- The trust 'Vision and Values' were included in information guides at patients' bedsides.
- A system used a range of metrics to identify good practice and highlight care shortfalls at ward level. The ward staff were able to benchmark themselves against other wards and would receive additional support to gain full accreditation, if necessary.
- The executive team were visible and known to staff of all grades.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the trust's strategy and good quality care.
- The governance framework included daily ward level safety huddles, monthly quality and safety board meetings, and clinical governance half-days that were led by senior medical staff, monthly care group meetings, and quarterly joint ward sisters meetings which were attended by matrons and senior nursing staff from across the medicines division.
- The reporting requirements for the division's four care groups had been standardised. Each care group contributed to both the divisional board meeting and quality and safety board meeting.
- The division had reviewed the governance structure and had carried out the appropriate changes to meet CQC requirements. For example, clinical governance rolling half days had been introduced with a standard agenda. The half days examined mortality trends, adverse incidents, serious complaints, serious errors (including prescribing errors), lessons learnt from RCA's and feedback from staff on safety or quality concerns.
- We viewed the Medicine Division management team structure flow chart. This clearly set out the sequential order of the division's management structure and how information from clinical staff and the four care groups was fed into the trust board.
- The hospital had introduced a balanced scorecard. This was a strategic management and planning instrument to monitor the effectiveness of services. This meant they were taking appropriate steps to monitor and manage quality and performance and that this information was accurate, valid, reliable, timely and relevant.
- The Medicine Division used a divisional dashboard. This gave senior staff and the board a comprehensive understanding of the division's performance, with integrated information on safety, quality, activity and

finances. The divisional dashboard used RAG rating and graphs as well as data to give senior staff and the board a quick way of understanding the division's performance.

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

Leadership of service

- We viewed the Medicine Division management team structure. The senior management structure consisted of divisional level matrons and clinical management teams feeding into the interim head of nursing, and four care group managers, who had direct access to the trust board. The head of nursing was an interim and there was also a vacant care group manager post for specialist medicine.
- Ward managers told us that they felt well supported in their roles and understood their governance responsibilities. The director of operations told us they liaised frequently with the chief of medicine and clinical directors.
- Staff told us that communication between the divisional teams was good. The division had daily board meetings. We observed a ward handover meeting and saw there was good communication between nursing and medical staff in terms of the leadership of the service.
- Junior doctors told us hospital consultants provided effective leadership. Junior and middle grade doctors

told us they felt well supported by their consultants and other senior colleagues. Overall, staff felt supported by the medical leadership in the division and the trust.

- A non-executive director attended Medicine Division Clinical Governance Review Meetings. We saw from the minutes dated August 2015 that they provided challenge and actively sought assurance. On this occasion, it was about the training of agency nurses at ward level.

Culture within the service

- Staff morale was high across the division. Staff told us they felt respected and valued. We saw multiple examples of staff working collaboratively and sharing responsibility to ensure patients received good quality care.
- Ancillary staff at a focus group told us the culture at the hospital was friendly.
- All the staff that we spoke with during the inspection were motivated to move the division forward. Staff' were committed to ensuring that patients received high quality care. Staff we spoke with told us the culture in the service encouraged openness and honesty.
- More than 50 staff had been selected to become trust 'ambassadors', to act as exemplars of best practice and guides to others. The 'Western Sussex Way' was the trust's commitment to ensuring a great experience for everyone who used their hospital services. Ambassadors were employees from across all directorates, departments and at all levels who had demonstrated a commitment and enthusiasm towards creating positive experiences for the people that they met including patients, visitors, members of the public or colleagues. We met many of the ambassadors whilst on site and saw they were very committed to their hospitals and wanted to tell us about the good work they were doing.

Public engagement

- Patients were engaged through feedback from the NHS Friends and Family test and complaints and concerns raised from PALS.
- The trust used a real-time survey system (RTPE) which enabled them to undertake a frequent review of the experiences of patients in more detail than is provided by the Friends and Family Test. From April 2014 to March 2015, 4,665 surveys had been completed by patients in different areas of the hospital including inpatient wards and a number of specialist services. There were five board measures for which the trust set goals through the year: hospital environment, assistance, compassion, communication and overall experience. These were monitored by the trust board through the quality scorecard each month. It is noteworthy that the trust achieved their own targets for improvements in all five measures.
- The trust engaged with the public, local community groups and stakeholders through a well-established Stakeholder Forum, a range of patient participation groups, and a patient feedback programme.
- Clinical governance meetings showed patient experience data was reviewed and monitored via the quality scorecard. However, we did not see evidence of any action plans to address issues raised by the public.
- The trust conducted a carers' survey in the form of a questionnaire. Carers' comments were analysed and the response from the hospital recorded.

Staff engagement

- Staff received a monthly trust newsletter 'Headlines' via email. The newsletter kept staff informed of developments within the trust and gave staff information on learning events at the trust.
- The trust provided opportunities for staff to improve their well-being. Staff at a focus group said they had access to courses that were not related to their job role, including 'mindfulness', yoga, and stress relieving activities.
- The trust had an award scheme that recognised exceptional staff members or teams. The Ford and Fernhurst teams had won the trust's 'Care for the Future' Award for achieving a maximum score on their external review for the Macmillan Quality Environment mark.

- The Patient First programme included a workforce sustainability work stream with key initiatives aimed at the recruitment and retention of the clinical and non-clinical workforce to meet the current and future needs of the service.

Innovation, improvement and sustainability

- We viewed the division cost improvement dashboard. We saw that there were a number of cost improvement plans for the Medicine Division, including a roll over scheme to ensure consistency in staff recruitment and retention payments, value stream mapping of the non-elective pathway improvement opportunities included increasing ambulatory care pathways, realignment of beds and capacity, standardisation of senior daily reviews; criteria led discharge and improved discharge planning and processes. This meant divisional staff were looking strategically at ways to provide best value.
- The Medicines Division was involved in a trust wide NHS Quest initiative which focused on improving quality and safety. This involved the trust taking part in collaborative improvement projects for Sepsis and cardiac arrest. Work was in progress on these initiatives at the time of our inspection.
- A ward accreditation scheme was being rolled out across the trust. It used metrics that reflected the trusts vision and values and reinforced the trust messages about the focus on patient safety.

Surgery

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

Information about the service

St Richard's Hospital provides a range of surgical services, including trauma and orthopaedics, urology, general surgery and gastrointestinal. There are approximately 131 beds for surgical patients including a 26 bedded private patient unit with 10 bariatric and 16 mixed speciality beds.

There are six main operating theatres with eight recovery beds; four theatres in the Chichester Treatment Centre with eight recovery beds and three theatres in the Day Care Unit with 12 recovery beds.

The majority of surgical activities undertaken at St Richard's Hospital were day case procedures, which contributed 59% of activity between January 2014 and January 2015. Elective surgery made up 19% of the work, and emergencies contributed 22% to activity. The main speciality was general surgery, which made up 30% of surgical procedures, with trauma and orthopaedics taking 24%, urology 13% and the rest 23%. The trust operated a private patient unit which specialised in bariatric surgery.

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

The CQC held a number of focus groups and drop in sessions where staff could talk to inspectors and share their experiences of working at the hospital. We spoke with over 40 members of staff working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, ward clerks, and housekeeping and domestic staff. We spoke with twelve patients and their relatives. We reviewed 10 sets of patients' records as well as other documentation. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection.

Surgery

Summary of findings

Overall we found that surgical services at St Richard's Hospital were 'Good'.

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

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

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

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

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

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

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

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

The availability of junior doctors out of hours was raised as a concern as staff felt they could not always access medical support promptly.

Surgery

Are surgery services safe?

Good

We rated St Richard's Hospital as 'Good' for safe because:

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

Patients were protected from avoidable harm because there were systems to report, monitor, investigate and take action on any incident that occurred. Identified concerns were closely monitored and actions taken to mitigate the risks to patients. For example, consistently staffing the wards and theatres to the required establishment was an acknowledged concern. This was monitored closely by managers and included on the trust's risk register. Staffing levels were discussed at regular meetings throughout the day and agency and bank nurses employed where needed to maintain safe staffing numbers. There were a number of vacancies across the surgical wards and theatres; however the trust had active recruiting campaigns both at home and abroad. This meant that understaffing did not impact the care that patients received.

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

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

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

However:

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

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

The availability of junior doctors out of hours was raised as a concern as staff could not always access medical support promptly.

Incidents

- It is mandatory for NHS trusts to monitor and report all patient safety incidents through the National Reporting and Learning System (NRLS). If an incident is assessed as a serious incident it is also reported using StEIS (Strategic Executive Information System). Serious incidents can include but are not limited to patient safety incidents for example loss of confidential information. Any serious incident which meets the definition of a patient safety incident should be reported to both StEIS and NRLS.
- All incidents at St Richard's Hospital were reported appropriately through the trust's electronic reporting system. There was an incident reporting policy and procedure in place that was readily available to all staff on the trust's intranet. Staff we spoke with were aware of the policy and were confident in using the system to report incidents
- There had been one 'Never Event' reported in the previous 12 months. We saw evidence of the investigation and noted learning had been shared internally and externally with manufactures and professional bodies to ensure learning was disseminated to protect others. (Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are implemented).

Surgery

- Ten serious incidents were reported trust wide for the Surgical Division on StEIS between August 2014 and July 2015. Two of these were at St Richard's hospital.
- Staff told us they were encouraged to report incidents and the managing of incidents was included in induction and updated annually in mandatory training.
- We reviewed three root cause analysis investigations undertaken between June and October 2015 and noted that the investigations remained incomplete. This meant any learning from these incidents would not yet have taken place.
- Learning from incidents across the trust was fed back to staff and had led to changes in practice to ensure patient safety. Learning from incidents was shared at the bi-monthly ward meeting and the daily ward 'Huddle'. Wider learning was disseminated through the trust through surgical division meetings and sister's meetings. We saw examples of learning from incidents included in the minutes of the meetings.
- All information relating to audits, complaints, incident investigations and never events were kept on the hospital's computer system where staff could access to review issues and identify any learning.
- Staff reported to us that it was not always easy to attend ward meetings if it was a day off, however if they had a hospital email address they could access the folder where they could view the range of incidents recorded.
- The divisional matrons oversaw this process to ensure learning took place. Staff gave us examples where changes in practice had occurred following learning from incidents. For example, on the Chichester Suite (Private patient unit) two patients had been readmitted to the unit following recent surgery. These had been flagged by the matron who undertook a morbidity review. Following discussions with the surgical team this had led to a change in practice.
- The main themes of the recorded incidents were staff shortages and slips, trips and falls. We saw action was taken to reduce the risk of further incidents such as falls risk assessments, and stickers to remind staff of those patients at risk of falling.
- Staff, patients and relatives were supported and informed of the outcome in accordance with the trust's Duty of Candour. The Duty of Candour requires healthcare providers to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- The trust kept appropriate records of incidents that had triggered a Duty of Candour response. The trust's policy included recording communication with the patient and any other relevant information on the electronic reporting system. However, managers told us that the duty of candour was not explicitly identified in the letters sent to patients or their relatives although the content of the letters complied with the guidance. They told us that is was an issue for educating the clinicians to complete letters appropriately.
- We spoke with consultants and senior managers, who told us about the clinical governance, risk and mortality and morbidity (M&M) meetings, which were held monthly by directorate and were used to discuss any learning from incidents. Minutes of the M&M meetings were available for inspection. These demonstrated learning from recent incidents had occurred. Managers told us that the details of each unexpected, preventable or unexplained death were reviewed by the corporate governance team.
- There was a robust process in place to monitor the mortality and morbidity findings on a monthly basis. All deaths within the hospital were subject to a two stage review process. All consultants with inpatient beds were required to review eight sets of care notes to determine if an incident was avoidable. Then an in-depth review took place by the mortality steering group. Reports were then fed into the quality groups and onto the board. We were told that there was robust challenge at every stage. For example why one hospital had a lower HSMR (Hospital standardised mortality rate) than the other. The medical director was required to explain in detail the reasons behind this.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism. We found that the NHS Safety Thermometer information was available on all of the surgical wards we inspected.

Surgery

- We saw evidence that safety thermometer data was being routinely used to improve the quality of care. For example the number of 'Harm Free Days' was available in each area. The staff we spoke with were proud the results in their area. On the Chichester Suite (Private patient unit) we saw the safety thermometer was clearly displayed at the ward entrance with high compliance scores recorded.
- Across the division, 96.2% of patients received harm free care in the period April to August 2015. This was better than the predicted target of 93.8%.
- We noted that the Patient Safety Thermometer data was discussed at the ward clinical governance meetings.
- Data indicated that 17 pressure ulcers occurred between August 2014 and July 2015. This rate was similar throughout the time period with no changes in the numbers reported. The rate of catheter acquired urinary tract infections (13) remained the same over the same time frame.
- The safety thermometer data recorded that, for the period April to August 2015, 90.7% of patients received a falls assessment within 24 hours of admission. This was better than the target of 80%.
- The number of falls that were identified as 'avoidable' was 0.77% which was in line with the predicted target. Nine falls were reported with a level of harm identified as three to six.
- The August 2015 Quality Scorecard indicated that the VTE (Venous Thromboembolism) assessment compliance was 94.1% against a target of 95%.
- Overall the Patient Safety Thermometer recorded 96.2% of harm-free patient days.

Cleanliness, infection control and hygiene

- There were infection prevention and control policies and procedures in place that were readily available to all staff on the trust's intranet. We found the surgical wards and theatre department to be adhering to national infection control guidance. We saw a very high standard of cleanliness in all the areas we visited.
- We noted that the hospital's infection rates were consistent with the national average for bacterial infections such as MRSA (meticillin-resistant staphylococcus aureus) and C. difficile during 2013/2014. There were no particular issues noted with infection in the surgical wards or theatres. The hospital recorded less than the target number of hospital infections for the year to date. The Quality Scorecard to August 2015 indicated that there were no hospital acquired MRSA cases; 13 cases of hospital C. difficile; 29 reportable MSSA (meticillin sensitive staphylococcus aureus) bacteraemia cases and 125 reportable E. coli cases.
- We spoke with matrons who told us that MRSA screening took place for elective patients before they were admitted for surgery. This was confirmed in the clinical notes we reviewed which demonstrated patients were MRSA screened prior to admission if possible and on admission if they did not go through the pre-assessment pathway.
- Patient led Assessments of the Care Environment (PLACE) are environmental and non-clinical self assessments undertaken by teams of NHS staff and include at least 50% members of the public, known as patient assessors. The overall internal PLACE compliance was recorded as 92% with Bosham and Coombes wards scoring 97.6% in the most recent cleaning audits.
- We noted although the trust participated in mandatory surgical site infection surveillance service that occurred during the inpatient stay, on readmission and post discharge for hip and knee replacements and fractured neck of femur patients the most recent results were not available. A Surgical Site Surveillance committee met monthly and the results fed into the surgical division clinical governance report. We saw the 2015 quarter one results for large bowel surgical site infection for St Richard's Hospital was 17.1%. The results demonstrated a year on year reduction in large bowel surgical site infections.
- There were designated staff with infection control responsibilities. The hospital had a dedicated infection control team, which provided support to staff.
- We saw that regular infection prevention and control audits took place in order to make sure all staff were compliant with the trust's policies such as hand hygiene

and the use of personal protective equipment (PPE). We noted that the most recent hand hygiene audits on Bosham and Coombes wards demonstrated 100% compliance.

- All surgical areas we inspected where patients were seen and treated were visibly clean and tidy. All patients we spoke with told us the hospital was always kept clean and tidy. They told us they noticed the nurses were always washing their hands.
- The sluice on Wittering Ward was not kept to the same standard. This was due to the macerator being broken and used bed pans had accumulated on top of the macerator. There was a red contaminated laundry bag on the floor. These issues were resolved by the nurse in charge whilst we were on the ward.
- We noted that storage was a problem across the hospital. Storage space was also a concern in the main theatres with corridors full of equipment. The main theatre corridors were cluttered with equipment and on Bosham and Coombes wards the equipment stored in the corridors meant that these areas were difficult to maintain and clean appropriately. We were told that there were plans to provide additional storage.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected. We found staff were generally aware of the principles of the prevention and control of infection (IPC). We observed staff regularly use hand gel on entering clinical areas and between patients. The 'bare below the elbows' policy was adhered to and personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas.
- On the Chichester Suite (Private patient unit) we observed two doctors, four nurses, a house keeper and a domestic were all bare below the elbows and using the hand sanitising gel appropriately in between attending to patients.
- Equipment was marked with a sticker when it had been cleaned and was ready for use. Disinfection wipes were available for cleaning hard surfaces in between patients.
- Decontamination and sterilisation of instruments was managed by an in-house accredited sterile services department that was compliant with the EU Sterile Services Medical Devices Directive. The facility was responsible for cleaning and sterilising all reusable instruments and equipment used in the operating theatres, wards, clinics and departments. Biannual audits took place to monitor compliance with the decontamination standards. The last audit took place in September 2015 and demonstrated a 96% compliance. An action plan was in place to address the outstanding areas.
- The trust had a waste management policy, which was monitored through regular environmental audits. We saw that waste was appropriately segregated, with clinical and domestic waste bins clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely.
- Linen cupboards were clean and tidy with bed linen managed in accordance with best practices.
- The cleaning of the hospital and theatres was undertaken by an in house domestic service. Cleaning equipment was colour coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately by the domestics which were checked and audited by a manager.
- However, some of the cleaning and domestic staff we spoke with told us there was sometimes a shortage of floor cleaning products especially at the weekends. They said "when that happens we just use plain water."
- Infection prevention and control was included in the trust's mandatory training programme. The trust provided training data which confirmed that the majority of staff had attended infection prevention and control training. Those staff we spoke with all confirmed they had completed this training.

Environment and equipment

- The general environment where patients were seen and treated was generally well maintained. We noted access corridors were light, airy with good signage. Emergency call bells were in place in each room and by each bed.
- However theatre corridors and storage areas were in need of refurbishment as the walls were damaged and difficult to keep clean.

- We were told that security was not a problem. The majority of wards did not require key codes or swipe entry access apart from the Chichester Suite which had restricted access via a digital lock out of hours.
- We saw there was a wide range of equipment available. Staff confirmed they had access to the necessary equipment they required to meet peoples care needs.
- However on some wards the electrical chargers for the patient tracking equipment were missing. Although staff told us they could use computers to log the information this was less convenient and led to possible delays. Managers told us that this was being addressed with more on order.
- Equipment was logged on an asset register which was supported by an outside contractor for maintenance purposes. This included both medical and estates equipment such as the lifts, air handling, water safety and generators. We saw one hoist which was overdue a service and this was clearly marked as out of use.
- There was a designated member of staff for medical devices in theatres who met regularly with the outside contractors and the equipment library to discuss new acquisitions and equipment maintenance issues.
- Staff in Chichester Suite confirmed there was “No problems with the equipment – we have everything we need.” They told us they could hire in electric beds or other equipment if required.
- Specialist bariatric equipment could be hired when necessary.
- We saw there were systems in place to monitor, check and maintain equipment. All the equipment we saw had been labelled to verify it had been electrically tested within the past year.
- Emergency resuscitation equipment, oxygen and suction equipment was available in each area and we saw it was routinely checked.
- Theatres had emergency intubation equipment held in the main theatre corridor, recovery, the treatment centre and the day care unit. All were appropriately checked and signed off. There were tamper proof seals in place on the majority of the emergency equipment trolleys apart from in the main theatre.
- Although we did not see the equipment training records, staff told us they had received relevant training on how to use equipment and felt confident and competent to use it.
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate log books being kept.
- All operating tables were suitable for taking bariatric patients.
- Single use equipment such as syringes; needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner.
- We noted that the theatres were well organised with good signage.

Medicines

- There were medicine management policies and procedures in place that were readily available to all staff on the trust’s intranet. The staff we spoke with were aware of the policies and protocols and knew how to access information regarding medicines management.
- We spoke with the ward pharmacist who visited the wards daily and undertook reviews of electronic prescribing, antibiotics and controlled drugs checks. They were not aware of missed dose audits taking place.
- In theatre the controlled drugs were stored in appropriate lockable cupboards. We reviewed the controlled drug registers in two theatres and noted they were checked daily by two members of staff. We found controlled drugs on the wards were regularly checked with entries double signed.
- We noted that the drugs fridges were checked daily to ensure drugs were kept at the correct temperature; however the ambient room temperature was not checked in any location we inspected. Many drugs need to be kept within certain temperatures for them to remain effective. For example, two types of antibiotics we checked stated they were not to be stored at temperatures over 25°C. It could not be verified that the drugs were stored below this temperature and they remained effective.

- The trust was about to start a Medication Safety Thermometer, which collected data relating to appropriate prescriptions and the administration of medicines.
- The Quality Scorecard indicated that there were 465 incidents involving drug or prescribing errors. This was less than expected for the year to date.
- There were 18 moderate or above medication incidents occurring in August 2015 against a benchmark of 13. These incidents were being investigated. However there were no themes identified as they were not related to a single area or staff group.
- We carried out random medicine checks in some of the ward areas and found all stock drugs to be stored appropriately and in date. For example, on the Chichester Suite it was found drugs were stored in locked cupboards within a locked room. We noted that the pharmacy porters delivered drugs to the locked clinical areas on the wards where the drugs remained on the side until put away in locked cupboards by staff.
- We reviewed a sample of Medication and Administration (MAR) charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on charts and on their ID band. The MAR charts we reviewed demonstrated that prescribing was in line with national guidance and that all were compliant with the National Institute for Health and Care Excellence (NICE) VTE guidance with a sticker confirming a completed VTE assessments and that prophylaxis had been prescribed and administered.

Records

- The hospital used a combination of electronic and paper records. A new IT system was in the process of being set up but this was not fully in use or embedded at the time of our inspection.
- Staff we spoke with told us that it would be useful to have the electronic records for governance and safety reasons. One consultant told us that for their appraisal they had to go through paper ledgers and records as there was no electronic data available.
- Managers told us that having electronic incident forms improved data collection as the system now didn't allow staff to submit without all the fields being fully completed.
- We looked at samples of medical and nursing records on the surgical wards and in theatre. In general, both nursing and medical records were accurate, fit for purpose, stored securely and completed to a good standard. They contained evaluation, progress and risk assessment updates. There was also information in respect to discharge planning. Discharge letters and requests for diagnostic procedures were undertaken via an electronic database.
- The care records included multidisciplinary input where required, for example, entries made by dieticians, physiotherapy and occupational therapists with referral to specialist advice, such as the dietician and tissue viability nurses. We reviewed ten sets of therapy notes and found they were well completed with good use of assessments and outcome measures.
- Surgical patients followed standardised pathways, which were personalised through individual risk assessments and the notes made in the care plans. The surgical care pathways included pre-operative assessment such as previous medical and surgical history, allergies together with baseline observations. Anaesthetic risk scores were used to ensure that only those patients suitable for day surgery were admitted as such.
- We observed clear and precise demonstrations of the WHO (World Health Organisation) checklist for each of the elective and emergency surgical procedures undertaken. Evidence of staff completing WHO checklist documentation were seen in all patient notes that we reviewed.
- The theatre register which recorded details of all surgical operations for each individual theatre was generally well completed with few gaps or omissions. A band 7 nurse oversaw the completion of the registers and ensured they were completed appropriately. The implant register was completed as required by the National Joint Registry.
- On the Chichester Suite (Private patient unit) records for NHS patients were held on the ward and were available for staff to access. However private patients' records were held by the consultant responsible for their care and were not held by the hospital.
- Nurses used laptops for recording patients' observations and for electronic drug administration.

- We were told that a new electronic system for recording patients admission and handover was in place and although there were some initial 'glitches' with the system they were aware of this and the system was improving.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on its intranet.
- There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
- Safeguarding training was included in the trust's mandatory training programme.
- We were told that all staff undertook basic safeguarding training. Those staff with additional responsibilities undertook level two and three training. The trust provided data that indicated 88% of staff at St Richard's Hospital had completed safeguarding training.
- All the staff we spoke with confirmed they had received safeguarding training as part of mandatory training. They told us they would report their concerns to the nurse in charge and contact the safeguarding lead if needed. They were aware of the safeguarding policy and how to access it.
- Staff gave examples of raising safeguarding alerts when vulnerable patients had been admitted with an unexplained injury and when concerns were raised by a patient about a family member.

Mandatory training

- Staff told us the trust provided good training and development opportunities. Mandatory training was monitored and all staff expected to attend on an annual basis. Training was provided through mainly online means and supplemented by face to face where appropriate.
- We looked at the staff mandatory training records and identified there was generally a good uptake of training for the surgical ward, however it took some time to update the electronic training records.
- In theatres, a practice development nurse helped to coordinate staff training. However mandatory training in theatres was at 43%. Staff told us this was due to staff shortages meaning that staff could not be released from duty to undertake training. The theatre manager explained that all staff had completed critical training such as resuscitation but there remained outstanding modules so the training could not yet be signed off.
- A weekly workforce report was produced which included staff training and appraisals. Ward sisters received monthly reports of staff compliance with mandatory training. We saw that training was managed electronically with the ward sister booking staff onto e-learning modules and noting this on the wards duty rota. For example, on the Chichester Suite, the report documented 80% compliance with mandatory training with dates booked and off duty planned for the outstanding staff.
- Included in the mandatory training were; safeguarding, infection prevention and control, information governance, health and safety, resuscitation, equality and diversity and fire safety.
- We spoke with consultants and doctors of all grades. They told us mandatory training such as safeguarding and infection control was available.
- The hospital tried to use the same agency staff that were familiar with the trust. We saw the new orientation and induction sheets available to support new temporary staff to the trust.

Assessing and responding to patient risk

- The trust had various systems in place to assess, record and respond to patient risks.
- The WHO checklist is a system to safely record and manage each stage of a patient's journey from the ward through the anaesthetic and operating room to recovery and discharge from the theatre.
- We were told that regular and routine compliance was monitored through audits, peer review and mock inspections. We noted that compliance with the checklist was closely monitored at every surgical intervention and audits of compliance took place on a routine and regular basis. The audits confirmed there were now very few incidents where the checklist had not been fully completed and each incident was followed up and discussed with the theatre staff. The Quality

Dashboard indicated there was 100% compliance with the WHO Surgical Safety Checklist to August 2015. The most recent recovery audit documented 98% completion.

- The trust currently used the national early warning score (NEWS). This scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support.
- We saw examples of staff on the surgical wards using the NEWS system to identify deteriorating patients and ensure that they were seen quickly by a doctor. The care pathways we reviewed demonstrated that the early warning monitoring system was being used appropriately and detailed the actions taken by staff when the patient's condition required escalation. For example, on the Chichester Suite the integrated pathway for bariatric patients included NEWS score checklist.
- Nursing staff told us that medical support was readily available when required as the surgical team and consultants attended to patients quickly when required.
- Recognised tools were used for assessing and responding to patients risk such as the malnutrition universal screening tool (MUST) and the venous thromboembolism (VTE) assessment tool to identify those at risk from developing blood clots.
- Risk assessments were undertaken where indicated for example moving and handling, skin integrity, nutritional needs, use of bed rails and venous thromboembolism (VTE). This information was then used to manage patient care.
- We saw day surgery patients had anti-embolism stockings in place where there use was indicated. We also found patients were usually having their risk of developing a venous thromboembolism (VTE) assessed.
- We observed documentary evidence in ward areas that demonstrated good clinical risk management in relation to pressure area care delivery. Patients had risk assessments in place and where a risk was identified appropriate action was taken. For example, where a patient's position was regularly changed and they had an appropriate pressure relieving equipment in place with specialist nurse input where required.
- However, there had been patients identified who had sustained avoidable pressure damage. In response to this the trust had increased staff awareness, improved reporting around pressure damage and appointed an additional tissue viability nurse.
- At shift change, a formal handover of care took place to ensure patients were appropriately cared for. Medical handover between specialities took place through formal referral and agreement.
- We saw theatre staff record that they followed the five steps to safer surgery, which included team brief, sign in, time out, sign out and de-brief. Theatre staff told us that theatre pathways were used for all patients. There was a recovery protocol in place which ensured access to anaesthetists and senior medical staff at all times.

Nursing staffing

- The hospital had set staffing levels for the wards based on an acuity tool. We reviewed staffing rotas and spoke with staff about safe staffing levels and patient acuity. We found there was usually appropriate staff numbers and skill mix in the clinical areas.
- Managers told us agency and bank nurses were used to cover vacant shifts, and there were now very few shifts where there were insufficient staff on duty.
- Staff told us understaffing would be reported on the trust's electronic incident reporting system. We did not see any recent staffing related incidents recorded.
- Data provided by the trust showed that during the period April 2015 to August 2015, the division had 96.6% of the planned complement of registered nurses during the day and 97.6% on night shifts.
- Theatres used The Association for Perioperative Practice (AfPP) staffing guidelines to ensure there was an adequate number of appropriately trained staff available for each theatre.
- Theatres lost several staff during the previous summer due to internal promotions and relocations. Many of these were orthopaedic staff and we were told that approximately eight theatre lists had to be cancelled due to the lack of appropriately qualified staff. The theatre manager told us of the recruitment drive to attract nurses from abroad. However, it was acknowledged there was a national shortage of theatre

staff and there remained eight vacancies currently filled by agency staff. The data indicated that cancellation of operations had been an issue during the summer but the last six months had seen a big improvement.

- The trust was taking positive action to recruit and retain staff. The recruitment strategy included investment in advertising, social media and recruitment agencies. The ward sisters had regular meetings with the HR department to monitor sickness and discuss recruitment. We were told actions the trust had taken to address the nursing shortages such as recruiting nurses from abroad.
- Specialist nurses were available to support patients and act as a resource for staff. These included specialists in breast care, vascular surgery, colorectal conditions, tissue viability and diabetes.
- There were also numerous 'Link Nurses' who supported the staff with help and advice on subjects such as infection control, moving and handling and micturition.
- Other staffing groups such as the physiotherapists and occupational therapists told us there was no issue with staffing generally although due to annual leave and sickness there were workload strains at times. There was currently a business plan being put forward for additional therapy staff to cover such contingencies.
- Staff in the Chichester Suite (private patient unit) told us the main recruitment issue was finding specialist bariatric nurses. They told us that it was difficult to find agency or bank staff with the right competencies. The usual staffing ratio was 1:4.5. They told us that this was sufficient to safely nurse the acuity of patients in the unit. We spoke with a newly appointed nurse who told us they had been very well supported since transferring to the unit.

Surgical staffing

- The most recent information indicated that between September 2004 and September 2014, the trust employed a lower percentage of consultants (37%) when compared to the England average (41%). There were also a higher percentage of junior doctors (16%) than the England average (12%).
- Middle grade doctors have at least three years experience as senior house officer or higher grade within their chosen speciality. Registrars made up 36% of the medical workforce, against an England average of 37%.
- Consultants told us that the theatre on call rota worked well and ensured there were no scheduled work commitments for the doctor on call. This meant they were not called away from elective patients to attend a trauma case or trauma cases were not kept waiting for the surgeon to finish in theatre before being seen. Consultant cover was available every day including weekends, with on call arrangements for out of hours and ad-hoc cover on bank holidays.
- The emergency theatre had adequate on call cover with two anaesthetists available.
- However, on Wittering Ward staff told us that at night the senior house officer was based in the emergency department and this meant that if they needed a doctor they sometimes had to wait several hours. They gave an example where the previous night a patient was admitted at 7pm. It was the early hours of the morning before the doctor could attend and write up the patient's medication. They told us that this could potentially impact on a patient's health and wellbeing.
- The availability of doctors was on the risk register for the Chichester Suite (Private patient unit). They told us this was because it was harder to access junior doctor support since the bed reconfiguration. The private patients received a consultant delivered service supported by junior NHS doctors if required. Bariatric patients were cared for by the bariatric medical team. A consultant described the challenges of two ward based junior doctors who had an extremely high workload. They told us that both consultants and registrars "acted down" to support them.
- We spoke with groups of consultants who all told us they were proud of the surgical service offered at St Richard's Hospital. In particular the colorectal screening pathway and the gastroenterology support were praised. All the consultants across the specialities told us they supported each other and that St Richard's Hospital was a "Fabulous place to work."

Major incident awareness and training

Surgery

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

Are surgery services effective?

Good

We rated St Richard's Hospital 'Good' for effective because:

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

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

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

However:

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

Not all staff had received an annual performance review or had opportunities to discuss and identify learning and development needs through this review. Staff reported that staffing shortages had impacted on the appraisal process and although this was improving time to undertake appraisals was still an issue.

Evidence-based care and treatment

- Staff were able to access national and local guidelines through the trusts intranet, which was readily available to all staff. Staff demonstrated the ease of accessing the system to look for the current trust guidelines.
- Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations. For example, patients attending for pre-admission assessments, had pre-operative investigations and assessment carried out in accordance with NICE clinical guidelines. The bariatric pathway was delivered against NICE guidelines.
- In theatre we noted that the anaesthetic equipment was checked in accordance with AGBI guidance. We reviewed a sample of patient protocols which met Royal College of Surgeons guidance.
- Following surgery patients were nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in

adults in hospital. This included recognising and responding to the deteriorating condition of a patient, and escalating this to medical staff following the early warning alert system.

- The staff we spoke with were aware of current relevant guidance and demonstrated how they were following NICE guidance on falls prevention, the management of patients with a fractured neck of femur, pressure area care, and venous thromboembolism. For example, anti-coagulant therapy was prescribed for patients at risk and anti-embolic stockings were measured and fitted to relevant patients. This was verified in the care pathways and clinical notes we reviewed.
- Within the theatre areas we observed that staff adhered to the (NICE) guidelines CG74 relating to surgical site infection prevention and followed recommended practice.
- The trust participated in both national and local audits which demonstrated compliance with best practice and national guidelines. For example, we saw the Chichester Suite (Private patient unit) monitored patient outcomes through a programme of audits such as pain and nutrition.
- The physiotherapists told us of the local audits they were conducting to look at reducing the risk of falls. We saw the audit results and the action plan to address the issues identified.
- The hospital provided a regional service for the management of severe and complex obesity. It was the first NHS service to be accredited as a centre of excellence by the International Federation for Surgery of Obesity.
- The maxillofacial unit had a high volume of complex skin cancer patients. Audit results showed a low rate of incomplete excision of skin tumours. At less that 4% this was much better than expected, particularly given the complexity of the cases.

Pain relief

- St Richard's Hospital had a nurse led pain management service in place. The Pain Team worked in collaboration with the surgical teams to help manage the patients' experience. They received referrals directly from the surgical teams, physiotherapists or from the patient or a relative. They also supported staff and patients with any pain issues through information and education.
- We were told that the pain nurses visited the wards weekly looking for patients in pain and supported staff to manage their pain better. Staff could access the on call anaesthetist for advice on pain management out of hours. We noted there were few complaints about pain management within the trust over the past year.
- There were protocols and guidance on pain management for staff including little prompt cards staff could keep on them as a reminder for post-operative analgesic medication.
- The hospital used a pain scoring tool to assess adult pain levels. In the records we reviewed we noted these were completed appropriately and pain relief was given when needed.
- Audits of pain management were included in the trust audit plan.
- All the patients we spoke with who had recently undergone surgery told us they had no problems in obtaining prompt, adequate pain relief.

Nutrition and hydration

- Prior to surgery patients had nutritional assessments undertaken as part of their general pre-operative assessment. A nationally recognised tool was used the malnutrition universal screening tool ('MUST'). The MUST assessment resulted in a final score which then influenced the patients care and treatment. For example, ensuring they were adequately hydrated before surgery. In the care records we reviewed we saw examples of appropriately completed nutritional assessment forms.
- Staff compliance with completing the form was monitored monthly and reported on the Quality Score Card. We reviewed this and noted that in August 2015, compliance with the MUST tool after 24 hours was 78.5% but this had increased within seven days to 93.4%. This indicated that the majority of patients had their nutritional needs assessed within a week of admission.

- Staff had access to dietician services weekdays between 8am to 4pm. Staff advised us there was a quick response rate from dieticians and speech and language therapists (SALT) who usually saw patients the same day. A SALT completed the initial swallow assessments on new patients who had swallowing difficulties and then provided feeding instructions to the nursing staff.
- We saw an example of the ward menu, which detailed vegetarian options, allergies and so on using a code system. The menu also detailed whether a meal was of soft consistency for patients with swallow difficulties.
- Staff confirmed that meal times were protected and that staff assisted patients with feeding when necessary.
- The hospital used a red tray system to identify patients who required assistance at meal times.
- Finger food was available for patients with dementia to encourage them to feed themselves.

Patient outcomes

- The trust routinely reviewed the effectiveness of care and treatment through the use of performance dashboards, local and national audits.
- Mortality and morbidity trends were monitored monthly through SHMI (Summary Hospital Mortality Indicator) and a commercial risk monitoring and benchmarking service. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues.
- The commercial benchmarking service provided the trust with useful information about the quality of surgical services in detail so that any risks identified could be localised and action could be taken.
- Multidisciplinary meetings and morbidity and mortality meetings took place trust wide. Any learning that was identified was recorded in monthly updates and reported to the trusts Quality Committee and then to the board.
- The trust had taken action to implement the findings of national recommendations. For example, there had been a reduction in the fractured neck of femur mortality results over the past two years following action taken to address previous poor performance. The 30 day mortality following a hip fracture was 4.1% which was half the predicted target of 8.2%.
- The trust benchmarked their performance in comparisons with other NHS trusts such as the national hip fracture database and the national joint registry.
- Surgery on the day of or after day of admission 81.6%, which was better than the England average of 73.8%.
- Patients with a fractured neck of femur who were had a pre-operative assessment by geriatrician was 69.9%; better than the England average of 51.6%.
- The percentage of patients who developed pressure ulcers was 0.3%. This was better than the England average of 3%.
- Patients who had a fall assessment following fracturing their hip was 97.8% once again better than the England average of 96.8%. The mean total length of stay was 13.9 days. This was shorter than the England average of 19 days.
- The 2014 lung cancer audit results demonstrated that 95.5% of patients received a CT (computed tomography) scan before bronchoscopy, this was better than the England average of 91.2%. 95.7% of cases were discussed in multidisciplinary meetings, which was similar to the England average.
- Performance in the 2014 national bowel cancer audit was either similar of better than the England average. 100% of cases were discussed in multidisciplinary team meetings. There was 98% data completeness for patients having major surgery, with 93.1% of CT Scans reported. 73.6% of patients were seen by a clinical nurse specialist. This was worse than the England average of 87.8%.
- In the 2014 organisational laparotomy audit St Richard's Hospital provided 21 out of 28 identified resources. In the 2015 laparotomy audit 2015, at least 80% of patients had appropriate care in six of the indicators.
- We spoke with the surgical divisional team who explained that some of the diagnostic tests were

undertaken at London hospitals. Where this impacted on the cancer waiting list times it was under discussion as to which hospital the breach in waiting times was attributed.

- The relative risk of readmission for elective admissions was similar to the England average at trust level and for the majority of on site specialties. The standardised relative risk of readmission was slightly higher than the England average overall for elective surgery at 105 compared to 100, however for non elective surgery it was lower than the England average.
- Information on patient reported outcome measures (PROMs) for patients who had groin hernia surgery, hip or knee replacements, or varicose vein surgery indicated that the trust generally scored in line with the England average. However, the PROMs outcomes for knee replacements were worse than the England average.
- Participating hospitals collect data relating to surgical site infections (SSI) for different kinds of surgical procedures over a minimum period of three months. We looked at samples of the SSI data for St Richard's Hospital and noted that for knee and hip surgery the trust performed better than other similar trusts for the same period.
- The 'Saving Faces' national survey showed high levels of satisfaction with the treatment outcomes with 95.9% of patients saying they would recommend this service.
- The trust was one of a few places in the world to offer Descemet Membrane Endothelial Keratoplast (DMEK). Only a handful of tertiary centres in the UK offer this treatment. The trust had been providing this treatment since 2014 with success rates matching international specialist ophthalmology centres. This form of corneal transplant has a far lower risk of rejection and patients achieve a better level of vision afterwards.
- The trust was a referral centre for Transanal Endoscopic Microsurgery (TEMS). TEMS is used for the treatment of early rectal cancer where the lesion is excised whilst avoiding the complications and morbidity and mortality associated with major resection. The trust offers a TEMS assessment service where the lesion is analysed and treated endoscopic if it is benign and via TEMS if it is malignant.

Competent staff

- The trust had in place appropriate recruitment and employment policies and procedures together with job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post. Ongoing checks took place to ensure continuing registration with professional bodies.
- New employees undertook both corporate and local induction with additional support and training when required. We spoke with newly appointed staff who confirmed their induction training gave them a good basic understanding of their role and responsibilities.
- We spoke with porters, cleaning, domestic and housekeeping staff who told us about their training and ongoing refresher training. They told us that it was good to have a reminder and for managers to check they were still working to the agreed standards and protocols.
- Newly qualified nurses and those returning to practice were supported through a six to 12 month preceptorship programme designed to advance their clinical and management skills.
- There were checklists in place for agency and bank staff.
- Learning and development needs were identified during the appraisal process. The trust collected data on this and used this to inform managers. For example, according to data provided by the trust the December 2015 appraisal rate for nursing staff in theatres was 86%.
- Staff on Bosham and Coombes ward told us that they acknowledged they were behind with their appraisals (50%) as there had been a lack of trained appraisers.
- Staff told us they felt supported in their role, and were able to access training via e-learning, which they completed mostly in their own time. Nursing and therapy staff told us they had access to outside training and development if relevant and agreed. For example, staff in the enhanced recovery programme told us they had attended a conference in Newcastle which has been a good opportunity to bring new ideas and perspectives back to the trust.
- Theatre staff told us they were supported to complete various courses to enhance their practice such as a

mentorship course and a scrub practitioner course. All staff completed basic competency assessments. We reviewed the competency assessments of two staff new in post and found they were well documented.

- We saw from the minutes of meetings that the junior medical staff were not compliant with their mandatory training despite numerous requests. This was being addressed through their medical supervisors.
- Nursing staff in the Chichester Treatment Centre told us how they maintained their competencies through a university approved physical assessment course. Every two months clinical governance workshops were held which included mandatory training and updating clinical skills.
- We spoke with the head of physiotherapy services who confirmed there was good staff engagement with training and appraisals. Data was shared by the HR department relating to appraisal dates and training dates. This worked well as a prompt which was then followed up by managers.
- The trust had a team of 8 surgical care practitioners working under the direction of a Consultant Surgical Director in bariatric, urology, colorectal, breast and orthopaedic surgery. Another six trainees started in September 2015 and were undertaking an MSc in Surgical Practice in conjunction with a university and the Royal College of Surgeons. A Surgical Care Practitioner is a registered non-medical practitioner working in clinical practice as a member of the extended surgical team under the supervision of a consultant surgeon.

Multidisciplinary working

- Throughout most of the surgical specialities there was effective multidisciplinary working. Considerable work had been undertaken on this since the merger of the three hospitals within the trust. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and GPs. Medical and nursing staff, and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- The consultants told us there were good examples of joint working across all three hospital sites within the trust. They gave examples of the joint rota for upper gastro-intestinal bleeding where the endosocopist went to where the patient was. They told us that joint working across the two main sites gave flexibility.
- The ophthalmic team told us that the service was integrated across the three hospital sites. They were working well together to improve the ophthalmic service.
- We observed positive and proactive engagement between all members of the multidisciplinary team (MDT). For example, we attended a MDT team handover and noted that 14 healthcare professionals attended and were able to input into discussions about the patients care and treatment.
- The fracture neck of femur pathway was embedded with the input of two gerontologists who provided ward based patient management Monday to Friday. We were told that the MDT work had improved outcomes for elderly patients who were admitted with fractured neck of femur.
- The maxillofacial, orthodontic and restorative consultants ran a monthly MDT for patients with complex facial deformity with severe jaw discrepancies.
- We spoke with the physiotherapists and they confirmed they attended the ward handover meetings and were fully involved part of the multidisciplinary team.
- On the wards and in theatre there were daily morning 'huddles' which involved the whole surgical team to discuss operational and individual team work and any relevant communications.
- There was good access to theatre with all day trauma and general surgical lists. Theatre staff told us they had good working relationships with the support services such as the sterile supply service, pathology, radiology and the outside equipment contractors.
- The clinical lead for head and neck and thyroid/ parathyroid surgery in the maxillofacial unit had developed benign thyroid/parathyroid MDT meetings at the hospital. The service allowed surgeons, endocrinologists and radiologists to discuss complex cases prior to surgery and achieved a more accurate localisation of the disease. Anecdotally this has resulted in very high success rates and was being audited at the time of he inspection.

- A new thyroid cancer pathway with MDT support from another trust had enabled patients with thyroid cancer to have surgery at St Richard's Hospital.

Seven-day services

- The hospital did not yet offer a full seven day service across all surgical specialities and services. There were challenges related to capacity, staffing and the financial implications of providing additional seven day services.
- Consultant cover was available every day including weekends, with on-call arrangements for out of hours and ad-hoc cover on bank holidays. The consultants told us that there were problems in maintaining a twenty four hour service over seven days for the two main hospitals twenty miles apart. They told us to achieve this involved a lot of locum consultants.
- Weekend and out of hours services were provided by on-call, agency and locum staff supplementing the permanent members of staff. For example, the ward based physiotherapists told us that they usually worked a five day week with an on-call rota for the weekends.
- Theatre staff told us that there was usually good access to physiotherapy, radiology and pathology Monday to Saturday with an on call rota on Sundays. However they assured us there were no problems in booking radiology for the trauma lists that took place on Sundays. The emergency theatre had adequate on call cover with two anaesthetists always available.

Access to information

- The hospital used a combination of paper and electronic records. We were told that there were some problems with the electronic records system which were being addressed before whole system roll out in January 2016.
- Both ward and theatre staff told us they attended the morning safety 'huddle' where any issues for discussion and urgent communications took place.
- There were notice boards around the hospitals which gave information for staff about training opportunities, staff meetings minutes, and the results from audits and incidents.
- Departmental meetings took place at every level throughout the surgical division and both staff and managers told us there was good dissemination of relevant information both relating to patients and operational issues.
- Staff told us that most clinical information and guidance was available on the intranet. They also reported having access to information and guidance from specialist nurses, such as the diabetic, stoma and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- We reviewed the consent form in use which complied with department of health guidelines. Two patient records were reviewed at random. These contained appropriately completed consent forms with all risks identified and in date.
- Patients that we spoke to told us that they had been given information about the benefits and risks of their surgery prior to signing the consent form in a clear manner. They had been able to ask questions if they were not clear on something.
- We observed that patients' consent in the Chichester Treatment Centre was checked throughout their journey; from the consultation with the anaesthetist and surgeon to transfer to the operating theatre for their operation. We observed consent being given by the patient to their procedure. Following a full explanation which included some of the risks to the surgery.
- Training on consent and the Mental Capacity Act 2005 was available and staff reported there was no problem with accessing the training.
- We were told that best interest decisions and deprivation of liberty decisions were taken where indicated and these were formally documented.

- We observed that consent was obtained for any procedures undertaken by staff. This included both written and verbal consent.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment.
- We were told that best interest decisions and deprivation of liberty Safeguard (DoLS) decisions were taken where indicated and these were formally documented. There were no patients currently being treated under a DoLS order.

Are surgery services caring?

Outstanding ☆

We rated St Richard's Hospital as 'Outstanding' for caring because:

This rating was given because of the team attitude created by the service leaders that had a high expectation of caring behaviour by staff. The compassion and kindness with which patients were treated was not down to individual practitioners - although we heard about and observed some very kind, gentle and patient staff working with quite challenging patients - it was a cultural emphasis on putting the needs of the patient first. This was fed down from the Board and executive team who recognised that patients and relatives valued caring staff above all else when they provided feedback. Caring was built into the ward accreditation scheme that was being rolled out and formed part of the Quality Strategy 2015-2018. We were told that patients and relatives were often happy to forgive genuine mistakes but were rarely happy to overlook indifference of lack of compassion and that this was pivotal to how services were delivered.

The patients we spoke with during the inspection told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. We also received very positive feedback from patients who had received care at St Richard's Hospital over the past few months. This positive feedback was reflected in the Family and Friends feedback and patient survey results. We were given clear examples of where staff had gone "the extra mile." Across the hospital we saw and heard about staff who were always kind and caring, who smiled and talked to patients as they worked. We had exceptional numbers of patients contacting us directly to provide very positive feedback on their care. We received very few negative comments.

During our inspection we observed patients being treated in a professional and considerate manner by staff. We observed staff treating patients with kindness, respect, professionalism and courtesy. They all undertook their duties with enthusiasm and commitment with several examples of 'going the extra mile' to ensure patients received good-quality care.

Patients told us they were satisfied with the quality and standard of care they received from doctors and nurses. Patients reported they were involved in decisions about their treatment and care. There was access to counselling and other services, where patients required additional emotional and psychological support, including a number of specialist nurses who provided emotional support to patients and made referrals to external services for support if necessary.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. We saw that Friends and Family information was displayed on notice boards around the wards and departments.
- The FFT response rate for St Richard's was higher than the England average at 37.7% for the 2,536 patients that completed the questionnaire.
- Each ward and department collected the feedback monthly and this was displayed for staff, patients and visitors to view. We saw that across the surgical division the feedback was consistently very positive with between 85% and 100% of patients happy to recommend the hospital to their family and friends in 2015.
- We noted that Selsey ward scored particularly high with between 96% and 100% of patients consistently happy to recommend the service.

- Real time feedback was also sought from patients and visitors and used to monitor performance between the publication of FFT data. There was good evidence that feedback was used to make changes that had been suggested.
- We spoke with 12 patients currently receiving care and some of their relatives, who all told us of their positive experiences.Patients described their experiences as “Outstanding.” One patient told us “Nothing is too much trouble for any member of staff.” Another told us “I’ve had a fantastic patient experience, everyone is fabulous; nurses, healthcare assistants, ward clerks.”
- One bariatric patient gave an example of staff supporting them to visit the dayroom rather than remain all day by their bedside. All patients told us they had a quick response when they pressed the call bell for assistance.
- We heard several patient stories where staff had demonstrated exceptional care and compassion towards patients and their relatives. For example, a hospital car park attendant who was about to go off duty had cycled across the city to find a supply of a particular brand of yoghurt for a patient who did not feel well enough to eat anything else. They cycled back to the hospital and delivered it to the patient before going home.
- One patient told us, "I was admitted via the ED and referred to a member of staff from the surgical team. They were brilliant, their attitude and manner were a credit to the service. I was then taken to Wittering ward where the HCA's and nurses were brilliant especially one in particular who looked after me through the night (nicest nurse ever). Under the care of the Consultants team and the most friendly and professional 1st class anaesthetist I was soon sorted and back home to recover."
- Another said, "I would like to thank all staff at Chichester Treatment Centre and on Pagham ward. I had a hernia operation and was very nervous when I arrived but all the staff there were so friendly, they kept me informed and made me feel at ease throughout the whole day. The aftercare team was also fantastic. I really cannot praise them enough, I am glad I came to Chichester for this operation."
- And another, "I recently had a replacement hip carried out at St Richards by my consultant and their team. I would like to express my appreciation to them and the Selsey Ward staff who made my experience almost enjoyable. I was dealt with by all in a most professional and understanding manner which was very impressive. I found the booklets and the meetings at the pre operative assessment and joint school informative and well presented."
- All the interactions we observed between patients, visitors and staff were relaxed, courteous and friendly.
- All staff we observed were consistently respectful towards patients and mindful of their privacy and dignity. They demonstrated this by knocking on doors, asking before entering behind curtains and obtaining consent from the patients before undertaking any task. For example, one patient was changing behind a curtain and the nurse asked if she could enter to give them a gown. Another nurse asked a patient if she could help him with his support stockings and another was asked if the nurse could come in behind the curtains to take observations.

Understanding and involvement of patients and those close to them

- We spoke with patients at all stages of their surgical journey through the hospital. They told us they felt involved in their care and in decision making about their treatment.
- The patients we spoke with told us they were given adequate information about the specific surgical procedure that applied to them. They said risks, benefits and alternatives were explained to them.
- One patient confirmed they wanted their family kept informed and this had happened with no problems.
- Another patient told us how they had been listened to when they told staff what they needed to feel comfortable and safe at night.
- Patients who consented during an outpatients appointment told us consultants were caring and professional. They felt they had time to ask questions and that their questions were answered in a way they could understand. One patient on Wittering ward told us that the communication felt personal and not at all clinical.

- One patient who had been admitted as an emergency over the weekend told us that the doctors; consultant, anaesthetist and nurses had all explained everything including their pre and post-operative care.
- A patient we spoke with on the day care unit showed us the information and exercise sheet they had been given to take home. The information included contact details in case of problems and dates for a follow up appointment. They told us the consultant had talked them through what was likely to happen and any after care and dressings that would be needed. Occupational therapists had sorted out aids for them at home, including raising the height of the bed and checked she could manage at home. They told us "It doesn't get any better than that!" During our interview we noted that the staff also checked she would have food at home and made sure she ate well before she was discharged.

Emotional support

- St Richard's Hospital had arrangements in place to provide emotional support to patients and their families when needed. This included support from clinical nurse specialists, such as the enhanced recovery team, breast and stoma care nurses, as well as the colorectal nurse and tissue viability nurses who all provided emotional support and practical help where needed.
- We spoke with the specialist nurses who told us about the care and support offered to patients. This included the vascular, oncology and breast care nursing staff who provided a counselling service. They told us they ensured patients were involved in the decision making about their treatment options and how they worked closely with the MacMillan support workers.
- In the Chichester Treatment Centre staff told us how proud they were of the positive patient feedback they received. They told us that because the results from the tests were immediately available patients did not have the additional strain of having to wait for results. Three oncology nurses were always available to support staff with breaking bad news and explaining the expected pathways to patients.
- A patient who had a medical background told us they observed male staff delivering holistic care with full regard for each patient's privacy and dignity.
- We noted that feedback on the wards indicated that staff were always patient, polite and sensitive to patient's needs. For example, one patient had commended staff on the way a very difficult patient who was very ill had been treated.
- Patients spoke highly of the therapy staff. They told us they were impressed with their skills and compassion. One patient told us "They were reassuring but firm about the amount of effort needed to regain my mobility."
- Pre-admission staff told us that where it was identified that patients required extra support this was arranged where possible before admission and discussed with the multidisciplinary team.
- The chaplains contacted other denominational ministers and leaders of other faiths by request.
- The hospital provided a chaplaincy service which provided spiritual, pastoral and religious support for patients, relatives, carers and staff. Chaplains together with volunteer ward visitors visited all the wards regularly throughout the week. They were available 24 hours a day throughout the week and were contactable by staff, relatives or carers through the hospital switchboard.

Are surgery services responsive?

Requires improvement

We rated St Richard's Hospital as 'Requires improvement' for responsiveness because:

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

The general environment in the one stop urology clinic did not meet the needs of patients using the area with only one toilet available and lack of clinical rooms. The lack of facilities impacted on the overall patient waiting times.

The needs of local people, commissioners and stakeholders were taken into consideration when planning services. The majority of specialties within the surgical

division consistently performed well. The trust was aware of those specialties which were performing below the England average and was taking steps to address the issues.

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

The percentage of patients whose operation were cancelled and were not treated within 28 days was generally lower than the England average. The pressures on beds in the hospital meant that there were times when non surgical patients were admitted to surgical beds and specialist surgical patients were admitted to general surgical beds. However, this was closely monitored and did not impact on the care that these patients received.

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

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

Service planning and delivery to meet the needs of local people

- The Urology team had identified an opportunity to improve safety, patient experience and length of stay for patients with benign prostate hypertrophy (BPH) through the introduction of a technique called Transurethral Resection in Saline. This technique results in virtually no blood loss, and eliminates specific risk associated with the usual Transurethral Resection. The trust invested in equipment at both sites and successfully reduced the length of stay for these men. In the six months prior the inspection 44% of patients were day cases and a further 35% were discharged after day one. This had released capacity in the system and secured additional funding through the best practice tarrif for investment in the equipment.
- The trust had arrangements in place to discuss the planning and delivery of local services with commissioners. Meetings took place where feedback and discussion of current issues took place.
- There were trust wide challenges in providing a consistent responsive service, as each of the two hospitals had different historical and geographical links with other specialist hospitals. For example, St Richard's Hospital in Chichester had closer links to hospitals in Hampshire for diagnostic and specialist treatment options, with Worthing Hospital linking with East Sussex hospitals. This meant that within the same trust patients did not always have consistency of treatment. For example urology patients were referred to another NHS Trust nearly 60 miles away for diagnostic tests.

Access and flow

- The maxillofacial unit offered patients with intermediate complex, or who were very infirm, ambulatory local day surgery using local anaesthetic. The unit had their own ambulatory day theatre where patients could be treated rather than having to return to the day surgery unit. This also reduced the risk of complications from a general anaesthetic.
- Surgical services were configured to provide good access for patients where possible. There was a wide range of surgical activity, both general and specialised to meet the needs of the local population. This included colorectal, breast surgery and joint replacement.
- Staff told us that there had been few operations cancelled over the past four to five months. However, four patients had been cancelled during the past week due to a bed shortage. The decision to cancel operations was taken at director level and all patients were re-booked within the time frame. We heard that eight lists were cancelled earlier in the year due to staff shortages.
- The percentage of patients whose operation were cancelled and were not treated within 28 days was generally lower than the England average but was higher in the same period the previous year.

Surgery

- The number of last minute cancelled surgical operations for non clinical reasons was 328 between October 2014 and September 2015. We noted that in the last two quarters the numbers had significantly reduced.
- The data relating to theatre utilisation at St. Richards Hospital was 84.4% for general surgery, 79.5% for trauma and orthopaedics, 76.7% for ENT (ear, nose and throat) and 87.4 for ophthalmic surgery. Staff told us that theatre 10 was utilised 71.5% of the time. They explained that this was because it was used for bariatric surgery which were long cases and orthopaedic surgery which involved a lot of hired equipment being moved.
- The available data demonstrated that in April 2015, the nine theatres at St Richard's Hospital were generally utilised between 65.7% for day surgery one theatre to 92% for main theatre two.
- Operational targets were that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. Admitted pathways are waiting times (time waited) for patients whose treatment started during the month and involved admission to hospital (adjustments are made to admitted pathways for clock pauses, where a patient had declined reasonable offers of admission and chosen to wait longer).
- The trust consistently performed similar to the England average but below the target for admitted adjusted referral to treatment (RTT) wait times. We were told that ophthalmology and ENT specialties were of particular concern at the current time.
- Consultants told us that the externally commissioned MSK (Musculoskeletal) referral pathway was not designed to meet the 18 week targets. This was because following referral by the patient's G.P. triage took place by a physiotherapy service based at another hospital. If a surgical referral was needed a letter was then sent to the orthopaedic consultants. This occurred at the 14 week period which left little time to arrange an appointment within the allotted time frame. One orthopaedic consultant told us that by the time patients got to see them the 18 weeks was already up.
- Divisional managers told us that weekly RTT meetings were held where engagement with the commissioning CCGs, current backlogs and waiting lists were discussed. They told us that there were system wide issues with geographical location, increased capacity and the number of independent healthcare providers. These issues were under discussion with the CCG and they were working with local GPs to educate them in alternative pathways.
- We were told that additional trauma lists were undertaken at the weekends with surgical and urology lists taking place in the day care unit to reduce the waiting lists.
- The overall trust average length of stay (LOS) was lower than the England average for elective admissions but similar to the England average for non-elective admissions.
- The Chichester Suite (Private patient unit) undertook elective bariatric surgical interventions on a bariatric pathway. Staff told us that any readmissions would routinely be admitted onto the general surgical wards rather than back onto the private patient unit due to bed capacity.
- Consultant anaesthetists told us that the three theatre sites at St Richard's Hospital were spread throughout the hospital which meant that staff and equipment often had to move across the hospital. They found this was more difficult when agency theatre technicians were employed which impacted on theatre times.
- Discharge arrangements were commenced as soon as possible in the patient journey. The hospital used a discharge lounge where patients waiting for transport home could wait. The staff from the discharge lounge phoned the wards each morning and then sent staff to help with collecting patients and packing them up. We spoke with patients who confirmed that their discharge arrangements had been discussed and their individual situation taken into account.
- On the day of our inspection there was a 'Red Alert' for surgical beds. This meant that there were not enough surgical beds in the hospital. Managers told us this was due to 'Back door' problems where patients discharge arrangements were causing delays. On the trauma/ orthopaedic wards there were nine patients awaiting supported discharge.

Meeting people's individual needs

- The oesophageal and gastric cancers liaised with Portsmouth hospital for diagnostic tests although the surgery was undertaken at St Richard's Hospital.

Worthing Hospital was closely linked to Brighton Hospitals where there was a joint surgical appointment until recently. Patients with hepato-biliary and pancreatic cancers were all referred to Basingstoke Hospital. Cancers of the head and neck were currently seen at Portsmouth Hospital but these would be moving to a shared service with Guildford although small procedures were undertaken locally. The consultants told us that St Richard's offered a good breast cancer service with close links to Portsmouth Hospital although any complex reconstructive work was undertaken at a specialist hospital in East Grinstead.

- All patients living with dementia had 'Knowing Me' forms completed which included preferences and basic information such as how they took their tea and details of the people closest to them.
- There was a standard process used for ensuring that the multidisciplinary team thoroughly reviewed each patient during the daily ward round. This involved a checklist which covered the entire patient experience including a clinical review and a seven point safety check. The use of this checklist and the process helped to ensure that each patient's individual needs were met.
- We spoke with the staff involved in the enhanced recovery programme which aimed to assist patients having hip and knee replacement surgery in feeling well enough to get home faster. The initial findings were the project was a success with a reduced length of stay, a reduction in the numbers of patients requiring blood transfusions (down from 12% to 1%) and those needing a urinary catheter following their surgery (down from 90% to 7%).
- We spoke with ward staff who told us about the plans to provide a dementia friendly room for ortho-geriatric patients. Staff told us that the environment was an improvement of the previous ward and were positive about the changes planned.
- The Chichester Suite had food prepared on the ward for the bariatric and private patients. We noted the kitchen had a five star hygiene award.
- There was access to patient information literature on the wards and in the clinics. For example we saw comprehensive booklets on hip and knee replacements. Patients we spoke with confirmed they had been given sufficient information about their treatment and care by the surgeon. However, there was not information readily available on the wards or in clinics in any language other than English. The wards had access to a telephone translation service.
- The hospital's website also provided information, and signposted to further sources of information and helpful advice.
- The hospital was aware there were challenges with variable access and flow across the trust and was taking action to address the historical and geographical difference.
- An example of this was the one stop urology clinic. Patients accessed the clinic by direct GP referral. Patients were able to have several tests within one appointment which avoided multiple visits. Patients were informed about the expected time the tests took and were provided with the test results on the day. A copy of the test results were also sent to the patient's GP.
- In addition a urology consultant had raised £60,000 for the equipment to carry out the diagnostic tests at St Richard's Hospital.
- However, staff told us that patients who used the one stop urology clinic sometimes waited up to 20 weeks for an appointment. This breached government targets of 18 weeks. They told us the delay was due to changes in the NICE guidelines combined with delays in obtaining MRI scans and general lack of capacity. Two additional clinics were put on each month to try to meet the demand.
- Recent patient satisfaction audits demonstrated a positive response for the urology clinic and output had increased with two healthcare assistants now tracking each patient through the system using a patient tracking form. However, staff and patients found the general environment with only one toilet available and lack of clinical rooms. This meant that patients having bladder scans who needed urgent use of the toilet facilities or those requiring a longer appointment for counselling impacted on the overall patient waiting times.
- The trust had implemented a fractured neck of femur pathway which started when the patient arrived in the emergency department. The pathway documentation was multidisciplinary and followed the patient through

surgery to recovery, rehabilitation and discharge. The pathway promoted early mobilisation was simple to complete and was constantly monitored and reviewed to improve patient outcomes. The outcome data was consistently better than the national average.

- The care of any surgical outliers was overseen by speciality consultants, and such patients were identified at ward level and within bed management meetings. On the day of our inspection there were two general surgical patients on the trauma wards and two medical patients. Staff told us the medical doctors were very good and operated a 'Buddy system' to ensure that patients were seen appropriately.
- There were also a number of medical outliers on the surgical wards. Managers told us that the medical outliers were always a challenge to arrange their discharge effectively. They told us that they had to be really proactive in managing their packages of care but unless there was funding available medical discharges were a challenge. Nursing staff met weekly with social workers to discuss those patients with complex discharge needs.
- The trust monitored performance on a daily basis for emergencies, weekly at executive level and monthly at corporate level. We were told that additional resources were in place for periods of high demand. The information was used to inform service provision for example the recent reconfiguration of surgical beds.
- Theatre staff told us how extra operating lists were added at the weekends or theatre lists were moved across the hospital to ensure that patients were not cancelled.
- In the day care unit urology patients had trials without catheters to help to improve their discharge to avoid hospital inpatient stays where possible.
- The Chichester Suite was the ward for private patients at St Richard's Hospital. This ward offered 25 beds, ten of which were dedicated bariatric beds. We were told that the ward could offer the rest of the hospital escalation beds if needed. The Chichester Suite was equipped and staffed to provide specialist bariatric surgery for private patients and was commissioned by the local Clinical Commissioning Groups. We heard that marketing of the suite had been curbed in order to support the escalation beds needed by the trust. For example, during the last winter period when the pressure on beds was "Tough and unrelenting" the Chichester Suite was used to take NHS patients from the main trust beds. Since then bed reconfiguration work had been undertaken to address this.
- The trust was aware of this and taking action where possible. For example, by forging new links with other trust's in Surrey and providing as much treatment and diagnostic treatment locally as possible.
- We spoke with consultants regarding cancer services. They told us that the service was variable across the specialities and across the two main hospital sites. This was due to historical and geographical multidisciplinary partners and different stakeholders.
- We heard that the hospital was generally able to meet patients' individual needs. For example, there was bariatric equipment available to meet the needs of patients with a high BMI (Body Mass Index).
- The Chichester Suite (Private patient unit) had a service level agreement with the physiotherapy department to provide therapy support for the private patients. Patients on the bariatric pathway were supported by specialist bariatric dieticians.
- On Selsey ward we heard of the positive initiatives in place to support patients living with dementia. Where elective patients were known to be living with dementia the pre-operative clinics, wards and theatres were notified in advance. The 'Knowing Me' booklet was used to help identify the patients' preferences and help to settle them.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected with access to the Patient Advice and Liaison Service.
- Complaints were monitored and discussed at departmental clinical governance meetings. There were mechanisms in place for shared learning from complaints through the daily ward 'huddles', staff bulletins and the briefings given to junior doctors and the nursing staff. Information about recent complaints was displayed on the wards and any changes in practice highlighted.

Surgery

- We heard of examples where complaints had led to a change in practice. For example, complaints about a junior doctor's communication skills had led to the doctor making an effort to improve their interactions with patients. They undertook a 360° patient survey with good results and no more complaints were received.
- Where complaints were raised, these were investigated and responded to, and where improvements were identified, these were communicated to staff. Staff were aware of the reporting process for complaints, and confirmed they had received feedback where it related to the ward or their practice.

Are surgery services well-led?

Good

We rated St Richard's Hospital as 'Good' for well-led because:

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

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

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

Vision and strategy for this service

- The trust undertook an annual planning and reporting cycle, and had developed a two-year operational plan and a five year strategic plan.
- The Operational Plan set out the trust's immediate objectives and identified the levels of activity, the type of facilities and the bed and staffing numbers required to achieve these.
- The Strategic Plan set out the trust's longer term term aims to improve standards of care and ensure sustainability.
- We reviewed the trusts Quality Report for 2015/16. This gave the achievements the trust had made over the past year and set out the priorities for providing a service that met the current and future needs of the local population.
- We noted that the first priority was to reduce mortality and improve outcomes with the goal to be in the top 20% of NHS organisations with lowest risk adjusted mortality.
- The second goal was to improve patient safety so that all patients received safe, harm-free care.
- The third goal was to ensure that 95% of patients received reliable care. This included ensuring equity in care for patients regardless of the day of the week in line with national developments in providing a seven day service.
- The fourth goal was to be in the top 20% of trusts nationally for patient and staff experience surveys.
- We reviewed the trusts Quality Strategy for 2015 – 2018 which set out the trusts strategic priorities for the next three years and identified improvement targets. The report stated that the trust's long term transformation strategy was driven by the 'Patient First' agenda. This was led by front-line staff who were empowered to initiate and lead the change programme.
- We spoke with staff about the vision and strategy for the trust. Although many had not seen the reports and did not know about a surgical strategy, they were all aware that the trust was engaging with them to improve outcomes for patients. They told us "It's all about putting the patient first."

- We did not see a separate surgical service plan but the overarching trust plan encompassed goals and priorities for the surgical services.
- We saw that the trust's vision and values were available on the trust's website for patients, visitors and staff to comment and understand.

Governance, risk management and quality measurement

- The trust had in place clinical and corporate governance structures with board level quality assurance oversight. The surgical division met monthly with business partners such as human resources and finance to discuss governance issues. Monthly integrated performance meetings were held where areas of concern were highlighted and discussed. Minutes were available from these meetings and we saw that issues such as incidents, complaints and risks were standing agenda items.
- The surgical division was divided into five care groups with a matron associated with each of the care groups. Each of the care groups reported at the weekly care groups meeting. Every other week the meetings were held cross site.
- Strategic operational planning meetings took place monthly with attendance from each of the clinical directorates. This took into account local site initiatives such as bed reconfiguration. Quality dashboards were used as a multidisciplinary tool for performance monitoring across the surgical division.
- In theatre safety meetings took place monthly to discuss governance and risk.
- Clinical governance was embedded at local level with structured standard agendas complete with minutes and action logs. The local groups reported to the quality committee and to the board via the trust's clinical governance committee. Minutes from these meetings were available for inspection and we noted that all risks, incidents and complaints were discussed.
- In addition monthly staff meetings were held where all aspects of clinical governance were discussed including the results from audits, incident and investigations. The minutes from these meetings and the results of any audits were displayed on the notice boards and available on the intranet.
- Each Friday the Surgical Division had a Clinical Governance Surgical meeting which provided documentation of the review of morbidity and mortality, a reflective look at surgical practice and a review of outcomes data. The meetings were multidisciplinary and open to all who cared for surgical patients.
- We spoke with the surgical divisional team who explained that all risks were routinely discussed; with the higher level risks being referred at trust level to the board.
- We were told that the highest risks currently being monitored by the trust were staffing, ophthalmology and referral to treatment times.
- The previous two months incident investigations which were classed above 'moderate' were reviewed to ensure any learning issues identified had taken place. The governance co-ordinator ensured that the identified actions had taken place.
- We spoke with senior managers who confirmed the main challenges were recruiting of sufficiently experienced staff and the daily pressures of managing the bed state. They told us that these two issues took up the majority of their working day.
- Divisional risk and governance meetings took place monthly. We reviewed minutes of meetings which showed discussion of incidents and presentations from departments.
- The local risk registers were managed by the ward and theatre managers. These fed into the directorate risk assurance framework, which were reviewed and updated monthly. These reported to the board via the clinical governance committee.
- We reviewed the risk register and noted that actual and potential risks had been identified, along with the control measures, likelihood of risks arising, consequences, a traffic light rating, and the required action. The risk owner was identified, and the risks were reviewed at governance meetings.
- Theatre staff told us that the main area of concern was recruitment of appropriately trained staff. They were concerned about the length of time it took to appoint a new member of staff. They told us that the other concerns such as training and appraisals could be easily addressed once there were sufficient staff.

Surgery

Leadership of service

- During the inspection we noted senior managers knew everyone by name. Each member of staff was treated with courtesy and respect.
- We spoke with the senior directors and senior clinicians with responsibilities for the surgical divisions. They told us that the Chief Executive was very approachable. They gave examples of support in improving staffing levels and a clear strategic direction.
- Staff in theatres and on the wards told us about the leaders and managers in their specific area of work. They were all very complimentary about the support and leadership within theatres. Staff told us it was "more like a family" and "there's very little hierarchy – everyone knows their roles and responsibilities."
- There was dedicated leadership and management training in place for staff with individual learning needs identified at appraisal.
- Staff told us there was good teamwork and that staff were motivated to deliver good patient care.
- Consultants reported that there were good opportunities for development.
- The theatre manager told us they were well supported by the matron and head of nursing. However, they had no direct line manager as the post was vacant. The theatre manager told us that they acted up as operations manager one day a week and were aware of the hospital wide issues.

Culture within the service

- There was a good atmosphere observed throughout the hospital with many staff having worked at the trust for many years. Clinicians reported that they were very involved in the delivery of the services, and we heard examples of this in our discussions.
- We spoke with all grades of staff across the hospital. They all told us they enjoyed working at St Richard's Hospital. One member of the porter staff told us "It's fantastic here – like working with an extended family." We were told "I'm always happy to come to work, we all get treated as equals and I'd recommend working at this hospital to anyone." Consultants told us they were proud to work for the trust and everyone worked well together as a team.
- Theatre staff told us about the open culture where they felt free to raise concerns and discuss issues. Many of the staff had worked at St Richard's for many years and were happy to recommend the hospital as a good place to work.
- The trust encouraged staff members who had a genuine patient safety concern to raise this within the organisation at the earliest opportunity through the 'Speak out safely' campaign. Staff we spoke with told us they would have no hesitation in raising concerns and some gave us examples where they had and action had been taken.
- Prior to the inspection we were made aware of concerns raised by a consultant in one of the surgical teams which had been on-going for some time. We interviewed staff, managers and consultant colleagues and were satisfied that the issues did not affect the care and treatment that patients received and had been addressed appropriately by the trust. We were assured that although there were still challenges with consultants cross site working within the speciality the situation was improving.
- We noted there were mechanisms in place for acknowledging and giving staff praise and positive feedback. Individuals had their contribution and efforts recognised. For example an individual staff member was identified who had improved outcomes for musculoskeletal patients; several staff received awards in the 'Proud to care awards' which recognised staff who 'go above and beyond the call of duty' to look after patients.
- The trust operated an 'Employee of the Month' award. Where patients, staff and members of the public could nominate a staff member who had gone above and beyond what was expected of them to make a difference to patients, visitors and/or their colleagues.
- Several staff received awards in the South East 'Proud to care awards' which recognised staff who 'go above and beyond the call of duty' to look after patients.

Public engagement

- As well as patients, comments were reported back to staff, the trust board and commissioners in order to inform priorities for improvements.

Surgery

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

Staff engagement

- The trust had various means of engaging with staff and the 2015 annual report identified that valuing staff was a priority. The annual staff survey was used as a benchmark to identify areas for improvement. A priority over the next three years was to improve the trust's engagement score
- For 2014/15, the trust's staff engagement score was similar to the national average of 3.74 at 3.73 within a score of 1 to 5, with 1 indicating that staff were poorly engaged and 5 indicating that staff were highly engaged.
- The trust had identified that staff engagement from the medical, dental, facilities and estates staff were staff groups to address.
- The doctors and consultants were able to raise any issues through the medical staff committee. Consultants told us that approximately 25% of all the consultants attended regularly. There were also monthly meetings held with the consultant body and the executive team. Although the timings made this difficult for some consultants to attend they told us that they were assured that the management team were aware of any issues they had. They felt that this was a "Step change" in the culture which had improved over the past two years.
- The 2014 annual staff survey indicated that 63% of staff responding would recommend the trust as a place to work with 71% who would be happy for a friend or relative to receive care at the trust. This was better than similar results for similar trust's across the country.
- Managers told us that following difficulties last winter staff annual appraisals were now running above 90%.
- Medical appraisals were fluctuating between 80 – 85%. The trust was looking to improve upon this with a new deanery appointment and an electronic appraisal system. Medical revalidation was supported within the trust but they were looking at improving the surgical revalidation support.
- New employees were supported through regular meetings at three, six and nine months to ensure they were settling into their post and there were no problems.
- There were no formal supervision sessions held but staff told us that staff all supported each other and gave examples where they had the opportunity to debrief following any upsetting or traumatic event with their peers or their line manager. All staff we spoke with felt well supported.
- Staff were supported by the weekly matrons meetings where the ward sisters joined them for coffee or lunch. The ward sisters held regular ward meetings to inform and support the ward staff. We heard that regular staff meeting were held in all the departments that were minuted.

- There were arrangements in place to support the health and wellbeing of staff such as arrangements with an annual flu vaccination programme, occupational health provider, and support from a counselling service, a staff physiotherapy service and mindfulness and stress management training for staff and managers.
- There were also health and social events such as exercise sessions; yoga, pilates and 'Zumba', try-a-bike sessions, healthy eating and lifestyle roadshows, sing-a-long stress busters and massage.
- There were staff notice boards available throughout the surgical wards and theatres giving staff information about local and trust wide issues including training, development and team meeting minutes.

Innovation, improvement and sustainability

- We found that staff across the surgical division were passionate, committed to the hospital, and their role within it. From the ward clerks and ports to the consultants and senior managers, all told us how they loved working at the hospital. We saw many examples where staff had been empowered to make changes – big and small that made a difference to the patients' experience.
- In particular we noted the orthopaedic enhanced recovery project which demonstrated good use of data to implement changes to service delivery. We saw as a result of the project patients were experiencing better outcomes with improved hospital experiences. There were plans to widen the scope of the project to include shoulder surgery. The enhanced recovery programme was the winner of partnership working award in 2013 and the joint school for hip and knee surgery received an award in the staff recognition and achievement awards in 2014.
- Ophthalmic patients were seen as outpatients and operated on within the day care unit. Staff told us that this 'One stop shop' ensured continuity and improved the patients' experience.
- The trust was one of a few places in the world to offer Descemet Membrane Endothelial Keratoplast (DMEK). Only a handful of tertiary centres in the UK offer this treatment. The trust had been providing this treatment since 2014 with success rates matching international specialist ophthalmology centres. This form of corneal transplant has a far lower risk of rejection and patients achieve a better level of vision afterwards.
- The trust had implemented a fractured neck of femur pathway which started when the patient arrived in the emergency department. The pathway documentation was multidisciplinary and followed the patient through surgery to recovery, rehabilitation and discharge. The pathway promoted early mobilisation was simple to complete and was constantly monitored and reviewed to improve patient outcomes. The outcome data for patients with fractured neck of femur was now consistently better than the national average.
- St Richard's Hospital was noted as a bariatric 'Centre of Excellence'. There were facilities, equipment and staff expertise to provide exemplary specialist care for bariatric patients.
- We saw that the ward dashboards were used at local level to improve care and where quality audits identified that improvements were needed action was taken immediately to implement this.

Critical care

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

Information about the service

The critical care unit (CCU) at St Richard's Hospital has capacity for 10 patients in 8 bed spaces and 2 single rooms that can be used for isolation purposes. The unit can be staffed flexibly in the provision of care and treatment for level three intensive care patients and level two high dependency patients. The unit is configured and funded for six level three patients and four level two patients but this is changed to meet clinical need.

A critical care matron leads the unit at St Richard's in addition to the CCU at Worthing Hospital. This provides consistency for nursing staff and contributes effectively to the standardisation of policies, care pathways and protocols at both sites. Consultants at the two hospitals work independently but do collaborate in cross-site governance processes. Both units share the same clinical director.

The CCU cared for 775 patients between July 2014 and July 2015. A team of seven consultant intensivists work in the unit. There is intensivist cover from 8am to 8pm Monday to Friday, with one daytime weekend shift also usually covered. Outside of these hours, consultant cover is sometimes provided by an anaesthetic generalist.

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

We spoke with 15 nurses, the lead consultant, four other doctors, two patients, two relatives and four other professionals, including a pharmacist, a microbiologist, two physiotherapists and a member of the housekeeping team. We also looked at eight patient records, three incident reports and 19 other items of evidence to come to our rating.

Critical care

Summary of findings

Overall we rated the CCU at St Richard's Hospital as 'Requires improvement'.

This rating reflects that there were on-going problems relating to short staffing according to standards benchmarked by the ICS, the Royal College of Nursing (RCN) and the Faculty of Intensive Care Medicine (FICM). The unit did not always have a consultant intensivist present or on-call, which meant that patients were not always seen within 12 hours of admission by a consultant intensivist. Nurse to patient ratios of 1:2 or 1:1 were consistently met, however ICS core standards guidance that a supernumerary senior nurse coordinator be present 24-hours, seven-days, was not always complied with.

The narrative reflects the good practice we found through our review of clinical audits, staff training, patient notes and outcomes as well as other performance indicators such as cleanliness and action taken on local audits.

Leadership in the unit was coherent, robust and well respected by the staff. We saw examples of innovation in improving patient safety and good practice, particularly in relation to the successful pilot of a new electronic patient records system that combined patient tracking software with observation charts and electronic prescribing. Significant challenges relating to infection control and capacity were clearly understood by the matron and lead consultant. They had undertaken scoping exercises to address issues, such as the introduction of new bed space equipment.

Staff practised in line with clinical guidance of national organisations such as the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians and the Intensive Care Society (ICS). Such guidance was embedded into the work culture and used to evaluate and improve practice through the sharing of learning and use of audits to update policies and procedures. Staff contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC). The CCU team had access to multidisciplinary specialists who routinely contributed to decision making and ward rounds in the best interests of patients. An established critical care outreach team (CCOT) supported patients across the hospital during limited hours.

The CCU was clean, hygienic and well maintained and staff demonstrated good infection control practices. However, there was room for improvement in the storage of waste and the management of related hazards. Equipment was serviced regularly and staff were certified in its use with regular training updates. We found full compliance with the trust's medicine management policy.

A robust incident reporting system was in place that staff used confidently to investigate incidents and errors. There was evidence that learning from investigations had taken place with an effective system in place to ensure all staff were aware of updates to practice. Overall this contributed to an environment in which safety was prioritised and patients received individualised care. This reflected the culture in the unit, however we found a lack of clarity over how staff effectively obtained decisions from the senior executive team regarding risks they were concerned about, particularly with regards to capacity and staffing levels.

We observed a commitment to personalised care delivered by staff who were competent, passionate and keen to develop professionally.

Critical care

Are critical care services safe?

Requires improvement

We rated critical care services as 'Requires Improvement' in safe.

Medical staffing was not consistently led by a consultant intensivist and the number of consultants meant that cover was not provided 24 hours a day seven days a week, which contravened critical care guidance established by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS).

This rating relates to areas we identified as presenting a risk to patients, staff and visitors: We found chemicals, a sharps bin and hazardous waste awaiting collection in a cupboard that was unlocked and readily accessible. This contravened the European Waste Framework Directive and meant that staff had not adhered to established safety requirements.

A supernumerary senior nurse coordinator was not always available overnight, which meant that ICS core standards were not met.

Senior staff were aware of the problems with staffing levels, which had also been highlighted by the unit's critical care network, and escalated through appropriate channels to the clinical director. It was not clear that the senior leadership team had effectively engaged with senior staff in the CCU to provide an appropriate resolution. It was also not clear that a robust system was in place to ensure compliance with trust and external waste management and chemical storage policies.

We found areas of good practice in the unit, specifically relating to an open culture of reporting and learning from incidents and an effective system of safety and infection prevention and control management for clinical equipment, including the unit's resuscitation trolley. All areas of the unit appeared clean and free from dirt and we found a highly dedicated, competent cleaning staff in place.

Patients received care and treatment from a multidisciplinary team that was well established and demonstrated awareness and application of safeguarding and risk assessment practices. The piloting and successful implementation of a new electronic patient records and management system demonstrated effective inter-hospital working between staff of different specialties, including IT and senior nurses.

Incidents

- Staff used an electronic incident reporting system to record and escalate incidents and errors and told us they were actively encouraged to do this as part of a 'no blame' culture in the unit. Incidents were investigated using a robust root cause analysis process led by a senior member of staff, and learning was shared through team meetings and a communication book that we saw used in nurse handovers.
- The unit's pharmacist had implemented a number of changes to medicines management to address administration and prescribing errors. As a result of learning from the incidents, potassium was now stored in a separate locked cupboard and checked out by staff who signed and dated its use. As part of their induction, newly appointed nurses were required to complete a pharmacy safety session and a competency checklist with the CCU clinical nurse educator (CNE). The pharmacist told us this had been effective at reducing the number of drug errors.
- 72 incidents were reported between May 2015 and August 2015 at St Richard's and Worthing Hospitals. In most cases it was clear that action had been taken to mitigate the risk of future incidents. For example, a transfusion specialist practitioner had been contacted following a patient experiencing an untoward reaction to a blood transfusion. Improved training for staff on the insertion of central venous catheters had also been provided as a result of incident investigations. The incidents were reported on a trust level instead of on an individual basis as the matron and clinical director, who were responsible for both sites, investigated them.
- Monthly mortality and morbidity (M & M) meetings had been established as part of a cross-site standardisation strategy that had addressed the issue of M & M meetings being held more regularly at Worthing Hospital. Specialty staff at St Richard's were invited to attend M & M meetings on a two monthly basis to present a case study to colleagues to share learning.

- There have been no 'Never Events' at this unit. 'Never Events' are serious, largely preventable incidents involving patient safety that can be avoided through adequate safety systems.

Safety thermometer

- NHS Safety Thermometer data was recorded and displayed in the unit. In the 12 months prior to our inspection, there had been no new harm to patients in 100% of cases, with the exception of August 2015 when the no new harm rate was 90%. A senior member of staff had displayed educational material for staff in response to this.
- There had been no unit acquired pressure ulcers in 2014, for which the unit had received a Gold Standard Award from the trust. There were three unit acquired pressure ulcers reported in 2015 prior to our inspection. Staff were aware of the risks of pressure ulcers caused by the use of high-dose adrenaline and hemofiltration and had obtained air mattresses to use with high-risk patients as a mitigation strategy.
- From April 2014 to May 2015, there had been one case of unit-acquired MRSA, no cases of unit acquired Clostridium Difficile (C.Diff) and six reported instances of unit acquired blood infections. This was highlighted as an area of unusual risk by the critical care network and the lead consultant was improving scrutiny of audit data to identify the actual risk.
- All patients had their level of risk assessed and documented for venous thromboembolism (VTE). The ward administrator reviewed patient notes to ensure this had been completed and the electronic patient records system prompted staff to conduct an assessment as a mandatory requirement.

Cleanliness, infection control and hygiene

- The unit was visibly clean and free from dust on high and low surfaces and equipment. All soft furnishings could be wiped clean and in a good state of repair. Cleaning schedules were posted for each clinical area and records we looked at were up to date with no omissions.
- Staff used 'I'm Clean' stickers and clinical tape to indicate when an item had been cleaned and disinfected. We saw staff used this procedure consistently, and all of the equipment that was ready for use was labelled appropriately. Nurses usually cleaned equipment initially and then the unit's equipment technician completed a second clean using detergent wipes and chlorine.
- An annual deep clean of the unit took place, during which time patients were temporarily moved to another hospital area with appropriate staff and risk assessments to support this. Staff we spoke with were consistently positive about the service received from the cleaning and housekeeping team.
- A dedicated member of cleaning staff was assigned to the CCU for 7.5 hours each day. We spent time speaking with one individual who showed us how they adhered to trust infection control policies, including the correct use of cleaning products and personal protective equipment. We saw that cleaning was documented and cleaning tasks were timed appropriately.
- A cleaning supervisor was available on call to perform a deep clean after the treatment of infectious patients.
- There was an open working culture in the unit that allowed staff to challenge infection control practice if they felt it could be improved. For example, we observed a consultant challenge someone who had not applied antibacterial hand gel to their hands before approaching a patient. During patient examinations, a system of white and yellow lines was used to indicate that only the staff involved in the examination should be in the immediate vicinity of the patient. This safeguarded patients from cross infection and also maintained their privacy and dignity. We saw that this practice was enforced.
- Staff conducted monthly observational audits of hand hygiene, which was found to be 99.8% compliant in August 2015. We saw evidence that doctors and nurses who failed to wash their hands at appropriate intervals were reminded of the trust policy on this. Monthly audit results of the prevention of the spread of C.Diff were variable. Between June 2015 and August 2015, staff were 77% compliant with trust policy. Action had been taken to address the prescribing of antibiotics with no stop date, which accounted for the compliance score. MRSA screening took place in 99.6% of patients in June 2015 and July 2015, with no data available for August 2015.

Environment and equipment

Critical care

- The CCU was well maintained and bed spaces conformed to the requirements of Department of Health Building Notes 00-09 and 00-01.
- Chemicals were stored in an unlocked room and we saw that the cupboard used for products controlled under the Health and Safety Executive Control of Substances Hazardous to Health (COSHH) regulations was unlocked during our visit, with the keys unattended in the lock. We also found that a room used to store hazardous waste was unlocked, with a waste storage truck also unlocked. This contravened the requirements of the European Waste Framework Directive (2008/98/EC) and presented a risk of unauthorised access.
- We found that sharps bins were stored in an unlocked dirty utility room awaiting collection. This presented a risk of needle stick injuries and unauthorised access to the storage room.
- An equipment technician was based in the unit and ensured that equipment was appropriately maintained and checked for safety, including the provision of portable appliance testing (PAT).
- The resuscitation trolley on the unit had been appropriately maintained and staff had documented daily checks of the equipment, including the automated external defibrillator.
- The unit had an on-site blood analysis room and laboratory, which we found to be clean and tidy with no evidence of blood spillages. We found that 10 items of bed equipment had been stored in the laboratory, which was not an appropriate location.
- Each item of equipment was validated and recorded in a log book as part of a system that meant each item used could be traced to an individual patient. Equipment sent to the central sterile services department was tracked with a serial number, which meant that it could be tracked and traced to ensure the unit was confident in the safety and maintenance of its own equipment.
- The CNE had recently updated medical equipment library training and competency records to ensure that all staff in the CCU were appropriately trained in the use of specific equipment. Four dates had been scheduled in 2016 for practical training on new equipment, which staff were allocated to with protected time.

Medicines

- Staff used an electronic prescribing system that was part of the electronic patient records software. A drug formulary and reference library was available electronically as part of this system.
- CCU staff ordered controlled drugs (CDs) and these were checked daily for correct quantities. We looked at the documented checks for CDs and found no errors or omissions. CDs were stored in a locked cupboard in accordance with national guidelines.
- Staff used a stock rotation system for medicines, which we found to be in date.
- The unit's pharmacist told us they were available to give training and guidance to staff to reduce the number of drugs errors, which they said occurred approximately twice per month across both hospital CCU sites. We saw that nurse appraisals included documented learning outcomes and competency in medicines administration.
- Staff told us that the differences in electronic patient records systems between the CCU and the rest of the hospital meant that when a patient was discharged to a ward, doctors had to copy all of the electronic prescription information into the hospital's main system, which was time consuming and took time away from other tasks.

Records

- Staff had worked collaboratively with the manufacturer to pilot, test and implement the IntelliVue Clinical Information Portfolio (ICIP) in the unit, enabling the implementation of electronic records. A dedicated critical care nurse provided full time technical support to staff. The system was used in both CCUs in the trust and staff had been provided with training on the system. Nurses we spoke with were positive about ICIP and told us they had been given adequate training to use the system confidently. We corroborated this by looking at training records, which indicated that all staff on the unit had completed relevant training.
- Multidisciplinary staff used ICIP to record the outcomes of assessments and treatment planning meetings, as well as verbal orders from doctors regarding

prescriptions. The electronic system included observation charts used for patients receiving neurological, tracheostomy or pressure ulcer risk monitoring.

- As this was a new system, it was not yet compatible with the main electronic patient record system in the hospital and so staff had to manually duplicate information between systems, including patients under the care of the critical care outreach team. We saw in practice this was time consuming but staff were positive about the improvements to care that had resulted from their innovative piloting of the new software.
- When a patient was discharged from the CCU, a multidisciplinary summary of their care and treatment was prepared to send with the patient to their next department of care or GP.
- Staff used colour coded paper for printed copies of discharge notes when a patient was moved to a ward. This meant that ward staff could immediately identify intensive care medical notes, and critical care outreach nurses could quickly locate the intensive care treatment history during their ward assessment. The discharge notes included past medical history, diagnosis on admission, allergies and a pain assessment.
- Staff completed risk assessments for falls and bed rails and we saw these were updated as a patient's condition changed.
- Critical care outreach nurses had access to both the ICIP system and the hospital wide electronic patient records system, which ensured they could access the most up to date observations and results of the patients they were asked to assess.

Safeguarding

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

Mandatory training

- The unit's dedicated CNE led a nurse learning and development programme, with specialist input from link nurses and doctors who delivered training on changes in practice based on audit results.
- 96.2% of Nursing and Midwifery Registered staff had up to date adult safeguarding training to level three and 100% of this staff group had completed child protection training. All registered nurses working on the outreach team had completed adult safeguarding level three training.
- Rates of up to date mandatory training completion in the twelve months prior to our inspection were: 96.2% fire training; 98.1% infection control; 96.2% information governance; 100% equality and diversity and 98.1% resuscitation training. All rates of training were within the trust's minimum requirements.

Assessing and responding to patient risk

- Staff monitored patients using the National Early Warning Score (NEWS) system. Where a patient was found to be deteriorating, their NEWS observations were completed on an hourly basis.
- Two senior nurses formed a critical care outreach team (CCOT) and responded to patients with a NEWS score of seven or above, using the hospital wide electronic patient tracking system. This system included a colour coding facility for ward staff to prioritise patients for CCOT review, depending on their condition. CCOT nurses had developed the use of a personal digital assistant (PDA) to update patient treatment throughout the hospital but this could not connect to the live

patient tracking system and needed a manual connection to a hospital computer. This could be time consuming and reduced the time CCOT nurses had to spend with patients.

- We saw that CCOT nurses were responsible for prioritising the assessment of large numbers of patients whilst working alone during hours that were limited by funding. This was accepted as an area for improvement by the senior team in the unit in order to expand the service. There were no incidents recorded relating to lack of assessment by a CCOT nurse.
- CCOT nurses were committed to improving care and treatment for deteriorating patients in the hospital. This included a programme of learning for ward healthcare assistants, nurses, and doctors on acute illness management (AIM) as well as respiratory and tracheotomy study days.

Nursing staffing

- Nurse to patient ratios met the requirements of the Royal College of Nursing (RCN) and were provided at 1:2 for level two patients and 1:1 for level three patients by nine nurses on shift during the day. There were eight nurses on night shift, seven days a week. Nurse staffing levels were reviewed daily and could be adjusted at short notice to meet patient dependency levels.
- The unit did not always comply with the ICS core standards requirement that a supernumerary senior nurse clinical coordinator be present on the unit at all times. This most often occurred overnight. We asked staff about the impact of this. One nurse told us, "It's difficult without a supernumerary 24/7. It can be very stressful at times although we do work very well together as a team."
- Nurses we spoke with told us they felt more supported when a consultant intensivist was in the unit and felt empowered to raise any concerns with any member of the medical team.
- CCOT nurses regularly worked shifts in the CCU to retain currency and practice in critical care nursing. We saw a strong collaborative relationship between CCU nurses and doctors and the CCOT team that enabled learning to take place between the teams.
- Handover meetings from the CCOT team to the site practitioners had recently improved. For instance, a daily handover at 5:15pm took place from the CCOT nurse to the site practitioners, who then handed over to their nightshift colleagues at 8pm. Although this process was time consuming, it mitigated the risks previously highlighted when handovers had not taken place.
- The ICIP system prompted staff to complete mandatory fields of information, such as a record of capacity checks, a MUST score and medicine information. This supported new staff to reduce documentation errors as the system actively reminded staff of the need for specific information.
- Nursing staff received one-to-one training and competency checks on the ICIP system and were updated on policies and best practice at away days. Staff were able to receive practical supervision and guidance on the use of specific care bundles from the IT liaison nurse who was on site several times a week.
- Nurses were organised into teams on an annual basis and given the lead for a particular specialty, such as renal, surgical, infection control and delirium. Away days for nursing staff were arranged for each specialty, which meant that training was tailored to the experience level of staff. Nurses in each team were allocated policy and link roles to ensure colleagues were kept up to date on best practice guidance.
- The CNE in the unit, who was a senior charge nurse and educational lead, worked with their counterpart at Worthing Hospital to develop learning resources for new members of staff. Specialist modules included the care of people with needs in various core specialties such as cardiology, respiratory, neurology and renal. Nursing management and the intrahospital transfer of critically ill patient training had also been developed and implemented.
- Newly appointed nurses were normally allocated three to four weeks of supernumerary practice. We were told this had recently reduced following unusual levels of staff sickness and the subsequent short staffing this had caused.
- Agency nurses were sometimes used to ensure nurse to patient ratios remained compliant with RCN guidelines. We saw that agency staff underwent a competency and qualifications check prior to being able to work on the

unit. Staff told us they were happy with the quality of agency nurses and they tended to be assigned the same individuals, reducing the need to spend extra time on orientation and support.

- A healthcare assistant was available seven days a week in the unit to support nursing staff and to provide additional support between the CCU and recovery if critical care patients were being cared for there.
- The unit had active formal relationship with a university to provide clinical placements and learning experiences for pre-registration nursing students. Students were given an induction using a supernumerary induction pack for new nurses and were also offered the opportunity to shadow a CCOT nurse for half a day.

Medical staffing

- The CCU was led by a consultant intensivist but did not meet the requirements of the ICS core standards because consultant cover was not provided on a 24 hour a day, seven days a week basis. This also meant that the unit did not comply with the standards of the Faculty of Intensive Care Medicine, that care must be led by a consultant intensivist. This shortfall in intensivist staffing had been known for some time and the critical care network identified that in 2014, there were 68 days without intensivist cover. It must be noted that this shortfall was mitigated by consultant anaesthetists providing cover when a consultant intensivist was not available.
- The consultant team had seven doctors, which was not enough for the unit to have a dedicated critical care consultant on call rota that covered 24hours a day, seven days a week. The lead consultant for the week usually worked one weekend day to ensure consistency for patients and other staff and was assisted by a core trainee doctor. During the week, an additional junior doctor was dedicated to the unit in the mornings.
- Medical cover overnight and at weekends could be led by an intensivist or an anaesthetic generalist. We discussed this with senior staff who told us that there was a plan to pilot a telemedicine model with a new intensivist, in order to increase consultant cover. If successful, the doctor would cover the CCUs at St Richard's Hospital and Worthing Hospital. The pilot was due to take place during a supernumerary ward round followed by a period of trialling for on call purposes, in addition to existing consultant cover. This meant that staff would be able to see how effective a telemedicine model could be without relying on it for the safe operating of the unit.
- Out of hours, a specialist registrar and a core trainee doctor covered the CCU, obstetrics and theatres. The registrar also covered the maternity unit, which was geographically distant from the CCU. On a Saturday, the unit was allocated a second core trainee between 8am and 6pm. Staff told us this cover was problematic because of the number of areas the doctors covered.
- All junior doctors were anaesthetic trainees and were led in their training by a consultant intensivist.
- The unit always had a member of staff with airway skills present. This meant that there was always a member of staff present who could intubate or extubate a patient.
- Staff told us that the use of locum doctors had recently increased because of a shortfall in trainee allocations from the Deanery.
- Junior doctors conducted daily handovers at 8am and 8pm.
- Consultants led twice daily ward rounds at 8:30am and 5:30pm.
- Doctors at this site received intermediate training in the use of medical information technology.
- We observed a medical handover and ward round and found an inclusive, supportive culture that was focused on patient outcomes and staff learning. For instance, a new locum doctor on their first day in the unit was made to feel very welcome and was given a formal introduction and orientation. When discussing each patient, doctors spoke with them directly and included them as part of the handover. The cohesiveness of the medical team was apparent and junior doctors were appropriately involved.
- Consultants were allocated specific policies to write and present to CCU colleagues, such as diabetes and renal failure policies.

Major incident awareness and training

- A senior nurse told us that a twice yearly call out to off duty nurses took place to establish who was likely to be able to attend the unit in a major incident. However, the

last documented major incident cascade check in the unit's major incident resource folder was dated 2011. This meant that it was not clear how senior staff knew who would be the most appropriate staff to contact as first responders in a major emergency.

- Senior nurses we spoke with had up to date knowledge on the major incident and evacuation policies and were able to explain how patients would be protected in such an event using established protocols and evacuation procedures.

Duty of Candour

- The electronic incident reporting system included a prompt for staff to engage with the duty of candour and ensure that appropriate communication took place with patients and those close to them where appropriate.
- We found understanding of the duty of candour varied amongst staff we spoke with. One nurse we spoke with said they had never heard of it and another said they had heard of it but did not know what it was.

Are critical care services effective?

Good

We rated critical care services as 'Good' for effective.

This rating reflects the care and treatment delivered by a team of competent staff who followed best practice guidance from the RCN, the ICS, FICM and NICE. There was active and consistent engagement with critical care networks to identify areas for improvement and develop these in line with established national benchmarks. The mortality rate from July 2014 to June 2015 was 10.1%, which was a lower rate than the national average for similar units.

A multidisciplinary team contributed to patient care and treatment, including microbiology, physiotherapy, dietetics, pharmacy and chronic pain specialist services. There was consistent leadership and support from a critical care outreach team that was proactive in delivering specialist training to nurses in CCU nurses and other clinical areas throughout the hospital.

Contribution to national audits and the use of local audits to check and improve practice meant that staff constantly challenged their work and shared opportunities for learning with each other.

Evidence-based care and treatment

- An annual programme of internal audits that met the guidance of the trust's clinical audit programme had been established, which adopted the Healthcare Quality Improvement Partnership (HQIP) recommendations for the prioritisation of topics. This included 'must do' audits defined by HQIP as well as audits based on internal divisional priorities and clinical interest. Most of the audits identified for the CCU were planned to be led at corporate level, including audits of the deteriorating patient, VTE and health record keeping.
- Staff had prepared study days based on the standards and guidelines of appropriate national organisations. For instance, emergency laryngectomy management training adhered to best practice guidance from the National Tracheostomy Safety Project.
- Staff used the principles of understanding and assessing mental capacity from the Social Care Institute of Excellence to help them adhere to the Mental Capacity Act (2005).
- Physiotherapists used the KSS Deanery ITU pathway at both critical care hospital sites to manage weaning predictors as part of patient rehabilitation.
- Physiotherapists engaged with the Respiratory Leaders Network, which enabled them to gain support and learning from senior physiotherapists in the field.
- The introduction of the ICIP system across both CCU sites had enabled staff to standardise working practices as part of the units' multi-professional teams, thus improving safety and streamlining staff training and guidance. For instance, the CCUs used different doses of inotropes before the introduction of ICIP and as part of its pilot, staff worked together to agree on a single approach to this based on the best practice highlighted in each unit. The approach of dieticians, speech and language therapy (SALT) practitioners and physiotherapists had also been standardised at both sites, resulting in a consistent approach to patient assessment and care.

- Audits of care bundles for patients who needed continuous positive airway pressure (CPAP) indicated that there were broad variations in how staff practised this between the two hospital CCUs. Audit nurses worked with CCU nurses to standardise their approach to this treatment and we saw that this had been successfully implemented.
- A plan had been created to train the nurse audit teams at both hospital sites in standardised approaches to audits using ICIP data. This followed the successful standardisation of other processes that had resulted in more consistent patient care and fewer errors in records.
- Clinical observations and assessments completed by staff adhered to the requirements of the D16 Adult Critical Care Clinical Reference Group defined by NHS England.
- The availability and input from physiotherapists met the requirements of NICE clinical guidance 83, rehabilitation after critical illness in adults. The physiotherapist team contributed to the local trauma network for rehabilitation practice.
- Staff engaged with the Sussex Critical Care Network in the provision of education sessions and the use of policy templates for the safe transfer of patients. Medics had been included in transfer education sessions to ensure that patients were transferred by competent staff with the necessary skills.
- The unit was part of the Thames Valley and Wessex Adult Critical Care Operational Delivery Network, which had undertaken an assurance visit in November 2015. Staff had used the findings of the visit to establish their practice against national benchmarks and to implement improvements to meet the requirements of their peers in the network.
- Treatment policies and guidelines were stored electronically on a clinical portal that was accessible through ICIP. When a policy was six months from expiry, an alert was generated automatically and a member of staff was assigned to review and update the policy. This meant that staff worked with policies that were up to date and based on the latest available guidance, which we saw in practice.
- Staff undertook audits on the completion of rehabilitation needs assessments and rehabilitation pre discharge assessments, against the Commissioning for Quality and Innovation target of 95%. The unit had consistently met this target since August 2015.
- Staff conducted monthly observational audits of high impact interventions, including central line insertion and continuing care, decontamination of infected equipment and the ongoing care of ventilated patients. In August 2015, the audit found 100% compliance in these areas. Compliance of the continuing care of peripheral lines was 99% and the continuing care of people with urinary catheters 98%. We saw that corrective action had been taken, including contacting the infection control link nurse to conduct a re-audit and an update of staff guidance on ICIP regarding catheter care.

Pain relief

- A chronic pain service doctor was available on call through a clinic that was based in the hospital.
- We saw that pain scores were recorded at appropriate intervals on ICIP and pain was managed according to this.
- A service level agreement was in place with a community care trust for the sharing of chronic pain services and a patient support group was being established nearby for patients suffering from chronic pain.
- CCOT nurses checked patient levels of pain during ward assessments and recorded this appropriately, escalating any issues to their ward colleague.

Nutrition and hydration

- Staff had completed a malnutrition universal screening tool (MUST) and waterlow (pressure ulcer risk) assessment for each patient on admission and monitored this at appropriate intervals.
- A dedicated dietician worked in the CCU Monday to Friday who could attend daily ward rounds and worked with patients at risk through deteriorating MUST scores. All patients were reviewed daily by the dietician.
- The dietician set total parenteral nutrition (TPN) protocols and re-feeding protocols for staff to use on a weekend and out of hours.

- Patients and relatives we spoke with told us that they were happy with the ability of staff to provide food appropriate to their needs. One patient said they were on a special liquid diet and that they had been "very happy" with the hot food provided for them.

Patient outcomes

- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality were benchmarked against similar units nationwide.
- The lead consultant and the critical care network had identified inconsistencies in the way delayed admissions were audited. This process was being restructured as a result. The consultant told us that no delayed admissions had been clinically inappropriate. In the twelve months prior to our inspection, an average of 4.25% of admissions each month were delayed by four hours or more. Staff told us they found the admissions policy flexible based on clinical need.
- The standard mortality ratio of the unit was 0.86, which reflected a mortality rate similar to, or better than, other CCUs in the critical care network.
- Unplanned readmissions within 48 hours of discharge were very low, with an average of 1% of patients per month in the year prior to our inspection, with six months of no unplanned readmissions.
- The CCOT team were active in the NHS QUEST deteriorating patient collaboration and had conducted audits of patients with acute kidney injury and sepsis, reducing cardiac arrests by 50%.
- CCOT nurses undertook a monthly review of cardiac arrests to identify the role of the Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) authorisation. For example, nurses considered whether someone without a DNACPR could have benefited from one and checked to see if resuscitation had been attempted on any patients with a DNACPR in place. The review included consideration of how the escalation plan was used for deteriorating patients and the findings delivered as part of a learning strategy with the resuscitation team.
- Staff were trialling new documentation relating to brain stem death tests as a proposed addition to the ICIP system before adding this permanently to the software. This was being trialled following a successful increase in the completion of safeguarding assessments by doctors after a safeguarding field was added to ICIP.
- Physiotherapists completed a weaning timetable for each patient as part of their rehabilitation plan. This was recorded clearly in patient electronic records.
- The rate of unit acquired infection in blood was noted to have increased between July and October 2015. This was being monitored and reviewed through the clinical governance structure.

Competent staff

- 46% of nurses had post registration critical care training certification, supported by 42 nurse mentors. Although this was below the 50% threshold established by the RCN, we saw that two nurses were due to complete the certificate in January 2016, which would then meet the minimum requirement. A further three nurses were in the process of completing their study programme and would achieve certification in May 2016.
- A nurse mentor told us that the mentorship programme was very good but helping other staff could sometimes be difficult to do comfortably because they were so busy.
- Nurses currently studying for the post registration critical care certificate were given 75% of their time to undertake the course.
- Clinical nurse specialists from CCOT provided induction training for new healthcare assistants and completed practical observations before they were able to work alone. Third year pre registration nursing students also spent time shadowing CCOT nurses as part of their learning experience.
- We saw that CCOT nurses were able to offer impromptu training to ward staff where necessary. For example, a ward nurse said they were not confident in the care of a patient recently discharged from the CCU receiving non invasive ventilation. The CCOT nurse offered immediate tuition on the equipment and checked their ward colleague felt confident.
- Nurses we spoke with said they were happy with the quality of learning and development provided, and that it was tailored to CCU.

- 81% of the nurses in the unit had completed an appraisal in the year prior to our inspection. Although appraisals were focused on professional development, one nurse told us they felt "static" after their appraisal 11 months ago as they had been turned down for the training they had requested.
- Registered nurses had completed an acute illness management course, which they said was beneficial for patients in the CCU.
- Nurses received specialist training from other practitioners in the trust during team away days. Previous training was delivered by the hospital lead for the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) as well as specialists in end of life care, fire safety, medical devices and nurse revalidation.
- Nurses were trained in life support at a level appropriate to their grade, including advanced or intermediate life support for band six and band seven nurses and intermediate or basic life support for band five nurses.

Multidisciplinary working

- A band seven clinical nurse specialist and a senior band six nurse managed the CCOT service Monday to Friday between 8am and 6pm to respond to the needs of deteriorating patients in the hospital. CCOT nurses also visited patients from the CCU following their discharge to a ward to ensure their care needs were being met. All patients who were treated using non invasive ventilation, continuous positive airway pressure (CPAP) or bi-level (BiPAP) positive airway pressure received a CCOT follow up visit in the ward. Outside of these hours, a team of site practitioners responded to the needs of deteriorating and seriously ill patients who were in other clinical areas around the hospital. A daily handover took place at 5:15pm each day between the CCOT nurse and the site practitioners.
- A CCOT nurse had developed a Sepsis 6 BUFALO pathway simulation training programme for staff in the hospital, particularly for emergency department nurses and middle grade doctors. The training was recorded and was available for staff on the hospital intranet.
- We saw a positive and collaborative relationship between the CCOT team and ward nurses and doctors, including a medical consultant who was particularly involved in the post intensive care treatment of a patient who had been discharged to a ward.
- Daily safety huddles were held in order to identify any risks to the operation of the unit and were well attended by different staff. During our visit we saw the huddles were attended by the ward administrator, an equipment technician, a physiotherapist, the duty CCOT nurse, CCU nurses, doctors and consultants and pre-registration nursing students.
- There was a multidisciplinary approach to the learning and development provided by CCU staff to colleagues across the hospital responsible for intensive care patients before admission and after discharge from the unit. For instance, physiotherapists delivered practical training sessions on the use of BiPAP, CPAP and Optiflow machines during respiratory training days established by CCOT nurses.
- Significant collaboration had taken place across multidisciplinary specialities to embed the ICIP system into practice. For instance, before the system was piloted, hospital IT staff, pharmacy staff, informatics specialists, CCU nurses and doctors and representatives from the manufacturer had liaised to ensure the system was appropriate for the critical care environment.
- Four physiotherapists provided the equivalent of 2.5 whole time equivalent staff to the CCU, each of whom had spent two months working solely in the CCU to develop their competencies for the specialist needs of critical care patients. Physiotherapists had also been trained in respiratory and surgical wards and focused on the early rehabilitation of patients, and completed risk assessments with nurses.

Seven-day services

- A dedicated critical care pharmacist worked between both hospital sites and was available at St Richard's Hospital three days a week. Out of hours and at weekends, an on call pharmacist was available.
- A consultant was available on call out of hours but this was sometimes an anaesthetic generalist and not an intensivist.

- This did not meet the requiremeThe on call consultant could access ICIP remotely to see patient observations and notes.

Access to information

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

Consent and Mental Capacity Act

- The electronic patient records system included a section to record mental capacity assessments as well as the person's resuscitation status, such as if they had a DNAR order in place. In all of the patient records we looked at, an appropriate mental capacity assessment had been recorded.
- We saw that the unit had access to an independent mental capacity assessor (IMCA) and that this service was used where appropriate.
- Staff had involved the appropriate professionals in a best interest assessment when a person's capacity was impaired or they were not able to consent. This was recorded along with an appropriate MCA assessment and could be initiated during a ward round where staff had concerns about a person's wellbeing.

Are critical care services caring?

Outstanding ☆

Critical care services were 'Outstanding' for caring.

We observed a consistently kind, inclusive and compassionate approach from staff at all levels of responsibility in the unit. Patients and relatives had been introduced to staff and told us they felt confident to ask questions whenever they wanted. Strategies were in place to mitigate the impact of anxiety and distress in the unit, including the use of patient diaries, bed baths and offering to take patients out of the unit in a wheelchair. This demonstrated that staff understood the wider emotional and psychological impact of the ITU and tried to ensure patients needs were met. Staff went the extra mile to mitigate against the risks of the critical care environment.

It was not individual acts of kindness by staff that achieved the outstanding rating but a culture of providing compassionate care to patients, family members and other staff. It was given that staff would treat people well but the leaders and staff of the service had an expectation beyond that, they actively sought ways to improve the patient's experience.

Staff clearly demonstrated that dignity and respect were embedded in their methods of working and this was consistently referred to in our discussions with patients and relatives as well as our observations.

Compassionate care

- Staff introduced a patient diary when a person remained in the unit for longer than four days. Diaries were used as a tool to help document each patient's journey in critical care and we saw that nurses and those close to them had contributed to diary entries with positive messages of clinical improvement, personal messages about family and friends and a record of each procedure the patient had undergone. The entries in patient diaries were given to patients on their discharge from the unit and they were encouraged to use them to help recall and understand their experience in the CCU.
- Staff showed an acute awareness of the psychological distress and anxiety that patients in the CCU could encounter, and demonstrated strategies to mitigate these. For instance, during a handover, staff showed that by giving a person a bed bath, their anxiety had been reduced. This was achieved further by changing their flow of oxygen, to help the person sleep.
- We spent time with a CCOT nurse who was visiting patients on wards. We saw they had a compassionate and kind manner that comforted people and reduced anxiety. A patient was particularly pleased when the nurse recognised them and said, "It's lovely to see you, you're doing brilliantly now." Staff took the time to explain to the patient what had happened and what the next stage of their treatment was, allowing time to answer any questions.
- Relatives we spoke with used words such as "polite, respectful, helpful" to describe staff and said, "Our overall impression is very positive. The system here works pretty well and it's hard to imagine they [staff] could do anything better."

Critical care

- We saw that where a consultant had to deliver bad news to a relative regarding a patient's deteriorating condition; they did so compassionately and gave people time to ask questions.
- Staff had conducted an end of life care survey amongst the relatives of some patients. We saw that the results were very positive. We also saw the relatives of a person with learning difficulties had commended staff for proactively involving their family member in their care and treatment.
- Staff gave patients a bed bath to maintain their personal hygiene and dignity where needed, including in sedated patients.
- Long term patients in the unit had been enabled to leave the unit in a wheelchair (to go outside or to the hospital chapel or café) with the support of staff where this had been deemed safe by a risk assessment. Staff told us that this had significantly contributed to improved patient morale.
- Staff understood the need to a routine to establish a time frame whilst patients were in the unit. They dimmed lights and reduced noise and activity overnight as far as was possible.

Understanding and involvement of patients and those close to them

- Staff used various means to help them understand the needs of their patients beyond critical medical treatment. For example, a 'Knowing me' document was used to help staff understand a patient's likes, dislikes and daily routine. This also helped staff to assess how well a person could communicate and how they could assist them to be understood if they could not communicate verbally.
- Patients and their relatives were included in discussions about the types of care and treatment given in the CCU and information about transfer to a ward. We saw that staff provided this information verbally and had also prepared a printed leaflet for people to refer to later, including explanations of a monitoring plan, physiotherapist treatment and other unfamiliar terms that people might encounter.
- Relatives said they had been involved in discussions regarding care and treatment by nurses and the consultant. One relative said they were particularly pleased a doctor had taken the time to explain a specific treatment and the future plan of care.
- Two band six CCU nurse ran a monthly follow up clinic as part of a rehabilitation programme for patients who had been ventilated for more than four days. Patients were offered the opportunity to return to the unit, look at the space they were treated in and talk to the staff that had cared for them. Staff used feedback from the follow up visits to change practices where required. For example, one patient told a nurse they remembered the loud noise a metal apron holder made and now associated the same noise with medical treatments. As a result, staff had changed such items to plastic models that did not make a noise.
- During a ward round we observed that patients and relatives were involved in discussions between doctors, who explained treatment plans and conditions clearly.

Emotional support

- During a bedside handover we saw that staff discussed their hope of contacting a person's next of kin to reduce the risk of isolation and they discussed alternative methods of finding them after direct phone calls had failed.
- A patient we spoke with told us they had been cared for very well by staff that, "make me feel really safe. If you're feeling really low, they cheer you up." The person told us that continuity of care had been very good and they felt well supported by seeing the same staff consistently.
- Staff were able to refer patients to community counselling services.

Are critical care services responsive?

Requires improvement

We rated critical care services as 'Requires Improvement' for responsive.

Access and flow was highlighted by senior staff as a particularly challenging area, which we saw was reflected in the rate of delayed discharges.

Mitigating strategies were implemented, including robust business continuity and escalation plan and the inclusion of delayed discharge investigations in clinical governance meetings. Space in the operating theatre recovery area was used for CCU patients to mitigate problems with flow when the unit was operating at capacity.

Staff ensured the individual needs of people were met, such as those with learning disabilities and patients being treated for the impact of substance abuse. Delirium and sedation were both monitored appropriately by staff using established tools.

Facilities for relatives and visitors were provided, including overnight accommodation.

Service planning and delivery to meet the needs of local people

- Staff planned training days based on the needs of the local population. For instance, tracheotomy study days included a talk about laryngectomies due to the relatively large number of these in the local community.
- The daily safety huddle included a discussion of the need for liaison with specialist nurses in organ donation and there was a clear process in place for an appropriate member of staff to lead on this.
- Staff demonstrated an awareness of the needs of patients who used illicit substances and considered their support during handovers. We saw that staff were also aware of the impact of alcohol dependency and were able to speak with people and those close to them sensitively about issues relating to this.

Meeting people's individual needs

- We observed a nurse handover and saw that staff had a good understanding of the individual needs of people beyond their critical medical treatment. For instance, one patient had asked staff to call them by a nickname to make their relationship less formal, which was communicated appropriately. Staff also discussed how they could reduce the anxiety of a person who had psychological distress related to substance abuse.
- Where a person with a DoLS authorisation in place had been admitted, staff used a handover to share their knowledge and understanding of this and were led by senior nurses who discussed implications for treatment.
- Staff had provided overnight accommodation for relatives who wished to stay in the unit. We spoke with a relative who had used this and they told us, "Staff have been really helpful and made us feel very welcome staying overnight, nothing was too much trouble for them." Relatives could also access one of the three hospital bedrooms.
- A well appointed visitors sitting room had recently been refurbished and was available 24 hours a day, seven days a week. Visitors were able to store their own food and had access to tea and coffee making facilities.
- Where a patient with an elevated pressure damage risk was discharged to the ward, the registered nurse would always request a pressure reducing air mattress be provided on the ward. If this was not have an air mattress available, the transfer would be delayed until the nurse in charge or manager made a decision based on clinical risk.
- Physiotherapists assisted patients in establishing short, medium and long term goals for their rehabilitation that were reassessed on a weekly basis in collaboration with the patient's consultant. Patients on complex care pathways were tracked in the hospital by physiotherapists who could visit them on wards. Physiotherapists had attended a psychology study day to enable them to meet patient's mental health needs during rehabilitation.
- Some nurses had not been trained in dementia care; however the unit had five dedicated dementia champions who could assist with related care and treatment concerns.
- Children were only accepted into the unit if a paediatric nurse and doctor accompanied them. This was a rare occurrence and only older teenagers who were physiologically similar to adults were accepted. Transfer arrangements were in place with a paediatric retrieval service. Sick younger children were stabilised on the paediatric unit prior to transfer to a specialist facility.
- Patients were assessed for their level of delirium by staff who used the Richmond Agitation Sedation Scale (RASS).

- Relatives told us they felt staff had developed good communication techniques to engage with a patient with learning difficulties. Staff had access to a resource pack in the unit that including visual communication aids and guidance on the use of Makaton.

Access and flow

- Staff discussed capacity and business continuity during the daily safety huddle, which included a record of the number of available beds in different parts of the hospital, a discussion of any wardable patients in the CCU, and identification of any patients elsewhere in the hospital waiting for a CCU bed. We saw that this was an effective process to ensure access and flow was managed efficiently and that it avoided delays wherever possible.
- There was a clear and robust policy in place for the discharge and transfer of patients, which staff were able to tell us about in detail. This included coordination between the nurse in charge, the site manager and the consultant. We saw that guidelines were available to staff on the intranet and from looking at records saw that these were followed routinely.
- A capacity management policy based on the identification of escalation needs was used to improve patient flow when risks were present due to bed capacity issues. Site managers were actively involved in this with senior nurses in the CCU, who worked with consultants to identify any patients suitable for discharge. Senior staff we spoke with said they felt that CCU patients were given low priority by site managers for allocating ward beds and that significant discharge delays occurred as a result.
- Critical care patients were sometimes cared for in recovery beds if the CCU was full to capacity. Operating department practitioners (ODPs) initially assessed the patients and then assessed their acuity with a CCU nurse. An on call ODP was available if critical care patients needed to be accommodated in the recovery department overnight. The recovery unit had a dedicated computer used to document the assessment and treatment of a critical care patient and if more than one patient was accommodated at a time, staff had to use paper versions of patient records.
- In the 12 months prior to our inspection, three patients had been cared for in recovery, although none of these were cared for at the same time in the recovery area.
- Staff had escalated the issue of delayed discharges through incident reporting and clinical governance meetings. It was not evident that this had impacted how critical care patients were prioritised by site managers.
- An average of 74% of discharges were delayed by between four hours and 24 hours in the 12 months prior to our inspection, with 29% of discharges in the same period delayed by more than 24 hours.
- Staff avoided out of hours discharges as far as possible. An average of 11% of discharges from the CCU to wards had taken place between 10pm and 7am in the twelve months to our inspection.
- The unit had very low levels of transfers for non clinical reasons with one patient being transferred for non-clinical reasons in 2014/2015
- The CCOT nurses had won a trust award for their research around therapies that could be delivered on wards thus avoiding the distress of a critical care admission and reducing costs. The implementation of their project had led to a reduction in the CCU admissions for patients with pneumonia and type 1 respiratory failure.

Learning from complaints and concerns

- A complaints policy was in place and made available to visitors in the unit. Staff we spoke with were able to explain the policy to us and what they would do if they received a complaint. Complaint investigations were assigned to an appropriate senior member of staff, who maintained communication with the person involved until the problem was resolved.
- We saw that staff offered patients the opportunity to submit a complaint where appropriate during the investigations of incidents, such as after a misdiagnosis. Where this occurred, staff also advised patients they could obtain help from the Patient Advice and Liaison Service.

Are critical care services well-led?

Critical care

Good

we rated critical care services as 'Good' for well-led.

There was a coherent and visible leadership team in the unit that staff told us was effective and conducive to a supportive and positive working environment. A matron led this unit and the critical care unit at Worthing Hospital and staff told us the matron was accessible and easy to contact. There was a substantive programme of nurse development in place although nurses told us this was sometimes difficult to engage with because of short staffing and pressures on the service.

Significant focus was placed on the sustainability of the service through an improvement in staffing, access and flow as well as in future development by improving isolation and infection control skills and increasing the number of beds available.

Nursing staff said that the medical team and clinical directors were approachable and collaborative and that learning and development opportunities were consistently provided and completed.

Vision and strategy for this service

- The lead consultant for the service understood that the unit did not comply with the medical staffing requirements of the ICS and this had been raised through the appropriate channels. The recruitment necessary to ensure the unit was compliant had not been approved by the senior executive team and the lead consultant was compiling evidence to demonstrate the benefits to patients and staff of increasing the numbers of consultants.
- We found that the vision and strategy of the service was coherent and shared largely between St Richard's and Worthing Hospitals. Plans specific to St Richard's included the expansion of the CCOT service to 12 hours a day, seven days a week.
- Significant focus was placed on the role of hospital ambassadors by the executive team but some of the staff we spoke with in the CCU said they were unaware of this service and it was not visible on the days of our inspection.
- Staff were aware of the Patient First Initiative that was part of the Quality Strategy 2015-2018.

Governance, risk management and quality measurement

- The pharmacist was actively involved with the governance of medicines management and had set learning objectives for staff to reduce drug errors.
- The matron was exploring a solution to the unit's risks associated with a lack of isolation facilities for people with known or suspected serious infections. This included preparing a business case to purchase Bioquell pods to convert existing bed spaces into self-contained pods that could be used to isolate infectious patients. Consultations had taken place with the senior clinical team and the manufacturer to install the pods but the decision had yet to be agreed by the hospital estates department.
- The restricted hours of the CCOT service was recorded on the unit's risk register and senior staff were seeking funding approval to increase this service initially by two hours a day to match the service offered at Worthing hospital, followed by the introduction of a 24 hour a day, seven day service.
- The governance system at St Richard's Hospital was shared with Worthing Hospital. We saw this was cohesive but did not include cross site collaboration between intensivists due to low staffing numbers and the distance between the two sites. A monthly cross site strategy and governance meeting, and a quarterly nurses and medical staffing meeting took place that considered areas of clinical risk and governance.
- Senior nurses, consultants, doctors and the senior leadership team attended the monthly meetings to discuss the project to standardise practice across both sites. We saw from the minutes of meetings that common policies to improve safety had been implemented as a result of discussing incident investigations and staff feedback. For example, a new glycaemic control common policy had been implemented following a past incident. The policy had been rewritten after feedback from staff to improve blood sugar outcomes.
- The matron identified the most significant risk to the service as delayed patient flow. Although the use of

appropriate management policies helped to mitigate the risks of delayed admissions and discharges to some extent, the lack of priority for critical care patients in the hospital's bed management system meant that capacity management was not always effective.

- Key messages and learning from directorate and clinical governance meetings were displayed for staff on notice boards. Most recent communications reminded staff to: document pain scores consistently, improve the maintenance of tracheotomy kits, complete mandatory training on treatment for blood clots and to implement a rehabilitation meeting once a patient had been in the unit for longer than 72 hours.

Leadership of service

- Staff at all levels of the unit told us they were happy with the leadership and the support structures but felt that pressures resulting from short staffing and high levels of capacity were accumulating. One member of staff told us they had worked in the unit for a long time because they felt very happy there and that everyone was included in communication from the senior team. Staff also told us they felt involved because of the multidisciplinary approach to the morning safety huddle that was inclusive across staff roles.
- Some staff identified areas in which training opportunities could be improved. For example, a nurse told us there was a lack of clarity around how staff were selected for training as they felt there had been an unequal approach to who could take management and advanced life support training.
- The clinical nurse educators (CNEs) at both critical care hospital sites had adapted the Critical Care Network Nurse Leads Forum (CC3N) clinical leadership competency framework to the band six nurse role, to provide substantive developmental opportunities to staff. This programme included the completion of a CC3N level one workbook, an orientation period in the leadership role and a twelve month assessed competency period. This strategy was used to stabilise the staff team and to secure long term commitments from nurses.

Culture within the service

- Staff told us about an inclusive working culture in which they were encouraged to work together to share advice and education. We saw evidence of this in our discussions and observations of physiotherapists, the unit's pharmacist and other specialists demonstrated they worked well together. A physiotherapist had presented examples of the work ongoing in critical care at the National Critical Care Conference, demonstrating a commitment to sharing learning and good practice.
- Nurses were organised into teams that provided a structure to focus on areas for policy development and practice improvement, such as infection prevention and control.
- Most of the staff we spoke with were positive about the working relationships of doctors and nurses of different grades. A nurse told us they felt the inclusive culture of the service was quite unique and it sometimes took doctors who came from different hospitals time to get used to working as part of such a team. The relationship between nurses and the clinical lead was described as good by nurses who also said they felt able to approach him at any time.

Public and staff engagement

- A nurse told us that if the CCU was not full and a ward needed a nurse, a site manager could redeploy a CCU nurse to a ward to look after up to four patients. They told us, "This is not safe. We take it in turns to do this but it's very time-consuming because we have to triple check things like medicine because we're not experienced in looking after medical patients on wards."
- Staff spoke positively about their involvement in the trusts Patient First STAR Awards, which recognised staff achievement and awarded the CCOT team as a runner up to the Care for the Future Award.
- There was not always a clear communication pathway between senior clinical staff and the executive team, particularly with regards to the outcomes of risks escalated through clinical governance. For example, we saw that the clinical need for an extra two consultant intensivists had been escalated by the lead consultant on a number of occasions, without a resolution. Staff we spoke with said they felt this was due to the limited funds available but they did not always feel that their concerns had been listened to and understood or that they were engaged with appropriately by the senior leadership team.

- The visitors day room had been refurbished following feedback from relatives. Feedback had also led to a photograph of each member of staff being displayed at the entrance to the unit. This also included clear details of who was in charge of each shift, who people could approach with a query and how people could identify staff roles based on their uniform.

Innovation, improvement and sustainability

- The CCOT team had successfully presented a business case to the Friends of Chichester Hospitals for the need for Optiflow machines. The team was provided with four machines as a result of this and another five machines were sourced as a result of a fundraising event held by nurses and a respiratory consultant.
- Learning from good and improving practice and site-level audits was shared with other critical units nationally, for example, the sharing of nurse-led Sepsis 6 BUFALO pathway training with a hospital in Bradford.
- The appointment of an experienced critical care nurse in an IT liaison role ensured the piloting and implementation of the ICIP system did not impact patient care or obstruct clinical staff. In addition, a robust multidisciplinary, consultative approach with critical care and IT specialists in the trust meant that the system was thoroughly tested as safe and appropriate for CCU use. Two dedicated IT staff had worked with the lead project nurse to configure the system to the clinical needs of the CCU and where available on call to troubleshoot systems issues, which had been very rare. There was an emergency backup to the power supply to prevent treatment interruption and hard copy printed patient notes were kept in the unit in case of a catastrophic systems failure. The next stage of the ICIP programme included adapting its use for CCOT nurses to streamline their patient tracking and records in line with the main CCUs.
- The CCOT nurses had won a trust award for their research around therapies that could be delivered on wards thus avoiding the distress of a critical care admission and reducing costs. The implementation of their project had led to a reduction in the CCU admissions for patients with pneumonia and type 1 respiratory failure.
- To address the shortfall in intensivist cover out of hours, senior staff had planned a pilot of a telemedicine model that would enable a new intensivist to cover the CCUs at both hospital sites. The pilot would include a supernumerary ward round and supernumerary on call cover to assess the method's suitability for critical care patients.

Maternity and gynaecology

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

Information about the service

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

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

The service has one telephone maternity triage service that covers both main sites. Both St Richard's and Worthing Hospital have an early pregnancy assessment unit and ambulatory gynaecology services, and there is a dedicated emergency gynaecology day unit on the Worthing site. Gynaecology inpatients are cared for on the combined surgical wards.

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

St Richard's Hospital staff delivered 2,729 babies, an average of 228 births a month.

There is a midwife led birthing unit at St Richard's Hospital. The birthing unit is designed to provide a relaxed environment for normal, uncomplicated birth. There are three individual en suite rooms with low lighting, two of which have birthing pools. The birthing unit is adjacent to a separate nine bedded delivery suite where obstetricians lead care and treatment.

On the labour ward at St Richard's Hospital there are eight delivery rooms and two obstetric theatres. Planned caesareans are carried out from Monday to Thursday. There are usually two or three a day.

At St Richard's, antenatal and postnatal care is offered on the 27 bedded Tangmere ward. There is a level 1 special care baby unit at Worthing Hospital for babies who require additional monitoring and a level 2 Local Neonatal Unit, for babies requiring short term intensive care, at St Richard's Hospital. Babies requiring greater levels of support are transferred to a hospital with a level 3 unit.

The service offers gynaecology surgery at both main hospitals. At Southlands Hospital, the service offers an ambulatory gynaecology, including colposcopy and hysteroscopy. Patients with gynaecological cancers are referred to the cancer centre at an adjacent trust.

Termination of pregnancy, for fetal abnormality is carried out at St Richard's Hospital with 294 such terminations being carried out in 2014/15. All other terminations of pregnancy are contracted out and performed by another provider.

Maternity and gynaecology

We visited all areas of maternity services and spoke with 79 members of staff, some on an individual basis and others in joint meetings, handover sessions and focus groups. This included staff of all grades including; midwives, doctors, consultant obstetricians, domestic staff, maternity care assistants, receptionists, ward managers and members of the senior management team. We observed care being given, staff interactions, the availability of equipment and the quality of the care environment. We reviewed written material such as policies, guidelines and safety protocols and we reviewed formal arrangements for audit and the management of risk in order to evaluate the governance arrangements.

Summary of findings

Overall, we rated maternity and gynaecology services as 'Outstanding'.

People were protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things went wrong. This was demonstrated in safety thermometer results which showed the maternity service had achieved 100% since December 2014.

The service provided effective care in accordance with recommended practices. Outcomes were good and the service frequently performed better than the trust own target. This was especially true of the work being done to reduce stillbirths and admissions to SCBU and NICUs. The service continually monitored outcomes for women and used incidents and complaints as opportunities for learning and improving services. There were high levels of multidisciplinary team working, both within the service and with external partners. Compliance with training was good and staff were offered additional opportunities for learning and development.

Care was compassionate and supportive and staff treated women and their families with respect and dignity. Outside the inspection visit we were contacted by many women who used maternity and gynaecology services to tell us about their experiences. All those who contacted the CQC were extremely positive about the care and support they received. Performance in the FFT and the maternity Services Survey 2015 showed performance above he national average.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Outstanding ☆

We rated the service as 'Outstanding' for 'Safety'. People were protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things went wrong.

This was because of the culture of learning from incidents and mistakes that pervaded the service and the focus on patient safety which resulted in the trust providing 100% harm free care in maternity services at St Richard's hospital since December 2014. There were some staffing shortages but these had not impacted on patient safety as there was sufficiently robust mitigation in place.

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

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

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

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

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

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. A staffing acuity tool was in routine use and clear escalation plans provided a rapid response where staffing shortages were identified. Consultant cover was provided above the level recommended in the national guidance but there were acknowledged shortfalls in midwifery staffing. The trust was aware of this and was mitigating against the risks associated with lower than ideal staff levels and recruitment was well advanced. Women still received safe care and the patient outcomes remained very good.

Incidents

- Between 1 November 2014 and 31 October 2015, 13 serious incidents were reported to have occurred in the maternity and gynaecology services across the trust. We read the reports of these incidents and saw that five involved the mother only, three involved the baby only and one involved both mother and baby. Two incidents involved delays in appointments, procedures and diagnosis, one incident involved a screening issue and one involved an invasive procedure. All the reports indicated that an independent multidisciplinary panel had collected evidence and a transparent investigation had taken place with a view to learn lessons rather than to apportion blame.
- We read the notes of some of the women's health integrated quality safety meetings and saw that medical staff were fully engaged in the analysis of incidents and identification of any trends.
- We spoke with the patient safety midwife who told us about the monthly patient safety meetings that were held alternately at Worthing and St Richard's. Staff attending these meetings included the head of midwifery, the quality governance and experience lead

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

- We saw the minutes of these meetings and noted that they discussed the monthly incident report, trends, safety alerts and the risk register. For example, we saw that ultrasound scanning had been added to the risk register because of capacity, as a result a member of staff had consulted colleagues and produced a 'working plan'. More scanning machines had been included in the trusts bid for the use of capital and additional scanning lists were being held in antenatal clinics over weekends to clear the backlog of nuchal combined scans (a screening test for Down's syndrome).
- Staff demonstrated their awareness of a 'never event' that had happened in the gynaecology day service at Southlands hospital, when a vaginal swab had been retained post procedure. As a result of this incident, a standard operating procedure for gynaecology invasive procedures had been adopted for all surgery conducted outside of an operating theatre. In addition, the World Health Organisation (WHO) checklist for safer surgery had been adapted for use in outpatient settings and staff training had been updated. This demonstrated to us that staff were using this incident to learn lessons and improve procedures.
- We saw the minutes of the gynaecology risk meeting of October 2015 which included an update on the actions agreed following the never event. The minutes indicated that a new colposcopy standard operating procedure had been written in line with invasive procedures safety checklist in theatre and compliance was being audited. In addition, new boards had been installed to support swab counts. This demonstrated to us that staff were using this incident to learn lessons and improve procedures.
- The investigation panel considered the trust's obligations resulting from the duty of candour. We reviewed an investigation and saw that parents were offered an opportunity to discuss events and a copy of the investigation report was made available to the parents of the baby. The investigation was thorough and the process was open and transparent.
- Staff were aware of the incident reporting system and the importance of learning from incidents. Seven of the serious incidents took place at St Richard's Hospital. One incident involved a woman with learning difficulties and the investigation identified the need for further training for midwives in the Mental Capacity Act. It was also recommended that this training should become part of the annual statutory and mandatory training requirements. This recommendation had been implemented and it was reported in the integrated performance meeting. The September 2015 edition of the staff newsletter included an update on the Mental Capacity Act.
- This same incident had led to careful consideration, from a multi disciplinary team approach, of the exercise of the trust's responsibilities in relation to the Duty of Candour. We saw from the investigation reports that the trust was fully aware of the need to be open and transparent and patients were informed, as a matter of routine, of incidents and information, including the investigation report which was shared appropriately.
- Issues, recommendations and action from investigations were reported, discussed and implementation tracked at various service wide meetings, such as, the monthly women's health integrated operational meeting, perinatal meetings, the labour ward clinical group meetings, the obstetric and genecology operational service meetings and the patient safety meetings. We were also informed that patient safety 'huddle' meetings had been introduced and were taking place daily on the wards and units.
- There was also a monthly newsletter to staff from the patient safety midwife. We saw the St Richard's Hospital editions for September, October and November 2015. All three editions included praise and congratulations from serious incident reviews as well as reminders about guidance and practice. For example, there was patient safety newsletter in the November edition where praise from the clinical care group for the maternity team was passed on from a perinatal meeting following a serious incident. There were reminders about completing documentation and convening the daily safety huddle.
- Other incidents were also reported and monitored across the trust. From 1 November 2014 to 31 October 2015 there were 984 incidents reported in maternity and gynaecology services. In 81% of these incidents there

was no harm to the patient. There were 18 incidents resulting in moderate harm, but there was no clear theme to these incidents. This level of reporting demonstrated an open and honest reporting culture and a commitment to continuous improvement.

- The patient safety midwife told us that information about learning from incidents was shared via 'Maternity Matters' a monthly bulletin circulated with pay slips, face to face group meetings, individual meetings and supervision. The patient safety midwife said that when action was taken at one site, they checked what was happening at the other site so that the learning was shared and procedures remain consistent.
- During the same period there were two maternal deaths and two babies died. These deaths were reported appropriately and fully investigated and found to be unavoidable. Support was offered to the families and the staff involved. The mortality and morbidity data from maternity and gynaecology was reviewed in the patient safety section of the monthly operational departmental and governance meeting. Perinatal meetings took place fortnightly.
- Whilst no harm had come to mother or baby, we felt that one case should have been fully investigated to establish the facts. The trust representative agreed and immediately reported this case through the incident reporting system. We also felt that assurance was needed to establish that this was a single error and not part of a wider problem with the processes for identifying and managing risk. The trust agreed and by the next morning had resolved to conduct a thorough audit of cases to ensure that risks were being properly identified and managed across the service.
- When we visited the early pregnancy assessment unit we were informed by the antenatal and new born screening midwife of a missed screening appointment that was picked up, ten days after it was due, by a Health Visitor. As a result the screening process is now tracked by team leaders who print off the list of women who have been discharged and they double check that all screening has been completed. This process has been adopted on both sites.
- At the focus group one midwife said "I feel the response to incidents is all about lessons learnt and what can be changed. Everyone feels involved at all levels and that makes people feel valued."

Safety thermometer

- The NHS Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care. It also records the extent of harm associated with maternity care. It is intended for public display so that the public are informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from perineal and/or abdominal trauma, post partum haemorrhage, infection, separation from baby and psychological safety. It also records babies with an Apgar score of less than seven at five minutes and/or those who are a admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.
- The maternity service participated in the NHS safety thermometer for the trust. This is a local survey carried out in relation to all patients on one day each month in respect to patient falls, catheters and urinary tract infections, pressure sores and venous thromboembolism.
- Results of the safety thermometer survey were displayed on Tangmere ward and we noted that there had been no reported incidents of these kinds since December 2014, achieving 100% harm free care.

Cleanliness, infection control and hygiene

- We observed all areas of the hospital providing maternity services, apart from the labour theatres which were in use. We found the standard of cleanliness to be good and there was evidence that domestic staff followed guidance in regard to the required cleaning standards, practices and frequency of cleaning. We found stickers on items of equipment indicating they were clean and ready for use. Domestic staff tended to keep their own cleaning schedules in the cleaning cupboard rather than displaying them in the rooms.

- Women said that they were pleased with the level of cleanliness.
- We saw the 'patient led assessments of the care environment' (PLACE), for the labour ward, birthing centre and Tangmere ward. This is a system for assessing the quality of the patient environment which involves local patients in the assessment. The labour ward assessment was conducted in August 2015 and scored 86% for ward cleanliness. There was some dust found in two rooms and on equipment. The ward scored 95% for 'condition and appearance', this was because of some repairs required to walls and marked paintwork. The ward scored 100% for hand hygiene, staff appearance and safety and privacy, dignity and wellbeing. The same assessment for the birthing centre took place in September with similar outcomes. However, in September the PLACE assessment for Tangmere ward scored 100% overall.
- We saw infection control audits undertaken for Tangmere ward for July 2015. The audit found that the ward was 91% compliant with the expected standards and made recommendations in relation to boxes stored on the floor rather than above floor level and regular cleaning schedules. Evidence of quality care and best practice was identified that personal protective equipment was being used correctly to reduce the risk of cross infection and that waste is handled correctly.
- We checked the curtains and found that they were all dated when they were reviewed and changed.
- We also saw infection control reports for high impact interventions for June, July and August. These reports included scores 100% of correct procedures for tasks such as central line and urinary catheter insertion but 99% for decontamination audit clean for June and August and 100% for July. There was 100% compliance with hand hygiene for all areas in June apart from gynaecology outpatients where two weeks of data was missing. In August the delivery suite had two weeks of missing data for hand hygiene audits and gynaecology had one missing week.
- Rates of infection such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile were better than the average for hospitals in England. There had been no reported cases of MRSA at St Richard's Hospital from July 2014 and no surgical site infections in gynaecology since June 2014.
- The audits of compliance with the National Specification for Cleanliness in the NHS for St Richard's hospital showed scores of 100% for the labour ward, 96%, antenatal unit and Tangmere Ward was also above the target set by the trust.

Environment and equipment

- The risk register showed that the trust had twenty four neonatal resuscitaires across both sites and 16 were either over ten years old and/or did not meet the specification required to follow the Resuscitation Council guidance for newborn life support. Fourteen of these 16 resuscitaires currently in use did not have the ability to deliver air of blended gas, as recommended in the guidance. The risk register did not have the date when this item was added or any columns for mitigation and action. We spoke to several staff about this and they said that they were being replaced but none were aware of a date for replacement.
- The scanning machines in the early pregnancy assessment centres at both sites were also on the risk register because the service felt they needed to be replaced. The risk register described the issue: "The limited resolution produced by both machines results in low quality images meaning higher rescan rates/missed diagnosis rates as sonographers have no confidence in these images." It was also noted that the need to rescan before providing a clear diagnosis caused anxiety for patients.
- A clinician we spoke with also linked this to a particular incident were the quality of images was a factor. Again, we were unable to obtain a confirmed date for the replacement of these two scanning machines and the risk register stated that a case for replacement was due to be written in September 2015.
- There were birthing pools in the birthing centre and on the labour ward. We saw that there were nets for use in an emergency should a woman collapse in the pool. The team practised emergency evacuation of the pool with the net once a year.

- We saw that resuscitaires were available on the labour ward and noted that they were cleaned and checked daily and were all within date before the next service. We also checked that the trolley for resuscitation which was fully stocked with equipment and had been checked each day. The trolley was secured with a tag and was easily accessible in the corridor of the labour ward. This meant the equipment was ready for use.
- We saw and midwives confirmed with us that cardiotocgraphy (CTG) equipment was available to enable them to monitor the foetal heart during the second stage of labour.
- We saw an equipment maintenance log for St Richard's Hospital. We saw that there was an entry on this log for a new breast pump for the Tangmere ward as a fault had been detected through routine checks. This demonstrated that there was an active maintenance programme for equipment.
- We saw a policy on the management of medical devices within the trust.

Medicines

- Drugs were in a locked cupboard and there was a locked cupboard within a cupboard to store the controlled drugs. The key was always with the midwife in charge. We saw that the records for all drugs were checked regularly and were complete.
- There were prepared drugs boxes for pre-eclampsia and sepsis. These boxes were checked weekly and there was a checklist inside. We found two insulin pens that were out of date. We told a midwife who said they would let pharmacy know.
- We also saw that the temperatures on the medicines fridge were checked daily. The fridge was not locked but was in a locked room.
- Also in the room, secured by a digital code, there was an emergency box prepared and ready for use in the event of postpartum haemorrhage (that is blood loss greater than or equal to 500 mL, within 24 hours of delivery). There was also an emergency 'grab box' for dealing with sepsis and pre-eclampsia. The boxes contained the relevant protocols.

Records

- There were green postnatal notes and buff coloured notes for babies. There were also hand held notes and the red books for babies. Red books are used nationally to track a baby's growth, vaccinations and development. There was a theatre record booklet for recording treatment and observations during surgery which stopped being used after recovery when it was absorbed into the postnatal record. The hand held notes for mothers contained useful information about pregnancy, screening, pain relief, choices and what to expect at the birth.
- There was an electronic recording system and the service was investing in laptops for community midwives to record patient details.
- We saw a reminder in a bulletin from the Director of Medical Education for staff to make clear entries in the notes including date, time, signature, printed name and designation. The reminder said that "a number of issues have arisen recently due to the inability to identify who had make entries in the notes." This showed us that the quality of medical recorded was monitored and action taken when necessary.
- We looked at six sets of notes at St Richard's Hospital. All but one set of notes had either a named consultant recorded (for high risk pregnancies) or a named midwife (for low risk) All had the appropriate risk assessments and all had legible signatures.
- We were told by several midwives and administrative staff, in one-to-one sessions and in the focus groups, that the maternity records had been relocated to off-site storage.
- The minutes of the Women's Heath Integrated Quality and Safety meeting that took place in September 2015, showed that staff were concerned that the decision to archive notes would have a "large impact on access for patient care, i.e. complaints, audits, risk and clinics as notes will need to be retrieved from off-site storage." There was no evidence this had caused any risk to patients.
- The issue had also been entered onto the risk register in September 2015. There was an update in October indicating that the trust had decided to employ an additional clerk for the 'retrieval and culling' of maternity medical records for one year. There was a

further note following a discussion at the women's health operational meeting advising staff to make better us to the electronic record system and that a case was being made for more computers on the wards.

Safeguarding

- All medical staff and midwifery staff had completed level 3 child safeguarding training. All midwifery staff had completed adult safeguarding training.
- We met with the named safeguarding midwife for the trust. The safeguarding midwife told us about a number of separate pathways they had developed in the service for more vulnerable women in pregnancy. There was a multi-agency pathway for teenage young parents supported by a young person's midwife, family support worker, health visitors and colleagues from social services. Together these health and social care professionals created "the team around the family."
- The trust also had a Family Nurse Partnership for vulnerable first time mothers facing challenging situations. In this partnership, nurses have a smaller caseload in order to work closely with a young woman throughout her pregnancy and until the child is two years old.
- We saw a local protocol for maternity services and adult drug and alcohol treatment services. This was for pregnant women and their partners who use substances. The public health midwife also told us about the work of the service with domestic violence and the NSPCC safeguarding and child protection model called 'signs of safety'.
- When we visited we heard of woman who had been referred for a caesarean section from another trust because of safeguarding issues. The woman was anxious because of an abusive partner. The referral and the elective caesarean was conducted within 24 hours at St Richard's Hospital. We spoke with the woman who told us she had been pleased with the speed of the service and with the care and treatment. The case was also raised by staff at the midwives focus group as an example of responding rapidly and dealing sensitively and effectively with a safeguarding risk.
- We saw that a consultant in community gynaecology had circulated a document to staff about female genital mutilation (FGM) and the responsibilities of individuals to report cases involving under 18's to the police and safeguarding. Since September 2014 it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patient's health record; there was a clear process in place to facilitate this reporting requirement.
- We saw an item on the risk register about a difficulty in exchanging safeguarding and child protection information with the British Pregnancy Advisory Service (BPAS). The trust was trying to resolve this situation, was referring to the department of health policy for sharing information entitled 'seven golden rules' and had raised the matter at the trust's safeguarding forum. It was reported that the issue was largely resolved.
- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
- We were told of and saw evidence of systems in place to monitor the disclosure of Domestic Abuse by midwifery staff in line with NICE guideline [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded.
- A safeguarding midwife at the focus group informed us that safeguarding supervision was taking place in accordance with the Department of Health requirement (Working Together to Safeguard Children, 2010).

Mandatory training

- Overall, across both sites, the service was meeting the trust target of 90% compliance in four out of ten training modules. Nursing and midwifery staff were 90% compliant with training in infection control, child and adult protection and health, safety and risk. They were just below their 90% target for completing training in fire safety, information governance, equality and diversity conflict resolution and resuscitation training. Medical staff in the service were 90% compliant with modules in infection control, child and adult protection and health,

safety and risk. They were just below their 90% compliance target in fire safety, information governance, back training, conflict resolution and resuscitation training.

- At St Richard's Hospital compliance was good across nursing and midwifery staff groups and across community midwifery. Compliance with all the mandatory training was close to 100% in ultrasound scanning and in gynaecology cancer liaison.

Assessing and responding to patient risk

- A senior midwife conducted a risk assessment when a woman requested a home birth. This meant that care was taken to assess and manage risk when considering the suitability of a home birth.
- The service used the Modified Early Obstetric Warning Score 'MEOWS' charts to provide graphic evidence of the health of a patient deteriorating. However, we noticed that a few charts had not been calculated to give an overall score and had not be signed by the clinician.
- We asked the trust for a recent audit of the completion rate for MEOWS charts. They said that they had not completed an audit since 2013, but had plans to complete them every three years so the next one was due in 2016.
- Whilst no harm had come to mother or baby, we felt that one case should be fully investigated to establish the facts. The trust agreed and immediately reported this case through the incident reporting system. We also felt that assurance was needed to establish that this was not part of a wider problem with the processes for identifying and managing risk. The trust agreed and by the next morning had resolved to conduct a thorough audit of cases to ensure that risks were being properly identified and managed across the service. This demonstrated a very proactive approach to managing concerns.
- The senior management team informed us of their plan to introduce telemedicine software into the service for the remote review of CTG. This would allow staff to review CTGs at a monitoring station and it would allow an opportunity for 'fresh eyes' review of CTG traces away from the woman in labour. It would also allow the on call clinician to review the CTG from home via a safe server. We were informed that a business plan had been prepared but had been put on hold in the summer pending further research on 'safety and efficiency' of centralised monitoring.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy.
- The senior midwives and doctors on duty provided CTG review known as 'Fresh Eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that is it was within normal parameters. The trust recognised that it was important to refresh the CTG training regularly and enable staff to attend. One of the clinicians said "it is genuinely fresh eyes and not four eyes."

Midwifery staffing

- The ratio of midwifery staff to births within the service, taken across both sites combined was slightly better than the England average, with one midwife to 25 births in May 2015. The England average for that month was one midwife to 27 births. The benchmark commonly used is 1 midwife to 28 births and the trusts own target was 1:30 or better.
- There had been a steady improvement in the midwife to birth ratio since March 2014.
- We asked the trust to supply vacancy numbers and they confirmed that for November 2015 there were 17.9 (whole time equivalent) vacancies in maternity and gynaecology in total across both sites.
- We saw the data for the numbers of staff that were planned to be working and the number of staff (including bank staff) who were actually working each month from May to August 2015. The number of actual qualified staff working appeared to be close to the numbers planned. However, there were fewer numbers of maternity support assistants and support staff working, compared to the planned numbers.

Maternity and gynaecology

- We attended a meeting with senior staff of the service and they agreed that the staffing levels were a challenge in maternity and gynaecology. The Divisional Business Plan described the staffing situation for midwives as 'frail'. This was due to a combination of factors including leavers, maternity leave and an increasing sickness rate which was 3.3% at the time of our inspection. Staff at the focus group said that staffing levels had been "challenging for the last six months and they were not better yet."
- In addition, the new recruitment system was adding delay to recruitment. They said that recruitment was underway for qualified staff and three had been recruited but were not yet in post. The trust had introduced the 'Trac' recruitment system to speed things up.
- A senior manager provided an example to illustrate the length of the time from interview to being in post. A new member of staff was interviewed in June 2015 and was still not in post in December 2015.
- The service did not use staff from an agency to fill vacant shifts in maternity but had an internal bank arrangement where existing staff, with a substantive contract, could cover additional vacant shifts. There were also a few who were working exclusively as bank staff. This meant all staff working on the unit were familiar with the policies and procedures in use and reduced the risk of incidents attributable to unfamiliarity with equipment and usual practice.
- The trust used an intrapartum acuity tool at least every four hours to monitor activity and staffing on the delivery suite. This enabled the coordinator and midwives to assess their 'real time' workload arising from the numbers of women needing care, their condition on admission and throughout the processes of labour and delivery. This meant that the coordinator was regularly assessing the capacity on delivery suite and could escalate when necessary to ensure the safety of women and babies.
- The telephone triage system was aware of the situation and was diverting women to St Richard's Hospital because the delivery suite at Worthing hospital was overly busy at the time of our visit and had closed to any new admissions. This divert was still in place when we had completed our visit at midday the following day. For the period January to October 2015 there were a total of 29 women who were diverted to Worthing Hospital although not all women that were diverted gave birth, many were reviewed, discharged and gave birth at a later date at the hospital they originally booked with.
- Staff in the focus group said that morale had fallen because of the staffing levels and staff felt they were struggling to maintain the excellent care they wanted to provide. When we asked about the impact on women and their babies, they said that the staff had to prioritise and that may mean, for example, not seeing women who wanted to be discharged because there were more urgent tasks to deal with. We asked if safety was affected, and they said it was not because they prioritised safety. They said that it was activities such as breastfeeding support and timely discharge that were affected. The evidence from breastfeeding data showed better than England average breastfeeding initiation rates which suggest that whilst this was a concern for midwives, it had not impacted upon the service provided to women.
- There were six to eight midwives in each community team. There were five teams and an additional team of case loading midwives for more vulnerable women. There was a community midwife responsible for younger people.
- There was a former community midwife in the focus group and they said "Community midwives work well and provide good continuity of care. They have more autonomy than hospital based midwives." "Case loads are OK, some have larger caseloads but, on the whole, it is manageable."
- We spoke with a senior midwife who said that the average community midwife caseload was approximately 70 cases for a full time member of staff. We were told that this was manageable because the case loading teams would care for the more vulnerable women. The most recent England average caseload is 98 cases per WTE community midwife according to Birthrate plus. The trust ratio was significantly better than the average.
- We spoke with a community midwife who had finished her visits for the day and had come into the hospital to make telephone calls and complete paperwork. The midwife said that she had a caseload of 80 and she only

worked four days a week. She said they routinely worked in excess of her contracted hours and that there was no time in the working day to complete paperwork. She also said that community midwives were required to provide backup for the birthing centre at St Richard's and that might take a day out of her four day week. She said that the trust was very supportive but, at the same time at times it felt "overwhelming."

- We were informed that midwives at St Richard's were required to attend the obstetrics theatre to provide instrument/scrub assistance or to act as the assistant to the obstetrician out of hours. This practice was contrary to the consensus statement on staffing obstetric theatres agreed by the College of Operating Department practitioners, the Royal College of Midwives and association for Perioperative Practice, published in May 2009 which agreed that "the midwife's primary responsibility in the theatre setting is to the mother and her baby."
- We spoke with two senior midwives who said that staff were already "stretched" without having to provide a midwife to assist the obstetrician in theatre in the evening. They said that not every midwife was trained to perform this task and so the burden fell on a limited number of midwives. When we spoke with the divisional director she confirmed that the problem was a lack of theatre staff and negotiations were underway to resolve the issue. We also found that this was an item on the risk register and the risk had been raised with the Director of Nursing in September 2015.
- We saw on Tangmere ward that there was a list of staff on duty along with details of their roles and the time of their breaks. There were five midwives on duty during the day and four at night time. The staff on duty matched the staff required. Staff said that seemed adequate if they were all there all the time but sometimes they were called to assist on the labour ward if it was busy. There was also a midwife coordinator on duty but one member of staff was required to 'scrub' and assist in the obstetrics theatre.

Medical staffing

- The skill mix and profile of the 62 medical staff in maternity and gynaecology services at the trust was similar to the average across trusts in England. The only difference was that there were fewer registrars at Western Sussex and slightly more middle grade doctors, that is, doctors who had been working at a senior level for at least three years, compared to the England average. This meant that the medical staff were more experienced than at other trusts in England.
- The intercollegiate document safer childbirth: Minimum Standards for the Organisation and delivery of care in labour recommends that there should be at least 40 hours of consultant presence on a labour ward with the number of deliveries at St Richard's Hospital. The arrangements made by the trust exceeded this level of cover with 80 hours of resident consultant cover per week on the labour ward at St Richard's Hospital. There was consultant presence from 8.30am to 6.30pm and always a consultant on call out of normal working hours.
- The national shortage of junior doctors in obstetrics and gynaecology and the inability of the trust to fill its obstetric registrar rota was on the risk register. We were informed of the mitigation involving the use of long term locums, some consultant obstetricians were 'acting down' to cover vacancies and there was effective collaboration across the two sites.
- The Divisional Business Plan and Strategy said, "The Division has had to have an innovative approach to recruitment and has introduced the role of resident on call consultants (ROCs) in order to mitigate the risks surrounding the reduced number of junior doctors."
- There was recruitment underway. There was an obstetric consultant of the week on each site and there was an obstetric anaesthetist available 24 hours a day, seven days a week. We found that the medical staff were fully engaged with the midwives and with other colleagues.
- Medical staff did not share the same rotas across the two sites, that is, they worked at either Worthing or St Richards's Hospital. But we were informed that staff from St Richard's had recently covered sickness for higher levels of sickness at Worthing rather than employing additional locum doctors. The clinical director for the service said that they worked well as a team and put the patients' needs first. They said that there were high levels of communication, cooperation and a collegiate approach.

- Weekly consultant meetings took place on each site and the labour ward consultant conducted a review of caesarean sections at each site every morning and at the multidisciplinary handover. There is a monthly divisional meeting.
- The risk register had an entry on the national shortage of ultra-sonographers and the impact this may have on the women receiving timely and appropriate scans. There were some dual trained midwives and gynaecology nurses providing some additional capacity and further ultrasound sessions were being offered to women at weekends. However, the issue was ongoing and a business case was to be developed in January 2016 to increase the number of dual trained staff within the service.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Outstanding ☆

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

This was because outcomes for patients were in line with or exceeded the national averages and trust own targets for most indicators. The work being done to reduce stillbirth was particularly impressive with a stillbirth rate that was much lower than the England average. The level of unexpected admission to SCBU or NICU was also impressively low with the trust achieving admission rates that were a fifth of the predicted levels.

The work being done by the trust around the management of the perineum during delivery had resulted in far fewer grade 3 and 4 tears than the trust's own upper limit target. This in turn led to far fewer women suffering long term complications such as pain, incontinence and prolapse.

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

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

People's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice and the service was continually monitoring patient outcomes. The service was seeking to make improvements in a number of areas including in the rates of normal births.

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

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

Maternity and gynaecology

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

Evidence-based care and treatment

- Women using the services of the trust were receiving care in line with the National Institute for Health and Care Excellence (NICE). For example, routine antenatal care was delivered in accordance with NICE standard 22, including screening tests for complications of pregnancy.
- We saw documentary evidence that the trust had benchmarked their guidelines against NICE guidance and that the guidelines were consistent with the relevant NICE guidance. For example, the local guidance on ectopic pregnancy and miscarriage was compliant with NICE quality standard QS69 and the local guidance on induction of labour was compliant with NICE quality standard QS60.
- We also saw that guidance published by NICE and other organisations was used to inform best practice in relation to investigations. For example, in one root cause analysis, reference was made to NICE guidance from 2014 in relation to maternal sepsis and fetal wellbeing. In another investigation report into a massive obstetric haemorrhage, reference was made to the national guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) Prevention and management of postpartum haemorrhage (2009) and the Royal College of Anaesthetists (RCOA) guidelines for the provision of anaesthetic services (2014). The ROCA guidelines were used to conclude that the anaesthetist should have remained with the patient until transfer to recovery.
- We were provided with a copy of 'Learning points of the week', a weekly bulletin written and circulated by a consultant Obstetrician and Gynaecologist. The bulletin included a reminder of the new NICE guidance on menopause; a link to the Health Foundation's report on continuous improvement in patient safety; and a reminder to staff to complete the twin and multiple birth pathway. There was a link to this local trust guidance in the bulletin. The consultant made the point that it was important to counsel women in advance so that they can make informed choices about labour.
- We saw that a local audit was undertaken in October 2015 on completion of the WHO checklist in maternity theatre. In the same year there were audits for antenatal care, the gynaecology day unit in Worthing and Bramber and Tangmere Wards. These audits were followed up with an identification of the lessons learned, action plans and implementation of the outcomes of the audit.
- We saw the audit programme for 2015/16 and saw that further audits were planned on caesarean sections, the outcome of multiple pregnancy and outpatient hysteroscopy as part of the ambulatory gynaecology service.
- The service was basing its strategic plans and quality strategy on the 'Better Births Initiative' which is the Royal College of Midwives project aimed at developing maternity services in the UK. They were also using the Department of Health Patients First programme to standardise and improve patient pathways.
- We were informed that there was a weekly meeting involving fetal surveillance where a case was presented and scenario's debated and discussed. The consultant said that the use of CTG monitoring, the use of 'fresh eyes' and interpretation is a matter for continuous debate and learning across the service.

Pain relief

- Women had hand held notes which provided information on pain relief. There were also leaflets available in the clinics and on the website. The leaflets set out options such as using transcutaneous electrical nerve stimulation (TENS) or Entonox or pethadine.
- An anaesthetist was always available for epidurals and we noticed that the women we spoke with found the anaesthetist helpful and reassuring.
- We spoke with a woman on Tangmere ward who said who said that her pain was well managed throughout labour. At the same time she said she felt in control.
- There is a birth centre at St Richard's Hospital with three rooms; two of these had birthing pools which meant that women could use water emersion for pain relief in labour. We saw these rooms and they looked comfortable and relaxed.
- There was adequate equipment such as a birthing balls and a V shaped pillow to support women in labour.

- The trust ran a workshop and leaflet on hypnobirthing. We met a woman on Tangmere ward who was in hospital for antenatal support and she had been learning scripts for hypnobirthing.

Nutrition and hydration

- We spoke with a woman who said that the food was "pretty good. There was a menu with choice and it was really pretty good."
- There was support for mothers with newborn feeding. One woman said that, “The feeding workshop was informative and the midwives were very helpful and I felt supported me.” The breast feeding initiation rates for April to November 2015 was 80% at St Richard’s Hospital, which was better than the national average of 75%.
- The hospital was one of the first in the country to receive the Unicef Baby Friendly Award in 1999. The midwife leading on public health, who informed us that the trust was now part of a multi agency initiative developed in West Sussex entitled ‘Five to Thrive’. It was described as a programme to support parents and carers with pre-birth to 2 year old children "to promote positive behaviours that help build baby brains and develop loving attachments." The public health midwife said that she was aware that the breast feeding initiation outcomes had been pretty static for some years and so the trust had decided to try a different approach. This new programme had been launched recently and was designed to be inclusive and holistic. That is, it would involve all parents however they choose to feed their baby.
- The public health midwife also told us about a new community based weight management in pregnancy programme that had been developed with a group of six service users. The programme had been given an ‘All Party Parliamentary Award’. It was designed as an alternative to just being weighed by a medical professional and advised to lose weight. It had begun with a discussion group based around the NICE guidance on weight management and the potential risks to babies.

Patient outcomes

- The trust was providing midwifery staff to complete training in manual perineal support at birth which research suggests may be protective against anal sphincter injuries.
- The rate of 3rd and 4th degree perineal tears was consistently below the projected level with 2.2% of women sustaining tears against a target upper limit of 6% in the YTD to October 2016.
- The hospital was performing better than the projected target of less than 15% of births being operative vaginal deliveries with 13% of births being assisted.
- The hospital had more successful vaginal births after caesarean section births than predicted with 77.7 % of opting women delivering vaginally compared to a target of 75%.
- Unexpected admissions to SCBU or NICU were much better than upper limit target of 10%. The YTD admission rate to October 2016 was 1.7%.
- The level of massive post partum haemorrhage was better than the upper limit target of 1% with 0 women suffering a blood loss greater than 2,500 mls for the YTD to October 2016.
- The CQC intelligent monitoring data showed that the trust was not performing significantly differently to the main body of NHS trusts in relation to maternal and neonatal readmissions, caesarean section and cases of puerperal sepsis and other puerperal infections. Where there was a deviation from the England average was in elective caesareans deliveries where, at the trust, these were 12% of all deliveries against an England average of 10.9%.
- The midwifery service at St Richard’s Hospital was providing 1:1 care in labour for all women. The women we spoke with confirmed this.
- Between April and July 2015 there were 957 births at St Richard’s and between August and November 2015 there were 928. Of these, 61.5% were spontaneous normal deliveries, which was worse than the target of 70%.
- Between April and November 2015 there had been one intrapartum stillbirth and one neonatal death following

a full term pregnancy at St Richard's Hospital. There had been none in 2014/15 and 2013/14. This was much better than the UK norm which was 6 per 1000 births of babies over 24 weeks gestation.

- The trust was involved in some forward looking trials such as the Affirm trial that was focused on reducing the numbers of stillbirths. They were the only trust in the south of England that involved in this study.
- The service was performing above its own target for women attending their first appointment within 12 weeks and six days of pregnancy. The target was to achieve this in 90% of cases and it was being achieved in 93% of cases from April to November 2016.
- In terms of rates for caesarean sections. The total number, including planned and unplanned, for the service was an average of 27.7% for the period from April 2015 to November 2015. This is against a target of 26% or less. The monthly rate has been increasing in recent months with 30.3% in September 2015 and 31.3% in November 2015. The increase in the caesarean rate to 32.3% in September 2015 in Worthing was investigated by the service. The conclusions of this investigation were that there was good evidence of consultant involved in both elective and emergency sections and guidelines were being followed. There was evidence that normal birth was being offered to women who had previously had a caesarean section but that there were often co-morbidities indicating a need for delivery prior to spontaneous delivery.
- We saw from the maternity dashboard for April 2015 to November 2015, that the service as a whole had not ever closed for new admissions. It had not closed in 2014/15 or 2013/14. St Richard's Hospital maternity services diverted 29 women to Worthing from January 2015 to October 2015.
- Information provided by the trust showed that St Richard's Hospital had diverted 11 women to Worthing between September 2016 and December 2016. A total of 10 women had delivered after transfer.
- The referral to treatment times in gynaecology were reported to be 93.1% compliant in September 2015.
- We saw the outcomes from the national neonatal audit programme for 2013 for St Richard's Hospital. The hospital was above the standard on two of the indicators, on antenatal steroids and breastfeeding. The hospital was below the standard on 2 of the indicators and had no data on a 3rd. The hospital did not achieve 100% of retinopathy screening and on consultation with parents by a senior member of the neonatal team within 24 hours of admission.
- The trust had received an All Party Parliamentary Award for their Weight Management in Pregnancy Programme.
- The trust had implemented the South East Coast and South Central Network/DH National Care Bundle for reducing stillbirth.
- The trust was a pilot member of the RCOG Patterns of Maternity care in English NHS Hospitals.

Competent staff

- The completed appraisal rate for nursing and midwifery staff at St Richard's Hospital was 80.9% We saw from various meeting notes that staff were being encouraged to complete appraisals.
- There was a 4% reduction in staff reporting that their appraisal left them feeling valued than in 2013. 37% of staff reported that they had not agreed clear objectives with their manager and 47% had not identified any learning and development needs at appraisal.
- We saw that the service had responded to this with further consultation with staff and a clear action plan, including refresher training on appraisal. Staff we spoke with said that appraisals were improving and becoming more useful. A midwife said that she had her appraisal and it had been good to set new objectives and targets.
- Maternity specific training and other learning and development were managed by the Practice Education Team. We saw from the monthly staff newsletter that there was an active programme of training including an antenatal and newborn screening study day and skills drills and review sessions.
- Women we spoke with all said that they were impressed by the skills of the midwives. One woman said, "They were so professional" and "My midwife was so skilled and knowledgeable."
- We were informed that all midwives were trained and competent to deal with obstetric emergencies such as postpartum haemorrhage, shoulder dystocia and cord prolapse. Senior managers and staff in the focus groups

were positive about the expertise of the staff and the cooperative team working. One manager said, "Our staff are fantastic. They embrace change, involve people and they always want to improve on what they do."

- We spoke with a relatively new member of staff. They had only been in post for three months but had already had an appraisal and had been offered lots of training.
- There is an annual update on CTG procedures and there has also been an external master class. Much of the learning comes from reviewing incidents and discussing how to respond in different scenarios.
- We also saw evidence of continued learning and development. For example, we saw a programme for an Antenatal & Newborn Screening Study Day covering areas like infections in pregnancy, communication, consent and informed choice in screening and sickle cell and thalassemia screening.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:13 and that the caseload of the supervisors to midwives was uneven (LSA Report 2013). However, the LSA adjusted the data to take account of SOMs who were on maternity leave which gave a ratio of 1:18 which confirmed that there were not enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Staff told us that the current ratio of supervisors to midwives was 1:20. We asked the trust to confirm the ratio and they provided information that demonstrated that the trust had 12 SoMs on the LSA database and two midwives were in training to become supervisors of midwives. This meant that there was ratio of 1:23. This is well below the NMC requirement. We were not able to confirm this with the 2014/15 LSA report as it had not been made available to the trust.
- Midwives reported having access to and support from a SoM 24 hours a day, seven days a week and knew how to contact the on call SoM.
- The screening midwife said “We are so lucky, we have endless opportunities for training and study days.” Other staff who attended the focus group said that the trust had a "great ethos" around training and learning was very accessible and encouraged.
- The trust had received a Health Education England funding award for their Learning Zone and Mobile Learning zone Initiative (2015). This project provided easily accessible mobile clinical simulation training for multidisciplinary teams within acute and primary care environments.

Multidisciplinary working

- We attended a morning multi disciplinary handover meeting on the labour ward at St Richard’s Hospital. It was a well attended meeting with medical staff, midwives, nurses, anaesthetists, and doctors from gynaecology, ward managers and the lead for antenatal. The board showed the women on delivery suite, on the Birthing Centre, on the antenatal ward and women whose labour was due to be induced. It also listed pregnant women on other wards and the home births. It was also noted that Worthing Hospital was on divert to St Richard's.
- We were told by managers and staff that team working was very good at the trust. We observed several meetings where staff from different disciplines were sharing information and expertise for the benefit of the patient.
- We saw notes of multidisciplinary, including perinatal meetings where obstetricians and midwives met with colleagues from the special care baby unit.
- We spoke with domestic staff and receptionists who said that they felt included and part of the ward and unit team.
- We also spoke with community midwives who attended meetings with each other, with hospital based midwives and specialist midwives, colleagues from social services, health visitors and consultants and GPs.

Seven-day services

- Consultants and anaesthetists were available at all times, either in the hospital or on call.
- We were informed that screening was available Monday to Friday.
- Outpatient scanning was usually only available Monday to Friday, but because of a shortage of staff, scans were also being offered at weekends to avoid a backlog developing. Ultrasound scanning was available for inpatients seven days a week.
- Gynaecology services were more limited at weekend and in the evenings. The gynaecology day unit closed at 8pm. Any gynaecology emergencies had to attend the accident and emergency department.

Access to information

- All clinical staff had ready access to patient specific information.
- The trust intranet provided ready access to policies and guidance.
- Good consultant level cover enabled junior medical staff ready access to support and advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with the antenatal and new-born screening midwife in the early pregnancy assessment centre. She told us that they had designed their own consent form which is signed and checked throughout the process.
- We also saw a trust wide internal audit of compliance with consent forms being used that was conducted in 2014/15. The recommendations from this audit were that only one standardised consent form should be used across the trust and this was the one contained in the policy. They also found that consent forms were not always signed by the doctor and the doctor may not have printed their name.
- We also saw an audit of consent forms used in gynaecology. This was conducted at St Richard's Hospital in 2014. The findings of this audit was that greater emphasis should be focused on documenting that the risks of surgery have been explained and consent has been obtained.
- We saw spoke with staff about the Mental Capacity Act 2005 and found they were well informed. One midwife said that there had been a useful update in the September 2015 edition of the newsletter. Staff had also been directed to an elearning site for a full training session on the Mental Capacity Act 2005.
- Midwifery and medical staff had a good understanding of their responsibilities when obtaining consent from children and young people.

Are maternity and gynaecology services caring?

Outstanding ☆

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

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

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

Feedback through the Friends and Family Test survey showed that women and their families had an exceptionally good experience in the maternity service. The response rate and scores were consistently above the national averages. This was validated by the most recent published results from the Maternity Services Survey

published in December 2015. The trust scored at least as well and often better in questions across all sections of the survey. The hospitals scored particularly well on questions about care in hospital following the birth.

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

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

Compassionate care

- In the CQC survey of women's experiences of maternity services conducted in 2013, the trust scored better than other trusts in relation to three areas. Those areas were about women being able to move around in labour and choose the position that made them most comfortable, having skin to skin contact with their baby shortly after the birth and staff introducing themselves. This demonstrates that the service was offering support and was compassionate.
- The Family and Friends Test data for November 2015 showed scores of 100% for all four questions. These included how likely women were to recommend the antenatal service to friends and family if they needed similar care or treatment and how likely women were to recommend the labour ward/birthing unit to friends and family if they needed similar care or treatment.
- The service was receiving feedback from mothers that was consistently good. In the Clinical Governance Report dated August 2015, managers reported 'positive feedback on Friends and Family overall 90 – 95%. The trust Quality Strategy 2015-2018 showed performance and response rates above the national averages for the maternity services at St Richard's Hospital. For 2014/15 the recommendation rate was 98.5% compared to an average of 95.1% for all trusts. The response rate was 32.3% for St Richard's compared to 22% nationally.
- The more recent data from the December 2015 Maternity Services Survey showed that the trust had improved performance and was considered to be at least as good and often better than the England average, according to the 211 respondents. In Labour and Birth the trust performed better than average for questions around moving during labour (88%)and partner involvement (96%). Staffing during labour questions resulted in a score that broadly in line with England average but better for clear communication (94%) and respect and dignity (93%).
- For care following the birth the trust scored better overall than the England average with particularly good scores for questions about the partner length of stay (96%) and cleanliness (94%).
- It was also mentioned that there were 'lots of plaudits' on the social media accounts.
- Maternity Services had a different social media account and were able to receive feedback through '@WSHTmidwives'.
- One patient commented that, "My baby was born by emergency c-section. In total I spent 6 days/5 nights in hospital and went through the whole induction process resulting in subsequent epidural and c-section. In this time I met countless medical professionals and other non-medical members of staff - the care given was compassionate, professional and faultless. All antenatal and postnatal care has been excellent and very supportive."
- Another new mother said, "This was our first baby so we didn't know what to expect and we hoped the c-section would be as special and intimate as a vaginal birth and we weren't disappointed at all, in fact we we're overwhelmed at just how special and memorable our experience was at St Richard's."
- Similarly it was reported that in gynaecology the hysteroscopy outpatients' satisfaction survey was positive.
- One women commented, "I was so fearful and anxious when I went along for this procedure but the consultant and their team were so understanding and reassuring, every step and option was explained to me. I'll be honest, the procedure itself wasn't pleasant but it was bearable and nowhere near as awful as I'd feared. I can't praise the clinic enough. My daughter was there with me the whole time and there was a nice cup of tea and a biscuit afterwards."

- One of the hospital awards went to a midwife who was reported to have travelled from Chichester to Worthing, in her own time, to take clothes to a mother with a baby on the neonatal unit without any.
- The report also talked about the support this midwife provided to a pregnant woman who had experienced a stillbirth previously and who felt let down by maternity services. The midwife answered calls at all times, day and night and offered very personalised and on-going support to successfully gain the trust of the woman.
- A trust midwife was the winner of the RCM National Award in the Best Midwife category (2015).

Understanding and involvement of patients and those close to them

- We spoke with a woman on Tangmere ward where there had been an issue about her choice of birthing partner. The issue was resolved satisfactorily by the midwives after they had taken further advice from the ward manager.
- We spoke with another woman whose partner had been with her first child and so she brought a friend with her for the birth of the second. She said the caesarean was not planned for that day but the process was smooth and the consultant performing the caesarean section had been the same as with her first child, he had been oncall this time. She said, "Everybody was really helpful and there was nothing she wanted to change."
- We looked at the data from the CQC's survey of women's experiences of maternity services for 2013. This demonstrated that the trust was about the same as other trusts in most of the indicators, better than other trusts in three indicators and worse than other trusts in one. The trust scored less well than other trusts in relation to the question: 'At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife at the hospital?' Since this survey was conducted in 2013 the trust has introduced a new maternity triage and advice line for pregnancy, labour and post natal care. This has attracted an award of innovation in service development.
- We saw that the trust had received an all-party parliamentary award for supporting partners to stay overnight on postnatal wards. We saw that there were sofa bed available and reclining chairs for partners.

Emotional support

- Staff had undertaken training on how best to pass on news that might be distressing.
- We were made aware of the counselling services available through the counselling midwives. We were informed that there was a three day turnaround for counselling for fetal abnormalities.
- There was a counselling midwife working across both sites at the trust. The service would make telephone contact in order to give women high risk results promptly.
- There was a bereavement room St Richard's that was used for woman who suffered fetal loss. It was spacious and slightly apart from the other delivery rooms which meant there was ready access to medical care in the event of complications but that the women was afforded privacy and was cared for away from the busy delivery suite.
- The trust had received an All Party Parliamentary Award for supporting partners to stay overnight on post-natal wards.

Are maternity and gynaecology services responsive?

Good

We rated responsive as 'Good' for maternity services.

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

The involvement of other organisations and the local community was integral to how services were planned and ensures that services met people's needs. There were

innovative approaches to providing integrated person centred pathways of care that involved other service providers such as the young parent's pathway and access to mental health support as part of maternity services.

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

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

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

Service planning and delivery to meet the needs of local people

- We spoke with the senior maternity team about the choices available to women deciding where to have their baby. We noted that women with low risk pregnancies could choose to have a home birth or attend the Birthing Centre at St Richard's Hospital. Women with medical or obstetric complications, and therefore assessed as at higher risk of developing complications, were advised to have a hospital birth but could choose between St Richard's or Worthing Hospital. We saw a leaflet on the website for women setting out these options.
- We spoke with staff in the early pregnancy assessment unit who told us that if an anomaly was found as a result of screening they would offer counselling to help the women decide if they wanted to proceed with the pregnancy. They said that they made sure all the information was available and that they knew about the all the options. If they decided to terminate the pregnancy, they have a choice of treatment at St Richard's or a referral to another provider. If they decided to continue with the pregnancy support was provided throughout the pregnancy and postnatal period.
- The trust was a founding partner in 'Baby Grow', a multi-agency initiative in West Sussex, for parents and carers with pre-birth to 2 year old children, which aimed to better co-ordinate the services for early help and intervention and provide an effective pathway of support for vulnerable parents, at the earliest opportunity.
- The trust was a partner organisation in the Family Nurse Partnership (FNP) programme that provided continued support for young and vulnerable parents during the pregnancy and first two years of the child's life. West Sussex mothers supported by the FNP initiative were almost twice as likely to initiate breastfeeding as other same age mothers in West Sussex. Parents supported through the FNP programme were more likely to have their children immunised.
- The trust had introduced personalised growth charts to help staff identify problems more accurately at an earlier stage in the pregnancy. Each woman had her own 'Growth Chart' that was based on her weight, height, ethnicity and parity.
- When women made their choice of where to give birth they were informed that, if their chosen site became very busy, they would be transferred to the alternative site.
- It was noted that there was no separate ward for gynaecology and gynaecology patients were cared for post operatively on general surgical wards. The staff we spoke said that, in the interests of patients, they would prefer to have a separate gynaecology ward. A senior member of staff said "We are managing but it is not ideal."
- Interpreting support was available for parents who had limited ability to speak or understand English.
- The trust had introduced bespoke maternity health care records and specialist care pathways for - diabetes in pregnancy, weight management in pregnancy, multiple pregnancy, HIV, instrumental birth, manual removal of placenta, third and fourth degree tears and a tracker for foetal anomaly.

Maternity and gynaecology

Access and flow

- There was a maternity telephone triage and advice line that covered both sites. This was a relatively new initiative and it was working well for pregnancy, labour and post-natal care. Staff in the focus group said that it meant that they did not have to answer telephone enquiries on a busy ward.
- The telephone triage service worked closely with both sites and kept up-to-date with acuity and staffing levels. The service was made aware when a service was becoming busy and when it was necessary to divert to one or other of the sites. The triage service was also able to make the two sites aware of women who had called and were likely to come into the service shortly.
- At the midwives focus group concerns were raised about the waiting times for the mental health specialist from another provider in pregnancy clinics. Staff said waits were regularly as long as two hours. The midwives said that they had attempted to organise the clinics differently with longer appointments and fewer people attending but that just created a longer waiting list. Occasionally extra clinics could be arranged. The staff informed women on arrival of the waiting time and these times were continually updated on the board. Where possible women were encouraged to go away and come back if the delay was very long and the staff organised car parking tickets and refreshments.
- We observed the handover on the labour ward when the consultant in charge and the staff went through all the activity on the board in the birthing centre, labour ward and Tangmere. The board also listed gynaecology patients and any pregnant women admitted on other wards for other conditions. The consultant told us that they looked at the board at least every two or three hours to check on progress and assess the intensity of the care required in relation to the staff available. A midwife on the labour ward said that they kept the activity levels under constant review and completed formal documentation every 4 hours as a minimum.
- The obstetric theatre at St Richard's Hospital was located on the labour ward.
- The Head of Midwifery told us that occasionally it was necessary, for safety reasons, to close one of the trust sites due to a shortage of beds or staffing or both. We were also told that women were informed, early in their pregnancy, that they may have to be diverted from the place they had chosen to give birth if the service was busy. We were informed that the trust had never had to close both sites at the same time and that women were not transferred in labour.
- We were given a copy of the maternity dashboard where the number of site closures and 'diverts' were recorded each month. In the year 2014/15, the total of internal diverts from St Richard's Hospital to Worthing Hospital was 21. We looked at a breakdown of the numbers and saw that the reason given for all diverts in 2014/15 was 'increased activity'.
- We saw that there was an escalation and contingency plan for maternity unit diverts and closures to maintain the safety of mothers and babies when the whole system or one constituent part of the system were unable to manage the demand being placed on it. This policy had been updated and ratified in November 2015. It was recognised in the plan that managing patient flow at times of increased activity and insufficient capacity would involve managing additional risk across the organisation.
- It was reported that, when services were on divert, some women who were booked to give birth in Chichester may opt to travel to Portsmouth when St Richard's Hospital was on divert. We noted that, not all women that were diverted gave birth, many were viewed, discharged and gave birth at a later date at the hospital where they booked originally.
- Data from NHS England regarding the non-admitted gynaecology pathway showed that 98.3% of patients were treated within 18 weeks of referral to the hospital. The non-admitted waiting time standard is 95%.
- The admitted pathway was 87% for gynaecology which fell just short of the standard of 90%. This featured in Governance meeting minutes and strategies were put in place to address this.

Meeting people's individual needs

- Women could choose a home or hospital birth. For hospital birth, they could choose to give birth in Worthing Hospital or St Richard's Hospital. At St Richard's Hospital, women with a 'low risk' of complications could choose to give birth in the midwife led birthing centre or on the labour ward.

- We saw a list of the home births planned in the area on the notice board in the community midwives room. There was also a rota of community midwives attending home births. This meant that there was an actual choice for women rather than a theoretical choice.
- The bereavement room at St Richards's Hospital was a large, spacious room with a side room for equipment. It was a room slightly apart for the delivery rooms and afforded a high level of care within a private and less clinical environment. Care for women who suffered pregnancy loss included the involvement of a chaplain, if wished and opportunity for photographs and mementos such as handprints. We saw the guidance for both intrauterine death and induction of foetal abnormality. We also saw a copy of the guidance for the sensitive disposal of foetal remains.
- There was a significant Polish community living in West Sussex and, at first, women from this community would tend to come late into the service for their booking appointment - the first risk assessment carried out by midwives usually before 12 weeks of pregnancy. The midwife told us they had organised a focus group within the community and realised there was a different understanding of the role of the midwife within that community. Now they have improved their communication and clarified the role of the midwife, the Polish women attend for their booking visit much earlier. This demonstrated the trust listened to people in order to the meet their needs.
- Staff in focus groups, in the early pregnancy assessment unit and on the labour ward confirmed they had access to language services for translation. There was a telephone line service and interpretations who could be booked in advance for face to face services. There were also information leaflets in different languages.
- The lead midwife on public health said that the service did not have specialist midwives for substance misuse, smoking cessation, infant feeding and mental health. However, they did have maternity support workers who were 'lactation consultants'.
- We saw that women could access specialist midwives and nurses for antenatal screening and diabetes. There were also specialist nurses and midwives including a Public Health lead, a weight management midwife, a foetal medicine midwife, a patient safety midwife, safeguarding midwives a practice development midwife a maternity clinical skills facilitator and research midwife and nurse colposcopists.
- Provision for young parents was good with multi-agency co-operation co-ordinated by the teen midwife. There was a specific young parent's pathway that guided midwifery staff to provide optimal care for young parents and their babies.
- The Head of Midwifery agreed the layout of the antenatal clinic and the early pregnancy assessment unit was not ideal. Women who may be experiencing an early miscarriage might have had to wait alongside women in the later stages of pregnancy. The Head of Midwifery said they were seeking to change the layout.
- Women with a miscarriage or termination of pregnancy at between 14 to 16 weeks, would be cared for and treated on the labour ward. Women experiencing pregnancy loss at a later stage would also be cared for on the labour ward.
- Information was freely available for women on the trust website. There were useful hospital tours on video for both sites on the website. There was also written information and choices and facilities and range of useful, up to date leaflets on all areas of pregnancy and birth.
- We saw the welcome pack for postnatal women was provided on Tangmere ward at St Richard's Hospital. The pack included useful information about returning to fitness after birth, caring for your baby, sleeping arrangements for your baby, breast feeding, facilities on the ward and visitors.
- Maternity Services had social media groups for patient support. Examples included weight management in pregnancy, young parents and a new diabetes in pregnancy group.
- Maternity Services had a Birth Afterthoughts Service so that women could return at any time to go through their birth experience and records and debrief. This was led by a trained midwife counsellor.

Learning from complaints and concerns

- The complaints policy and details about how to make a complaint were displayed on noticeboards. Leaflets were available in clinics and on the wards. We also saw details of the how to contact the Patient Liaison Service (PALS).
- There were 49 complaints received in maternity and gynaecology between 1 October 2014 and 30 September 2015. Twenty two of these complaints were about services delivered from St Richard's Hospital.
- The trust separated the complaints into main themes and found that, of the 22 received at St Richard's Hospital, most were about aspects of clinical treatment, communication and the attitude of staff.
- We looked at six complaints and the response from the trust in detail. These complaints were about home birth, induction of labour, the closure of one site and diversion to the other site, physical and emotional support for women experiencing a miscarriage and complications following a caesarean section.
- We saw that the responses were from the Chief Executive. We looked at the trust's response to complaints and found that they had apologised and investigated the issues in detail. They provided a response to each of the issues raised in the complaint and used each complaint as an opportunity to learn and improve the service. For example, as a result of the complaint about home birth, the maternity leaflet and guidance on homebirth was amended to say: "Anyone who needed an induction was advised to have a hospital birth."
- Similarly, the complaint about the support available for women experiencing a miscarriage enabled the service to review the care provided and make changes. We saw this complaint was discussed anonymously at the clinical governance and quarterly meeting so that lessons could be learned and shared across the service.

Are maternity and gynaecology services well-led?

Outstanding ☆

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

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

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

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

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

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

Vision and strategy for this service

- We spoke with a range of staff all of whom were aware of the trust's vision. When we asked the question at the focus group they all said in unison "We care..". They were also able to list the strategic themes such as "We care about quality" and "We care about being stronger together."
- We saw a copy of the women's and children's Divisional Strategy and Business Plan for 2015/16. The strategy set out the risks and challenges for the year including staffing, maintaining quality standards with current staffing ratios and a capital programme already committed elsewhere.
- We were also provided with a copy of the Maternity Quality Strategy entitled 'Better Births'. This strategy

placed the emphasis on person-centred care, focusing on normalising birth and reducing stillbirth and reviewing every death occurring in the hospital to ensure learning. The strategy was developed with the involvement of service users and staff. Staff were aware of it and were able to tell us about the engagement event.

Governance, risk management and quality measurement

- We spoke with the midwives leading on patient risk, governance and women's experience. We found that there were reliable risk management processes in place including systems for learning from incidents, sharing the learning and implementing change across both sites.
- We saw that action plans were developed and implementation of the recommendations was tracked at trust level.
- We saw that the division had a comprehensive register of risks and that these risks were graded and mitigation put in place where possible. The risks were dated and reviewed regularly until they were resolved and removed from the register. Highly graded risks were escalated to the trust wide risk register.
- We found that there were highly effective governance processes for maternity service. These involved good levels of incident reporting and thorough investigation and learning from serious incidents. Clinical outcomes were being monitored and there was a rolling programme of audit and review. Complaints were used as an opportunity for leaning and service improvement.
- Maternity on the two sites were sharing the same protocols and one of the senior midwives told us that integration was good and joint meetings were the norm. Perinatal, Governance and Patient Safety meetings alternated between sites.
- The trust is a member of the South East Coast and South Central Network maternity dashboard pilot.

Leadership of service

- Midwifery staff spoke positively about the leadership of the service at departmental level and their support in general. We saw good examples of leadership at ward level.
- Staff said that senior managers were visible and approachable. This meant that they were easily accessible to staff.
- Staff told us that team work and collaboration was good and they felt supported and able to approach managers in the service.
- The senior managers in maternity and gynaecology said that, as a service, they felt "heard" within the trust.
- Staff in the focus groups were very positive about the local leadership of maternity and gynaecology services. Two members of staff did say that they had only recently met the Head of Midwifery even though she had been in post since April 2015.

Culture within the service

- The level of engagement with CQC about the trust was unprecedented and overwhelmingly positive. Staff wanted to tell us about the work they were doing and plans for the future.
- Staff appreciated that they could raise any issues with the senior leadership team who were described as visible and approachable.
- Staff said that there was an open, honest and collaborative culture. They said that there were few differences across the different sites and a good level of consistency.
- At the staff focus group a midwife said, "The culture is all about one to one care and it is women centred." Another member of staff said; "Policy and all things are up for discussion. Everything is negotiated and I can talk to people at all levels and they will listen."
- The midwife leading on quality and patient experience said: "I am proud of our staff, they embrace change." She referred to the strategy development day on Better births. She also said that they were now using social media to open new channels of communication both with staff and service users.
- One member of staff said "It is a very happy place to work" and another praised the team work between midwives, doctors, domestics, receptionists, therapists, nurses and managers.

Public engagement

Maternity and gynaecology

- We were informed that there used to be a Maternity Services Liaison Committee (MSLC) through which the trust services uses could engage with people who used the service. However, the MSLC is no longer functioning.
- The service engaged with women and their families via face to face drop in sessions hosted by midwives that were held at local children and family centres.
- There was also a maternity expert group made of women who have recently used the services and it included those who had a concern or had made complaint about the service. Members of the group contributed to 'walk around reviews' of the service, providing feedback on what they saw. There was a social media page for this group.
- Service users were also involved in an engagement event around the development of the 'Better Birth' quality strategy for maternity. The event engaged over 90 key stakeholders to inform direction and emphasis for service development.
- Social media was used extensively to gather the views of women who had used or were using the service.
- The 'Listen and Involve' project was a new initiative which improved access and support available to pregnant women, mothers and their families, particularly those from 'harder to reach groups'.
- The trust was the winner of the Kent, Surrey and Sussex Academic Health Sciences Network Award for Innovation in Patient, Carer and Public Engagement (2015) for the 'Listen and Involve' project.

Staff engagement

- The staff survey feedback for 2014 indicated that 8% staff in maternity and gynaecology felt less involved in deciding on changes that involved their work than they did in 2013. The service responded with an action plan and increased the number of opportunities for staff to engage such as the 'Better Births' programme and 'Patient First' initiative.
- Most staff in the focus groups said they felt engaged in decision making. However, we were also told by a few people that they felt they were not involved in key decisions that affected their work. For example, a few staff felt that they were not consulted or involved in the decision to relocate maternity health records off site.
- We saw notice boards with feedback from the women and children staff survey for 2014/15. The feedback included the things that made staff proud, such as, the standard of care. It also listed three improvements the staff have said they would like to see which included confidence that managers would act on the feedback provided.
- Maternity Services had a social media group for staff members called 'Staff Chat'.

Innovation, improvement and sustainability

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

Services for children and young people

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

Information about the service

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

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

Howard children's ward has 18 beds, one level 2 high dependency bed and three beds on the children's assessment unit.

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

During the inspection, we visited the neonatal unit, the children's assessment unit, Howard ward, and day surgery recovery.

We spoke with 13 children and their parents or carers, 22 registered nursing staff, two support staff including health care assistants and nursery nurses, six medical staff, two play specialists, two students, and one member of the managerial staff. We reviewed 18 sets of medical records as well data provided by the trust.

Summary of findings

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

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

There was a culture of joint working and learning from others. This worked across the trust with examples such as 'Harvey's Gang' (which the trust is justifiably proud of) and with other local providers and children's agencies. The result of this was that children and families had a seamless journey through separate services, both internally and externally. Outcomes for very young children living in challenging circumstances benefited from this joint working.

Most importantly, the staff and leaders of the service were self-aware, they knew the limits of care they could provide safely, they understood the areas they needed

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

Are services for children and young people safe?

Outstanding ☆

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

There was a genuinely open culture in which all safety concerns raised by staff and people who used services were highly valued and integral to learning and improvement. Staff understood their responsibilities in raising concerns and reporting incidents and near misses; they were fully supported to do so. Monitoring and reviewing activities enabled staff to understand risks and gives a clear, accurate and current picture of safety. The management of incidents was robust and established amongst all staff. There was evidence of learning and communication to staff regarding outcomes of investigations. The trust could demonstrate a long period of 100% harm free care from September 2014.

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

A proactive approach to anticipating and managing risks to patients was embedded and was recognised as being the responsibility of all staff. Risks to children and young people who used services were assessed, monitored and managed on a day to day basis. These included signs of deteriorating health and medical emergencies. There was particularly good management of the risk of deterioration on the neonatal unit, with very high levels of consultant oversight and involvement. Staff were well equipped to respond to the deterioration of patients and followed an established early warning scoring system with clear escalation processes in place.

The trust took a very proactive stance on ensuring medical staff were well versed in the management of paediatric and neonatal resuscitation. Staff worked across the site providing clinical simulations within different clinical settings.

Services for children and young people

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

Incidents

- An electronic reporting system was established throughout the children and young people's service. All staff had access to this system and were aware of how to log incidents and near misses. A senior staff member recorded the outcome and feedback onto the electronic system and investigated reported incidents and near misses. This meant staff who reported incidents received feedback from the system.
- Feedback and lessons learnt from incidents took place at several forums such as at regular Integrated Paediatric Governance Meetings, communication folders set up in clinical areas for staff, weekly patient safety meetings on the wards and units and monthly feedback communications from the patient safety nurse.
- There had been no serious incidents or 'Never Events' at the trust between November 2014 and October 2015. Embedded learning had taken place after a serious incident three years prior to our inspection after the death of a young person. Lessons learnt were shared amongst all general practitioners, this trust and two other trusts in the locality.
- Morbidity and mortality (M and M) meetings took place fortnightly and all babies needing support beyond usual postnatal care were discussed at this forum.
- Each case presented at the M and M meetings was subject to a double review process to maximise the opportunity for learning. The junior doctor was required to present to their consultant initially and get feedback about the case prior to presenting to the wider group. This ensured that highlighted and succinct key messages and learning points were delivered rather than being lost amidst historical or less pertinent details.
- There was access to the local neonatal network morbidity and mortality meetings. This meant knowledge, skills and learning were shared between trusts in the area.
- All retrievals, where children and babies are collected and transferred to another care provider, were reported onto the electronic incident reporting system for monitoring of how the retrieval was conducted.
- Duty of candour amongst medical and nursing staff was understood and opportunities for learning were actively sought. An example was given where there had been a delay of antibiotics given to a child. The staff involved discussed the incident with the parents and listened to their concerns, which resulted in a change to the order of the handover of care, which reduced the risk of this occurring in the future.
- Duty of candour was prominent in the children and young people's service. There were three recorded cases of parents and carers being given explanations and apologies even when the incident or near miss did not reach the duty of candour threshold, between August and October 2015.
- The trust could demonstrate a long period of 100% harm free care from September 2014.

Cleanliness, infection control and hygiene

- A range of infection control audits took place regularly throughout children's services to assess the effectiveness of cleanliness and hygiene in the clinical areas.
- Technical audits, which audited the average cleanliness of areas against the National Cleaning Standards (2007), were performed approximately once every two months. These showed the children and young people's service consistently achieved higher than the NHS standard.
- Infection control audits assessed environment, hand hygiene, decontamination, handling and disposal of linen, parent kitchen environmental, handling and disposal of waste, handling and disposal of sharps and use of PPE. These audits showed areas for improvement were identified, and re-audits showed progress.
- The monthly Women and Child Health Infection showed consistent compliance of 100% was achieved across the children's unit for a range of infection control measures such as; the care of central lines, peripheral lines, urinary catheters and decontamination audits.
- The playroom had a daily cleaning schedule completed by the play therapists. Toy boxes in the playroom were

cleaned 3-4 times monthly. A daily wipe over was done of all surfaces in the playroom and was recorded in daily and monthly signed checklists. The cleaning of the toys and playroom was audited by the trust's walk around audits.

- Only wipeable and washable toys were used in the isolation side rooms for infectious patients. This prevented any soft toys harbouring infectious bacteria.
- Babies who became unwell within 10 days of birth could be admitted to an isolation room on the neonatal unit where they received the same expert care as other babies on the unit, but did not pose an infection risk to other neonates.
- The Quality Scorecard for the Women and Children's Division showed from October 2014 to August 2015 there were no cases of hospital attributable MRSA. The Trust Infection Control Committee Surveillance report dated September 2015 confirmed this.
- Data from patient led assessment of the care environment (PLACE) audits looked at ward cleanliness, ward condition, appearance, hand hygiene, staff appearance and safety, showed scores of between 98% and 100%. Plans were made when 100% compliance was not achieved, stating actions, allocating responsibility as well as a completion date. A rag rating system was used to monitor the progress of action plans with improvements noted in subsequent PLACE reports.

Environment and equipment

- Resuscitation equipment was located throughout the children and young people's service. There were two resuscitation trolleys on Howard ward and one resuscitation trolley in recovery in the day surgery unit.
- There was one resuscitation trolley in the high dependency side room, and one trolley in the stabilisation room on Howard ward. Staff performed and recorded their daily checks of the trolley in the stabilisation room. The trolley in the high dependency side room did not always have its daily checklist signed. Checks were made every day in October 2015, five days of checks were not recorded in November 2015, and from 1 to 9 December 2015 (which was the day we checked the log), five days of checks were not recorded.
- Resuscitation equipment in the day surgery recovery room had age and size appropriate equipment for children. Staff recorded their checks of the resuscitation trolley two to three times per week. This was on the same days that children's day surgery lists took place.
- There was a trust wide policy for the management of medical devices. This stated all medical devices should be serviced and repaired in accordance with the manufacturer's instructions or recognised quality standards. Equipment service and repair request logs showed job reference numbers for servicing and repairs and was accessible for staff.
- Equipment was regularly safety checked by the trust's electro-biomedical engineering (EBME) department. Seven pieces of equipment were sampled on the neonatal unit and nine were sampled on Howard ward. All equipment checked was found to be within date.
- There was a retrieval room on Howard ward for critically unwell children awaiting transfer to other providers for more specialist care. The retrieval room was dedicated to stabilising poorly children, with resuscitation equipment and emergency medicines.
- The EBME department provided support to the neonatal unit of all equipment, including equipment funded by charities.

Medicines

- Medicines were secure in the children and young people's service. Medicines were kept in a drugs room on Howard ward, which had access only by a swipe card.
- Controlled drugs, which are drugs controlled under the misuse of drugs legislation such as morphine, were kept in a locked box within the drugs room on Howard ward. Only the nurse in charge had the key to the controlled drugs box, and there was a two person sign off in place for any administration of controlled drugs to a patient.
- Emergency drugs, such as adrenalin, were within date and sealed on Howard ward and in the recovery area of day surgery. This meant staff could notice with ease if anyone had tampered with the emergency drugs.

- Controlled drugs were not consistently checked on Howard ward. From September 2015 to December 2015 there was four days when the checks of the stocks of controlled drugs were not recorded. There were also three days when only one signature was recorded.

Records

- Medical records were completed appropriately. We reviewed 18 medical records; all 18 had appropriate assessments and reviews documented. There were two cases where a patient had not been seen by a consultant within 12 hours of admission to the ward. One patient was seen by a Specialist Registrar, and in the other case, medical staff had sought advice from the consultant by telephone. We were told that a consultant always attended if medical or nursing staff felt it was necessary.
- Paediatric plans were added to the antenatal concerns folder when a baby with a known anomaly was due for delivery within the following two weeks. Medical records for babies contained pertinent notes from the prenatal stage. This meant the likelihood of prenatal concerns not being transferred to the paediatric notes was minimised.
- Babies on the neonatal unit born at the trust had their medical records linked into their mother's notes. Babies had a proforma of their care pre-birth which then informed the start of their own medical records once they were born. Nursing records had a coloured page at the front of the notes for concerns to be clearly recorded and given prominence in records.
- Monthly paediatric walk around audits included the auditing of medical records. Medical records were audited to check completion of the malnutrition assessment, observation checks, the use of care plans, and the completion of fluid and feed and drug charts. Paediatric walk around audit results were sampled from September 2015 and showed records were completed appropriately 80% of the time.

Safeguarding

- The safeguarding team consisted of 15 staff members, including executive leads for safeguarding, named doctors and nurses and safeguarding nurses. The designated lead for safeguarding had a job description which clearly defined their roles and responsibilities in relation to safeguarding and promoting the welfare of children and young people; they received training and supervision in relation to this role.
- Weekly safeguarding meetings were held at each site to look at all safeguarding issues and provide supervision to named nurses and midwives. There was representation from the child and adolescent mental health service (CAMHS) and from the trust's emergency department at the meetings.
- The trust had a clear accountability framework which covered individual, professional and organisational accountability for safeguarding children; all staff were aware of the framework.
- The named doctor for safeguarding children ensured there was good access to child protection supervision for medical staff.
- A multi-agency safeguarding hub (MASH) in the locality was being set up and was due to go live in January 2016. The trust's safeguarding team were involved with the setting up of the MASH.
- The trust was compliant with section 11 of the Children's Act 2004, which provides an audit to ensure an organisation's functions safeguard and promote the welfare of children.
- There were weekly multidisciplinary child protection meetings and psychosocial meetings. These meetings enabled safeguarding staff to receive and share information with staff involved in looking after children with protection orders and those with psychosocial problems.
- Safeguarding nurses attended at morning medical handovers. This enabled the sharing of information between the safeguarding nurses and the medical staff.
- A self harm pathway was in place for all patients attending hospital after self harming. This ensured they received care appropriate to their needs and that relevant professionals could be involved in safeguarding them.
- Staff knew how to respond to safeguarding concerns. One example was where a nurse was concerned about

possible domestic violence between the parents of a child, and was able to share and receive information with social care. This meant any ongoing support or concerns would continue to be met in the community.

- Safeguarding children level three training figures were 89% for nursing staff and 81% for medical staff. The target for the training was set at 95%. There was a clear understanding of who had not completed the training and why (such as maternity leave, new starters and long term sickness). There were clear plans in place to get at least 95% compliance. The local clinical commissioning group (CCG) audited the trust's safeguarding provision, including training, and a full action plan was created with ownership by the chief executive.
- Four members of staff had completed Level 4 Safeguarding training.
- Children attending the children's assessment unit (CAU) or Howard ward by bypassing the emergency department when referred directly by general practitioner were not flagged by the electronic system to ascertain if they are subject to a child protection plan. Therefore parents or carers were asked if their child had a social worker.
- There had been 3 unexpected child deaths in the community in 2014. All 3 children were brought to ED in accordance with the child death protocol for further investigation. A multiagency event was held in November hosted by WSHT to discuss child deaths for 2013/ 2014.

Mandatory training

- Mandatory training for staff covered the areas of health, safety and risk; resuscitation; safeguarding children and vulnerable adults; conflict resolution; equality and diversity; fire safety; infection control; information governance; and back training. Overall, nursing staff mandatory training compliance was 72%, and medical staff compliance was 63%. The figure was low because conflict resolution had recently been introduced but this meant not all staff were regularly trained in minimising risk and practicing safe care.
- The practice development nurse rostered all nursing staff to attend two days each year to complete mandatory and competence training.
- Accounting for staff on maternity leave and staff who had just started working at the trust, all other staff groups were up to date with life support training. The trust had assessed that 42 nurses needed to have completed basic life support training. Allowing for those on maternity leave and those who were very new, the trust met this target. Advanced life support training targets were met when the two staff on maternity leave and three new starters were excluded from the numbers. This meant that 94.5% of nurses who were eligible had BLS training and 100% of those requiring ALS had completed training.
- The trust resuscitation officer provided paediatric resuscitation training and covered basic and advanced life support. The trust neonatal lead provided neonatal life support training. The trust simulation lead provided training for stabilisation and life support, in accordance with advanced paediatric life support and paediatric intensive care unit guidance. This meant training adhered to national guidance.
- The trust hosted regular British Resuscitation Council accredited courses for European Paediatric Life Support (EPLS) and Paediatric Immediate Life support (PILS). The department had an APLS qualified instructor, two EPLS instructors and two NLS instructors within the paediatric consultant team and further instructors throughout the wider consultant body within the trust, for example the Emergency Department and Anaesthetics.
- The department aimed to adhere to the Standards for Children and Young People in Emergency Care Settings laid down in the Intercollegiate Document (2012) and endorsed by the RCPCH recommending APLS or equivalent to be undertaken at Consultant and Middle grade level every four years with consideration of any extended training needs at doctor's appraisals.
- Basic life support (BLS) training was provided annually and within induction and Trust Simulation Events, Clinical Governance rolling half days, with PILS as an additional adjunct for junior members of the team.
- Neonatal Life Support (NLS) was provided, as per the recommendations, every four years with annual refresher updates provided in house by NLS instructors.

Of the 7 consultant paediatricians at St Richards Hospital, 6 were in date for APLS and the 7th was booked onto a course in March 2016. Of the Middle grade doctors 4 of the 5 who required APLS were in date and one was booked on a course in March 2016.

- All medical staff had completed current basic paediatric life support training (100%).
- All medical staff who required NLS were in date for this (100%).
- The department team prided itself on the strong use of simulation training both within the simulation suite and within the paediatric, neonatal and emergency department clinical environments. They had used this for enhancing consultant's and junior staff's individual skills and strengthening teamwork. Notable achievements included testing important emergency protocols e.g. major paediatric haemorrhage within ED and reskilling a senior consultant following a period of extended sick leave.

Assessing and responding to patient risk

- The neonatal tertiary units did not use an early warning scoring system but the neonatal units at the trust worked to a network agreement of individualised care planning based on consultant review. Written plans were in place so staff knew how to monitor and escalate concerns for each baby. The written plans included the triggers for a consultant review.
- There was an escalation tree in place as a checklist for all staff, including bank staff. This was a clear process for when a baby became unexpectedly unwell. The neonatal unit could provide level three critical care and was able to manage a deteriorating baby until the retrieval team arrived to transfer them to a specialist unit.
- The trust had very clear policies and algorithms on the management of specific neonatal conditions such as potential sepsis, meconium aspiration, falling blood sugar levels and fitting. The management guidelines contained clear information on escalating support and treatment to the next level.
- A paediatric early warning scoring system was used in the trust to assess children's observations, such as blood pressure, pulse and oxygen saturations. Escalations for higher scoring children were made using the situation, background, assessment, recommendation (SBAR) method. SBAR is a structured method for communicating critical information that requires immediate attention and action. Escalation was made first to the nurse in charge then to medical staff. The consultant was available directly if required.
- Monthly paediatric walk around audits included audits of early warning scores being completed appropriately. One sample of the September 2015 audit showed early warning scores were appropriately completed 100% of the time.
- Patients receiving high dependency care on Howard ward were located in a side room directly opposite the nurses' station, this meant there was ease and speed of access at all times.
- Nursing staff were very proactive in ensuring locum doctors understood the expectations of the ward or unit and the need to contact consultants if there were any concerns at all. Nursing staff confirmed they were encouraged to override a decision and contact a consultant directly, if they felt there was a need to do so.
- Contingency arrangements for the care of critically ill children were in place which included 24 hour availability of clinical staff with the appropriate competency in advanced paediatric life support and consultant resident on call cover.
- The environment was secure and access was limited to those who needed it. The doors to the unit were locked and only accessible by swipe card or by ringing a door bell. Staff on the neonatal who were uncertain about who was ringing the bell came to the door to check before allowing people on to the unit.

Nursing staffing

- Nursing levels were set according to the paediatric acuity and nurse dependency assessment tool (PANDA), and was evaluated by the Royal College of Nursing (RCN) guidance (2013) called 'Defining Staffing Levels for Children's and Young Peoples Services'. This describes the different nursing levels required according to age and dependency.

Services for children and young people

- Audits were completed three to four times a year to map the nursing levels against the standards required for care of children under two 2 years of age, children over two years of age, and children requiring high dependency care.
- Between May and August 2015, the permanent nursing staff level was down each month by 11 whole time equivalents (WTE) on average. The trust acknowledged recruitment difficulties and mitigated against the risks by the use of agency and bank staff. There was no discernible impact on patient safety from lower than ideal staffing levels.
- Over the four month period May to August 2015 the average planned staffing to actual staffing for registered nurses was 113 planned to 104 actual. For health care assistants the average planned staffing was 34 compared to 33.5 actual.
- There were two WTE vacancies for St Richard's Hospital; recruitment was in progress at the time of our inspection.
- The neonatal unit had not used any agency nursing staff for over three years. Existing staff undertaking bank work met any shortages in nursing levels.
- The level two neonatal unit at St Richard's Hospital was aligned to the Department of Health neonatal toolkit standards (2012) and the British association of perinatal medicine (2011). The trust provided compliance data through the neonatal networks and measured progress through monthly workforce audits using a nationally validated tool.
- There was one advanced paediatric nurse practitioner at St Richard's Hospital with discharge and prescribing rights. This meant in the absence of a doctor, children could receive medication or be discharged home.
- Specialist nurses supported all long term conditions services across both sites.
- There had not been any ward or neonatal unit closures.

Medical staffing

- The paediatric team had a three tier medical rota. This included an establishment of eight consultants, six tier two (or middle-grade) doctors, and eight tier one (or junior) doctors.
- There were split rotas for neonatal care and paediatrics between the hours of 9am and 5pm and additional tier one cover in the early evening and weekend mornings. Consultants worked extended hours (until 7pm) on four or five weekdays every week.
- Four 'long day' shifts, on each of the tier two rotas, in a six week cycle were covered by consultants and between two and two and a half night shifts were covered by a resident on call consultant each week. This was in addition to the traditional consultant on call.
- There was a six-week rota where medical staff rotated through the service. Between the hours of 9am and 5pm there were two registrars covering the service and one registrar at night.
- There was one vacancy for a middle grade doctor at St Richard's Hospital. Internal staff working extra hours, along with the use of locums, addressed any shift gaps. A consultant managed and risk assessed the middle grade doctor shortage.
- There was a flexible consultant workforce. Three consultants provided resident night shifts at St Richard's Hospital.
- Consultant staff led specialist services for respiratory medicine; critical care; diabetes and endocrinology; enuresis; rheumatology and chronic pain; neonatal medicine; cardiology; oncology; febrile neutropenia; neurology and epilepsy; and ambulatory care. Specialist nurses supported these services.

Major incident awareness and training

- The trust had an emergency preparedness, resilience and response policy in place. This policy outlined roles and responsibilities in the event of a major incident such as an adverse weather occurrence or a transport related disaster. The policy gave clear guidelines for specific services within the trust to create emergency response plans.
- Staff confirmed they had to sign up to a register of availability in the event of a major incident.

Are services for children and young people effective?

Services for children and young people

Good

Effectiveness was rated as 'Good' for the children and young people's services.

There was a comprehensive audit programme in place for both local and national audits, with demonstrated implementation of learning from action points. In many areas patient outcomes were significantly better than national benchmarks and showed year on year improvement.

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

Multidisciplinary working was well established and there were very good external links to tertiary centres and specialist networks. Mutual respect was apparent at all levels and across professional boundaries. The very close liaison between obstetricians and paediatricians was clear and this resulted in early input from paediatricians when a neonate was likely to need additional support.

Consent practices and records were actively monitored and reviewed to improve how people were involved in making decisions about their care and treatment. The legal framework and trust policy on consent was well understood by staff.

The rating failed to reach outstanding because performance in the National Paediatric Diabetic Audit outcomes fell short of the national average of all participating NHS trusts.

Evidence-based care and treatment

- The staff on the paediatric unit at St Richard's Hospital followed national best practice guidance in the care of the children they treated. The hospital services met the Department of Health guidance, 'Getting the right start: National Standards Framework' (2003) in that children and young people received care that was integrated and co-ordinated around their particular needs, and the needs of their family.
- The neonatal unit worked closely with local tertiary provision to ensure that services worked closely to meet the national standards of care.
- The trust had a programme of current and planned audits which included both national and local audits.
- A monthly clinical audit report was produced for scrutiny and assurance at the divisional meeting which detailed the status of each local or national audit, and had outcome reports embedded. The reports included an action plan when benchmarks were not met, including expected dates of completion and dates for re-audit.
- An audit of paediatric head injury leading to hospital admission found that head injury forms were not being completed. An action was made for these forms to be introduced and junior doctors encouraged to complete them by December 2015. A re-audit was planned to check the implementation of this action.
- The neonatal unit was working towards gaining the United Nations Children's Fund (UNICEF) Baby Friendly Initiative, which improved the practice of infant feeding in health care settings. This meant trained staff would be able to support the experience of parents in feeding their babies.
- The neonatal unit was also working towards accreditation to the BLISS (Baby Life Support Systems) Baby Charter, which is a scheme that ensures a family centred approach in the care of sick and premature babies.
- Howard ward participate in the 15 steps challenge as set out by the NHS Institute for Innovation and Improvement. This challenge provides a toolkit for staff to assess the environment regarding what impression it gives within the first 15 steps of somebody walking into it. Feedback forms were completed by reviewers with improvements identified which were used as frameworks of improvement.
- The paediatric service reviewed Mortality and Morbidity (M and M) data in the patient safety section of the monthly Operational Departmental Governance

meeting, There were annual meetings with tertiary critical care services and neonatal M and M data was reviewed through the perinatal meetings which took place fortnightly on the Chichester site.

Pain relief

- There was a trust wide pain team available 9am to 5pm. There was also out of hours availability through the anaesthetic service. There was ward staff representation at the paediatric pain group who met once every three months.
- A flexible working system was in place to ensure anaesthetic care for sick children could be provided. If the consultant anaesthetist on call was a trained paediatric anaesthetist, and a sick child required the care of an anaesthetist, then roles were swapped to prioritise the care of the child.
- A pharmacist was based on Howard ward who could arrange for prompt pain relief medication to be made available, once prescribed.
- There was one nurse prescriber on Howard ward who could prescribe pain relief in the absence of a doctor. A patient group directive (PGD) was in place for nurses on Howard ward. This meant children requiring urgent access to over the counter pain relief such as paracetamol and ibuprofen could receive these medications without the need to wait for a doctor to attend and prescribe.
- A paediatric pain policy was in place that detailed an analgesic ladder. This described three steps for pain assessment that nurses used on the ward.
- Nurses and medical staff on the paediatric unit monitored and managed pain using a variety of strategies including prescribed analgesia timed to be effective prior to any procedures.
- There was a Paediatric Chronic Pain Service provided in response to very high spending on sending children with complex pain conditions to remote national tertiary specialist centres. It is one of 17 such services nationally. The success of the service was measured and showed average pain scores improved from 8/10 pre treatment to 2/10 post treatment. There was also a significant improvement in the level of disability the children and young people were experiencing with 70% having no disability on discharge.

Nutrition and hydration

- The staff on Howard ward were proactive in monitoring the nutrition and hydration of children and young people admitted to the ward. All children admitted were assessed using as a screening tool for the assessment of malnutrition in paediatrics (STAMP). Patients had their STAMP assessment documented in their medical records. A bedside checklist also reminded staff to monitor this.
- Once the assessment showed there to be no immediate risk of malnutrition then the decision to stop malnutrition monitoring was considered.
- Special diets, such as gluten free, were supplied in conjunction with the pharmacy and catering departments. A board in the ward kitchen informed the housekeeper about which children required special diets.
- The neonatal unit managed to attain very high breastfeeding rates through additional support for mothers with babies in the unit. The rate on discharge was around 70% - higher than the England average for all babies.
- Facilities were available for parents of children and babies to make drinks and snacks on the ward. They were also welcome to bring in particular food for their child, if they wanted.

Patient outcomes

- Performance in the National Neonatal Audit indicated good results for the percentage of babies having their temperatures taken on admission to the unit with the most recent score being 100%. This practice was embedded and formed part of the admission process.
- The proportion of babies being screened for retinopathy of prematurity was 100% (previous score was 80%) which was better than the average of participating trusts.
- The proportion of babies being exclusively fed with breast milk at discharge was 55% (previously 65%) which was better than the average. An additional 5% of babies were partially fed with breast milk.
- Readmission rates for asthmatic children were 14.5%, which was better than the England average by 2.5%.

- Readmission rates for children with epilepsy were 19%, which was better than the England average by 8.9%.
- There were no emergency readmissions after elective admission at St Richard's Hospital among patients in the under 1 age group between February 2014 and January 2015. This reflects the low number of paediatric surgical patients.
- There were emergency readmissions after elective admission among patients in the 1-17 age group between February 2014 and January 2015. However, no treatment specialty reported six or more readmissions. Overall the numbers reflect very low numbers of children undergoing emergency surgery at the hospital.
- The trust met the paediatric best practice tariff for diabetes. This is a year of care tariff payable to paediatric diabetes units when they meet certain criteria, which cover all aspects of high quality diabetes care.
- Readmission rates for children with diabetes were 26.3%, which was worse than the England average by 11.9%. This was considered and felt to be because most care of diabetic children took place in primary care provision and there was a significant shortage of GPs in the area served by the trust.
- Performance in the national paediatric diabetes audit indicated the trust performed worse than the England & Wales average for their share of patients with glycated haemoglobin (HbA1c) under the threshold but scored similar to the England average for median HbA1c (13.4% for trust compared to 17% average). HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time.
- This trust was part of the trauma network for children. This meant the trust was able to provide emergency trauma care to children with the support of other specialist units.
- There had been a local audit to assess whether improvements had been made against the trust's performance in the 2013 national asthma audit which demonstrated ongoing monitoring of patient outcomes.

Competent staff

- All staff on Howard ward were qualified children's nurses. 60% of nurses on the neonatal unit were qualified in service (QIS) with 2.61 whole time equivalent (WTE) in training. The aim was to have 75% QIS. This meant staff caring for children were able to meet the needs of children specifically.
- Both medical and nursing staff were appraised each year. Appraisal rates for nursing and nursing support staff were 92% and the appraisal rates for medical staff was 98%. This meant staff were developed and had their performance evaluated regularly. For example a middle grade doctor was supported in their area of specialist interest and was facilitated in shadowing opportunities with visiting specialists.
- A development programme was in place for staff nurses to progress into leadership roles, with academic accreditation. This included leadership training, European Paediatric Life Support training and physical assessment skills.
- There was a planned rolling programme of simulation training for the stabilisation of the critically ill child. A successful pilot of this training had taken place, however the rollout of the programme had not commenced at the time of our inspection.
- A range of competencies was available for nurses such as; patient group directive, naso-gastric feeding and tracheostomy competence. All registered nurses on Howard ward and the neonatal unit had intravenous and central venous access competencies. Data showed 90% of staff on Howard ward had the single check competency for administering medications. Three nurses had completed the chemotherapy administration competence. Assessment forms were used so that when competency training was undertaken there was a clear record.
- There was a competency framework in place for healthcare assistants.
- There was a preceptorship programme in place for newly qualified nurses. This provided a structured transition from student nurse to qualified nurse. All new nurses to the trust had a competency booklet that they were supported to complete.
- A practice development nurse had a dedicated role to support nursing staff in their revalidation. This included supporting learner in practice, professional competency updates and the building of revalidation portfolios. This

meant the trust was active in supporting nurses through the process of renewing their registration to practise with their professional body, the Nursing and Midwifery Council.

- Clinical supervision was not standard and was only available on request on Howard ward. This meant there was no structured method of support for nursing staff to meet their developmental needs.
- Competencies were not always required for specific types of care, although they were encouraged. During our inspection, one nurse was providing high dependency care despite not having completed the high dependency care competencies. The nurse in charge had responsibility for overseeing that care. This meant nurses were encouraged to develop additional responsibilities which was enabled with oversight from senior staff.
- Clinical nurse specialists worked with the multidisciplinary team to provide ongoing management of children with long term conditions. This included the appointment of an Adolescent and Transition Nurse in May 2015 to support adolescents moving from Children's to Adult Services. The role was patient focused but also available as a resource for families and staff.
- There was a lead nurse for children and young people with complex needs.

Multidisciplinary working

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

of being in hospital. The play specialists provided distraction from unpleasant procedures such as the taking of blood. The play specialists attended the daily safety huddle.

- Services for children with long term conditions were multidisciplinary. This meant the holistic needs of a child and their family were met. For example, the diabetes service consisted of medical staff, specialist nurses, dieticians, and psychologist support. This supported the service in meeting the best practice tariff.
- The children and young people's service was part of a wide range of clinical networks including the critical care network; diabetes network; cardiology network; oncology network; epilepsy network; and Wessex surgical network. There were also established links with other providers for specialties including respiratory medicine, children's intensive care, cystic fibrosis and neonatal care. This meant there was shared support and learning between multiple providers of care in the region.
- A review of patients who required but did not receive a mental health bed was undertaken after joint communication between the trust and the child and adolescent mental health service (CAMHS). CAMHS were trialling the provision of a specialist nurse in the emergency department to provide an expert assessment of need and care planning when required. The aim was for fewer admissions and additional support with care planning. This trial was still ongoing at the time of inspection so we could not assess the effectiveness of this intervention.
- There were established transition pathways for long term conditions such as diabetes, epilepsy and respiratory conditions. These pathways included the provision of multidisciplinary child and adult clinics and events. An adolescent and transition nurse was implementing the 'Ready Steady Go' programme. This programme prepared young people for the transition of their care from children's services to adult services.
- Allied health professionals supported the ward according to demand for their services. Physiotherapists attended Howard ward every day and occupational therapists were involved with discharges on demand. Speech and language therapists provided an on demand provision with regular telephone contact with the ward. A dietician supported the ward on most days.

Seven-day services

- A consultant of the week system was in place throughout the service, this coupled with the resident consultant on call allowed for daily neonatal ward rounds and good oversight of all children admitted to the hospital.
- The on call consultant spoke with the on call registrar and with the senior nurse on duty every evening. There was a senior nurse on call every night.
- The community children's nurse service was provided from 8am to 6pm Monday to Friday, with 24 hour availability for end of life care. Funding from the local clinical commissioning group (CCG) had been agreed to extend the service to weekends and was expected to commence in April 2016.

Access to information

- There was a bleep system in place to allow staff to contact senior nursing staff for advice and support.
- Data collected on the neonatal unit was entered onto a live patient data management system that connected most neonatal units across the country, with one staff member responsible for checking data quality and consistency.
- The paediatric neonatal leads were copied in to all scans and communications where an anomaly had been detected in pregnancy and were involved in discussions where the anomaly was likely to result in the need for longer term paediatric involvement.
- Electronic recording systems allowed all staff to access patient specific data readily.

Consent

- A trust policy for consent to examination or treatment was in place. This policy had a section detailing parental responsibility and the assessment of Gillick competence for staff to reference.
- There were separate forms for young people aged 16-18 who were consenting to surgical procedures, which adhered to the Gillick principals.

Services for children and young people

- We observed parents and children being informed prior to gaining verbal consent what the intervention was and why it was needed.
- An internal audit had been commissioned to assess consent practices against trust policy. Three recommendations had been made with clear action plans to meet these recommendations.

Are services for children and young people caring?

Outstanding ☆

We rated the service as 'Outstanding' for caring.

It was the sheer volume of positive contacts to the trust and directly to the CQC that showed the service was considered outstanding by those using it.

There was a strong, visible person centred culture that was evident in all grades of staff and all disciplines. Staff were highly motivated and inspired to offer care that was unfailingly kind. Relationships between children and young people who used the service, their families and staff were strong, caring and supportive. This was particularly true of those families where the child had a long term or complex condition and on the neonatal unit. These relationships were highly valued by staff and promoted by leaders.

Of particular note was the nurse manager of the neonatal unit who rushed around making sure all 'her babies' and 'her' mothers were happy and being well cared for. The relationship between her and the paediatricians was warm and respectful and this set the tone for all staff on the unit. Parents told us they felt welcomed, safe and nurtured through the difficult time of having a preterm or sick baby.

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

Families we spoke to were very positive about staff and the service they received. Relationships between children, families and staff were very open and friendly. Children and young people were active partners in their care. Staff were fully committed to working in partnership with children and young people and promoted empowerment enabling children a voice and to realise their own potential. Individual preferences and needs were reflected in how care was delivered.

One young patient wrote to the trust saying, "I have written this card to thank every single nurse, doctor, consultant, dinner lady, HCA, cleaner and porter who has helped me through the toughest period of my life. There is so much I could write about every single one of you and all the comments and things you have done to support me which have begun to change my life for the better. So many of you have been my rocks whilst I have been in hospital and I can't express in words how much all you have done for me means to me. Thank you for putting me on the road to recovery. I want to make a promise in this card that when I recover I will come back and visit you and hopefully make all of you proud to have known you helped me as I couldn't have done it without you. Please pass this letter around everybody on this ward until everyone has had a look because you all deserve to read it."

Emotional and social needs were highly valued by staff and were embedded in their care and treatment. Young people were supported to develop and manage their own health.

The level of positive feedback made directly to the CQC was unprecedented. We received many comments, emails and letters from parents who were fulsome in their praise of the service and how their child had been cared for.

Compassionate care

- All staff were passionate about their roles and were very dedicated to making sure children and young people received the best patient centred care possible.
- We observed staff respecting the privacy, dignity and respect of patients. Staff closed curtains during care, lowered their voices so discussions could not be overheard and comforted patients throughout

procedures. Staff lowered themselves down to the child's level for discussions and used clear, understandable and age appropriate language. Staff had a good rapport with patients and families. For example, we observed on Howard ward a patient's sibling fainted. Staff handled the situation very efficiently, getting a chair and water immediately. A consultant was on hand who managed to look after the patient, their sibling and comfort the mother.

- We reviewed results from a number of different patient experience surveys and the feedback was very positive. For example, all 'NHS Choices' comments for St Richard's Hospital Children and Adolescent Services rated the service as 5/5. Comments from surveys included "Such lovely, friendly, happy, supportive staff", and "Everyone has been so kind, thoughtful and caring, you have all been a wonderful team."
- Friends and Family tests showed a recommendation rate of nearly 100%. However, the response rate was low, especially Howard ward at 8.9%. Such low response rates meant wards may not have been getting an overall picture of the experiences of friends and family, which may actually be doing them a disservice as the recommendation rate is so high.
- The trust performed broadly in line with other trusts in the National Children's Survey 2014 but where there was a variance from the average, the trust scored better than national averages. There were no questions where the trust scored worse than the average.
- The trust used local surveys to supplement the FFT survey and to gather more 'real time' evidence. The results from these were consistently high.
- The 'Harvey's Gang' initiative won the Kate Granger Award for compassionate care at the NHS EXPO 2015.
- The hospital monitored plaudits as well as concerns. Comments included, "To All the Wonderful Neonatal Team. Thank you all so much for the outstanding medical care and friendly emotional support. Every member of your team cared for our baby girl with a smile and made us feel as reassured as possible. Thanks also for all your help and advice with breast feeding your perseverance and patience really paid off, and now she won't stop."
- Another parent wrote, "We cannot express enough our gratitude, for the most amazing expert care you have given our little baby over the last couple of weeks and the amazing support, advice and reassurance you have given us from the beginning. We have been overwhelmed by your endless dedication and hard work and care you give to each baby. Knowing that when we had to leave he was in the best possible hands and being looked after by the most wonderful caring nurses."
- A mother on the children's ward wrote, "Thank you so much for all your care our son received during his stay. You cheered him up, encouraged him and sympathised with him in the right quantities and at the right time. And a special thank you for his birthday gifts, a lovely touch for a miserable boy on his birthday."
- One couple reported that staff, "Made us feel welcome, looked after, loved and cared for. You have really touched our hearts with everything you have all done for us."
- Another said, "My son was very scared and anxious and you were all patient and reassuring (I hope your ears have recovered). A big special thanks to (a named staff member) who got through to him when nobody else could. And for his game and lovely blanket you gave him - he takes it everywhere. It's very reassuring knowing there is such a fantastic place to come, if anything goes wrong with the children we are very lucky to have such an amazing ward."

Understanding and involvement of patients and those close to them

- All adolescents received a 'Ready, Steady, Go Transition Plan' as part of their 'Transition, moving into adult care' information pack. The plan enabled adolescents to check their understanding of health issues such as self advocacy and managing emotions. It provided them the opportunity to access more information or help if they did not feel confident in a particular area. This supported adolescents and enabled them to be confident in taking control of their own health when moving into adult services.

Services for children and young people

- Patients and families were also involved in the creation of their own unique 'passports', which included their full health history and background. If a child had a learning disability, the information was tailored to meet their individual need and ensure understanding.
- Parents and carers of children told us staff focussed on the needs of the child and their family. They felt involved in discussions about care and treatment options and told us they were confident asking questions.
- Staff told us they discussed goals with families and gave them advice. We observed staff explaining to families what they were going to do before proceeding. During one observation, the equipment made beeping sounds, the nurse explained that they would go off, that this was normal, and for the family not to worry, before she proceeded. The nurse advised whether the readings were within normal range, and advised a time when she would return.
- We observed staff interacting with children and parents. Staff created a warm and caring environment, greeted children by name, and in turn, patients and families spoke to staff on a first name basis. Staff were friendly and kept patients and families informed. Children advised us they felt listened to, which is reflected in data from the 'National Children's Inpatient and Day Case Survey 2014'.
- An elected member of the West Sussex Youth Council sits on the Children's Board at the trust.

Emotional support

- Staff supported children, young people and their families in the first instance. Referrals to other services such as counselling services, Child and Adolescent Mental Health Services (CAMHS) and chaplaincy, could be made if further specialised support was needed. Information boards were prominent in ward areas and provided leaflets detailing where to find support services.
- Staff advised there were weekly Psychosocial Meetings with CAHMS to review psychological support. These meetings focused on the mental health of children and adolescents, as well as how to support adults with mental health issues who have children.
- Staff understood the impact the condition and treatment had on children and young people and this was embedded in their care using a multidisciplinary approach. For example, we spoke with a play specialist who described how they used play to support a patient who was afraid of needles. The patient was encouraged to practice using needles on toys. The play specialist asked them how they thought the toy was feeling, enabling empathy and understanding, until the patient was no longer afraid. Play specialists spent time with patient's siblings, providing them with attention and support when they were in the hospital environment.
- Patients had a named consultant written above the patients' beds. Consultants knew all family members present on wards. Consistency meant staff built up relationships with children and their families. These relationships meant that all concerned had an enhanced experience in hospital. Something we witnessed on several occasions.

Are services for children and young people responsive?

Outstanding ☆

We have rated responsive of this service as 'Outstanding'.

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

The involvement of other organisations and the local community was integral to how services were planned and ensured services met the needs of the children and young people. There were innovative approaches to providing person centred care that involved departments outside those normally considered part of children and young people's services. The 'Harvey's Gang' service is a shining example of a hospital and trust wide commitment to responding to the needs of children and young people, particularly those with complex conditions.

There were integrated person centred pathways developed with other providers that ensure the holistic needs of vulnerable young children are met through shared working and information sharing.

Families had access to the right care at the right time and this was managed appropriately.

Services for children and young people

There was an open and transparent approach to handling complaints. Information about how to make a formal complaint was widely available however, families tended to contact the service directly when they had a concern or sought support from the Patient Advice and Liaison Service (PALS).

Service planning and delivery to meet the needs of local people

- Staff told us they actively involved children, young people and families when planning and delivering services. For example, wards had a 'Patient Perspective' board displaying patient questionnaire results. Answers given by parents, children and teenagers were separated. Staff gave examples of service changes as a result of the questionnaire, for example, buying more equipment for the adolescent room, such as a PlayStation.
- We saw evidence the trust involved and engaged with local communities in planning services for children and young people. Community nurses visited regularly to check on patient progress, which aided discharge planning and continuity of service. The 'Neonatal Outreach Service and Support Group' who provide training, such as resuscitation and assistance with obtaining equipment, supported families through the discharge process. Appointments were made after discharge on a needs basis.
- Trust staff worked with the local authority and other key stakeholders to deliver joint services such as the 'Baby Grow', a multi-agency initiative in West Sussex, for parents and carers with pre-birth to 2-year-old children, which aimed to better co-ordinate the services for early help and intervention and provide an effective pathway of support for vulnerable parents, at the earliest opportunity.
- The trust was a partner organisation in the Family Nurse Partnership programme that provided continued support for children of young and vulnerable parents during the first two years of the child's life. The scheme showed real benefits for children. For example, parents supported through the FNP programme were more likely to have their children immunised.
- There were good links to a local children's hospice and a community hospice service that provided support and respite for children with life limiting and life threatening conditions and also provided facilities for families in the last few days of a child's life and after death. Families using both the children's ward and the neonatal unit were referred, when appropriate.
- There were good links with tertiary centres and specialist hospitals so paediatricians could access expert advice about complex conditions. Care could be shared by both organisations to reduce the travelling and time away from home for the family.
- The trust recognised workforce development as key to achieving the Standards for Defining Staffing Levels for Children and Young People (RCN 2013). They had initiated a band 6 development programme to support future recruitment from amongst their senior band 5 nurses.

Access and flow

- Ward layout was effective in terms of use of space and efficiency, with a stabilisation room by the ward entrance.
- There were very good networks of support for children in the community. An example of this is the Advanced Nurse Practitioner who looked at alternatives to hospital admission/attendance and promoted self care by parents. Staff contacted patients several days after discharge to discuss any concerns or developments, which aided in preventing unnecessary re-admissions.
- The National Service Framework for acute care of children and young people (2003) states children should not be cared for on adult wards, but on wards that are appropriate for their age and stage of development. In particular, the needs of adolescents require careful consideration. The service at St Richard's Hospital met the standards associated with this statement.
- Adolescent beds were separate from younger children on the ward and patients stayed in single sex rooms from the age 13 upwards, which meet National Service Framework (NSF) standards.
- There were instances where children were cared for on an adult ward. However, this was on the maternity unit, where it is the norm and on the private patients ward where it is parental and patient choice and the young person was in a single room.

Services for children and young people

- The median length of stay was similar to the England average for elective patients aged 1-17 years and non-elective aged <1 years. This reflected that only day surgery was carried out electively.
- The median length of stay was better than the England average for non-elective patients aged 1-17 years. This meant that, in accordance with national guidance, that children and young people were kept in hospital for as short a time as possible.
- The non-admitted RTT was generally above the required 90% standard month on month. Trust wide the performance averaged 93% from January 2015 to September 2015. There was a slight drop off in the latter two months from a high of 97% but the trust had identified this and put mitigation in place to ensure ongoing good service delivery. Measures included additional clinics, triaging referrals and making onward referrals to tertiary centres to avoid delays and a proactive stance to reduce non attendance.
- The MIAMI initiative showed collaboration with local primary care services whereby GP's could refer children with minor illness and injuries to a paediatric led community outpatient service. This reduced the need for a hospital appointment and helped maintain throughput.
- There were clear pathways for the admission of children attending the emergency department or being referred directly to the service.
- There was no elective inpatient surgery undertaken at St Richard's Hospital. Arrangements were in place should a child having day surgery need to be admitted because of concerns about their condition that prevented discharge from the day surgery unit.

Meeting people's individual needs

- The hospital supported families who were likely to spend long periods on site, by providing a kitchen and separate bathroom facilities. On ward bedrooms were available, as well as additional fold up beds next to patients so parents could not only be on site, but sleep next to their child. Parents had open visiting hours with all other visitors allowed on the wards between 8am and 8pm.
- The wards provided a friendly, homely environment. Where patients' had their own room, the doors were decorated to make them look more like a bedroom.
- Adolescents were given space, there were separate playroom for younger children and those aged 13 upwards. Both were light and airy with a good selection of toys in the children's playroom. The adolescent room had a disco ball, football table, TV and DVD player and games consoles.
- Staff told us access to interpreting services was good. In many cases, they used the 'Language Line' telephone service; and had not experienced any problems when they needed to book an interpreter.
- Staff could describe the ethnic and religious diversity of the people who used their services and explained how they could make modifications to ensure they were culturally sensitive.
- Information was provided in age appropriate formats, for example, a leaflet on Micturating Cystourethrogram (a scan that shows how well a child's bladder works) gave information in the form of a story entitled 'Sharon has a very important test'.
- Staff recognised and understood how families could feel overwhelmed in a hospital setting where they may not have the same support network as at home, particularly those who had children with complex needs. Staff supported families by watching over children when parents need a rest and provide 1:1 cover when needed.
- The High Dependency Unit was next to the nurses' station for easy observation and could be adapted for use when patients had behavioural problems and where staff may need to provide quick intervention.
- Staff were proactive in meeting the needs of children and young people. The Chief Biomedical Scientist set up 'Harvey's Gang' after a paediatric oncology patient wanted to know what happened to his blood when it went for testing. Now any critically ill children can have a tour of the laboratory where they are given their own lab coat, which a member of staff makes in their own time. This initiative won the Patient First STAR Awards 2015 for Compassionate Care and is being introduced by four other trusts. Staff were very enthusiastic about 'Harvey's Gang' and described the positive impact it had on children and parents in promoting understanding.

- Staff used a number of initiatives to support patients and promote understanding. For example, 'Ben' bear, was an adapted soft toy that children used to practice procedures. Children could insert a nasogastric or oro-gastric tube through his nose or mouth, the bear could be filled with red paint to practice withdrawing blood. Patients' were involved in creating these initiatives, for example, a surgery patient agreed to photograph each stage of surgery from preparation to recovery, to support understanding and allay fears. The photos were turned into a book so others could see what was going to happen to them.

Learning from complaints and concerns

- The trust had a complaints policy and staff knew how to access it. Staff felt the process was open and honest. Staff showed awareness of actions to take when concerns were raised. This included trying to resolve any problems at the time they were raised. Staff were proactive in working in partnership with children, young people and their families, which minimised the need for people to raise complaints. If there were complaints, staff knew what to do and how to signpost people to the complaints procedure.
- We reviewed complaints made between October 2014 and September 2015. Six complaints had been made about services for children and young people. There were no discernible themes or trends.
- Information about how to make a complaint or how to contact the Patient Advice and Liaison Service (PALS) was displayed in wards and throughout the hospital.
- One service improvement as a result of a concern raised with the trust was the provision of specialist equipment, including a bed, for young people with complex needs. Working with a mother who found it difficult to leave her very mobile son (because he could not recognise risks) the trust sourced a company to make a bespoke bed. This meant parents and carers felt able to go for a meal or bath knowing their child was safe.

Are services for children and young people well-led?

Outstanding ☆

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

This was because of the culture and ethos that pervaded all aspects of the service, which resulted in a motivated and enthusiastic workforce. The encouragement of innovation, listening to families and staff and executive support in the introduction of new initiatives resulted in service improvement and better care that met the needs of people using the service. The public were very well engaged with the service and their opinions were actively sought. This encouragement resonated from the trust board to ward level with a member of the local youth parliamentary committee attended the Children's Board meetings along with a family member of a child with complex needs.

Leadership, governance and culture were used to drive and improve the delivery of high quality person centred care by ensuring there was a clear process of assurance from 'ward to board' and more importantly, back again.

Leaders had an inspiring shared purpose and motivated staff to succeed. Staff of all grades and disciplines were proud of their service and wanted to deliver high quality care. Comprehensive and successful leadership strategies were in place to ensure delivery and to maintain the desired culture. The trust was committed to 'growing its own' through formal leadership education and individual development.

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

Vision and strategy for this service

- Knowledge of the trust's vision and values was good across staff groups. For example, one staff member told us the vision of the service was to put the patient first, referring to the new 'Patient First' Initiative as set out in the Quality Strategy 2015-2018. Another staff member told us further detail about the vision of 'We care', as set out in the strategy.

- The trust had a very good sense of direction and firm commitment to improvements in the safety and quality of patient care. This vision was well publicised and we found staff from across the service 'bought in' to the vision and values.

Governance, risk management and quality measurement

- A Paediatric Integrated Governance meeting was held monthly. A clear pathway was in place for the escalation of assurance and concern from this meeting, firstly into a monthly Women and Children's Governance meeting, then to the Trust Quarterly Governance Meetings, and then to the Children's Board which the chief operating officer chaired.
- A staff member told us the risk register was completed at senior level but they were confident that senior staff members escalated issues appropriately. One example was around people tailgating into the ward when parents held the door open for others. This was entered onto the risk register and escalated. Now there is a parent's room located just outside the ward to restrict the amount of access through the doors, as well as tailgating warnings by all ward doors throughout the hospital.
- The WSHFT Children's Board was executive led with non-executive representation and involvement of parents and young people. It was established to drive safety and quality across children's services.
- Weekly and monthly meetings were established for heads of nursing, clinical directors and heads of service. This ensured any governance issues were acknowledged and actioned between formal governance meetings if the need arose.
- Staff were aware of themes on the risk register. This meant staff were informed by their managers of the general governance of the service they work in.
- Monitoring of infection prevention and control provided an accurate and up to date overview of how well the service was reducing the risk of cross infection.
- A regular planned programme of audits monitored patient outcomes.

Leadership of service

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

Culture within the service

Services for children and young people

- All staff were proud and happy to work at the trust. The workforce was willing to be flexible to provide the best possible care. This demonstrates commitment and ownership of the service by the staff.
- Teamwork was a trend with most staff referencing teamwork as a good thing about working in this service.
- We heard from several consultant paediatricians who told us about an approachable and support executive team. They felt the trust encouraged openness and respect.
- Trust champions asked to speak to us and tell us about how highly they valued the trust and how they were motivated to talk to as many people as possible about this.

Public engagement

- The public were actively engaged in the governance of the children and young people's service. A member of the local youth parliamentary committee attended the Children's Board meetings along with a family member of a child with complex needs.
- The public were invited to participate in fundraising events for the service. Fundraising events held in both a local racecourse and the trust's medical education centre had enabled the purchase of five parent beds on Howard ward.
- A parent support group for parents of babies in the neonatal unit performed fundraising for the unit.
- Young people and staff from outside the unit were engaged in the '15 Steps Challenge' where children and young people's provision was reviewed. The report of one visit showed they thought it was good the doctors had written funny things on a playroom whiteboard and that patients and families wanted free Wi-Fi.

Staff engagement

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

Innovation, improvement and sustainability

- Trust paediatric staff had led work with the local paediatric intensive care forum which had introduced and implemented a regional tool for the recognition and management of paediatric sepsis.
- A bespoke leadership programme had been implemented for nurses to progress to 'in charge' level.
- A unique project was being undertaken with the local clinical commissioning group (CCG) to support families in considering self help strategies during their child's illness and prevent hospital admission where appropriate.
- Care pathways for children were being improved by advanced paediatric nurse practitioner (APNP) roles. This responsibility had traditionally belonged to medical staff. Using the APNP role for this purpose negated the need for over medicalization.
- The paediatric chronic pain service provided specialist support in avoiding long journeys and admissions to specialist hospitals.
- Nurses joining the trust were required to undertake an innovation project as part of their induction assessment. GP referral forms had been developed because of this.
- There was a Paediatric Chronic Pain Service provided in response to very high spending on sending children with complex pain conditions to remote national tertiary specialist centres. It is one of 17 such services nationally. The success of the service was measured and showed average pain scores improved from 8/10 pre treatment to 2/10 post treatment. There was also a significant improvement in the level of disability the children and young people were experiencing with 70% having no disability on discharge.
- The neonatal outreach service offered specialist support for the transition from hospital to home. Support provided included resuscitation training for parents, discharge planning and support at home. The outreach nurses worked closely with primary care professionals

to provide a safe and effective transition from one service to another. The service also reduced the length of stay and readmissions. In 2014, 472 cot days were saved with a financial benefit of £212,400.

End of life care

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

Information about the service

End of life care at Western Sussex Hospitals NHS Foundation Trust provides a service for a population of around 450,000 people. There are approximately 950 beds across two sites of St Richard's and Worthing Hospitals. There were approximately 2,000 deaths per year 2014/15 across the two hospital sites. Half of all deaths occurred in acute care settings.

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

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

As part of this inspection we visited seven wards and the intensive care unit and urgent care areas looking specifically at EOLC and reviewed the medical and nursing records of 14 patients. We also visited the bereavement office. We observed care being delivered on the wards and spoke with 36 relatives and 13 patients, most of who were identified as requiring EOLC. We also spoke more generally with other patients about the overall care provided on wards and the attitude of staff. We met and spoke with numerous ward staff including healthcare support workers, junior nurses, and ward managers. We met the chaplains and the mortuary manager and were shown the resources and facilities they had available to them.

End of life care

Summary of findings

The overall rating for end of life care services for St Richard's Hospital is 'Outstanding'.

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

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

Staff provided a service that was caring. The specialist palliative care team (SPCT), mortuary and chaplaincy staff worked effectively and cohesively as a team to provide a seamless service. Most audits performed by St Richard's scored above England averages, which underpinned the rating given for this service. Feedback made directly to CQC, from relatives of people who had died at St Richard's Hospital was overwhelmingly positive. They told us they, "could not have asked for more" and that staff in all areas of the hospital were caring, respectful and attentive. They talked about being involved and appreciated being supported to remain near their relative at all times.

The trust had prioritised the correct use of Do Not Attempt Resuscitation forms as a tool for engaging with patients and relatives about how they would like care to be delivered should there be an unexpected or expected but significant deterioration in the patient's condition. Consultants had oversight of decisions made by junior doctors in consultation with family and we saw examples of clear challenge where a consultant was not content that sufficient thought had been given to the decision to withhold resuscitation that was requested by the relatives.

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

The management structure, staff involvement and culture of the service were also outstanding. Staff feedback was exclusively positive throughout the inspection with all grades of staff supporting the trust focus on providing good end of life care. There was a positive vision for the future sustainability of the service.

End of life care

Are end of life care services safe?

Good

St Richard's Hospital was rated 'Good' for safe.

We found patients were being looked after in a safe, clean environment across all clinical areas by specialist trained nurses and doctors. Within the trust's End of life (EOLC) service, there had been no never events or serious incidents reported between August 2014 and July 2015. Medicines were appropriately prescribed in line with National Institute for Health and Care Excellence (NICE) guidelines. This meant the majority of patients received adequate medicines to keep them comfortable and free from pain.

The 16 (DNACPR) forms reviewed were completed within the Resuscitation Council UK guidelines with clear evidence that patients and their families had been consulted and their wishes documented.

Incidents

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

Cleanliness, infection control and hygiene

- There were 0 cases of Methicillin Resistant Staphylococcus Aureus (MRSA) and 38 cases of Clostridium difficile (C-Diff) over a 1000 bed day period across the trust. Both of these scores were lower than the England averages.
- The wards that we visited were visibly clean and tidy. We saw all staff washed their hands appropriately, making good use of hand washing facilities and hand sanitiser gels. We also saw staff observed the bare below the elbows policy in all clinical areas.
- The hospital undertook regular auditing of cleanliness in all areas of the building against the National Specification for Cleanliness in the NHS. The results showed high levels of compliance with the specification.

Environment and equipment

- There was sufficient equipment available to meet the needs of people on the wards at all times.
- Syringe drivers (small infusion pumps used to gradually administer small amounts of fluid, with or without medication to a patient) in use were T34 McKinley and were standardized to one type which helped minimise the risk of human error.
- All equipment required for inpatients and for patients discharged home was accessed via the trust's equipment library. Staff told us that the equipment library took responsibility to record, clean and service

every piece of equipment loaned. Nursing staff from the specialist palliative care team (SPCT) told us that this was a fantastic resource which helped to minimise delays for patients on rapid discharge care pathways.

- The mortuary had no lifting equipment for bariatric patients with a body mass index BMI over 40. This had been risk assessed by staff and the moving and handling team, however the risk had not scored high enough to be added to the risk register. This situation was being reviewed at the time of our inspection. The mortuary had received a private donation which meant that plans had been submitted to the estates department for work to commence on improve the viewing facilities.
- Service records were available for equipment, such as the commercial instrument washer in the mortuary. These showed that equipment was being maintained and serviced in line with the manufacturers' recommendations.
- A chapel and multi-faith room were available to all.

Medicines

- We reviewed 16 sets of notes at St Richard's Hospital and saw that anticipatory medicines for patients nearing the end of life were prescribed appropriately by medical teams who followed the national guidelines. This is medication that patients may need to make them more comfortable. Doctors were aware how to access guidance on the intranet to assist them with this. We saw clear guidelines for medical staff to follow when writing up anticipatory medicines for patients.
- The safe and effective use of medicines was audited under the National Care of the Dying Audit for Hospitals (NCDAH) 2013/14.The findings showed medicines were prescribed as required, for the five key symptoms that may develop during the dying phase. The audit showed that the care of 65% of patients across the trust achieved 5 out of 5 criteria measured against the England average of 51%.
- The trust used a new Electronic Prescribing Medicines Administration (EPMA) for three months prior to our inspection. Junior doctors and a pharmacist told us that they found it was more time consuming than the previous system. Research published in the Pharmaceutical Journal of the Royal Pharmaceutical Society showed that electronic prescribing reduced both medication errors and costs to NHS organisations, where it was used. The trust told us that they were aware there was some concerns across these groups and they were working to address these through additional support and training.
- Medicine Administration Record sheets for individual patients receiving EOLC were clearly completed and provided evidence of compliance with the trust symptom control guidance.

Records

- During our inspection we reviewed 16 sets of patient care records. All the records we looked at were legible, signed and dated, easy to follow and gave details of people's care and treatment.
- In all 16 cases where we reviewed records that included a DNACPR form the decision to withhold resuscitation was made in discussion with the person or their family. The assessment of capacity to consent was recorded in the patients' medical notes, as was the discussion with the patient or family members.

Safeguarding

- We spoke with two members of staff in the Specialist Palliative Care team about protecting people from the risk of abuse. They knew how to contact the safeguarding team via the hospital intranet and switchboard. They also knew they could contact the local safeguarding team in and out of hours.
- Care plans were individualised for patients who were identified as requiring end of life care, and were based on the 'One Chance to Get it Right' system introduced by the Department of Health in 2014. This described the five priorities of care that must be in place in the last days of life and included food, drink, symptom control and psychological, social and spiritual support.
- We saw risk assessments recorded in patients' records including infection control risks, and, risks of falls due to decreased mobility. We saw assessment of risk relating to discharge home and clear evidence of advanced care planning spoke with two family members and two patients about conversations documented in their notes and found that people's accounts of conversations matched what was recorded.

End of life care

- Staff we spoke with all had a sound understanding of their responsibility in relation to safeguarding adults.
- The trust had a dedicated Adult Safeguarding lead nurse.
- All staff we spoke with told us they had received adult safeguarding training within the last two years. We saw training matrixes on the wards visited that confirmed this.
- The trust safeguarding policies had been reviewed and were in line with current national guidance.

Mandatory training

- All new nursing staff were required to complete syringe driver training as part of their induction and were assessed for competency prior to using the syringe drivers. All staff we spoke to on the wards and within the SPCT told us they were trained, assessed and competent in syringe driver use. We saw data to support this claim.
- All new staff received training on end of life care within induction as a part of the trusts mandatory training.

Assessing and responding to patient risk

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

Nursing staffing

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

Medical staffing

- The SPCT included three consultants who work jointly between the trust and two local hospices. This gave the trust a total of 1.2 WTE consultants in palliative

medicine. They provided an on call service 24 hours a day, seven days a week for clinical support and advice. Patients who were known to be approaching the very end of life could be admitted directly to one of the local hospices.

- The Palliative Medicine Consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.
- The Consultants working across the acute hospital, the community and the local hospice allowing for improved continuity and management of patients using more than one of the services.

Major incident awareness and training

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

Are end of life care services effective?

Outstanding ☆

We rated the hospital as 'Outstanding' for effective end of life care.

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

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

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

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

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

Evidence-based care and treatment

- The palliative care team used a combination of National Institute for Health and Care Excellence (NICE), End of Life Quality Care Strategy and Royal Colleges' guidelines and quality standards to determine the care provided.
- The end of life care pathway used at St Richard's Hospital was based on the five priorities of care, approved by the General Medical Council (GMC) and Leadership Alliance for the Care of Dying People. This is a coalition of organisations that have set clear expectations for high standards of care.
- The trust took part in the National Care of the Dying Audit (NCDAH). The results for 2013/14 showed the trust had scored 100% in five of the indicators. The trust also achieved four out of seven of the organisation key performance indicators in the National Care of the Dying Patient audit.

End of life care

- The trust used evidence based end of life care and adhered to the NICE guidance relating to end of life care such as the Quality Standards 13 end of Life Care for Adults and Clinical Guidelines 140 Opioids in Palliative Care. The trust audit plan 2015-2016 confirmed that the use of these was monitored.
- NICE Quality standard for end of life care for adults, Quality statement 6: Holistic support – spiritual and religious states that, "People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences." It suggests that there should be evidence of availability of local chaplaincy services in accordance with NHS chaplaincy: meeting the religious and spiritual needs of patients and staff (Department of Health 2003). We judged that the chaplaincy service at St Richard's Hospital was particularly good at meeting the needs of the community it served.
- Nursing staff completed risk assessments to identify individual risks such as pressure damage. The use of pressure damage risk assessments was audited routinely. The absolute levels of hospital attributable pressure damage were low. The minutes of the trust board meeting held on 29 October 2015 showed the rate of pressure damage of grade 2 and above at 0.78 per 1,000 bed days. Monthly auditing of pressure damage prevention measures was taking place.
- The trust reported the harm free score for October 2015 as 95.8% which was better than their own target which had been set based on the national average.
- All end of life care plans we looked at were personalised, reviewed, dated, acted upon and contained patients and families wishes. Medical staff involved in the provision of end of life care were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person's life; this included the option of clinically assisted feeding.
- Patients who were in their last year of life were not automatically identified when first admitted via urgent care services unless they were on an advanced directive end of life care plan or a DNACPR in place from the community. However, all departments had strong links with the palliative care team and knew how to make referrals to them when necessary.
- We reviewed 16 (DNACPR) forms. We found that of the 16 reviewed all had been completed within the Resuscitation Council UK guidelines. In the records of the 14 patients we found that clear and comprehensive records were taken of the discussions between staff and patients (where possible) and their families. We saw that DNACPR forms completed on previous admissions or in the community had been reviewed by a consultant and cancelled where it was felt they no longer applied.

Pain relief

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

Nutrition and hydration

- We saw that people were being adequately hydrated and nutrition was given high importance by all staff but especially by the Specialist Palliative Care team. We saw mouth care, fluids and appropriate foods being given and offered. Individual medical records showed that referrals were made to the dieticians, when necessary.

End of life care

- The dietician's involved in providing end of life care made provided comprehensive assessments and provided guidance and advice for ward staff. This was recorded in patient notes.
- Medical staff involved in the provision of end of life care were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person's life; this included the option of clinically assisted feeding.

Patient outcomes

- The trust had participated in the national clinical audits which they were eligible for including the 'Care of the dying audit' in 2013/14 and they were gathering statistics towards the 2015 audit.
- Rapid discharge fast track care plans were in place following several national drivers to improve patient choice surrounding place of death (DOH End of Life Strategy 2008). The trust established a rapid discharge home pathway for end of life care in 2012, which aimed to improve discharge arrangements to enable more patients to die at home, if that was their preference. This was audited from the 18th August to18th September 2015. The audit showed that 79% of patients died in their preferred place of care which was much better than the national average.
- All equipment required for inpatients and for patients discharged home was accessed via the trust's equipment library. Staff told us that the equipment library took responsibility to record, clean and service every piece of equipment loaned. Nursing staff from the Specialist Palliative Care team (SPCT) told us that this was a fantastic resource which helped to minimise delays for patients on rapid discharge care pathways.
- The Quality scorecard included in the Board meeting minutes dated March 2015 showed achievement of 94.4% episodes of harm free care against a target of 92%.
- Western Sussex Hospitals NHS Foundation Trust was one of 16 member trusts of NHS Quest. This meant they were able to access a range of additional benchmarking and peer review activities. NHS Quest is the first member convened network for Foundation Trusts who wish to focus relentlessly on improving quality and safety. NHS Quest members work together, share challenges and design innovative solutions to provide the best care possible for patients.

Competent staff

- The Palliative Care CNS team were all trained in specialist palliative care. The consultants had also completed higher level specialist training in Palliative Medicine. This meant that there were high levels of expertise and good understanding of current issues within the team.
- The specialist palliative care team nurses told us that they currently received end of life learning, group supervision, annual appraisals and four weekly external supervision from a psychologist. We saw documented evidence of this. Nurses told us that although they had great support from each other within the team having access to external supervision had made a positive impact on them.
- The SPCT ran a rolling 'End of life' education programme. The trainer teaches health care assistants (HCA's), student nurses and new doctors. Training took place on specific wards which enabled more staff to attend.
- The SPCT provided a green folder on each ward which contained the 'Guidance for care of patients in the last days of life' information, and contact numbers for the team. The rationale is to facilitate dying with dignity, comfort for patient and provide carers with support. Nurses on the wards told us they found the folders extremely useful.
- All staff had training in equality and diversity as part of their induction. Guidance was available on wards, in the chapel / multi faith room and on the intranet to support staff in providing care in accordance with peoples religious and cultural preferences.

Multidisciplinary working

- There was good multidisciplinary working across the end of life service. The SPCT had forged strong bonds with community nursing teams, the hospice and local hospitals. This helped when facilitating fast track discharges to the patients preferred place of death.

End of life care

- In the National care of the Dying Audit the trust scored 100% on the multidisciplinary team recognising that a patient is dying against the England average of 61%. Communication regarding the patient's plan of care for the dying phase scored 100% against the England average of 59%.
- Multidisciplinary team (MDT) working was integral to the delivery of effective EOLC at St Richard's. 16 patient records we reviewed showed us that ward areas had regular multi-disciplinary meetings to discuss and agree management plans for patients. There were entries by all members of the multidisciplinary team in patients' medical records. We also saw good evidence of leadership and challenge being provided by the consultants to junior doctors on the elderly care wards.
- Medical staff from the SPCT worked sessions at the local hospice and in the community. This allowed for better continuity of care and provided a more standardised model of care across the local healthcare economy.
- At a strategic level, the EOLC board had representation from many disciplines including the palliative care consultants and nurses, resuscitation officers, mortuary staff, HR and finance representation, paediatric staff, the organ donation co-ordinator and non executive directors. Support for the group was also provided by the audit team and clinical effectiveness team. This breadth of involvement demonstrated the cross trust commitment to developing and improving EOLC at St Richard's Hospital. We saw the minutes of several ELOC Board monthly meetings that demonstrated attendance and showed dissemination of information across the hospital.

Seven-day services

- Inpatients at St Richard's Hospital had access to specialist palliative care input around the clock for seven days a week. NICE Quality Standard for End of Life Care for Adults (2012) statement 10 states that, "Service providers ensure that systems are in place (such as shift patterns and on call rotas), to provide timely specialist palliative care and advice at any time of day and night for people approaching the end of life who may benefit from specialist input." Adequate medical and specialist nursing cover was available to provide a very good service level across all areas of the trust. The current arrangement with the local hospice allows hospital staff to have access to specialist medical advice outside of normal working hours.
- At the time of our inspection, St Richard's Hospital provided a five day service was provided with 24 hours a day consultant on call cover.
- Funding had been agreed for the staffing complement to increase by an additional 2 WTE Clinical Nurse Specialist and increased consultant hours to cope with increased demand on the service and offer better availability of the face to face service to inpatients. The decision to increase the capacity of the team was based on a 130% increase in patient referrals over the preceding twelve months.
- The SPCT staff told us that at the time of our inspection they were seeing 85% of patients within five days of referral, which they hoped would improve.

Access to information

- All staff had access to patient's records, including the SPCT.
- Information was available for patients on the wards, bereavement office and chaplaincy. All the information leaflets we saw were only printed in English. The bereavement office staff told us they had access to language line and interpreters for interviews where required. Appointments for this service were made in advance giving them time to arrange additional support, when necessary.
- The trust had produced a booklet called 'The end of life and understanding the changes that occur'. It explained what happened to an individual when they are dying and how those close to them and staff might best support them. We saw a range of tools and guidance for staff. These were discussed with the patient wherever possible and with their permission the team involved families and careers in planning processes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw clear information about the Mental Capacity Act 2005 (MCA) guidance on the trust's intranet at St Richard's Hospital. Training records confirmed that staff

were provided with training in the Mental Capacity Act 2005. A few staff we spoke with were uncertain about the act and their responsibilities in relation to the legislation.

- We examined 16 records and 16 DNACPR forms of which eight had a mental capacity assessment form completed appropriately. One stated “No capacity” but we found the DNACPR form did not record that the decision had been discussed with family members.

Are end of life care services caring?

Outstanding ☆

We rated end of life services as 'Outstanding' for caring.

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

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

Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. People thought that staff went the extra mile and that the care they received exceeded their expectations. We spoke with thirteen patients and thirty six people close to them about the care received at the end of a patient’s life.

All of the people we spoke with provided very positive comments about the care received from the Specialist Palliative Care Team (SPCT), the chaplaincy, bereavement office and the mortuary service. These teams were regarded as providing a service above what was expected of them to support and include families in the care provided. It was clear that there was a strong culture of person centred care for patients and those close to them.

We received far more written feedback than usual prior to the inspection. It was also overwhelmingly positive. People told us that they had been supported very well and that their loved ones had been very well cared for.

Compassionate care

- Hospital staff demonstrated a strong commitment to empathy and enhancing the environment for dying patients and their relatives in busy hospital areas. We saw that families were encouraged to participate in care if they wished (e.g. mouth care).
- We spoke with thirteen patients and thirty six people close to them during our inspection about the care received at the end of life. All people we spoke with told us that members of the palliative care team were caring and compassionate and did everything they could for their patients.
- The bereavement and chaplaincy service was available for support to staff when a patient they had provided care to died. The staff counselling service was available for all staff at the trust.
- The multi faith and no faith chapel was open to staff, patients and relatives where the chaplaincy was also happy to offer support. The lead chaplain told us they would go and offer support to any person in any area required.
- We saw photos where staff had provided exceptionally compassionate end of life care. A young dying patient had wished to get married in the last days of her life. Staff provided all the wedding items including a dress which they personally funded, so the patient was able to get married in hospital, shortly before their death.
- People and families we spoke to told us unanimously that the care and they received was “fantastic” and that the nurses went “above and beyond the call of duty to make people feel valued and respected.”

End of life care

- The NHS Friends and Family Test questionnaire delivered results which were consistently above 90%. St Richard's Hospital achieved 92.9% in 2013/14 and 92.1% in 2014/15 for the percentage of patients who would recommend the inpatient services.
- One of the consultant paediatricians had developed an end of life care service to support families caring for a dying child. They were not paid for this aspect of their work and it was not part of their job description but having identified a need they provided a 24 hour a day, seven day a week telephone advice line and undertook home visits during both day and night to ensure the child had good symptom control and that the family felt supported.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care and treatment. Their families and carers told us they also felt involved. One family member told us that medical staff had fully explained the care and prognosis of their loved one. A patient told us "I just want to go home. I want to pass away in my own bed looking out into my lovely garden listening to the bird song." Their family member told us the team had arranged the necessary care package to transfer their loved one back home to their preferred place.
- Family rooms were available and families and friends were permitted and encouraged to stay overnight. We asked about adaptation of care to ensure the needs of people with protected characteristics, as defined by the Equality Act 2010, were met. We were told there was no problem with gay partners or friends staying over on the same terms as any other spouse. Staff demonstrated great flexibility and an attitude of solving problems rather than being inflexible; they were kind when considering whether a person's wishes could be met.
- We observed interaction between medical teams and family members of a person who was receiving EOLC. The doctors and nurses worked hard to help the relatives understand what was happening and what the patients preferred plan of care was.

Emotional support

- Emotional support was evident throughout the inspection. One example was where the whole SPCT team, chaplaincy, bereavement office and mortuary had worked together to bring comforting information regarding a deceased relative who had passed away many years ago. Another account was where the mortuary staff had gone above and beyond to make a viewing possible in exceptionally difficult circumstances.
- The emotional support provided by the SPCT, chaplaincy, and bereavement office and mortuary staff was outstanding. There were many good examples seen where staff were offering good emotional support. For example, when relatives come to collect death certificates and want to view their loved one the bereavement office staff provide a free parking ticket, accompany the family to the chapel of rest and stays with them until they wish to leave.
- The chaplaincy and pastoral volunteer team were available to provide support for families and carers, including an on call service out of hours. The team provided a dedicated service which supported people through the end of life process and recognised that they needed to support the emotional wellbeing of families after they had left the building.
- Wards had end of life care facilitators (bereavement care champions), whose role was to act as facilitator and first point of contact for advice. There was availability of counsellors and psychologists to offer support for people families and staff who required them.

Are end of life care services responsive?

Outstanding ☆

End of life services were 'Outstanding' in relation to responsiveness.

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. All teams worked exceptionally hard to meet the needs of patients at the end of their life. There were some delays in discharges throughout the trust, but these did not affect people receiving end of life care where the trust managed to support 79% of people to die in their referred place of care.

The involvement of other organisations and the local community was integral to how services at the hospital were planned and ensured that services met people's

needs. We saw evidence from data that fewer people died in hospital than the national average for all trusts. We also saw that a higher proportion of people had input from the Specialist Palliative Care Team than was the norm nationally.

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

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

Service planning and delivery to meet the needs of local people

- The palliative care service was widely embedded in all clinical areas of the hospital. The SPCT took referrals mostly from GPs and urgent care services and acted and responded to new referrals in a timely fashion. The SPCT saw 95% of patients within 48 hour of referral, which was much better than the England average of 56%.
- Across the trust, 98% of patients and their relatives had a discussion with a healthcare professional regarding their recognition that the patient is dying. This was better than the England average of 75%.
- The chaplaincy service was on call 24 hours a day and provided support for people regardless of whether they had a particular faith or no faith at all. For 70% of patients, an assessment of the spiritual needs of the patient and their nominated relatives or friends had taken place. The England average is 37%.
- Across the trust 25% of patients were discharged within 48 hours of the decision to discharge being made. The remaining 75% were delayed up to six days due to requiring local authority nursing home assessment or packages of care.
- The chair of the EOLC Board was a consultant surgeon who was also the Chief of Service (Core) and Director of Medical Education at the trust. This has raised the profile of EOLC across the trust and removed responsibility for good EOLC from the SPCT alone and made it the business of all staff.
- End of life care was a core component of the 'Western Sussex Hospitals Quality Strategy 2015-18'. The document showed a commitment to strategic and operational planning to meet the needs of people at the end of their lives.

Meeting people's individual needs

- Personalised care plans encouraged tailored care to individual patients at the end of life. The examples we saw were completed properly and gave an overview of people's preferences and needs.
- Across the trust we found considerable respect for the cultural, religious and spiritual preferences of patients. The chaplaincy service had 70 volunteers across both sites to help visit patients and offer Holy Communion to people who could not get to the chapel. All volunteers had a full employment check including disclosure and barring Service (DBS) to check suitability to work with vulnerable people, and undertook the trust induction programme for new staff. Holy communion was available for both Anglican and Catholic patients.
- The chapel was available every Friday to allow Muslim patients, staff and visitors a dedicated time for prayers. The local Imam came into the chapel to lead this. There was also a separate room available for Muslim prayers. This contained prayer mats and copies of the Quran. However, there was no ablution area for Muslims to wash themselves prior to prayer within the chapel. The lead chaplain told us that this was unavoidable due to the availability of space. Muslim people were either dry washing or washing prior to using the prayer room.
- On most of the ward areas we found quiet rooms were used for breaking bad news. Staff told us they were doing their best to promote privacy and dignity at all times. We saw this was effected in practice as staff were careful to close doors, speak quietly when in public areas and draw curtains around beds when providing care.
- Translation services were available 24 hours per day either through a telephone service or individual translators. There were many staff at the hospital who spoke the languages that were represented in the local communities (such as the Polish and Philippino communities) who could support patients by interpreting, when necessary.

End of life care

- The trust had introduced many initiatives as part of their work to implement 'Putting People First', the National Dementia Strategy. The Dementia Strategy supported staff to provide good care to people with dementia, many of whom were approaching the end of their life. There was a dementia lead nurse and link nurses on wards and in departments as well as specific resourcing such as a activity boxes and 'Twiddlemuffs'. Staff and families had access to specialist services and nurses trained in caring for people living with dementia and people with learning disabilities. All staff were offered 'Sage and Thyme' courses (communication skills training for dealing with patients and families in distress).
- The Quality scorecard in the board minutes dated March 2015 showed the trust beat all their own targets related to dementia care. This included 98.7% of patients identified as having dementia being referred to a specialist service against a target of 90%.
- The needs of people who required end of life care were prioritised within the hospital. At St Richard's there were generally sufficient side rooms to enable people to be cared for in a side room, where relatives could stay close by.
- St Richard's Hospital provided three rooms for relatives who needed overnight accommodation at the hospital. They comprised of a bedroom with two single beds, a communal kitchen and lounge area.
- We saw evidence of good discharge summaries with clear information for ongoing care and transfer. This meant that the specific needs of people were made known to the staff taking over their care after discharge.
- Information for people their families and carers was available. We saw leaflets and booklets explaining symptoms and treatment options. The chaplaincy and bereavement service carried an assortment of information leaflets for example 'Help when someone dies in hospital'.
- Facilities and guidance for staff on caring for people after their death according to their religious beliefs were available on the wards and in the mortuary. The staff we spoke with were aware of the content of these guidelines.

Access and flow

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

during times of increased activity in the hospital. Good contingency and business continuity plans were in place for situations where there might be a significantly increased number of deaths.

Learning from complaints and concerns

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

Are end of life care services well-led?

Outstanding ☆

End of life care services at St Richard’s Hospital were 'Outstanding' regarding being well led.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

The trust was aware of what they were doing well and areas where there were still challenges to address. We saw a flexible and adaptable service that responded effectively to national initiatives and local demand in a timely manner. It would not be possible to deliver the quality of service we observed if leadership was ineffective. We saw local and service leadership that encouraged collaborative working and sharing of ideas and information to the benefit of dying patients and their families. All the staff we spoke with were clear that they were led by people who were approachable and supportive; they could give clear examples to demonstrate this.

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

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

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

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

Vision and strategy for this service

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

Governance, risk management and quality measurement

- We saw a clear governance structure from ward and department level to the board. Ward staff were represented on the EOLC board and could also discuss issues with individuals from the SPCT. The SPCT board fed upwards and received information from both the Quality Board and the Divisional Boards. In turn these reported to the Trust Executive Committee and to the board.
- The End of Life board met monthly and took responsibility for strategic development and monitoring of EOL Care. The palliative care team took the lead on end of life care and rapid discharge home to die pathways.
- Staff were clear about incident and statistic reporting and how this was used to inform practice improvements across the trust.
- The Audit Plan 2015-2016 showed that audit of EOLC issues were planned for the service, going forward and showed pro-active rather than reactive leadership of the service.
- There were risk registers for the palliative care service and for mortuary. Not providing seven day services was identified as risk and featured on the register, along with mitigating measures that were in place. The lack of bariatric lifting equipment had not been considered a high enough risk to be added to the register but was a known concern.
- Western Sussex Hospitals NHS Foundation Trust is one of 16 member trust of NHS Quest. NHS Quest is a member convened network for Foundation Trusts who wish to focus relentlessly on improving quality and safety. NHS Quest members work together, share challenges and design innovative solutions to provide the best care possible for patients.

Leadership of service

End of life care

- We found that local leadership of the palliative care, bereavement, chaplaincy and the mortuary service to be extremely good with managerial support at all levels. We also saw good leadership for the service at divisional trust senior management level for the service.
- There was good communication between local service leadership and divisional management who acted on requests by the service to drive improvement.
- The trust scored slightly better than the England average for the percentage of staff who felt there was good communication with senior managers in the most recent NHS Staff Survey. The proportion was increased from the previous survey. Staff also reported good levels of support from their immediate managers.
- The number of staff who volunteered to attend focus groups and to meet with the inspection team was unprecedented. The feedback was almost entirely positive about trust senior and middle managers.
- The overall staff sickness rate across the trust had been consistently better than the England average for the past four years.

Culture within the service

- There was a positive culture amongst the teams providing end of life services. All staff we spoke with spoken told us they felt valued and supported as part of the team and their line managers who had an open door policy. Everywhere we went throughout the hospital we saw staff smiling either when engaging amongst themselves or with patients and visitors. One member of staff told us “If I was diagnosed with cancer or a terminal illness this is where I would want to come.” Another member of staff said “This is a great place to work, I absolutely love it here.”
- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important EOLC was and how their work impacted on the overall service. This included non clinical staff such as administrators and ancillary workers such as porters and housekeeping staff.
- The passion and dedication towards delivering good care at the end of a patient’s life was clear to see throughout our inspection. The palliative care, bereavement, chaplaincy and mortuary team dedicated a lot of hours, beyond their contractual obligations, to delivering the best service possible within their available resources.
- The staff from the palliative care team, the chaplaincy service, and the mortuary were open and transparent. They said they were happy to raise concerns and believed the management culture was open and that learning could take place. Staff told us good supportive relationships had been forged with management, all departments within the hospital and local outside agencies. This helped to facilitate inpatient and ongoing care within the community.

Public engagement

- Relatives were wholly involved in their loved ones end of life journey and were consulted every step of the way. One relative told us “I did not believe how much support I would get from the nurses. I know that when the time comes to say good bye I will have made some lifelong friends."
- Friends and family members accessed the bereavement support service via the bereavement office at the hospital. Bereavement counselling services could be accessed through the bereavement office or with outside agencies as preferred. One of the bereavement office staff told us they tell relatives “It’s the last nice thing we can do for you before you leave this hospital.” This summed up the general culture of the service.
- The trust had installed a sculpture in the reception area of the hospital 'The Gift'. This was a celebration and recognition of the gift given to patients by people who had donated organs and tissue for transplant. A service of thanksgiving for all organ and tissue donors and their families was held at Chichester Cathedral.

Staff engagement

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

End of life care

Innovation, improvement and sustainability

- There was evidence of the trust embracing EOLC for non-malignant palliative care patients and working with a range of key stakeholders to develop excellent EOLC for all.
- The trust, in discussion with the palliative care team had developed a clear vision and strategy for the sustainability of the service. This was reflected in the Quality Strategy 2015-2018 which provided details of how the strategy was to be implemented.
- One of the consultant paediatricians had developed an end of life care service to support families caring for a dying child. They were not paid for this aspect of their work and it was not part of their job description but having identified a need they provided a 24 hour a day, seven day a week telephone advice line and undertook home visits during both day and night to ensure the child had good symptom control and that the family felt supported.

Outpatients and diagnostic imaging

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

Information about the service

St Richard's Hospital, Chichester offers outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required. The hospital had medical and surgical specialty clinics, as well as paediatric or obstetric clinics. In the last year 326,556 patients attended the hospital for outpatient services.

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

During the inspection we spoke with 56 members of staff which included managers, nurses, doctors, administrative staff, allied health professionals and volunteers. We also spoke with nine patients and their relatives.

Summary of findings

Overall we found outpatients and diagnostic imaging to be 'Good'. CQC policy states we do not rate the effectiveness of outpatient services and the rating was based on the other domains inspected.

Staff contributed positively towards patient care and were proud of the services they provided. They behaved in a professional manner and treated patients with kindness, dignity and respect. Staff felt managers were approachable and kept them informed of developments within the trust.

Clinicians in outpatients had access to patients' records more than 99% of the time. The outpatient and radiology departments followed best practice guidelines and there were regular audits undertaken to monitor quality.

All areas were clean, tidy and uncluttered with good infection control practices in place.

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

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging as 'Good' for safe because;

There was a well embedded incident reporting culture amongst all staff groups. There were good systems of feedback in place and evidence of changes made as a result of reporting incidents.

The areas we visited were clean, tidy and staff on the whole demonstrated good infection control practices.

Full medical records were available more than 99% of the time and there were good systems in place to ensure referrals were processed securely.

Incidents

- Staff reported incidents using an electronic reporting system. Feedback was automatically received from this system. Outpatient staff discussed incidents at communication meetings each morning. Senior staff reviewed information about reported incidents at the governance meetings. Managers passed on any lessons learned at governance meetings back to their teams. We saw lessons learned displayed on a notice board in a staff room.
- Staff we spoke with gave us many examples of where a change had been made as a result of a reported incident. For example, a reclining chair was installed in the nuclear medicine department. This was a result of staff identifying potential manual handling difficulties as a result of a patient becoming unwell.
- In the last calendar year, the radiology department reported six incidents to the Care Quality Commission in line with Ionising Radiation (Medical Exposure) Regulations (IR (ME)R 2000). Staff dealt with the incidents in an appropriate manner and gave patients an explanation of what had happened. In addition to this, radiology staff reported a variety of incidents on a regular basis.
- Staff we spoke with described their Duty of Candour with confidence. It was part of their induction process, mandatory training and details of it appeared in the trust's newsletter, which we saw.

Cleanliness, infection control and hygiene

- All areas we visited were tidy, clean and uncluttered.
- We looked at four clinic rooms. All had daily cleaning checklists which had been routinely completed. Disposable curtains hung around examination beds. They were clean, free of dust, and labelled and dated. This is in line with the National Specification for Cleanliness in the NHS. The dates the curtains were last changed were within six months of the inspection.
- A recent environmental audit scored 85% for cleanliness, which was better than the trust's own target score.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with Health Technical Memorandum (HTM) 07-01, Control of Substance Hazardous to Health and the Health and Safety at Work Regulations 2005.
- We saw sharps bins were available in treatment areas where sharps, such as injection needles were used. This was in line with Health and Safety Regulation 2013 (The Sharps Regulation 5 (1) d). We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed and by whom. Temporary closure mechanisms were engaged.
- Sanitizing hand gel was available at the main reception to the hospital, but not in all outpatient waiting areas. There was a hand washing basin in every room we saw and guidance on World Health Organisation's 'Five steps to hand hygiene' was on soap dispensers.
- The hand hygiene audit score for the last month was 100%, which was better than the target score of 85%. We were unable to see staff hand washing between patients, as clinic room doors were shut when patients attended.
- We saw staff in clean uniforms and adhering to the trust 'Bare Below the Elbow' policy.

- Personal protective equipment was available in all areas we visited. In general we saw staff using gloves and aprons.
- Equipment was cleaned between each patient and 'I am clean' stickers were applied to indicate that it was ready for use. We saw equipment with 'I am clean' stickers on, indicating it was clean. Dental equipment was cleaned with a track and trace process. This enabled staff to see when and where it was in the decontamination processes.
- Staff told us that eye clinic rooms were deep cleaned between each patient and we saw 'I am clean' on clinic room doors to indicate they had been cleaned. In the radiology departments, staff told us if a patient with an infectious disease attended, they would book the patient at the end of the list. The cleaning team would attend immediately after to deep clean the room.

Environment and equipment

- Seating in the waiting areas and in clinic rooms departments was made of wipe clean fabric.
- Staff and patients undertook regular assessments of the clinical and waiting areas. We saw results of these assessments and action plans arising from them. This indicated all areas were being monitored for cleanliness, appearance, privacy and dignity.
- Equipment was maintained regularly with a service contract. We saw spreadsheets of equipment maintained under this contract, which was in accordance with the trust's medical devices policy. Staff told us they had no issues with equipment being broken or unavailable.
- The resuscitation trolley in outpatients had equipment for adults and children. It was a sealed unit and checked daily by two members of staff. The resuscitation trolley in radiology had daily checks and we saw checklists were complete.
- In radiology, equipment service folders were in every room. All equipment was regularly serviced. We saw an annual quality test of radiology equipment occurred each year. In addition to this a radiation protection committee reported annually on the quality of radiology equipment. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R 2000).
- Lead aprons were available in all areas of radiology for children and adults. Regular checks occurred of the effectiveness of their protection. We saw spreadsheets which showed checks occurred regularly and equipment provided adequate protection.

Medicines

- Staff stored medicines securely in the nuclear medicine department. We saw medicines stored in a locked fridge, in a room with key pad access. The keys to the fridge were stored in a separate room with key pad access. Only nuclear medicine staff had the access code to the key pad. Radioactive medicines were stored securely in a protective environment until they were no longer radioactive. We saw records of the storage and disposal of these materials.
- Drug cupboards in outpatients were locked. Only registered nursing staff held keys to the drug cupboards. This was in line with NICE guidelines MPG2.
- Medical gases were stored securely and we saw staff checked the oxygen cylinder daily to ensure it was working and gas was available when required.
- Some medicines need to be stored within a limited temperature range. They should be stored in a dedicated fridge. Regular temperature checks should occur to ensure the limited temperature range is maintained. However, a separate drug fridge was not available in the phlebotomy department. Staff stored drugs in a fridge, but the temperature was not checked. In addition to this food and milk was stored in this fridge.

Records

- At St Richard's Hospital the medical records department had on average 26,501 requests each month. The department consistently made more than 99% of records available each month for a 12 month period.
- Medical records could be obtained at short notice by tracking them around the hospital. Porters delivered records to clinics the night before for morning clinics and were securely stored in a locked room overnight. Records would be delivered by lunchtime for afternoon clinics. At the end of clinics, staff put records into a plastic box, which was sealed and returned to medical records.

Outpatients and diagnostic imaging

Safeguarding

- In the sexual health clinics, staff demonstrated excellent safeguarding knowledge and practice. A clinic was established especially for young people with safeguarding concerns and a specialist clinic was established to deal with victims of exploitation.
- All staff we spoke to in outpatients demonstrated a good awareness of what to do if they had safeguarding concerns. We saw that over the past year staff had raised six adult safeguarding alerts. They could explain what to do if they had concerns and who to contact.
- Clinical and administrative staff received safeguarding training. Staff had adult appropriate safeguarding training annually, some to level two and some to level three according to their role. 100% of staff had attended children's safeguarding training in the past year. 94% of staff had attended vulnerable adult training in the past year.
- Diagnostic imaging staff told us they had level one safeguarding children's training. Children attended the department. This was not in line with in the Safeguarding Vulnerable Groups Act 2010 or the Royal College of Paediatrics' Child Health Guidance, 2010 which recommends staff interacting with children to attend level three safeguarding training.

Mandatory training

- Nursing staff told us they could access mandatory training and were supported to do so. We received data which indicated 92% of outpatient staff had attended mandatory training in the last year. This was better than the trust's target score of 90%.
- Radiology staff had attended mandatory training regularly. 91.5% had attended mandatory training in the past year. This was better than the trust's target score of 90%.

Assessing and responding to patient risk

- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas we visited and signed by all members of staff. Radiology staff had a clear understanding of protocols and policies. Protocols and policies were stored in coloured folders in each room.
- We observed good radiation compliance as per policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. We saw radiographers referring to the IR (ME) R regulations for a patient's examination. A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with Ionising Regulations 1999 and IR (ME) R 2000 Regulations.
- The booking centre booked all outpatient appointments. They had good processes and practices in place to ensure patients could not be lost in the system. Paper referrals received into the hub were scanned onto a computer system, then filed. The referral was entered onto the administrative system the same day. The computer system automatically sent a letter to patients informing them their referral had been received. Staff at the booking centre checked referrals daily and gave appointments accordingly. We saw staff checking through the referrals and copies of letters sent to patients.
- The recent introduction of daily safety huddles in each area was welcomed by all staff we spoke with. In diagnostic imaging they were supplemented staff with weekly emails.
- We saw records for the correct and timely disposal of radioactive waste in the nuclear medicine department.
- All rooms in the phlebotomy department had emergency call bells to summon help if an emergency arose.

Staffing

- At least one trained and one untrained nurse staffed the outpatient department during clinic opening times. Staff told us department did not use agency staff. We saw records that confirmed no agency staff were used. The department used their own staff as bank if they needed additional staff. We saw data which indicated that the appropriate number of nursing staff were available for the outpatient departments for through May, June, July and August 2015.
- Radiologists were available between 9am to 11am in the morning and 1pm to 3pm in the afternoon to discuss

patients and their results with junior doctors. A radiologist was available through the day, every day, to provide reports. In addition to this, a radiologist was available every day until 9pm in the evening.

- In some areas, staff told us an electronic recruitment system had helped to speed up the recruitment process. New staff could be recruited in a timely manner. In other areas staff told us their were significant delays with recruitment and posts were not advertised until a month after the post had been vacated.

Major incident awareness and training

- Staff could describe what their role would be in the event of major incident. This was in line with trust policy. They showed us where they could access information on what to do. Staff told us they had practised for emergencies.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

CQC policy states the effectiveness of the outpatients service is inspected but not rated.

There was evidence of good team working in clinics, within the diagnostic imaging department and across the specialities.

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

Evidence-based care and treatment

- We saw a variety of audits were undertaken on a regular basis in outpatients and radiology. They included checking the quality of external reporting for chest x-rays, assessments of clinical areas and the quality of scans in nuclear medicine amongst others.
- In foot care clinics, consultants triaged referrals daily, same day access was available for diabetic patients with foot problems and foot specialists were also available. This was in line with the National Institute of Health and Care Excellence Guideline (NG 19).

Patient outcomes

- One audit demonstrated that 98% of all patients who had a cardiac catheterisation had a good quality scan, which was better than the benchmark of 70%.

Pain relief

- If a patient required pain relief in outpatients or radiology, a senior nurse could be contacted to administer it. If further pain relief was required, a patient would be given a prescription which they could take to the pharmacy department within the hospital.

Competent staff

- Staff told us that additional staff were available during the induction process so that sufficient time was allocated to get to know the area they were working in. Staff were moved through different clinical areas regularly to maintain their competency in a variety of skills. There was a system for assessing the competency of staff in several skills. We saw completed competencies for phlebotomy staff. In addition to maintaining their own competency, phlebotomy staff provided training in phlebotomy techniques to nursing home staff, GP practises, junior doctors and students.
- In radiology there were several stages to gaining competencies in different skills. Competency certificates were kept in individual staff folders. We saw folders with completed competencies in.
- In radiology, in compliance with IR (ME) R regulations, certificates were held for those staff in the hospital who were able to refer patients for diagnostic imaging tests. We saw copies of these. This gave assurance that only those qualified to request a diagnostic examination were able to do so.
- We saw that all employed radiology staff were registered with the Health Care Professions Council (HCPC). Managers checked the registration of their staff regularly. Radiology staff who administered medicines were required to be certified to do so and we saw certificates for those staff which were in date.

- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the nursing and midwifery council (NMC).

Multidisciplinary working

- Staff told us they felt well supported by other staff groups. Learning was shared between different staff groups at regular teaching sessions. Staff from several different staff groups told us they attended and benefitted from this training.
- One stop clinics involved several different staff groups working together and occurred in breast, urology, gynaecology, and dermatology specialities.
- Staff told us there was good communication between staff in the booking centre and care group managers, who could be contacted via phone or email if queries arose. We saw evidence of email communications between staff members.

Seven-day services

- Radiology consultants worked seven days a week. The diagnostic imaging department provided a seven day a week on call service.
- Some clinics ran at the weekends but most outpatient clinics were provided Monday to Friday.

Access to information

- Staff told us they had good access to medical records. We saw data which confirmed this.
- Radiology examinations were available on a secure computer system. Staff had individual pass codes to log on to the system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with told us their consent had been given prior to examination or treatment and they received clear information about the care they were to receive. We saw examples of completed and signed consent forms.
- Staff were able to describe the process of dealing with a patient who may not have the capacity to consent to treatment. They knew the named person to contact if they needed any extra assistance or advice. We saw laminated cards which clearly detailed this process.
- Mental Capacity Act 2005 training was included in mandatory training. 94% of outpatient staff had attended this training.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as 'Good' because;

Staff treated patients with kindness, respect and maintained their privacy and dignity. We found there were processes in place to respond to patients' emotional needs.

Compassionate care

- In the most recent Friends and Family Test (October 2015), 90% of patients would recommend the outpatients department, which is broadly in line with the national average of 92%. A patient satisfaction survey completed at the hospital between April and October 2015 scored 94%.
- The diagnostic imaging team carried out a patient satisfaction survey in June 2015. 95% of patients felt the staff were friendly and reassuring. 94 % of patients felt their privacy and dignity was maintained and 92% felt their exam was fully explained.
- We observed staff dealing with patients in a kind and courteous manner.
- Patients we spoke with felt they had been treated with dignity and respect. They told us staff were always friendly and professional.
- In outpatients, there were individual clinic rooms, with signs on doors to provide privacy for patients. Staff respected these signs and we saw them knock and wait.

Outpatients and diagnostic imaging

- In some areas consultants told us they always had staff in attendance who could chaperone, in line with trust policy. However, not all clinics had a chaperone immediately available but would ensure one was present should a request be made.
- In the CT waiting area we saw male and female patients sitting together. There were no separate waiting areas and some patients had already changed into hospital gowns.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they had good access to information on the hospital website and had received information about how to prepare for their appointment. However, several patients told us they were not told how long they should expect to be at the hospital for. We saw information leaflets for different clinics that booking staff sent to patients with their appointment letter. They stated that the appointments would take longer than a usual appointment and one asked patients to keep their whole afternoon free.

Emotional support

- Macmillan nurses were available to provide support in the breast care clinics. Other areas had quiet rooms for patients to be able to spend time with their families. Oncology nurses were always available in urology clinics, if patients required extra emotional support.
- Staff told us they had good support networks within their teams if they needed emotional support.
- Patients in the bariatric clinic had an assessment by a psychologist for their suitability prior to surgery.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as 'Requires improvement' because;

The trust had consistently not met the referral to treatment time standard or England average for the past two years. The time to grade referrals as to their priority varied between specialities and could take as long as 44 days, increasing the time from referral to treatment.

The hospital cancelled 14% of outpatient appointments in the last year, 4% of those were with less than six weeks notice.

In histopathology the length of time it took to provide a result for some tests had worsened in the past months with only 51% of results being available within five days.

However, the trust was consistently meeting its cancer waiting times and the diagnostic imaging department was providing access to tests and results in a timely manner.

The hospital provided one stop clinics for several specialities which reduced the number of appointments a patient needed. Clinics ran in the evenings and at weekends to cope with demand and respond to the needs of patients.

Service planning and delivery to meet the needs of local people

- In response to patient feedback, some clinics operated out of office hours. 1,727 clinics had taken place at weekends over the past year. In addition to this 1,837 clinics ran after 5pm on weekdays.
- In radiology there was a walk in service for patients referred from their GP who needed a chest x-ray. This service also ran for patients referred from their GP where a broken bone was suspected. This meant patients could attend the department at a time suitable for them. The department had a number of radiographers qualified to report on x-rays.
- The hospital provided a one stop clinic for urology patients. Patients could have their consultant appointment and investigation and procedures in one place. Patients received their results immediately after the procedure. This had reduced patient attendances by three to four visits.
- Patients we spoke with liked the efficiency of one stop breast clinics. It enabled them to access examinations, diagnostic tests and a variety of health professionals at one appointment. It prevented several individual appointments.
- The phlebotomy department provided blood tests to outpatients. They operated a service for outpatients from 8am to 4:45pm and to the wards from 7am to 11am.

Outpatients and diagnostic imaging

- Outreach teams were available in the sexual health clinics and a 'pop up' clinic was being moved to a site more convenient for patients.
- In the ophthalmology department staff noted an increase in patients attending the department with age related macular degeneration (AMD). In response to this, the department worked with a specialist eye hospital to train more staff to treat this condition.

Access and flow

- Non-admitted pathways are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital. Operational standards are that 95 %of non-admitted pathways should start consultant led treatment within 18 weeks of referral. The non admitted referral to treatment times (RTT) for this hospital from December 2013 was consistently worse than the England average and the standard of 95%.
- Since March 2015 the non admitted referral to treatment times for children's services were below the standard of 95%. There was a decline in compliance and in October 2015 was at 70%.
- In the last year 14% of all patient appointments were cancelled by the hospital and 4% of these were cancelled with less than six weeks notice. Staff told us that if a clinic was cancelled at short notice an incident form was completed. Some staff told us clinics could be cancelled as frequently as once a week. This meant they would have to call all patients on the cancelled clinic list. On some occasions staff told us clinics could be cancelled after patients had started to arrive. We saw a patient had commented on this on a recent patient satisfaction survey. They said, "(I) Waited 35mins to be told the doctor hadn't arrived."
- We saw in a 26 week period, a total of 21 fracture clinics had been cancelled. Some staff told us the reception teams cancelled clinics and in this case, waiting patients could overhear this being done. During our inspection we saw one clinic had been cancelled due to lack of staff.
- Over the past calendar year the trust set up 804 extra clinics with less than two weeks notice in order to deal with the waiting lists.
- Over a 12 month period the trust performed mainly above the England average of 95% and above the standard of 93% for two week urgent GP referrals. 99% of patients waited less than 31 days from referral to first treatment. This was above the England average of around 98% and standard of 96%. 94% of patients waited less than 62 days for their first treatment for cancer. This was above the England standard of 85% and England average of 84%.
- The booking centre staff scanned all referrals the same day they came into the department. All cancer referrals received a specific code in order to identify them quickly on the computer system, which we saw in action. The waiting list team dealt with these referrals as a priority and they showed us the process in detail. Cancer patients were offered an appointment straight away.
- All other referrals were taken daily to the different speciality teams to be graded into different levels of priority. When this had been done, the referrals were returned to the booking centre so that appointments could be offered. The target time for the referrals to be graded was five working days. The length of time it took to grade referrals was checked at random.
- In April 2015, across all specialities, the target time was only met 30% of the time. The longest time it took to grade referrals was 44 days. In May, across all specialities, the target time was achieved 14% of the time.. The longest time it took to grade referrals was 23 days. This indicated the five day target time to grade referrals was not being met and impacted on the time from referral to treatment. There was a considerable variation in the time it took different specialities to grade.
- Over a six month period from May to October 2015 the histopathology department on average provided results for 85% of all specimens within seven days. On average 87% of bowel screening results were available in seven days. For specimens where a piece of tissue had been removed to provide a diagnosis 70% of the results were available within seven days on average. Over a six month period (May to October 2015) the amount of time taken to provide a result within seven days had reduced from 84% to 51%. The number of specimens dealt with during this period had increased from 601 in May to 1,613 in October.

Outpatients and diagnostic imaging

- However, we found that patients received x-rays and scans in a timely manner and these were reported promptly. There was no waiting time for an x-ray. 65% of all x-rays of inpatients or from the emergency department were reported on in five days or less. 67% of x-rays of patients referred from GP's were reported on in five days or less. On average 95% of outpatient x-rays received a report within 13 days.
- At the time of inspection the waiting time for a CT scan was four weeks. 96% of scans for emergency department and inpatients were reported on the same day. The remaining 4% were reported on in a day or less. On average routine scans were reported on in seven days.
- During our inspection, the waiting time for MRI scans was five weeks. 94% of scans for patients in the hospital or emergency department were reported on in less than a day. On average 95% of routine scans were reported in 12 days.
- The waiting time for an ultrasound scan was five weeks. 99% of patients in the hospital or emergency department had their scan reported on in one day or less. 93% of routine outpatient scans were reported on in five days or less. On average 95% of scans were reported on in 10 days.
- Some urology patients had to go to another hospital for a specialised scan, which resulted in their treatment being delayed.
- In the nuclear medicine department the waiting time was three weeks for the scan and four weeks for the report. Which meant patients had a result of their investigation in a timely manner. The department ran to time for its appointments. Occasionally a patient waited longer than six weeks for a scan. This was due to a planned wait where a patient had to reduce or stop their medication prior to the scan taking place.
- Waiting times for patients in clinics was monitored. 89% of patients were seen within half an hour of their appointment time, 97% were seen within an hour and 3% waited more than one hour. Where there were likely to be longer waits, patients could use a pager to be called when it was their turn and were then free to leave the department.

Meeting people's individual needs

- Staff told us patients with dementia or learning disabilities were identified on arrival to reception. These patients were sent as a matter of priority. We saw dementia friendly signs in areas patients would visit. These signs were pictures rather than words. There was a contact person available if staff identified a patient may have difficulty understanding or consenting to treatment.
- We found there were arrangements to meet the needs of children and young people. Staff in the plaster room told us children were fast tracked through fracture clinics and into the plaster room. We saw the children's waiting area were well equipped with washable toys. Families could access pagers so they could take their children out of the waiting area if they chose to. Baby changing areas were available. There was a diabetic clinic available that had been set up for young people only.
- Patients we spoke with told us they had the opportunity to change their appointment to a time that suited them better.
- In waiting areas seats of differing heights were available. However, very few patient information leaflets were available in the waiting areas we visited.
- Staff had access to lunchboxes for patients who had been delayed, either in clinic or by transport. Some waiting areas had free drinks for patients.
- Patients attending the diagnostic imaging departments had access to pagers. This allowed them to leave the department if they wished. They could be contacted when it was their turn.
- Staff told us patient leaflets were not available in other languages in outpatients, but they could be accessed in radiology. If required, a translation service was available on the phone via dedicated line.
- There was no hearing loop in outpatients, and staff told us they could access sign language interpreters if required.
- The weighing scales in the outpatient departments were not suitable for bariatric patients, so they could not be weighed in the department.
- In addition to the MRI scanner within the hospital, there was an additional mobile scanner located within the

hospital grounds. The mobile scanner could not accommodate wheelchairs or trolleys. The manager sent less complex and more mobile patients to the van, so this potential problem was managed. Patients cared for on trolleys and in wheelchairs had their MRI scan in the main department which was more accessible.

Learning from complaints and concerns

- Leaflets informing patients how to make complaints were available in waiting areas. Staff felt able to handle complaints and preferred to do so at a local level to diffuse the situation.
- Staff told us they received feedback about complaints via the computer system and their managers. No changes had been made to service delivery as a consequence of learning from complaints.
- The most common cause for complaint about the outpatient department in the last calendar year was communication. There were 44 complaints made about the outpatient department to the hospital during that period. Overall, 10% of complaints made to the trust were in relation to outpatients.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as 'Good' because;

Staff engagement was good across all staff levels and there was a positive culture of team working.

Staff felt involved in decision making and were aware of developments throughout the trust. The senior management team were approachable to staff at all levels.

Vision and strategy for this service

- Staff had good awareness and knowledge of the vision for the hospital. There was a real sense everyone was working together for the same aim. Staff spoke proudly about their achievements and working at the hospital. In addition to this, they were driven in delivering further improvements to their service.
- In outpatients, managers had worked with an external company to identify areas of improvement. An action plan, which we saw, had been developed to deliver these suggested improvements.

Governance, risk management and quality measurement

- Clinical staff oversaw the management of referrals to outpatients and radiology, both urgent and non-urgent. There were many failsafes in place to ensure that patients did not get lost in the system. The booking centre staff alerted care group managers if issues arose. Booking centre staff worked with care group managers to assess and deliver outpatient services.
- The diagnostic imaging department was following policies and procedures in accordance with IR (ME) R regulations. This was overseen by a radiation protection committee and advisor. There were twice monthly clinical governance meetings within this department where risks complaints, incidents were discussed.
- A divisional clinical governance review meeting occurred every three months. Minutes from these meetings were available for inspection and we noted that all risks, incidents and complaints were discussed. We saw action plans arising from these meetings.
- Meetings to discuss and manage the referral to treatment times for medical and surgical divisions occurred every week. They involved clinical oversight of long waiting patients, which included an action plan for each patient. This mitigated risk to long waiting patients. We saw minutes of these meetings and action points arising from these.
- There were a variety of audits ongoing in the outpatients and diagnostic imaging departments. In addition to patient satisfaction surveys. Managers and clinicians continually measured the quality of reporting, the environment and we saw action plans that arose from these. An example of this was the rearranging the seating area of a waiting room in response to patient feedback.

Leadership of service

- Staff felt their managers were approachable and they could discuss any issues with them. They were aware of

who the senior managers were and the on-going changes in the hospital. The senior management team were visible to staff on the floor and were contactable if issues arose.

- One member of staff had been offered, and gained a place on the Florence Nightingale Leadership Programme. In addition to this the trust was developing a clinical leadership programme.
- Staff felt a redesign of pathology services had been poorly managed in the initial stages. Staff were concerned about job security. However, lessons had been learned and staff were reassured that no job was under threat. The redesign had meant that roles would be used to support training and service development. Staff now worked across the different trust sites to ensure continuity and timely reporting.

Culture within the service

- Throughout all areas we visited there was a very positive culture of team working amongst all staff groups. There was an overwhelming pride in the work they did and a can do attitude.
- Staff of all levels had an appreciation for what other staff members did within and between teams.
- Staff we spoke with felt valued within their teams and as part of the trust.
- The diabetic team told us they were 'one team delivering one service' across all sites. This showed staff worked together with common values and with standard approaches to treatment of these patients.
- We noted staff within outpatients and diagnostic imaging were proud of the team dynamics and the willingness to change and develop their service, to meet changing needs.
- Supportive working relationships were evident in areas we visited.

Staff engagement

- Staff felt they were able to raise any concerns or ideas with managers. They told us staff conferences were a valuable source of seeing what was going on elsewhere in the trust. All staff we spoke with felt the chief executive was visible within the trust, had an open door policy and was approachable. Some staff felt that although the Chief Executive hadn't visited their service or department, they felt informed by the regular newsletters.
- The introduction of ambassador roles enabled some staff groups to have a greater involvement with other teams and staff groups, where prior to this they had felt isolated from other teams.
- Staff told us they felt that appraisals were a useful process and development was positively encouraged.
- Some staff told us they did not always feel valued for the work they did and others had no rest areas available to them.

Innovation, improvement and sustainability

- Staff in the eye department had worked towards a paperless system. This was to come into effect when the new department at Southlands hospital was opened.
- A consultant in the urology department had raised considerable funds to provide a service which would reduce the time between diagnosis and treatment.

Outstanding practice and areas for improvement

Outstanding practice

- The positive attitude of outpatient and diagnostic imaging staff was an outstanding feature of this hospital. The outpatient nursing staff knowledge of vulnerable adult and safeguarding children and how they should proceed if concerns arose and compliance with training in this area. The management of medical records meant that more than 99% of full records were available to staff in clinics.
- The level of 'buy in' from all staff of the trust vision and value base was exceptional. We were flooded with requests from staff wanting to tell us about specific pieces of work they were doing, how much they liked working for the trust and how supportive the trust executive team were of innovative ideas and further learning as a tool for improvements in patient care. The trust ambassadors worked to promote the positive work that the trust was doing to other staff and visitors.
- Multidisciplinary working was a very strong feature across the hospital that resulted in better patient care and outcomes. There was clear professional respect between all levels and disciplines of staff. We saw real warmth amongst teams and an open and trusting culture. Exceptional examples of this included how 'Harvey's Gang' was growing and developing as more staff became involved a local initiatives such as the joint working 'Five to Thrive' protect and Family Nurse Partnership which improved outcomes for the children of young and vulnerable parents.
- The trust had won a Dr Foster Better, Safer Care at Weekends award.
- The level of feedback from patients and their families was exceptional. We received many letters and emails before, during and after the inspection visit. It was overwhelmingly and almost exclusively positive. Amongst the hundreds of people who contacted us to say how good the hospital was were just a few who felt unhappy with the care they had received.
- We were contacted by many of consultants working at the hospital, from across all specialities who wanted to tell us about how good it was to work at the trust. They wanted to tell us the executive team were approachable and supportive, that their ideas were listened to and that they felt the trust provided very good care to most people.
- In ED the focus on access and flow, coupled with the work being done with local stakeholders such as GP's and the CCG's had resulted in a department that was mostly able to meet the key performance targets. People were seen quickly and were not kept in the department overly long.
- The attention and consideration of peoples individual needs and genuinely patient centred care was evidenced across the hospital. The work of the learning disabilities nurse specialists, the neonatal outreach nurses and the SPCT were all notable. In the critical unit the staff remained focussed on the person and not the technology with people being pushed out of the unit in a wheelchair, if they were well enough, to help them maintain a sense of normality. Staff encouraged fathers to stay overnight on the postnatal ward to provide support to their partner and to begin the bonding process with their baby.
- The trust wide learning from incidents and complaints was well embedded. In all areas of the hospital, staff could give us example of where improvements had been made as a result of complaints, comments or incidents.
- The executive team provided exceptional leadership and had a very good understanding of how the hospital was working in both the longer term (through a sound assurance framework) and on a day to day basis (through a regular ward and department presence and open door sessions). There was clear team work amongst the executive team and their positive leadership style filtered down through middle managers to local managers.

Outstanding practice and areas for improvement

- The Medicines Division was involved in a trust wide NHS Quest initiative which focused on improving quality and safety. This involved the trust taking part in collaborative improvement projects for Sepsis and cardiac arrest. Work was in progress on these initiatives at the time of our inspection.
- The 'Knowing Me' initiative along with the other initiatives to improve hospital experiences for people with dementia.
- The involvement of a learning disabilities nurse for patients admitted who had a learning disability improved the outcome and experiences for this group of patients.
- The level of staff engagement and involvement in service planning was exceptional, with the trust ambassadors giving a very clear message about staff 'buy in' and belief in the work they were doing.
- The very strong governance systems allowed the trust to focus on safety and improved patient outcomes at all levels. Local managers could see how the wards and departments in their control were performing. The board involvement allowed proper assurance through involvement in governance meetings.
- The trust executive had a very sound understanding of their hospitals. They did not need to look up how areas were performing as they were very aware of the areas of strengths and weaknesses.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital SHOULD take to improve

The hospital should ensure all staff mandatory training is up to date.

The hospital should ensure the numbers of chemotherapy trained nursing staff on duty reflect the established number required at all times.

The Medicine Division should recruit consultants to ensure an adequate level of medical expertise which reflects the England average.

The hospital should ensure all staff receive an annual appraisal to ensure their continuous professional development needs are met.

The hospital should ensure there is an adequate supply of pressure relieving equipment for patients on all wards.

The hospital should ensure continuity on recording of medicines fridge temperatures on all wards, and that emergency medicines are checked in accordance with their own policy, to ensure they are always available for ready use in an emergency.

The hospital should review the levels of medical and nursing staff on each shift in critical care, in line with established national guidelines. The hospital should also consider the working practices of existing senior physicians during the pilot phase of a telemedicine model of care.

The hospital should review the security and storage of hazardous waste and chemicals on the critical care unit.

The trust should ensure grading of referrals occurs within acceptable timescales.

The trust should ensure RTT is met in accordance with national standards.

The trust should ensure staff who work in the diagnostic imaging department and who provide care to children have the appropriate level of safeguarding training.

The trust should ensure drugs in the OPD that require refrigeration are stored in a temperature checked fridge. This should be used for the sole purpose of storing drugs.

The trust should review the availability of supervisors of midwives.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (f) The hospital must ensure that there are sufficient quantities of pressure relieving equipment to ensure the safety of service users and to meet their needs;

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (g) The hospital must ensure the proper and safe management of medicines by ensuring medicine fridge records are up to date and daily checks on emergency medicines.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...